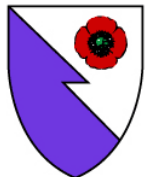


“Frailty – working together, now and in the future”

Dr Matt Thomas

Consultant Geriatrician – Poole and
Bournemouth Hospitals

Acute Frailty Network



Royal College
of Nursing



Royal College
of Physicians



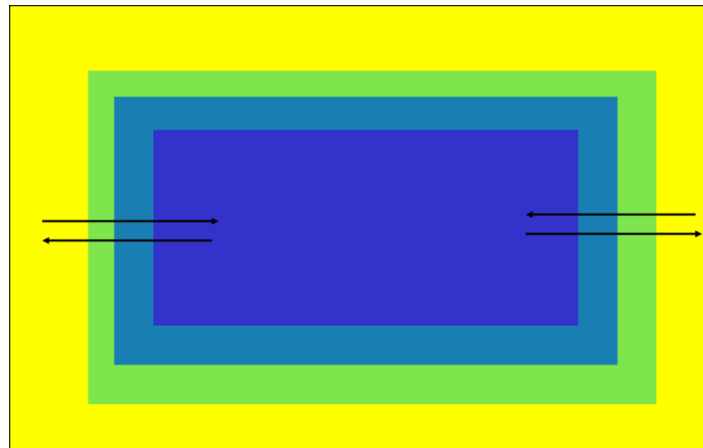
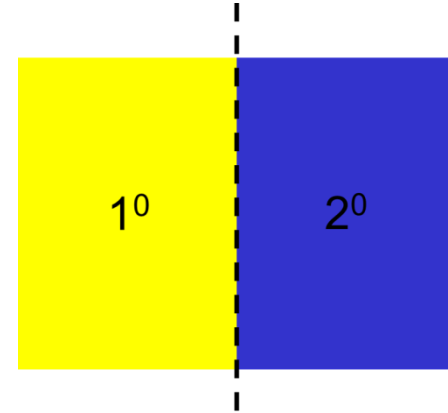
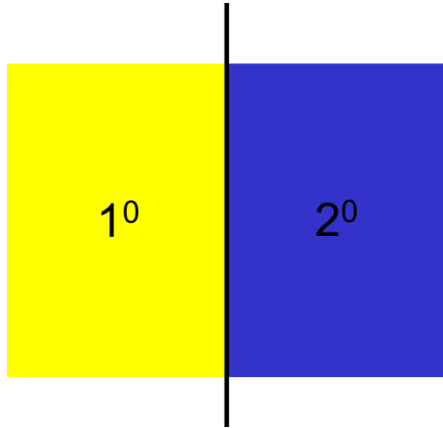
- Summary

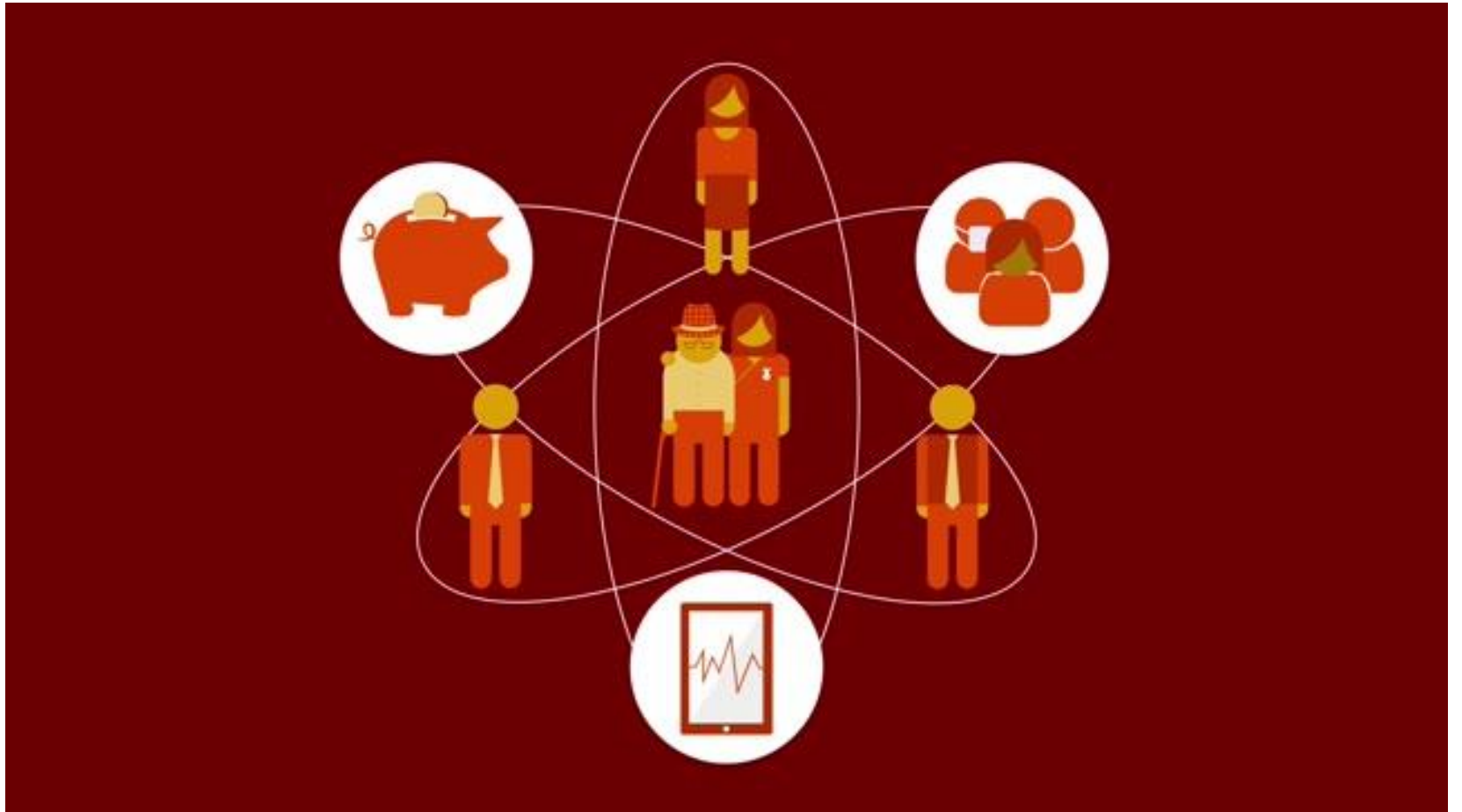
- Geriatric Liaison has been an integral part of some disciplines for some time with proven benefits
- Other areas are coming on stream
- We need to work together to find the time to deliver CGA
- Every so often you need to recalibrate

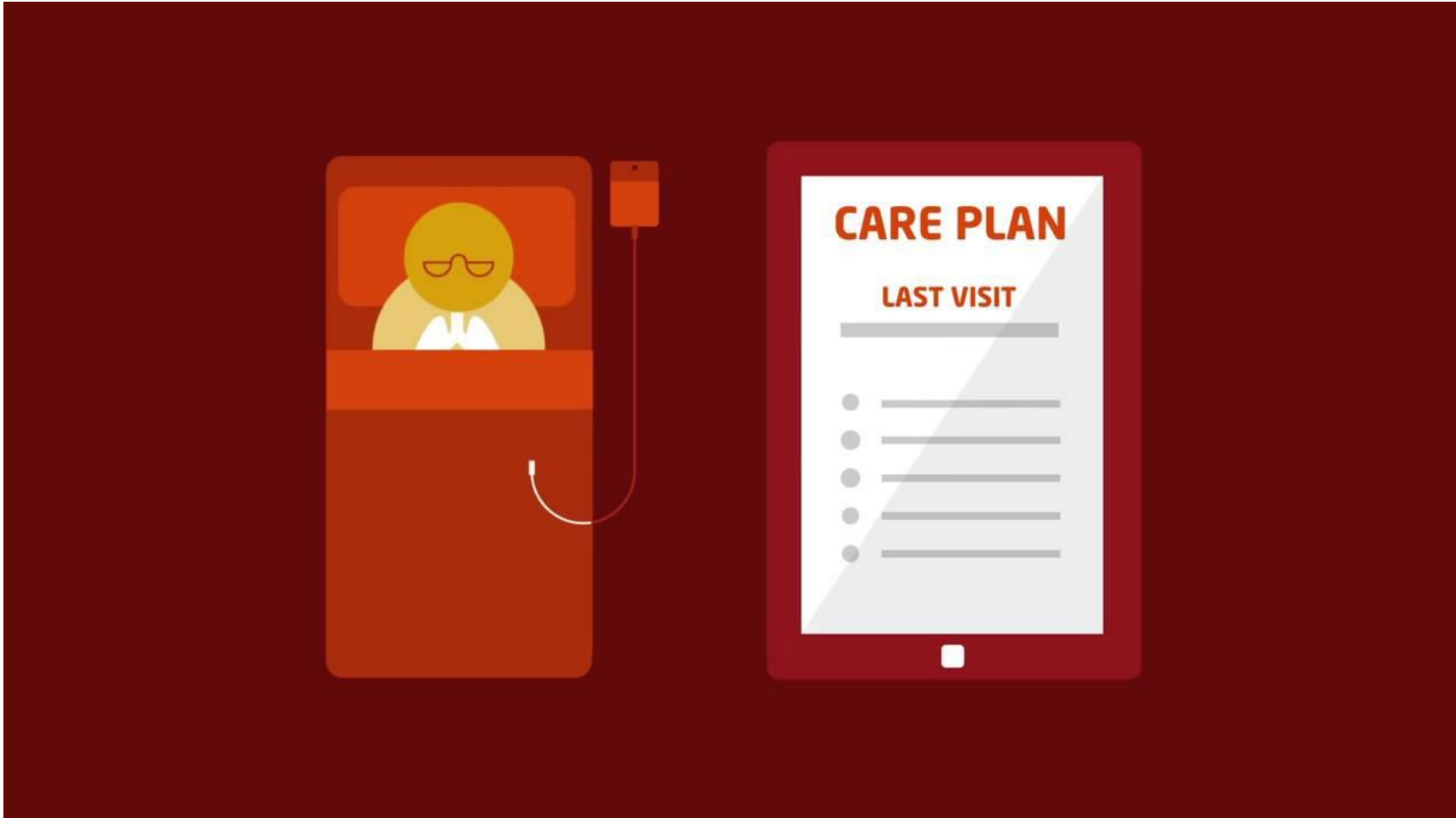
- Only part of the story
- ED
- Orthopaedics
- Surgery
- Oncology
- Cardiology
- The world!

- Recalibration

- Only part of the story







- Emergency Department

Norfolk and Norwich Hospital creates A&E for elderly patients

7 November 2017

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The new A&E department for the elderly is expected to be up and running by December

The first specialist A&E department in the country for patients aged over 80 is to be set up next month.

Controlled evaluation of comprehensive geriatric assessment

Age and Ageing 2014; **43**: 109–114
doi: 10.1093/ageing/aft087
Published electronically 23 July 2013

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A controlled evaluation of comprehensive geriatric assessment in the emergency department: the ‘Emergency Frailty Unit’

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Abstract

Background: the ageing demographic means that increasing numbers of older people will be attending emergency departments (EDs). Little previous research has focused on the needs of older people in ED and there have been no evaluations of comprehensive geriatric assessment (CGA) embedded within the ED setting.

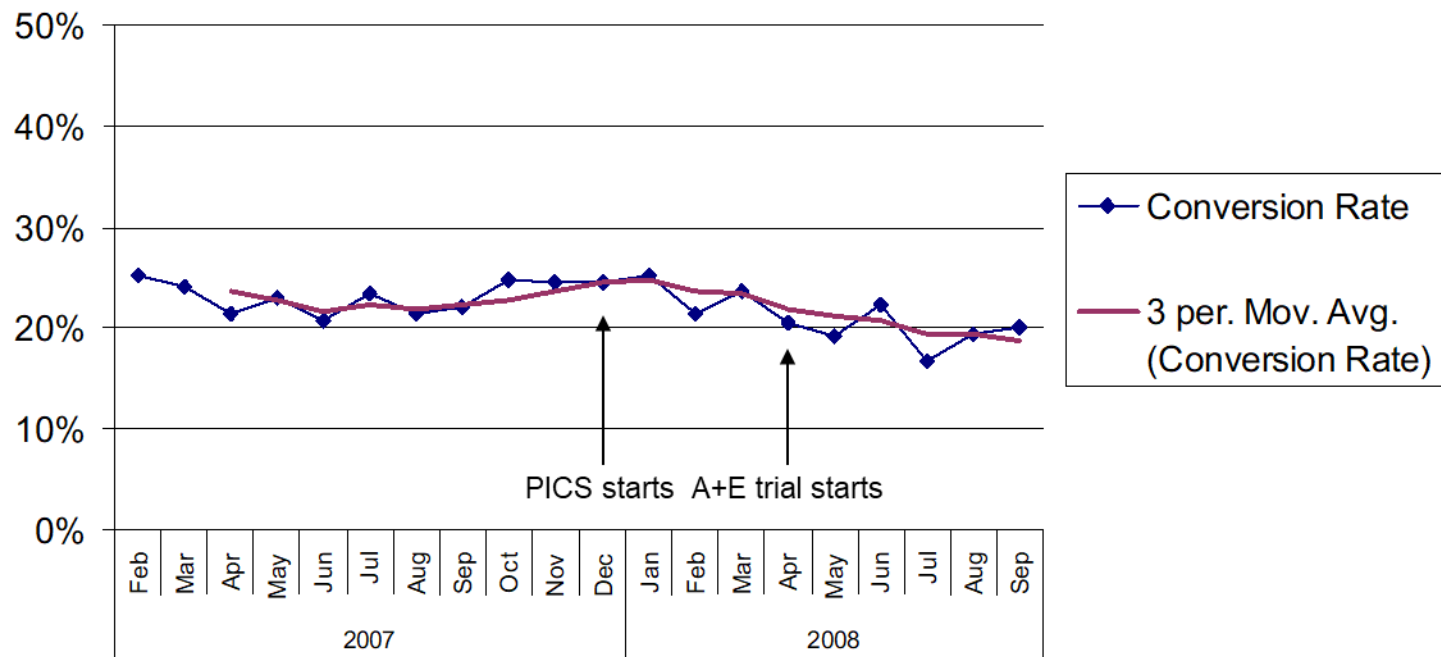
Methods: a pre-post cohort study of the impact of embedding CGA within a large ED in the East Midlands, UK. The primary outcome was admission avoidance from the ED, with readmissions, length of stay and bed-day use as secondary outcomes.

