How to set up an Acute Geriatrics service

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Geriatrics is for freaks who live with their mothers and never have sex.
• The evidence base
• What can/should a service look like and why?
• What I’ve done
• Future direction
"We’re launching a campaign to get people to take up smoking again!"
The Evidence ..... 

- **Cochrane review 2011**
- Comprehensive geriatric assessment for older adults admitted to hospital

- Patients in receipt of CGA were more likely to be alive and in their own homes at up to six months and at the end of scheduled follow when compared to general medical care. In addition, patients were less likely to be institutionalised, less likely to suffer death or deterioration and more likely to experience improved cognition.
• *Age and Ageing* 36(6):670-675

• The older persons' assessment and liaison team ‘OPAL’: evaluation of comprehensive geriatric assessment in acute medical inpatients
  – Harari D, Martin FC et al

• Management of falls, delirium, chronic pain, constipation, and urinary incontinence improved. Over twice as many patients were transferred to geriatric wards, with mean days from admission to transfer falling from 10 to 3. Mean LOS fell by 4 days post-OPAL.
Service aims and objectives

• To provide an early, tailored, comprehensive geriatric assessment
• To reduce unnecessary hospital admissions
• To reduce the length of stay of those who need admission
• To prevent complications associated with hospitalisation

To improve the quality of care delivered with a side effect of saving money?
Which patients

- Age or needs defined service?
- The ‘frail’?
- Single organ issues?
- ‘Social’ admissions?
- Likely discharges only?
Possible methods of identification

- Hospital informatics
- Notes review and nursing handover
- Real-time monitoring
- Checklists e.g. FRAILsafe
Conflicting priorities?

- Priorities could be guided by whoever is holding the pursestrings?

  - Clinician
    - To provide the best clinical care for the patient

  - Commissioner
    - To have less people admitted to acute hospital

  - Acute Trust
    - To have a shorter length of stay and less complications

- A well run, properly funded acute geriatrics service could be a win – win situation?
What did I start with?

- No formal, regular geriatrician input
- REACT
- Internal and external resistance
- No money
Where are we now?

- 2 consultant geriatricians (1.25 WTE)
- 1 SpR geriatrics
- Specialist nurses (band 6 & band 7)
- Band 7 OT
- Band 6 physio
- Cover 8-6, Monday - Friday
Where are we going?

- 4 consultants
- ?another junior doctor
- ?acute medicine SpRs able to join us if interested
- Changes to the support rota
- Band 3 posts
- 12 hours per day, 7 days per week
The Future

- Will anyone listen to Francis’ findings?
- Impact of OOH, NHS privatisation and CCGs
- More data
- Changes to training resulting in improved skills in geriatric basics for all

- All ‘front-door’ services should have acute geriatrics embedded within them
Thankyou

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