Episode 3.2 Show Notes
Community Geriatrics

Presented by: Dr Jo Preston & Dr Iain Wilkinson

Faculty: Dr Amy Heskett, Alison - Community nurse SGH

Broadcast Date: 9th May 2017

Learning Outcomes

Knowledge:

- To understand different types of hospital at home services and how they work
- To recall the factors which may influence adverse outcomes in either hospital or home environments, e.g. delirium, hydration.

Skills:

- To recognise when someone can be treated at home Vs admission to hospital.
- To balance the risks of home treatment and hospital admission, as a professional working in either environment.

Attitudes:

- To consider whether the person in front of you can be managed at home.
- To be person centred in decisions regarding home treatment

Social Media Spots this week

National Osteoporosis Guideline Group new guidelines are out and are here. NEW NOGG guidelines

Wenurses - tweeting for revalidation

Emergency medicine cases podcast- really good episode on UTIs

Definitions:

Rather than a specific definition it may be better to think about aims of the services (see below). Some terms you may hear about are:

- Hospital at Home: community- based provision of services usually associated with acute inpatient care.
  Defining and disseminating the hospital-at-home model, Leff, CMAJ 2009
- Intermediate Care: Intermediate care services are provided to patients, usually older people, after leaving hospital or when they are at risk of being sent to hospital. The services offer a link between places such as hospitals and people's homes, and between different areas of the health and social care system – community services, hospitals, GPs and social care.
  National Audit of Intermediate Care 2014
- Case Management: a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality cost-effective outcomes (Case Management Society of America 2010).

Practical Definition:

All of these services aim to provide management outside of hospital where possible and safe to do so. The scope of what the provide can be quite wide though from: a full hospital at home service with intravenous antibiotics etc. to services more focused on other aspects including advance care planning. They all though avoid paternalism and the risks associated with hospital admission.

Review of literature

For any service to be effective it needs to be multidisciplinary and responsive.

- Occupational therapy is an example of a key profession to integrating the health and social care services needed to enable people to achieve their wellbeing outcomes (*Reducing Pressures on hospitals - report by College of Occupational Therapy*)

Who is at risk of admission to hospital (and hence who may have the most to gain from community interface services?

- Those under 5 years old or over 85.
- Those from socio-economically deprived areas (up to 90% more likely to have unplanned admission in GP practices in most vs least deprived areas.

- People with high levels of morbidity and chronic illnesses (independently)

Avoiding hospital admissions. What does the research say? Purdy 2010, Kings Fund publication

There is increasing recognition of the interdependence between hospital and community-based health and social care services, particularly for those who are frail and/or suffer from long-term conditions.

- 50 - 60 per cent of medical inpatient beds are occupied by patients who could be cared for in an alternative setting and a significant proportion of these are older adults with frailty and / or long term conditions.
- There is evidence that proactive care and supported rehabilitation and discharge could reduce length of stay and deliver better patient experience.
- The key to reducing the use of acute beds lies in changing ways of working across a system, including changes within hospitals, rather than piecemeal initiatives.

Table 2 Summary of evidence on the impact of community-based initiatives on unplanned admissions

Intervention	Impact on unplanned admissions	Disease area/client group	Evidence source
Case management	Reduces	Heart failure and some older frail people	(Purdy *et al* 2012) (Purdy 2010)
Care co-ordination as part of integrated health and social care teams	Reduces	Older frail people	(Philp *et al* 2013)
Specialist clinics	Reduces	Heart failure	(Purdy *et al* 2012)
Education and self-management	Reduces	Adults with asthma and COPD	(Purdy *et al* 2012) (Purdy 2010)
Exercise and rehabilitation	Reduces	COPD and cardiac	(Philp *et al* 2013) (Purdy *et al* 2012)
'Virtual integration'	No significant reduction	Diabetes +/or over 75	(Curry *et al* 2013)
Virtual wards	No impact	High risk	(Bardsley *et al* 2013)
Vaccine programmes	No impact	Asthma, COPD, older people	(Purdy *et al* 2012)
Medication reviews	No impact	Older people, people with heart failure or asthma	(Philp *et al* 2013) (Purdy *et al* 2012)
Falls prevention	No impact	Older frail people	(Philp *et al* 2013)
Integrated care pilots	Increases emergency admissions Decreases elective admissions	Varied	(Roland *et al* 2012)
Hospital at Home	Increases	Older patients with a range of conditions	(Purdy *et al* 2012)

Table from [Reconfiguration of clinical services - Kings Fund 2014]

Using hospital admissions and / or financial endpoints in evaluations as they do not show the whole picture.

Even with successful implementation, there is little evidence to suggest that more community-based models of care will generate significant savings. Future workforce projections also present challenges to community-based models of care.

Sheppard et al have reviewed the evidence for hospital at home services. There are a small number of studies which give weak evidence and a short follow up time. The same authors are currently recruiting to a large trial on hospital at home services.

Cochrane Review

Evidence for quality

- There is strong patient satisfaction associated with virtual ward programmes and case management programmes
- Available evidence points to a positive impact of integrated care programmes on the quality of patient care and improved health or patient satisfaction outcomes.
- Evidence from a randomised controlled trial indicated that patients were more satisfied with 'hospital at home' than with inpatient care because it was possible to provide a more personal style of care and staying at home was considered to be more therapeutic.

Reconfiguration of clinical services - Kings Fund 2014

We then talked through a case example with Dr Amy Heskett (Community geriatrician - Kent, UK) and Alison (OPALS nurse St George's Hospital, Tooting, London) with a focus on practical considerations regarding looking after an older person in their own home.

Curriculum Mapping:

This episode covers the following areas (n.b not all areas are covered in detail in this single episode):

Curriculum	Area	
NHS Knowledge Skills Framework	Suitable to support staff at the following levels: ● Personal and People Development: Levels 1-3 ● Service Improvement: Level 1 - 2	
Foundation curriculum (2016)	**Section**	**Title**
	1.2	Delivers patient centred care and maintains trust
	1.4	Keeps practice up to date through learning and teaching
	2.7	Works effectively as a team member
	3.9	Recognises, assesses and initiates management of the acutely ill patient
	3.10	Management of long term conditions in the acutely unwell patient
Core Medical Training	Confusion, Acute / Delirium Personal behaviour (Be able to provide specialist support to hospital and community based services) Management of long term conditions and promoting self-care	

	Management and NHS structure (Describes in outline the roles of primary care, including general practice, public health,community, mental health, secondary and tertiary care services within healthcare) Geriatric Medicine
GPVTS program	Section 2.03 The GP in the Wider Professional Environment ● Core Competence: Managing medical complexity Section 3.05 - Managing older adults ● Core Competence: Managing medical complexity ● Core Competence: Working with colleagues and in teams ● Core Competence: Practising holistically and promoting health
ANP (Draws from KSF)	Section 6 Section 7.1 Section 10 Section 11

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