Results: attendances to ED increased in older people over the study period, whereas the ED conversion rate fell from 69.6 to 61.2% in people aged 85+, and readmission rates in this group fell from 26.0% at 90 days to 19.9%. In-patient bed-day use increased slightly, as did the mean length of stay.

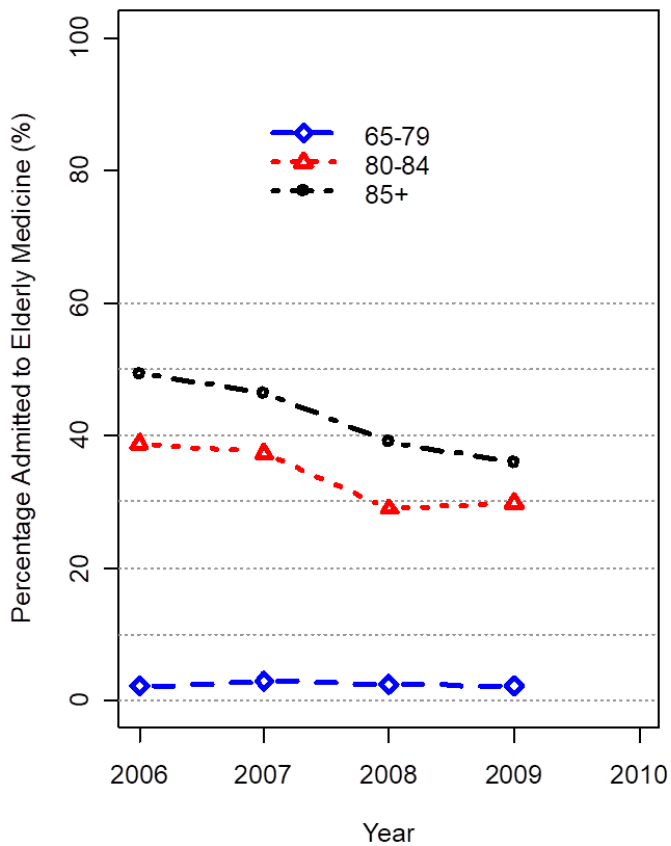
Discussion: it is possible to embed CGA within EDs, which is associated with improvements in operational outcomes.

Keywords: *comprehensive geriatric assessment, CGA, emergency medicine, health services research, older people*

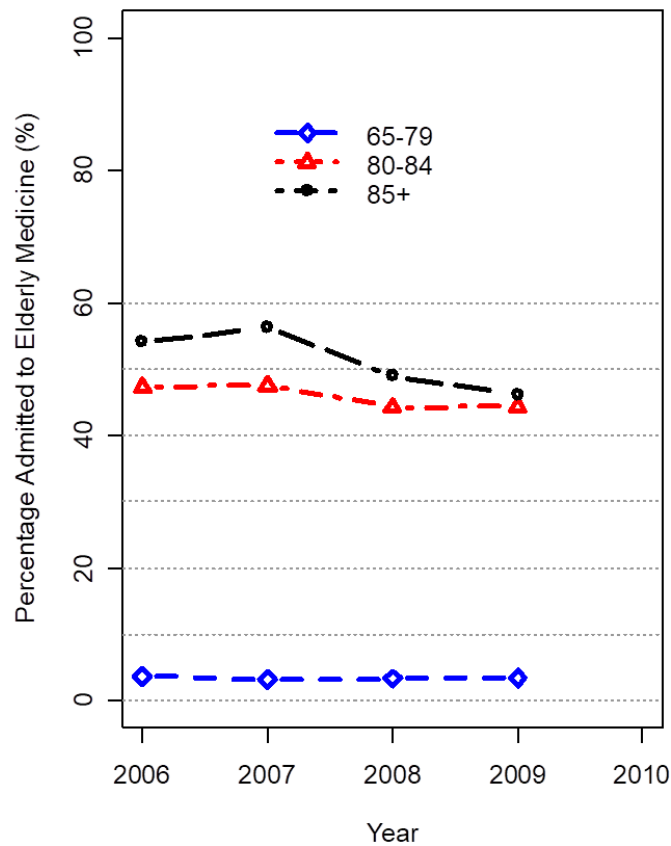
Conversion Rate in A&E Patients aged 65+



In hours



Out of hours



Frailty Advanced Nurse Practitioner ED Trial

Background

The practice of referral to the Older Persons Medicine team (OPM) within the emergency department (ED) to date, has been for patients to be assessed by an ED clinician then formally referred, prior to any discipline specific assessment/intervention from the OPM MDT. This process was identified as an opportunity for service improvement and supported by ED and OPM managers. An audit was carried out from May - September 2018 (Graph 1) which identified the time taken for frail patients to be assessed by ED clinicians, in comparison to the time taken to be (informally) assessed by the ANP. Frail patients are often triaged as being of a lower level of acuity and it has been suggested that triage systems do not consider the many complexities that lead to their attendance (Bellelli et al 2014). They present with complex problems on a background of multiple co-morbidities and polypharmacy, and require comprehensive assessment by a multi-disciplinary team. Older people living with frailty are at risk of rapid decline, deconditioning, increased risk of delirium and loss of reserve when admitted to hospital (Ellis et al 2014, Craswell et al 2016). Admissions for this group are associated with poorer outcomes, multiple returns, higher mortality and increased lengths of stay (Grief 2003, McCusker et al 2013). The implementation of a comprehensive geriatric assessment (CGA) has shown to improve outcomes in the ED (Conroy et al 2014, Cooper et al 2010). The suggested change in practice was for the OPM ANP to work under the governance of ED consultants as part of the initial assessing and clerking team, to assess patients with frailty at the earliest opportunity with the aim of expediting admit/discharge decisions and completing a CGA with our OPAL team.

Project Scope

Inclusion Criteria:

Patients who meet the criteria for the frailty pathway including:
 Patients over 65 or 75 with frailty syndromes including Dementia, Parkinsons Disease, MS.
 Patients over 75 living in residential care, or with home social care packages

Exclusion Criteria:

Resus Patients.
 Patient without frailty syndromes who would be referred through an alternative discipline specific pathway (due to admission rights of the OPM ANP for frailty only).
 Frail patient's with surgical conditions/complaints.

The service was available weekdays 8am-6pm and the ANP discussed all patients with an ED consultant to ensure safe and evidence-based clinical reasoning and decision making.

The OPM ANP worked as part of the initial clerking and assessing team within the ED and identified those patients that met the frailty pathway criteria, assessed, examined, ordered investigations, interpreted results and prescribed treatment in accordance with best practice guidelines. Admission/Discharge decisions were acted on accordingly.

The trial period spanned 3 months with regular review intervals by key stakeholders and involved close working with OPAL to achieve an MDT approach.

Throughout the trial period we have seen a decrease in the waiting time for patients with frailty.

Data Collection

- Data collection methods were identified with the engagement of RBCH QI and information team and focussed on identifying:
 - Time to be assessed
 - Number of patients seen by OPM ANP.
 - Outcome
 - Time of referral/discharge
 - Admission Avoidance
 - Length of stay in the department.

Outcomes And Improvements

to be assessed within the emergency department. (Chart 1). This has resulted in a streamlined service for our patients and ensured that they are assessed and managed with a CGA approach.

We have improved MDT working and communication with community services to ensure patients are adequately reviewed and supported after discharge to promote independence, reduce the likelihood of re-attendance and highlight potential problems that could lead to future ED attendances.

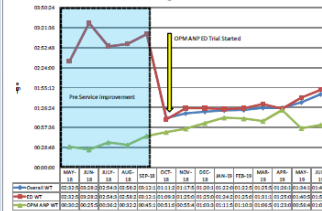
Our practice change has assisted with increasing admission avoidance figures by over 50% in comparison to 2017 (Chart 3). The ANP was responsible for the physical examination, ordering and interpreting test results for patients with undifferentiated diagnosis, achieving a diagnosis and prescribing treatment under the supervision of the ED consultants. Collaborative practice with our MDT and community colleagues enabled us to achieve more discharges from ED.

The OPAL team and social services have been able to assess patients sooner which has decreased overall length of stay in hospital as discharge plans were implemented from the point of presentation. Collaborative MDT practice that caters for the complex needs of the older person has been shown to improve outcomes for this patient group.

We have been able to support and signpost relatives to relevant services such as Dementia And Delirium Services, Social Services, Community Therapy and Voluntary Services. We have received positive feedback from patients and relatives who have highlighted that they were satisfied with the care and treatment received by the team.

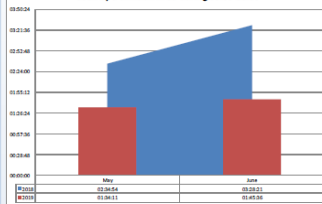
Measurements And Results

Average waiting time for Elderly patients to see a clinician within ED during 08:00-18:00



Waiting Times
 Chart 1 demonstrates the overall waiting times for frail patients to be seen by a clinician in ED has decreased by approx. 02:11:00 hours.

Comparison of overall waiting time for Elderly patients to be seen by a clinician in ED during 08:00-18:00



- Orthogeriatrics

FRACTURED PROXIMAL FEMUR IN NEWCASTLE UPON TYNE

J. GRIMLEY EVANS

Newcastle Age Research Group, University of Newcastle upon Tyne

20

J. Grimley Evans

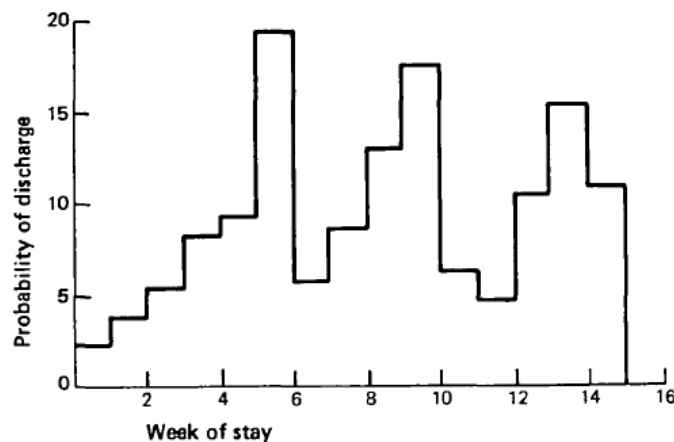


Fig. 2. Probability of discharge by length of stay (weeks) for Newcastle area residents in 1971.

A striking feature of our results is the difference between the mean length of stay experienced by patients admitted to the two hospitals in Newcastle. The hospitals have different catchment areas for patients with fractured proximal femur and the difference in length of stay may reflect social or other factors in the selection of patients as well as management policies. Identification of relevant factors is clearly a matter of importance.

2007: Specialty of Ortho-geriatrics is born

BGS
new s l e t t e r

Issue 18
October 2007
ISSN 1744-3343

Editor: David Beesmore

Our historic alliance

with the world of orthopaedics

The BGS has established an exciting new collaboration with the British Orthopaedic Association, with the shared aim of improving the clinical care of patients with fragility fractures and promoting effective secondary prevention to reduce future falls and fractures.

Sponsored by the BOA and BGS, it has also been endorsed by the Age Assessment Association, the National Osteoporosis Society, the Faculty of Public Health, the RCN, the Society for Fracture Surgery, the Fracture of the Royal College of Surgeons and the Specialist Surgical Association of Great Britain and Ireland - a vital demonstration of multidisciplinary commitment to improving hip fracture care. The Blue Book then offers a framework for joint working and clinical governance activities that can build on the success of two BGS/BOA national joint "Instructional Courses" for trainees and consultants held in 2006 and 2007, with a third now planned for 2008 (see www.nhs.uk/education).

