Rapid assessment teams and early discharge of the elderly from ED; vunerable in the current financial climate?

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The demographics are clear; the UK, like most of the 'western' world, is an ageing society. Since the 1930s in England alone, the number of people aged over 65 has more than doubled and today a fifth of the population is over 60. In 30 years from 1995 to 2025, the number of people aged over 80 will increase by nearly half and the number of people over 90 will double. The implications of these data, for the NHS and Social Services over the next 20 years and beyond, are reasonably predictable. In 1998/99 the NHS spent 40% and Social Services spent 50% of their budgets on the over 65s. These percentages will inexorably increase although not necessarily in direct proportion to the population change.

The National Service Framework for Older People,[1] published by the Department of Health in May 2001, is a policy paper which recognises this challenge. It describes a fairly high level strategy plus the principles that need embedding to ensure that the needs of the elderly are at the heart of NHS and Social Services reforms; reforms envisaged by the NHS Plan, published in 2000, and Modernising Social Services, published in 1998.

The elderly who attend an emergency department can be broadly categorised into three discrete groups. The first are those with a distinct diagnosis (acute coronary syndrome, a fracture needing operative treatment, ischaemic bowel etc) who are admitted under the care of the relevant specialty. Secondly there are those who are unwell, or off their legs, but the cause is unclear. They need a work up to establish a definitive diagnosis and appropriate treatment. They are admitted under the care of the medical or geriatric specialties. The final group are those with an acute but intrinsically minor problem; in the normal scheme of things a younger fitter patient with the same condition is not admitted for treatment. The majority of patients in this group have an acute (or acute on chronic) musculoskeletal problem, although ENT, ophthalmological and superficial infections are other typical causes. The elderly person who also has co-morbidities may be unable to go home. The clinical problem they have may be just enough to upset their equilibrium to the extent that the fine, almost homeostatic, balance they have with their home environment is disturbed. They are no longer safe enough to be discharged; even if they are safe for discharge we may not know it because we know little about their domestic circumstances. These patients take a long time to assess. Scrutiny of their daily drugs list or a quick peek at the size of the bag containing their prescribed drugs can be enough to sink the heart but it is a clue that there will be a slow turnaround. The resource impact that these patients impose on an emergency department is significant.

It helps if they live in a nursing home or have good family support; it helps if the relatives have accompanied them to hospital or have left a phone number. If not and they live alone or have a frail co-dependant partner then unmasking details of their home life and support networks is time consuming and frustrating. Their frail partner (or pet) doubles the problem to be solved.

The aim is to keep these people out of hospital but if a short stay ward admission is needed then the stay needs to be as brief as possible. Short stay admission is a useful but expensive option while assessment of their activities of daily living continues. Admission to such a unit enables compliance with the four hour target.

The patient's GP is clearly a source of help but is unlikely to comment on safety now that the patient has an acute problem.

The National Service Framework for Older People acknowledges the paradigm shift occurring in our attitude to the elderly. It mentions that there have been concerns about inequalities of access with poor, unresponsive, insensitive, and even discriminatory services in the past but these are becoming less common. The Framework highlights the work of nine task groups commissioned to report on where care for the elderly is provided, process issues around the delivery of care and finally specific conditions such as stroke, falls, and mental health (including dementia).

'Modernising discharge from hospital', published in January 2006 in the NHS Library for Health[2] describes several strategies to improve discharge from hospital. In particular the paper aims 'to provide all staff working in emergency care settings with the major changes affecting discharge planning' **[sic]**. The main focus of this paper appears to be on the patient in a ward, rather than in an ED cubicle.

The Care Services Improvement Partnership, founded in 2005 and part of the Department of Health, offers a service development guide for integrated mental health services for the elderly, including dementia.[3] It makes one reference to A&E **[sic]** and that is that there must be teams who can offer rapid assessment of older people with suspected mental health problems who present to A&E. It does not go into any more detail so we cannot get to grips with what this statement actually means.

The model of rapid assessment teams, consisting of nurses, allied health professionals and doctors, who all have excellent connections with local primary care and community services is well established. This is the means to help expedite rapid and safe discharge for frail elderly people.

How many NHS hospital trusts have such a system in place? If short stay is needed, pending full assessment, how many trusts have such units? Is there enough capacity to offer this service? Is the expertise there? There is an imperative to audit these services. If not in place then they need to be; if they do exist they are at risk of being cut in the current financial and budgetary climate. The long term implications of not investing or sustaining this service are clear.

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