Central to the strategy are the two key initiatives, the Blue Book on the Care of Patients with Fragility Fractures and the National Hip Fracture Database, which were jointly launched with widespread TV, radio and press coverage on September 19th.

Blue Book
The second edition, newly rewritten and updated, replaces a Textbook published several years ago and is now an authoritative evidence-based clinical practice guide for the multidisciplinary team, and include a set of six specific clinical practice manuals: Geriatrician, Optician, Nurse, Anesthetist and Civilian. Contributions gratefully to the Blue Book's multidisciplinary working group, with Colin Cawley as its editor. It can be downloaded as a pdf file from www.nhs.uk or from www.nhs.uk.

National Hip Fracture Database (NHFD, www.nhfd.co.uk)
This joint BGS/BOA venture is entirely complementary to the Blue Book. It has involved the creation of an ongoing web-based database of key events, process and outcome indicators to monitor and improve the clinical care of hip fracture patients by enabling units to measure the care they provide against the standards set out in the Blue Book. It has been developed from several existing audits, including the Scottish Hip Fracture Audit, which has been established for several years and has now galvanised the Scottish government into setting explicit

for better health in old age

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The National Hip Fracture Database

British Orthopaedic Association

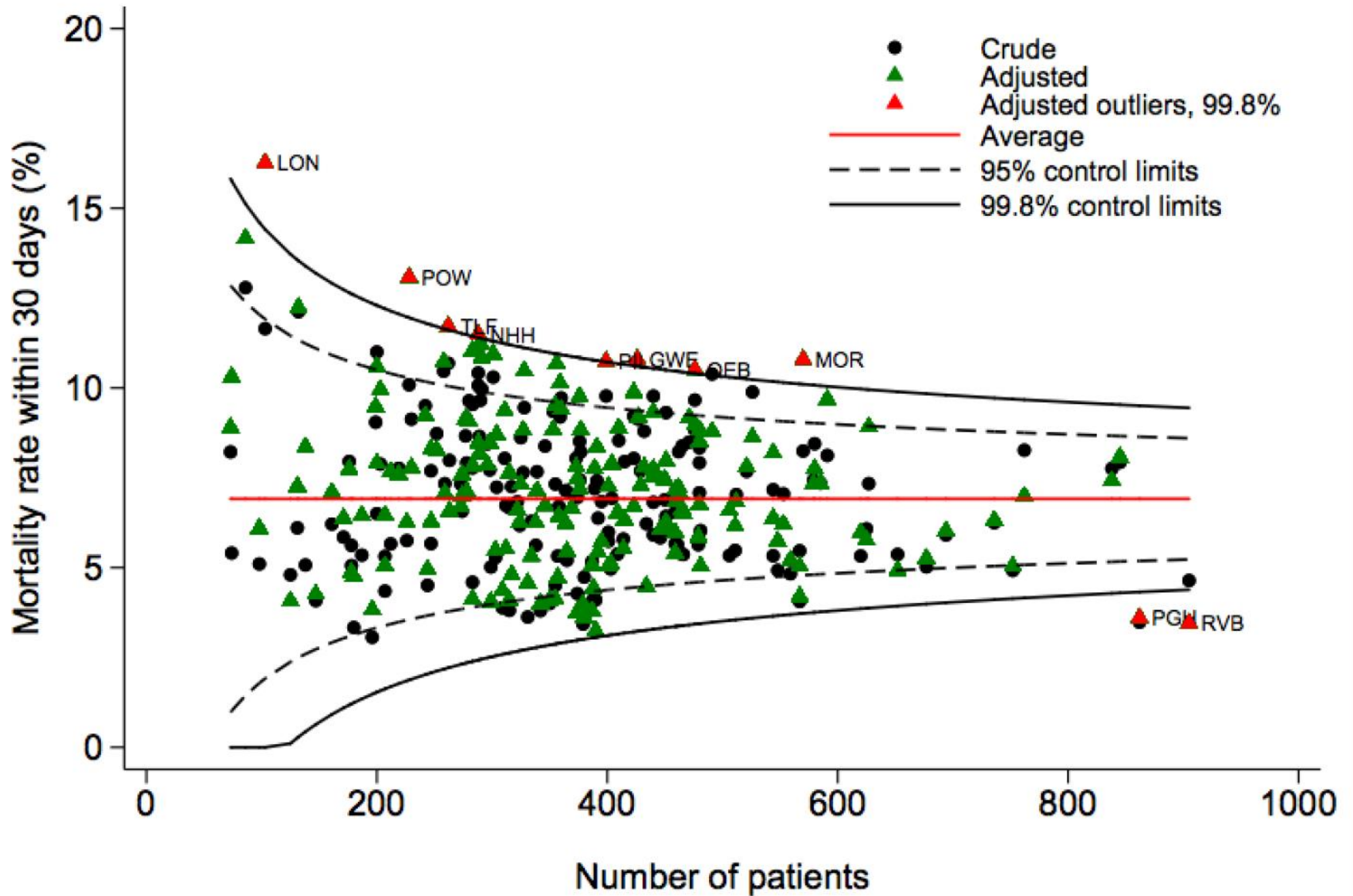
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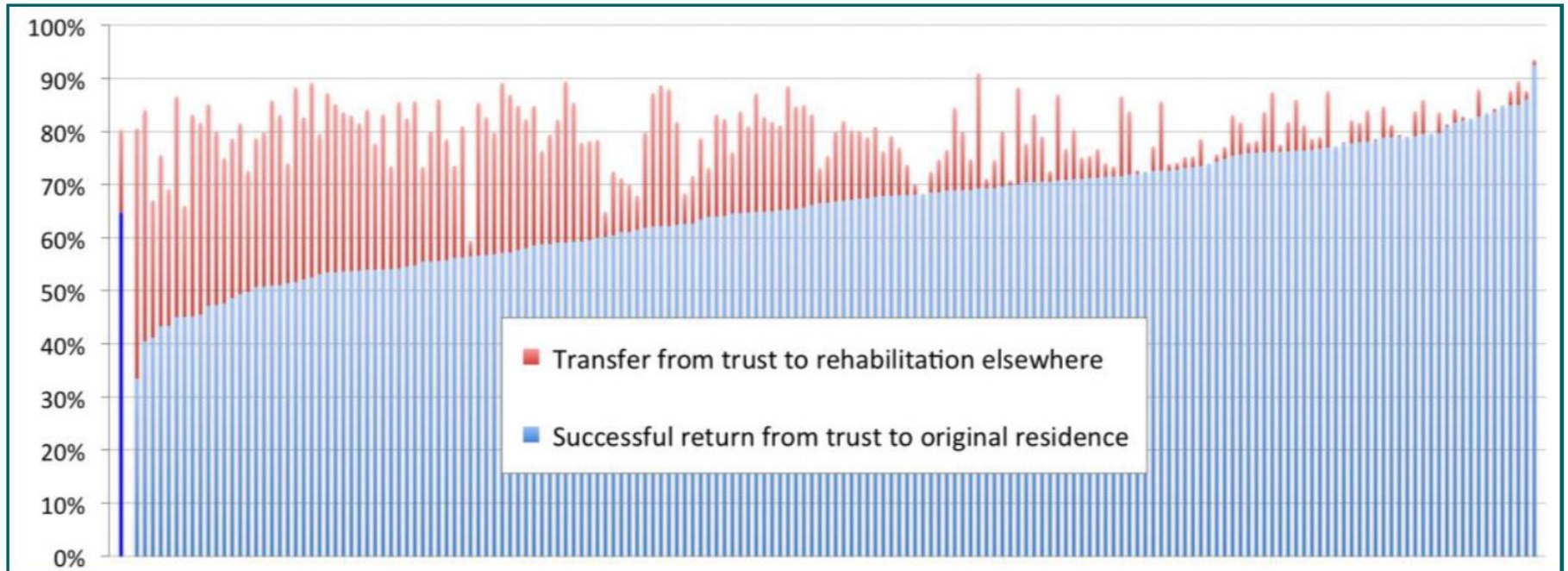


THE CARE OF PATIENTS WITH FRAGILITY FRACTURE

Published by the British Orthopaedic Association September 2007

KPI	Area of care
Key performance indicator 1	Prompt orthogeriatric assessment
Key performance indicator 2	Prompt surgery
Key performance indicator 3	NICE compliant surgical approach
Key performance indicator 4	Prompt mobilisation after surgery
Key performance indicator 5	Not delirious when tested after operation
Key performance indicator 6	Returned to original residence by 120 days





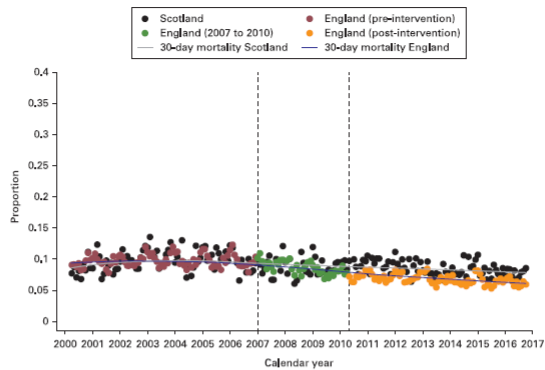


Fig. 1a

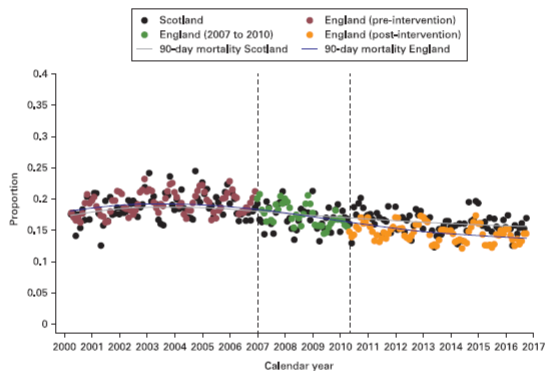


Fig. 1b

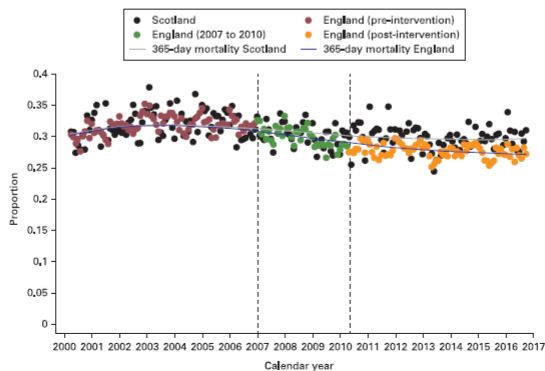


Fig. 1c

Charts showing monthly changes in a) 30-, b) 90- and c) 365-day mortality among adults aged more than 60 years, 2000 to 2016. Dashed lines represent introduction of the National Hip Fracture Database in January 2007 and the Best Practice Tariff in April 2010.

- TARN

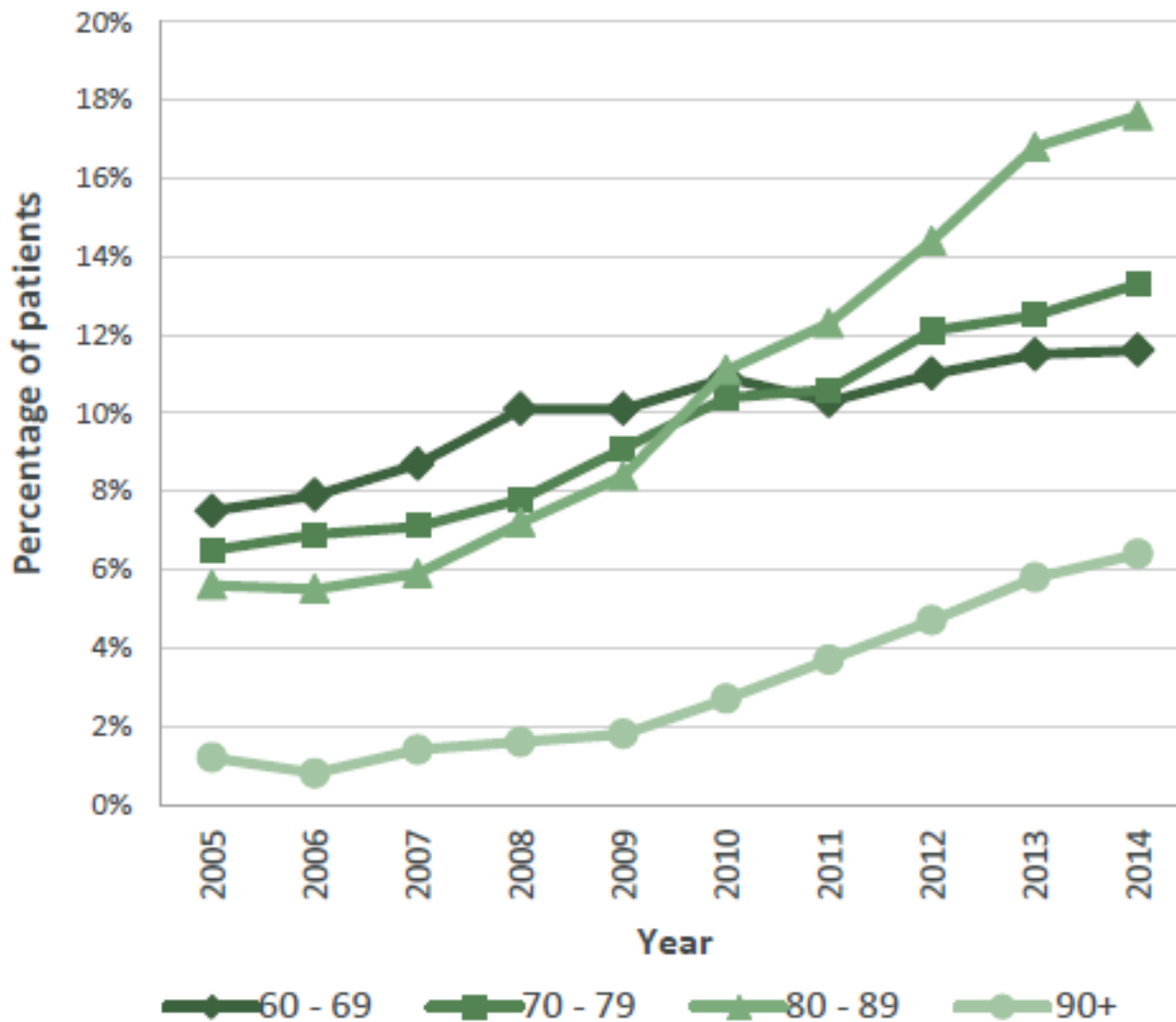


Figure 3a: Severely injured patients since 2005

Major Trauma in Older People (ISS>15)

Injury mechanism by age band

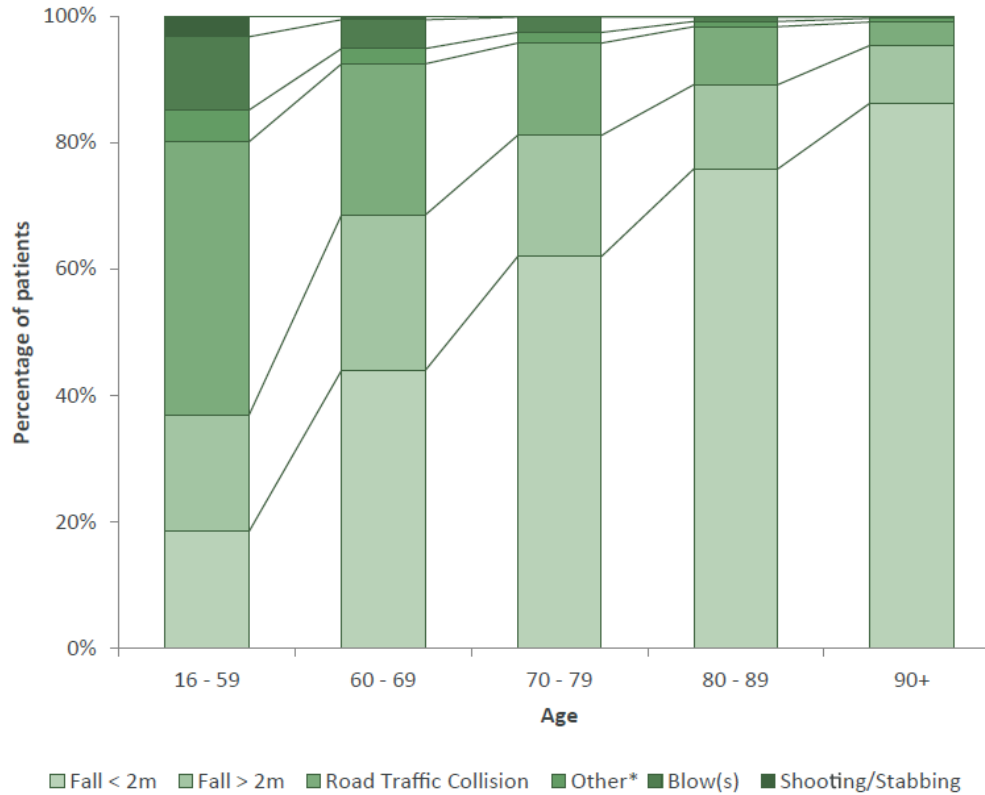


Figure 5: Mechanism of Injury of ISS> 15 patients by age (Appendix 2, Table 5)

Mechanism of injury changes with age. Low falls become a much more common cause of major trauma. A fall of <2m is now the most common mechanism of injury within the TARN database (it should be noted that patients with single fractures distal to the elbow or knee or an isolated fractured neck of femur are not included in the TARN dataset even if the patient spends more than 3 days in hospital; the inclusion of these injuries would further increase the number of patients suffering injuries from falls <2m).

*'Other' includes blast, burn, crush or other mechanisms that are not recorded by TARN separately

Major Trauma in Older People (ISS>15)

Location of Incident

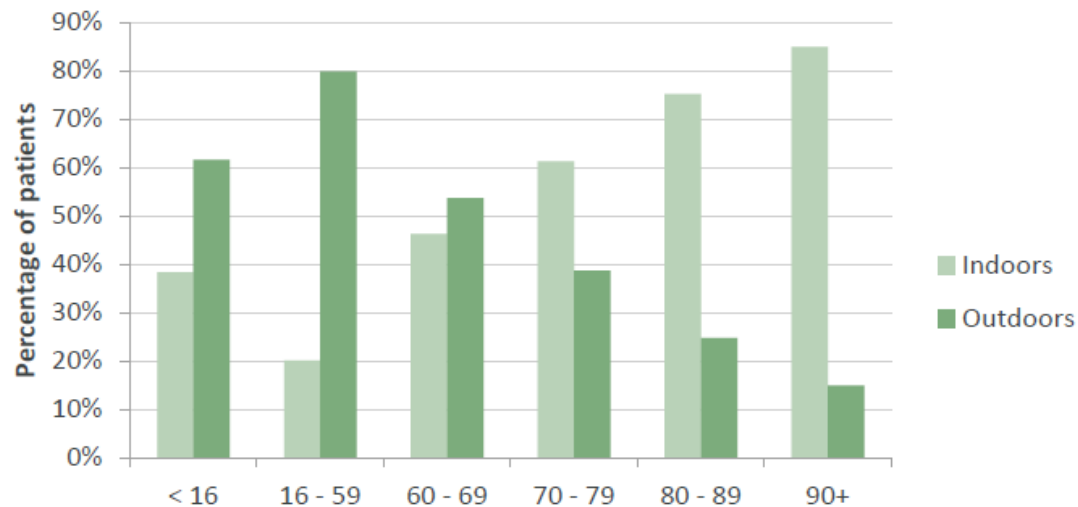


Figure 7: Location of major trauma by age (Appendix 2, Table 7)

The location of incident changes as expected with the predictable alterations in the activity level of the population with age. In younger people most major trauma occurs outside, whereas older people are very much more likely to be injured indoors. This has significant implications for the future targeting of injury prevention efforts, and in particular the prevention of injuries in older people. This data also suggests that a review of accommodation design for older people should be considered to identify, for example, how injuries from falls may be reduced such as looking at designs of floors or other surfaces. In addition the need for further investigation into falls prevention is highlighted by this data.

Major Trauma in Older People (ISS>15)

Process

Emergency care

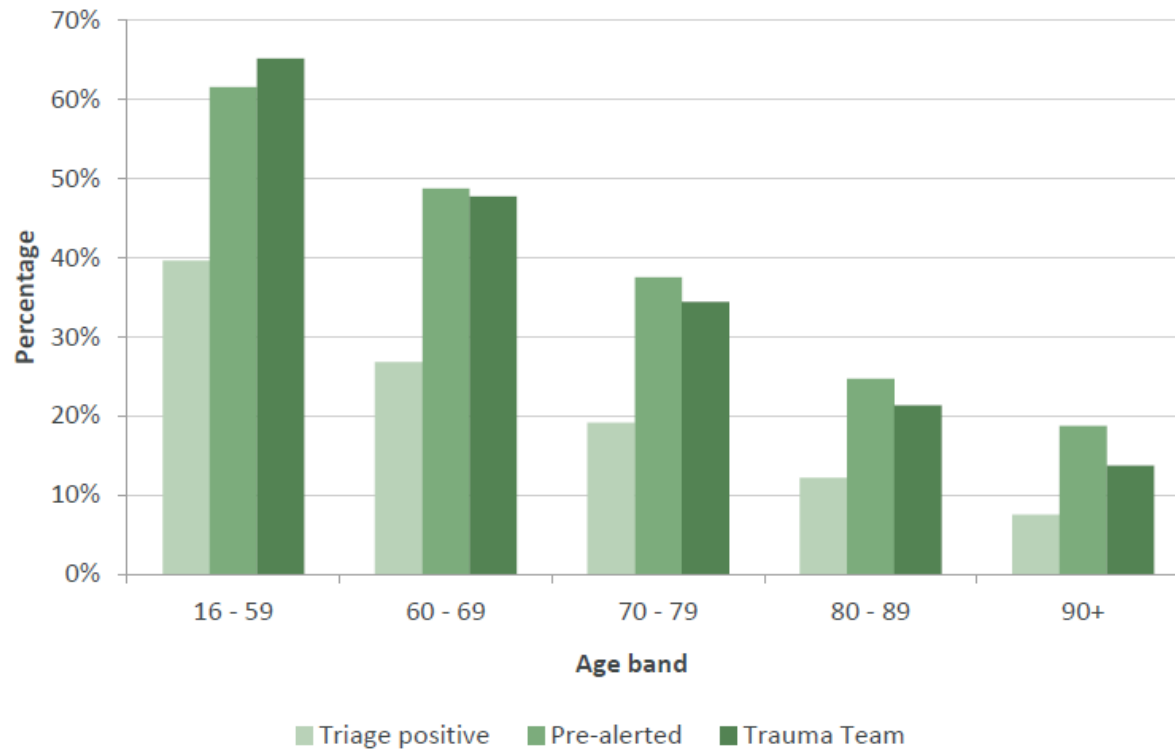


Figure 9: Percentage of patients and triage status (Appendix 2, Table 9)

Major Trauma in Older People (ISS>15)

Grade of most senior clinician treating patients on arrival

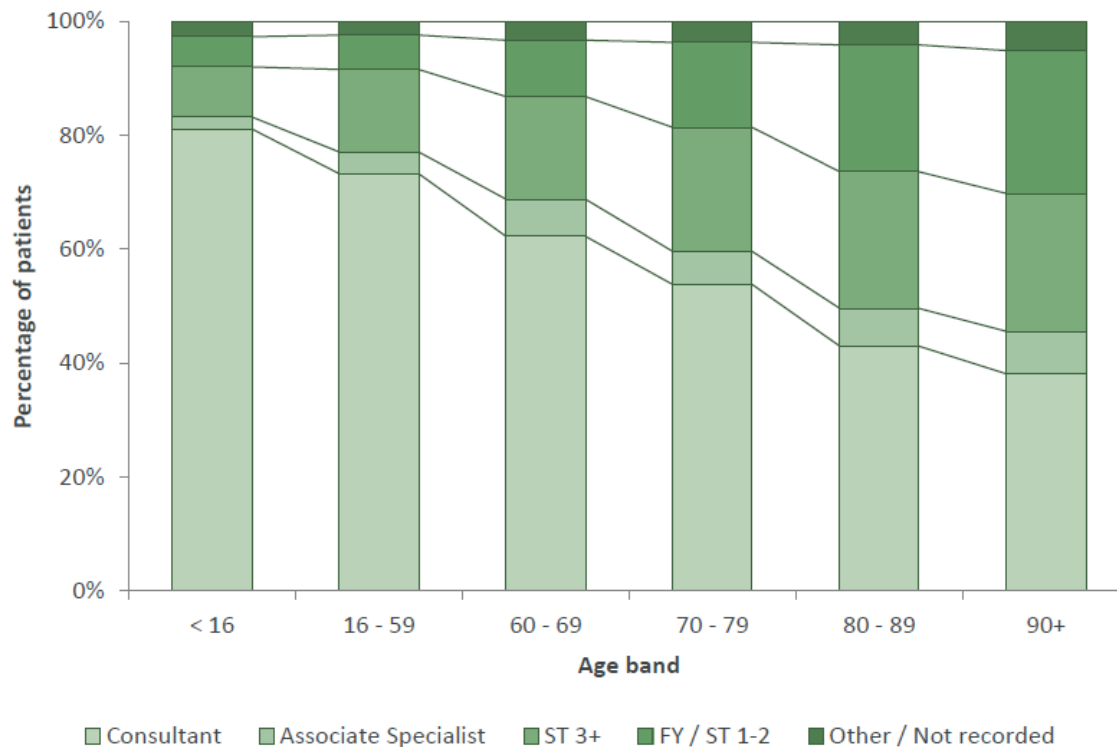


Figure 10: Age and seniority of initial treating clinician (Appendix 2, Table 10)

Half of all older patients directly admitted with major trauma are seen by a consultant on arrival in the Emergency Department (see Table 10). There is a clear trend related to age, with older patients not being identified early (low level of pre-alert) and so being initially treated by more junior doctors. It is likely that a more junior initial assessment leads to delays in investigation and treatment (see later sections).

Major Trauma in Older People (ISS>15)

Prevalence of deaths by injury mechanism

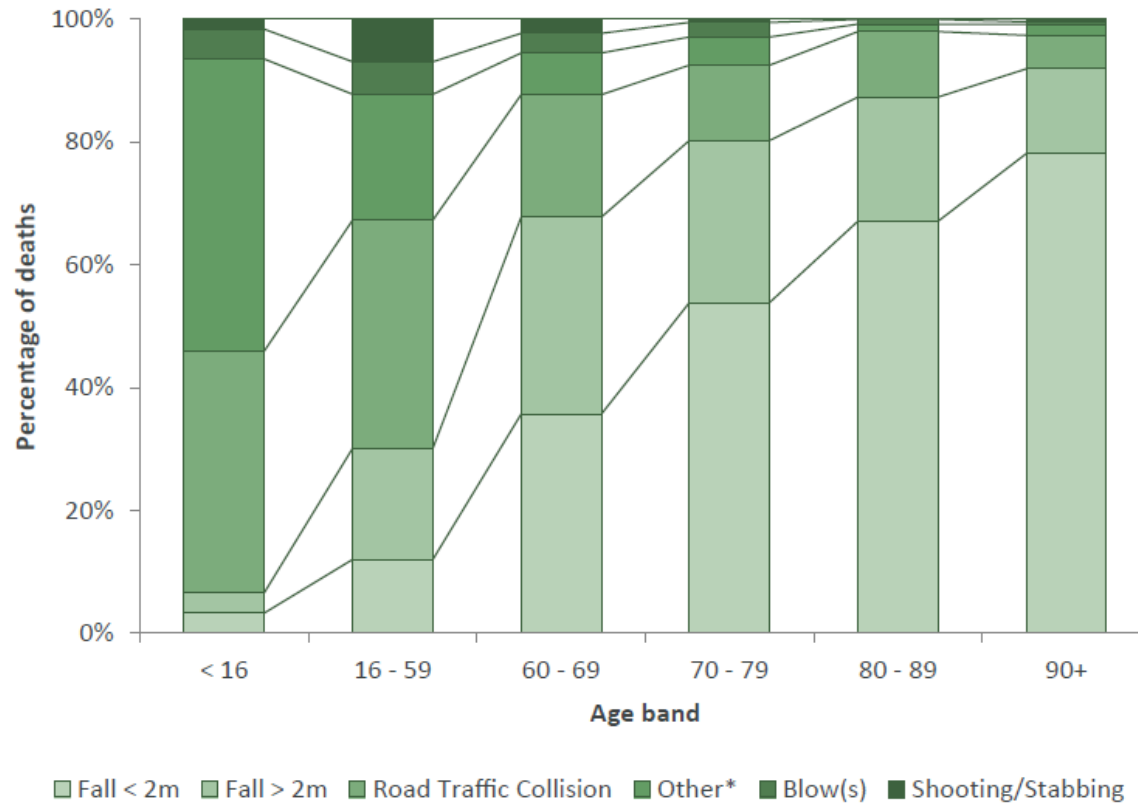


Figure 23: Injury mechanisms associated with death (Appendix 2, Table 22)

BOAST: BOA Standard

The care of the older or frail orthopaedic trauma patient

Background

The care of orthopaedic trauma in the older or frail patient is dependent on coordinated multidisciplinary working to manage the physical injury, co-morbidities and rehabilitation, including measures to prevent further injury. Previously, patients with a hip fracture have been the focus of such collaboration but the need extends to patients sustaining other injuries. The frail patient with severe injuries is at risk of under-triage, delayed diagnosis and consequent sub-optimal care. The Trauma Audit Research Network (TARN) Elderly Trauma report¹ showed in that, in this group, it is not high energy mechanisms but falls from a standing height that predominate.

Inclusion:

All patients admitted having sustained a fragility fracture and patients sustaining major trauma who have a Clinical Frailty Scale (CFS) of 5 or more.

Standards for Practice

1. All patients should be managed in a frailty pathway which includes Comprehensive Geriatric Assessment (CGA)² commencing within 72 hours of injury. The pathway should demonstrate collaboration between pre-hospital services, Emergency Departments, Orthopaedic, Anaesthetic and Orthogeriatric clinicians. A written policy should define how the teams cooperate to manage ward-based patients in the peri-operative period (from admission to 24 hours post-op), including at weekends and on bank holidays.
2. Networks should have pathways to guide which patients should be discussed and transferred to a Major Trauma Centre (MTC) within 24 hours of admission. These pathways should include MDT review of all patients with ISS > 15 who are not transferred. Network clinicians should be able to review imaging and utilise teleconferencing when appropriate.
3. When indicated, cross-sectional imaging should be obtained at initial presentation in the emergency department. Instances of later cross-sectional imaging should be the subject of an on-going audit. Imaging of the head should also include the cervical spine. When an unstable spinal injury is identified or cannot be excluded, the method of cervical spine protection must be clearly communicated and recorded.
4. Ceilings of treatment, including transfer, escalation and the appropriateness of cardiopulmonary resuscitation (CPR), should be discussed jointly by the treating teams. This should be documented and include the patient and those close to them, considering advanced directives, lasting powers of attorney and safeguarding issues. These decisions should be made at consultant level and prior to any surgery.
5. Protocols for the reversal of anticoagulation must be available and all patients should be assessed and treated for their risk of venous thromboembolism. Each hospital should have a guideline that is consistent across the Trauma Network.
6. Patients with a serious head injury (GCS 8 or less) should be considered for transfer to a neuroscience unit.
7. There must be a pathway for the management of chest wall trauma that includes early access to regional analgesia. There must be network guidelines for the selection and transfer of patients who may benefit from early surgery to stabilise the chest wall. These transfers must take place within 48 hours of the decision for surgical management.
8. Pain management must be through a defined strategy utilising patient-specific tools and incorporating peripheral nerve blockade when appropriate. Each hospital should have a specific pain guideline for this population with an emphasis on limitation of opioids, guidance in renal impairment and avoidance of non-steroidal medications.
9. All patients should have a multifactorial falls risk assessment and should be referred to falls prevention services if indicated.
10. All patients should have a bone health review, be investigated and prescribed appropriate medication when indicated.
11. All patients should have a nutritional assessment. No patients should be made nil by mouth unless immediate surgery is planned. Drinking fluids in the preoperative period should be encouraged, in line with local policies.
12. Units should routinely be using a validated delirium assessment tool (such as the 4AT) and have a delirium policy which describes preventative measures, ensures rapid identification of potentially reversible causes and delivers individualised interventions in line with NICE CG103.
13. Patients should not be nursed flat unless it is documented that this is essential. Early sitting up / bed tilt to decrease risks of recumbency should be encouraged.
14. All surgery in the frail patient should be performed to allow full weight-bearing for activities required for daily living and within 36 hours of admission, in line with current hip fracture care. Patients should be seen by a physiotherapist on postoperative day one with early identification of functional rehabilitation goals as detailed in the rehabilitation BOAST.
15. All patients with complex peri-articular or peri-prosthetic fractures should be discussed with specialist fracture surgeons within robust network pathways.
16. All patients must be entered into a discharge-planning pathway with a rehabilitation prescription and clear coordination between inpatient and outpatient therapists. All patients should receive information regarding expected functional recovery and rehabilitation, including advice about return to normal activities such as work and driving.
17. Each hospital should submit data to national databases (NHFD, FLS-DB and TARN) to monitor its performance against national benchmarks and quality standards.

¹ <https://www.tarn.ac.uk/content/downloads/3793/Major%20Trauma%20in%20Older%20People%202017.pdf>

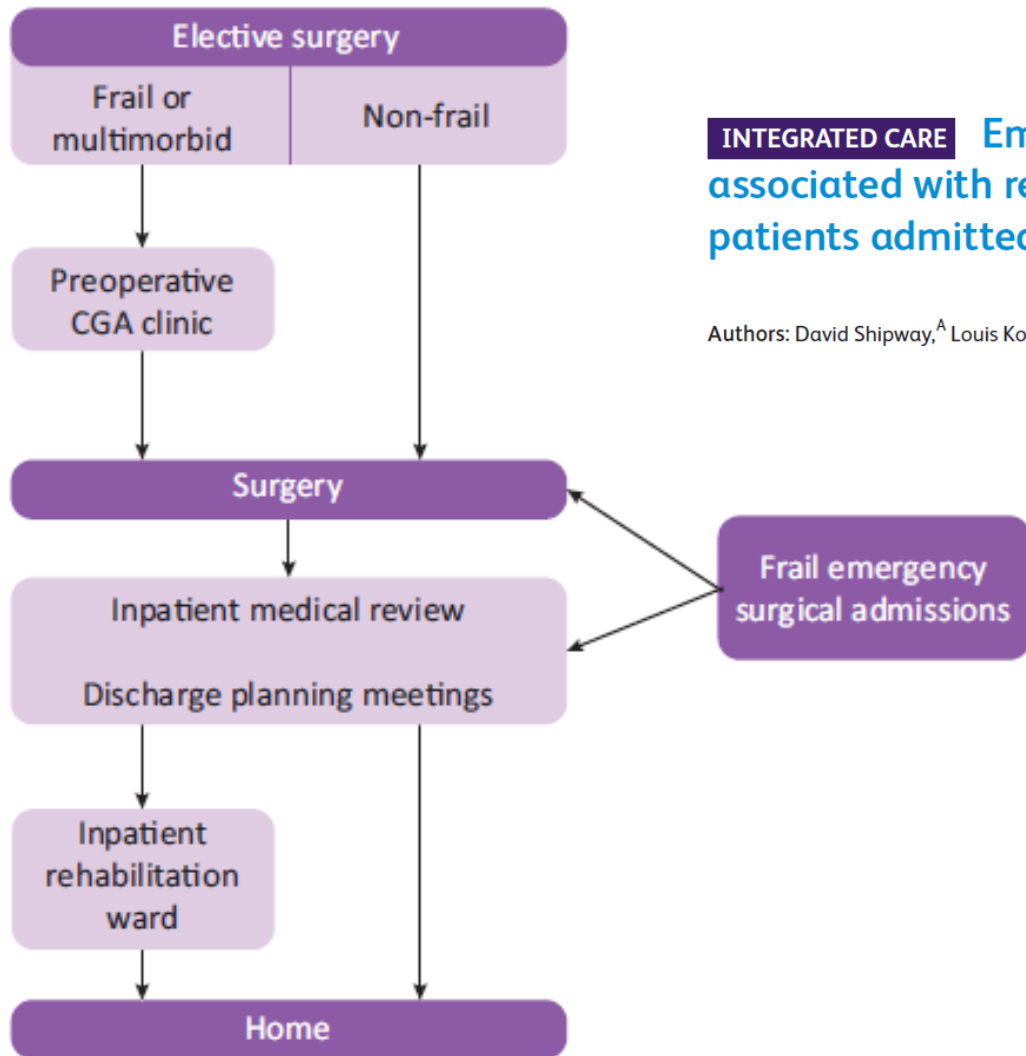
² A comprehensive geriatric assessment is an inter-disciplinary diagnostic process to determine the medical, psychological and functional capability of someone who is frail and old. The aim is to develop a coordinated, integrated plan for treatment and long-term support. <https://www.nice.org.uk/guidance/qs136/chapter/quality-statement-2-comprehensive-geriatric-assessment>

- Perioperative care of Older People undergoing Surgery

Integrating Care Throughout The Patient's Surgical Journey



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INTEGRATED CARE Embedded geriatric surgical liaison is associated with reduced inpatient length of stay in older patients admitted for gastrointestinal surgery

Authors: David Shipway,^A Louis Koizia,^B Nick Winterkorn,^C Michael Fertleman,^D Paul Ziprin^E and Krishna Moorthy^F

Fig 1. Model of care - embedded geriatric surgical liaison. CGA= Comprehensive Geriatric Assessment

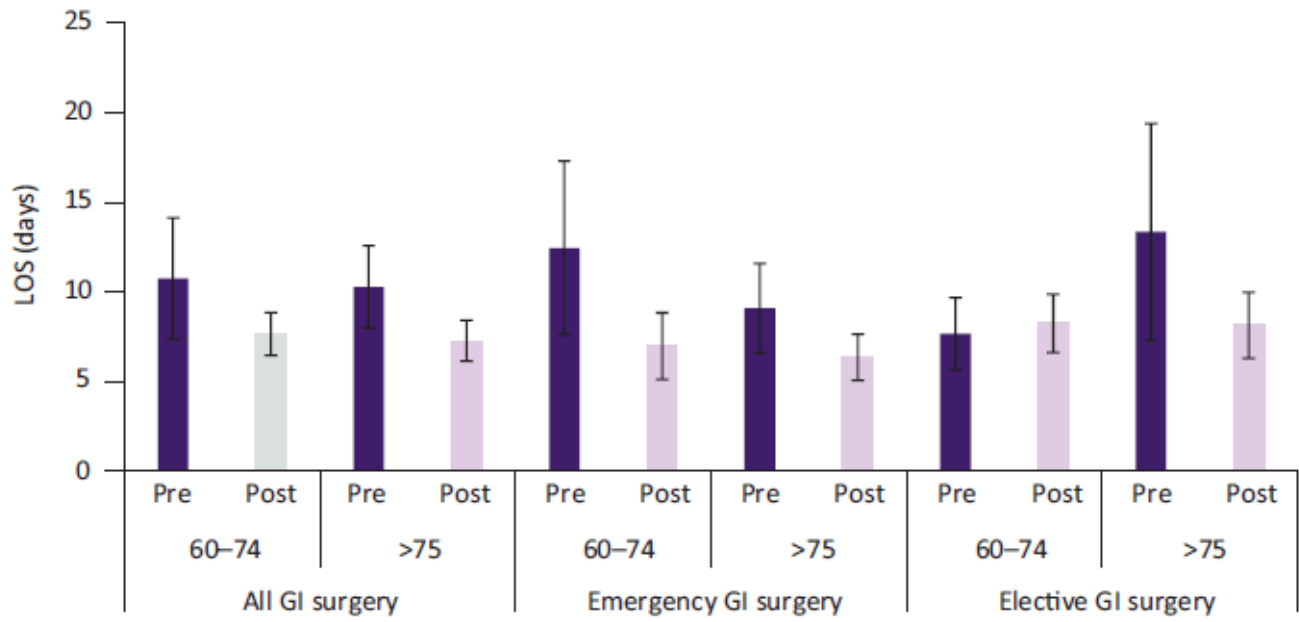


Fig 4. Mean length of stay (LOS) pre- and post-service implementation, divided by subgroup. GI = gastrointestinal

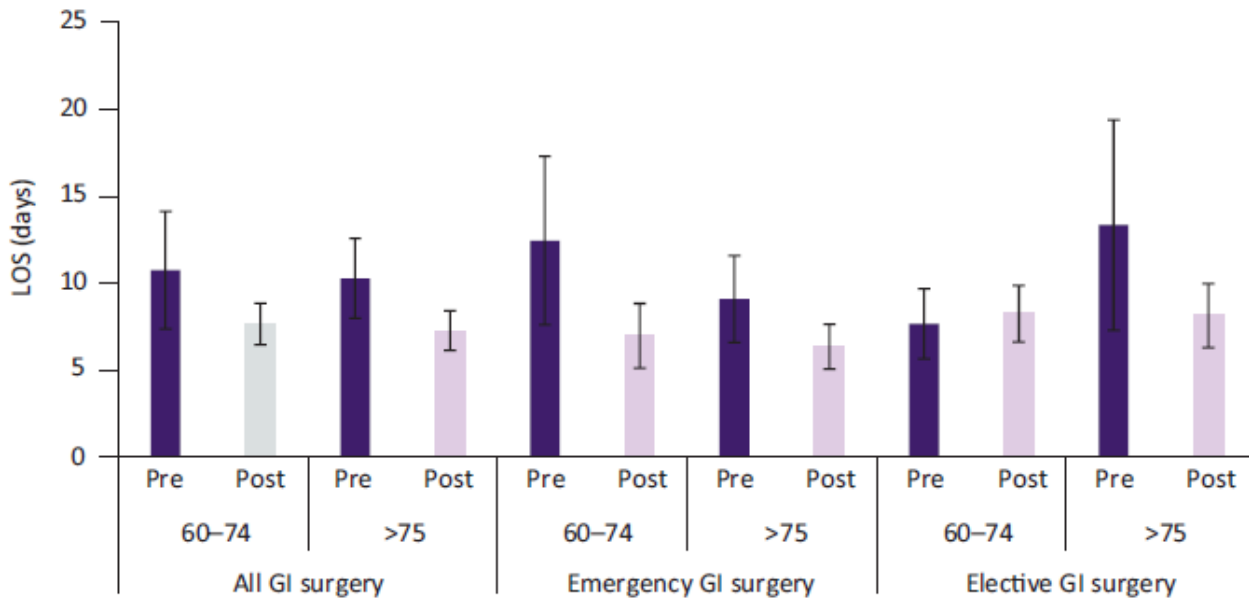


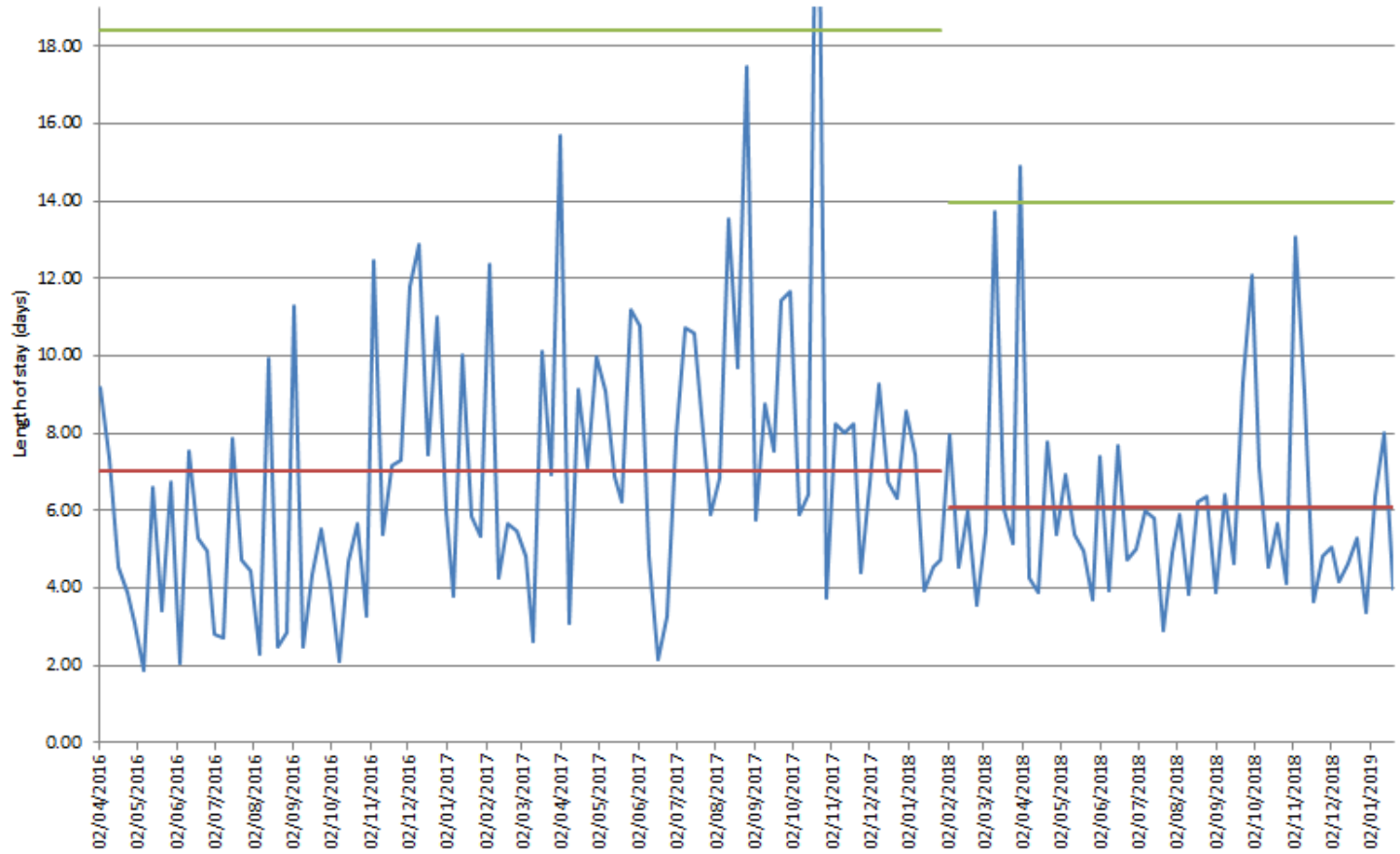
Fig 4. Mean length of stay (LOS) pre- and post-service implementation, divided by subgroup. GI = gastrointestinal

Results

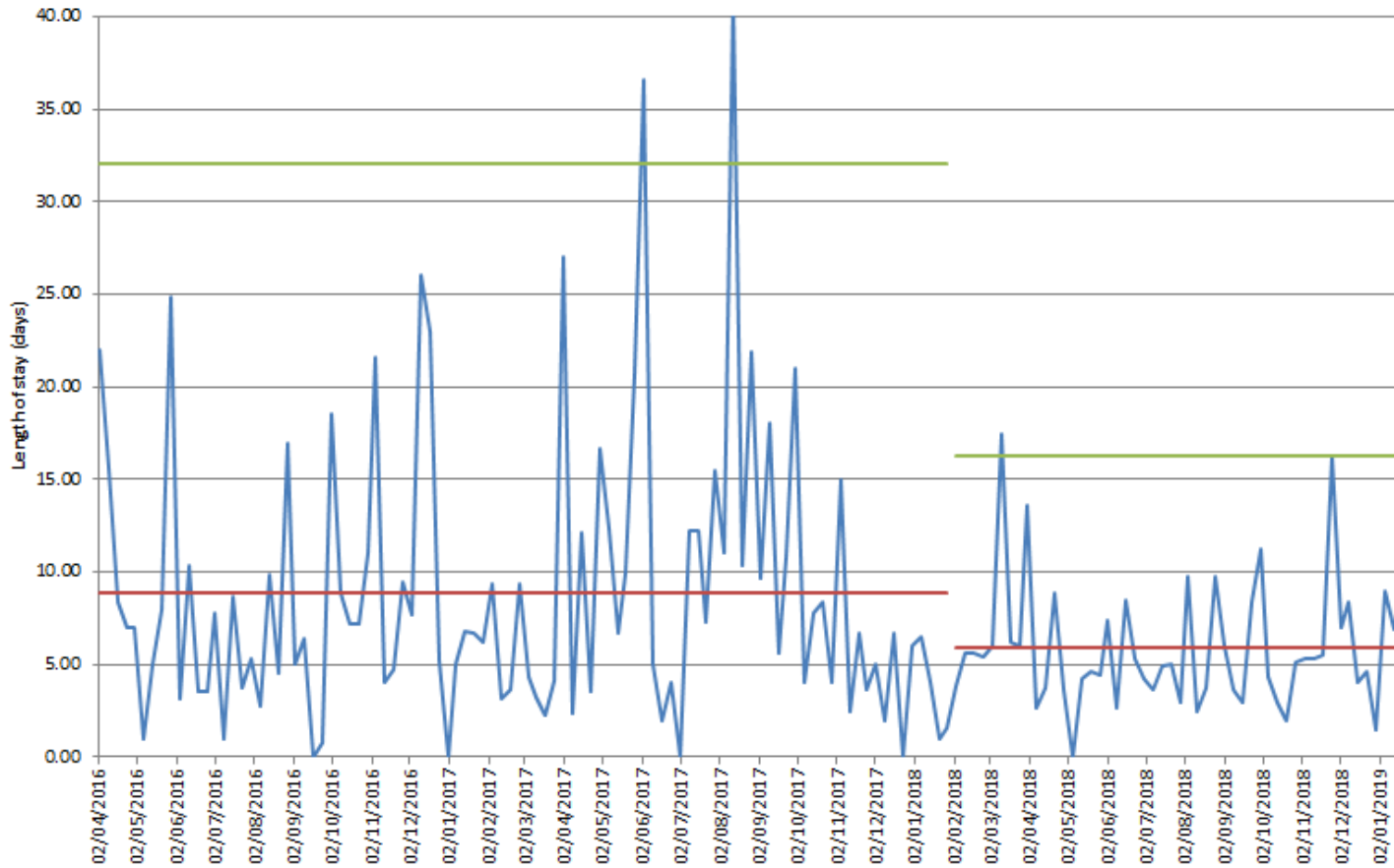
- Length of Stay – Vascular Patients

Year	Number of patients	LOS all ages	LOS 75 and over	LOS 85 and over
2015-16	459	9.11	8.98	9.22
2016-17	648	9.25	8.89	8.92
2017-18	608	9.85	9.25	10.04
2018-19 YTD	437	8.16	8.33	7.02

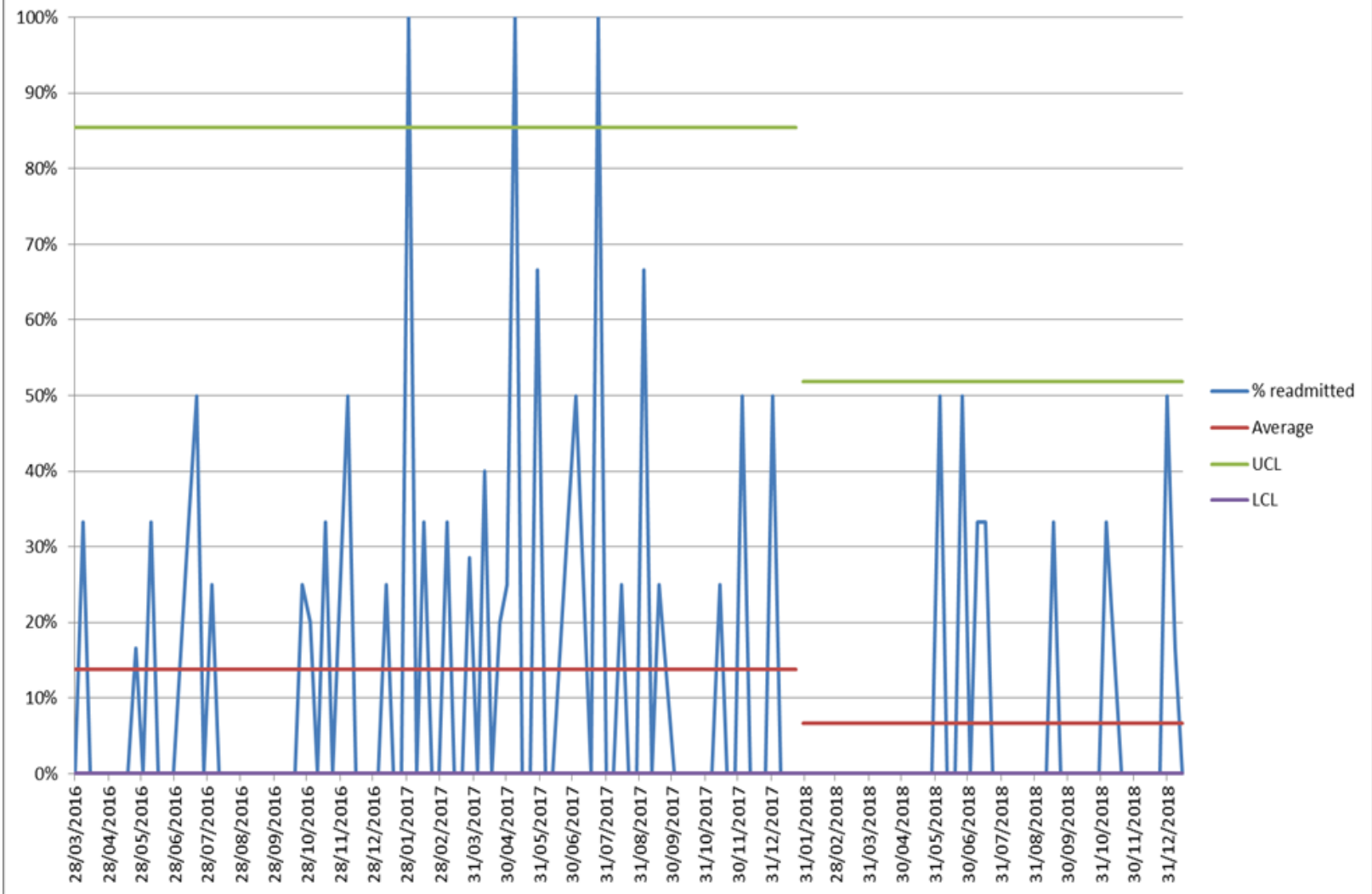
Length of stay for 85+ year olds on Surgical wards



Length of stay for 85+ year olds on Ward 14



Readmissions for patients aged 85 or over from Ward 14



- Past, present and future

- Oncogeriatrics

The effect of a geriatric evaluation on treatment decisions and outcome for older cancer patients – A systematic review

Marije E. Hamaker ^{a,*}, Marthe te Molder ^b, Noortje Thielen ^b, Barbara C. van Munster ^c, Anandi H. Schiphorst ^d, Lieke H. van Huis ^b

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Conclusion: A geriatric evaluation affects oncologic and non-oncologic treatment and appears to improve treatment tolerance and completion for older cancer patients. Fine-tuning the decision-making process for this growing patient population will require more specific and robust data on the effect of a geriatric evaluation on relevant oncologic and non-oncologic outcomes such as survival and quality of life.

Functional versus chronological age: geriatric assessments to guide decision making in older patients with cancer

Enrique Soto-Perez-de-Celis, Daneng Li*, Yuan Yuan, Yat Ming Lau, Arti Hurria*

The effect of a geriatric evaluation on treatment decisions and outcome for older cancer patients – A systematic review



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Non-oncologic interventions

Treatment outcome

ABSTRACT

Aim: The aim of this systematic review is to summarise all available data on the effect of a geriatric evaluation on the multidisciplinary treatment of older cancer patients, focussing on oncologic treatment decisions, the implementation of non-oncologic interventions and the impact on treatment outcome.

Methods: A systematic search in MEDLINE and EMBASE for studies on the effect of a geriatric evaluation on oncologic and non-oncologic treatment decisions and outcome for older cancer patients.

Results: 36 publications from 35 studies were included. After a geriatric evaluation, the oncologic treatment plan was altered in a median of 28% of patients (range 8–54%), primarily to a less intensive treatment option. Non-oncologic interventions were recommended in a median of 72% of patients (range 26–100%), most commonly involving social issues (39%), nutritional status (32%) and polypharmacy (31%). Effect on treatment outcome was varying, with a trend towards a positive effect on treatment completion (positive effect in 75% of studies) and treatment-related toxicity/ complications (55% of studies).

Conclusion: A geriatric evaluation affects oncologic and non-oncologic treatment and appears to improve treatment tolerance and completion for older cancer patients. Fine-tuning the decision-making process for this growing patient population will require more specific and robust data on the effect of a geriatric evaluation on relevant oncologic and non-oncologic outcomes such as survival and quality of life.

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Global geriatric oncology: Achievements and challenges



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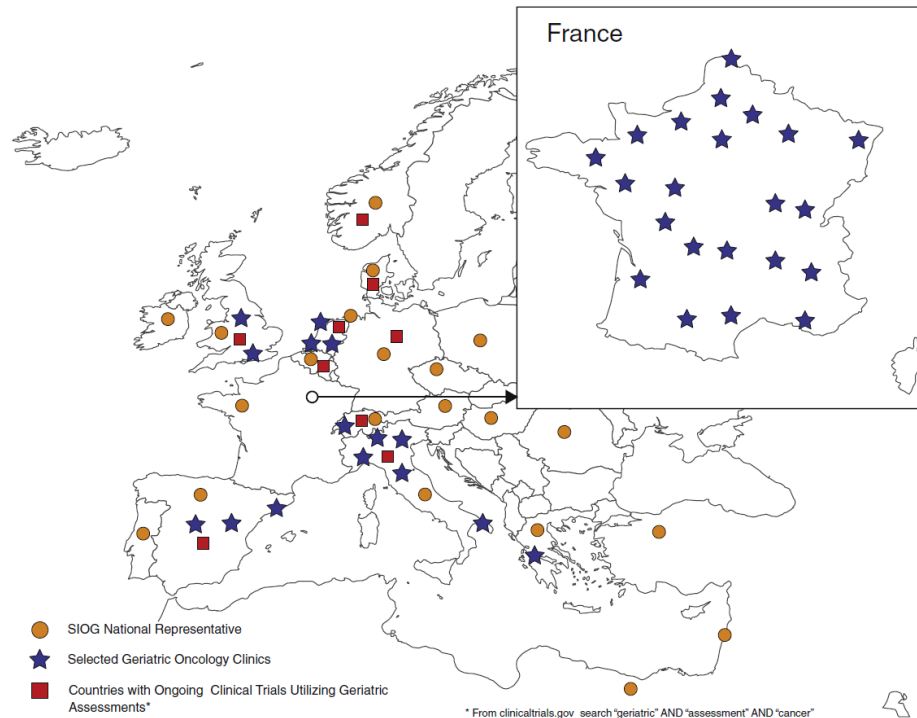


Fig. 5. Selected Geriatric Oncology Initiatives in Europe.

Table 1

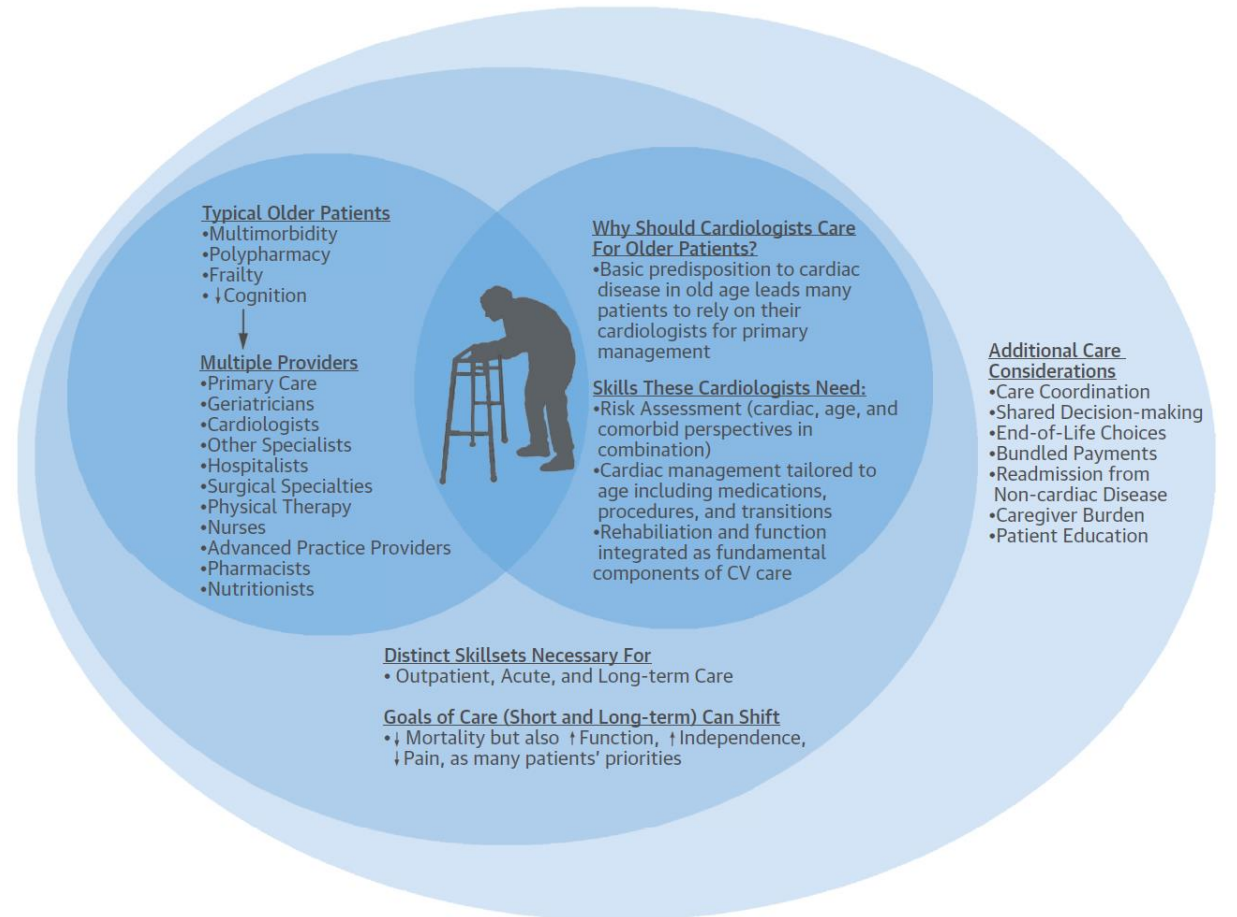
Summary of ASCO/ESMO global curriculum for geriatric oncology [21].

- | | |
|-----------|--|
| Awareness | <ul style="list-style-type: none">• Understanding the importance of the geriatric assessment and its domains• Recognizing competing causes of mortality• Understanding differences in tumor biology and pharmacology in older adults |
| Knowledge | <ul style="list-style-type: none">• Understanding that abnormalities in the geriatric assessment should lead to interventions and impact treatment decisions• Familiarizing with international guidelines• Utilizing the geriatric assessment to predict chemotherapy toxicity |
| Skills | <ul style="list-style-type: none">• Performing and interpreting a geriatric assessment• Collaborating with other healthcare workers, geriatricians and caregivers• Integrating the geriatric assessment into treatment decision-making and therapeutic choices |
-

- Cardio-geriatrics

The population of older adults is expanding rapidly, and aging predisposes to cardiovascular disease. The principle of patient-centered care must respond to the preponderance of cardiac disease that now occurs in combination with the complexities of old age. Geriatric cardiology melds cardiovascular perspectives with multimorbidity, polypharmacy, frailty, cognitive decline, and other clinical, social, financial, and psychological dimensions of aging. Although some assume that a cardiologist may instinctively cultivate some of these skills over the course of a career, we assert that the volume and complexity of older cardiovascular patients in contemporary practice warrants a more direct approach to achieve suitable training and a more reliable process of care. We present a rationale and vision for geriatric cardiology as a melding of primary cardiovascular and geriatrics skills, thereby infusing cardiology practice with expanded proficiencies in diagnosis, risks, care coordination, communications, end-of-life, and other competences required to best manage older cardiovascular patients. (J Am Coll Cardiol 2015;66:1286–99) © 2015 by the American College of Cardiology Foundation.

CENTRAL ILLUSTRATION Future of Geriatric Cardiology: Proposed Care Model and Skillsets Required by Cardiologists Caring for Geriatric Patients



Bell, S.P. et al. J Am Coll Cardiol. 2015; 66(11):1286-99.

Framework of contributing and resulting factors involved in the assessment and management of the older adult with cardiovascular (CV) disease highlighting the complex interplay among health care providers, patient dynamics, goals of care, systems of care, and the necessary key skills to provide optimum patient-centered care.
 ↓ = decreased; ↑ = increased.

- HOW CGA

- 2014-15, just over 1 million people aged 75 or older were admitted to acute hospitals
- Comprehensive Geriatric Assessment (CGA) saves lives and keeps more people at home than usual care
- In a hospital admitting 1,000 older people per month
 - around 200 would be classified as severely frail
 - application of CGA might result in
 - 12 more people being alive and in their own home
 - 40 fewer people being admitted to long term care

Geriatricians and the demographic challenge



Acute Frailty Network



Each year, **1,000,000** people aged 75 or older are admitted to acute hospitals in England

200,000 of these will be severely frail



These patients have a mean length of stay of **33.6 days**

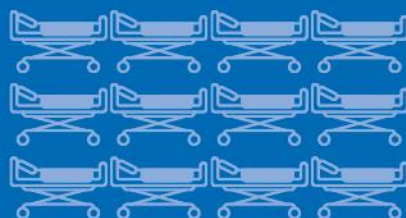
Severely frail older people therefore use **6,700,000** bed-days every year



The frail population is likely to increase by **148%** by 2035



1,500 Geriatricians are employed in the NHS



Each geriatrician would need to provide in-patient care for **4,480** older people with frailty per year

This equates to **12** patients per day, per geriatrician

Assuming no **holidays, study leave, other clinical or non-clinical work**

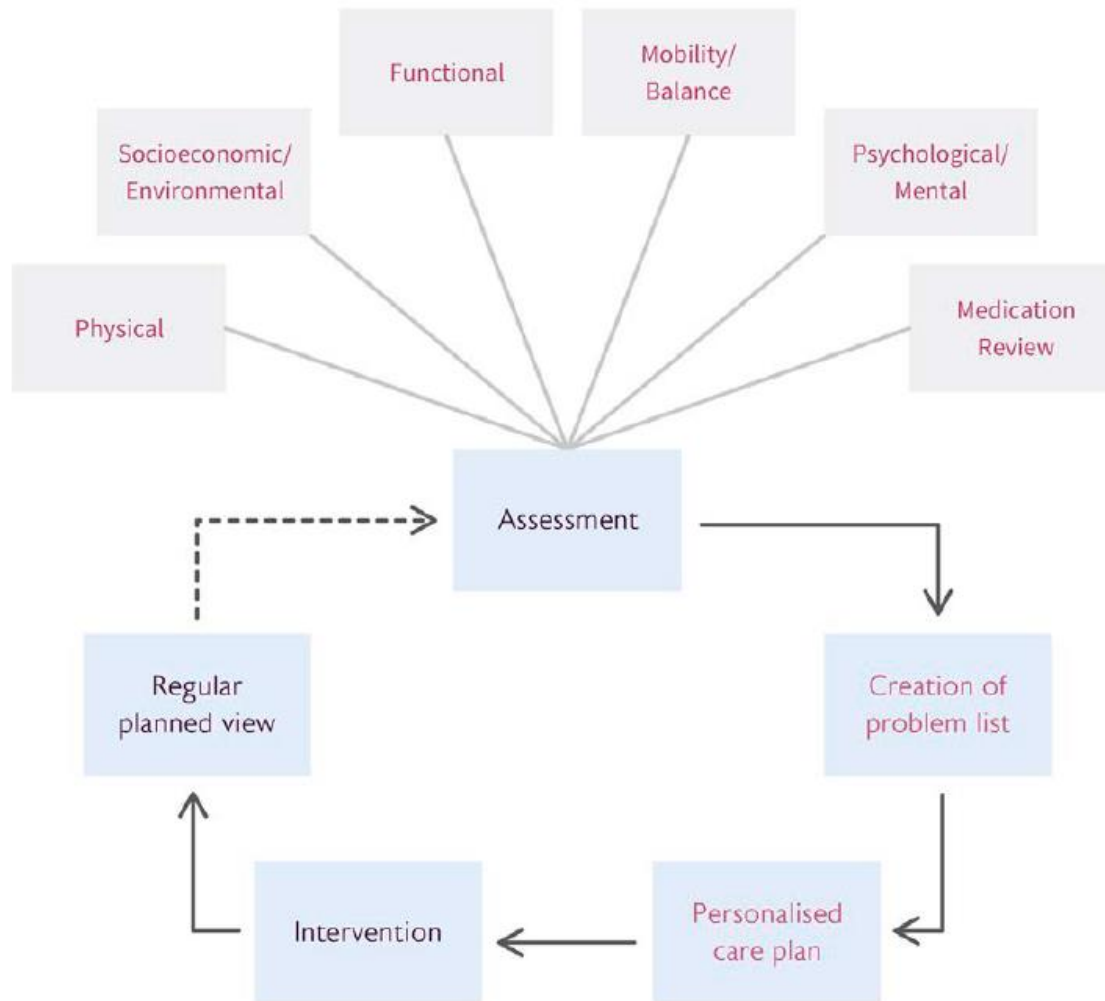


How can we meet this increasing demand?



Stop training doctors other than geriatricians?

Develop geriatric competences in the wider workforce?



- It remains unclear how CGA can be delivered hospital-wide reliably and at scale, and whether it is possible without depending upon geriatricians.
- HOW CGA

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Comprehensive geriatric assessment for frail older people in acute hospitals: the HoW-CGA mixed-methods study

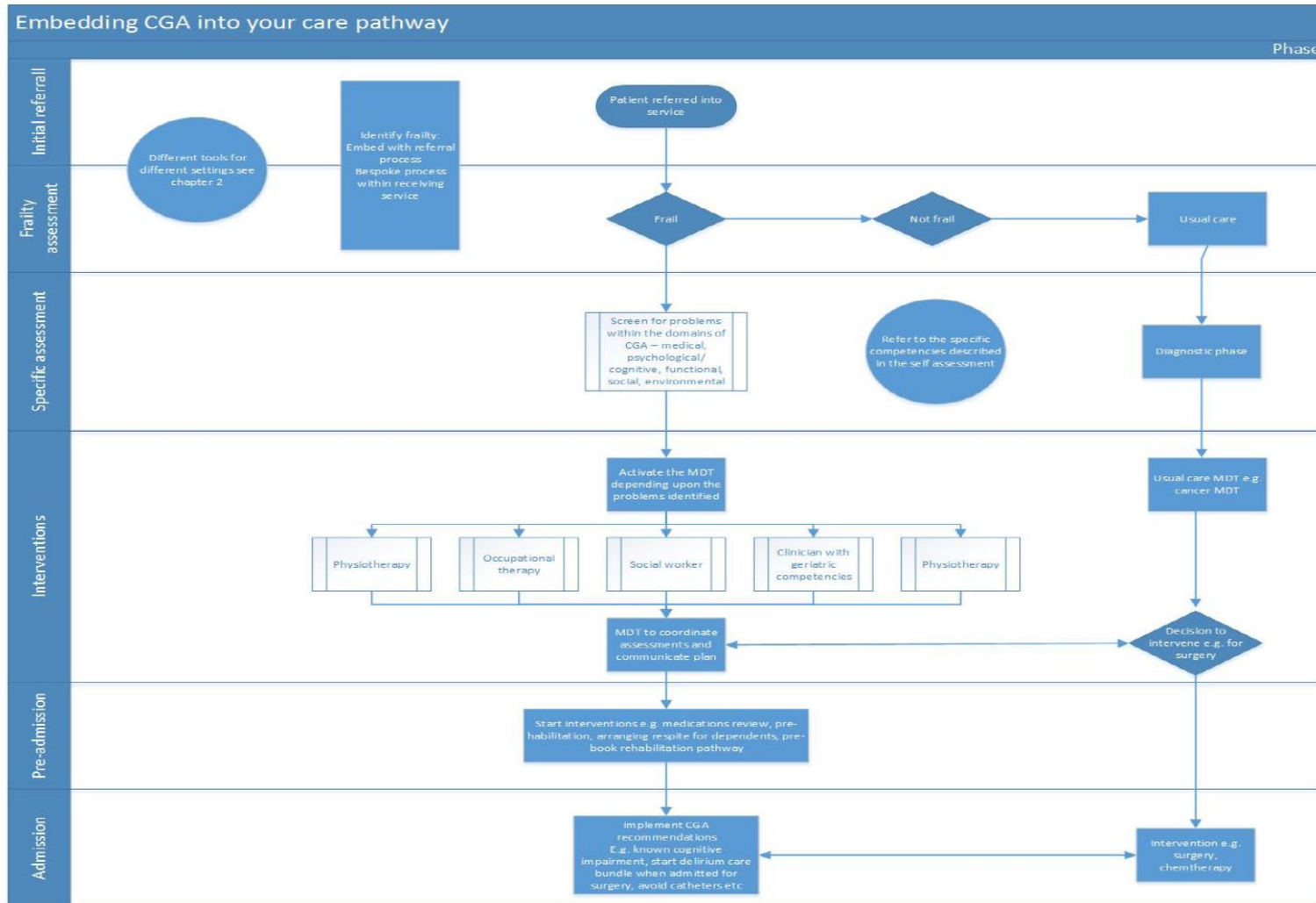
Simon Paul Conroy, Martin Bardsley, Paul Smith, Jenny Neuburger, Eilís Keeble, Sandeepa Arora, Joshua Kraindler, Cono Ariti, Chris Sherlaw-Johnson, Andrew Street, Helen Roberts, Sheila Kennedy, Graham Martin, Kay Phelps, Emma Regen, David Kocman, Patricia McCue, Elizabeth Fisher and Stuart Parker

← → ↻ 🏠 🔒 https://www.bgs.org.uk/resources/resource-series/hospital-wide-comprehensive-geriatric-assessment-how-cga ☆ 🔄 👤 ⋮

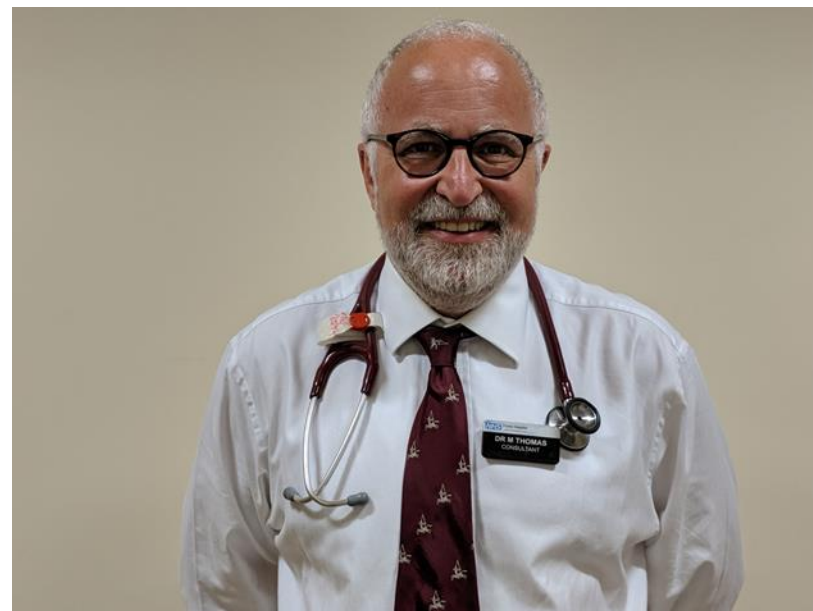
📁 Managed Bookmarks 📧 📧 Carestream EPR

<h3>HoW-CGA - Introduction to the service level toolkit</h3> <p>28 AUG 2018</p> <p>IN A SERIES CLINICAL GUIDELINES</p>	<h3>HoW-CGA Chapter 1: Using data to identify problem and convince others about the solution</h3> <p>28 AUG 2018</p> <p>IN A SERIES CLINICAL GUIDELINES</p>	<h3>How-CGA Chapter 2: Self-assessment</h3> <p>28 AUG 2018</p> <p>IN A SERIES CLINICAL GUIDELINES</p>	<h3>HoW-CGA Chapter 3: Team approach to change</h3> <p>28 AUG 2018</p> <p>IN A SERIES CLINICAL GUIDELINES</p>
<h3>HoW-CGA Chapter 4: Barriers to implementation</h3> <p>28 AUG 2018</p> <p>IN A SERIES CLINICAL GUIDELINES</p>	<h3>HoW-CGA Chapter 5: Review, expansion and sustainability</h3> <p>28 AUG 2018</p> <p>IN A SERIES CLINICAL GUIDELINES</p>	<h3>Hospital Wide Comprehensive Geriatric Assessment (HoW CGA) - History of the project</h3> <p>28 AUG 2018</p> <p>IN A SERIES REPORT</p>	<h3>Hospital Wide Comprehensive Geriatric Assessment (HoW-CGA): Overview</h3> <p>28 AUG 2018</p> <p>IN A SERIES FACT SHEET</p>

Figure 1: Embedding CGA into care pathway



- Recalibration



- “Ask your patient not what you might do for them but what it is right to do for them”

- Summary

- Geriatric Liaison has been an integral part of some disciplines for some time with proven benefits
- Other areas are coming on stream
- We need to work together to find the time to deliver CGA
- Every so often you need to recalibrate