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Old age psychiatry and geriatric medicine collaborative training

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@HeartOfGold_42

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Consultant old age psychiatrist
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Contents

- Review of curricula for geriatric medicine higher specialist training in old age psychiatry
- Presentation of a pilot joint training programme conducted in the West Midlands
- Discussion of next steps – how to make collaborative training and working sustainable in the future
- Q&A

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Geriatric Medicine HST curriculum 2010 (amendments 2016)

- Delirium - section 32
- Dementia – section 33
- Psychiatry of Old Age – section 42
- Optional higher level competencies – section 49

https://www.bgs.org.uk/resources/clarification-of-training-requirements-for-higher-specialist-trainees-in-geriatric

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Dementia in training curricula

- Geriatric Medicine HST curricula
- Multiprofessional framework for advanced clinical practice for practitioners working with older adults
- BGS Medical undergraduate curriculum in Geriatric Medicine
- Extremely limited in GIM, CMT, neurology, psychiatry – review work undertaken 2012 (Dr C Nicholl, BGS ETC)

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Dementia – Section 33

To be able to assess and manage patients who present with dementia and also to assess and manage patients with dementia who present with other illnesses in acute and intermediate care

Knowledge

Diagnostic criteria for dementia, including in younger people with dementia, people with learning disabilities, and people from minority ethnic groups

Differential diagnosis of dementia

Investigation of patients presenting with dementia, including neuroimaging and neuropsychological assessment

Pharmacological and non-pharmacological management of dementia

Palliative care of people with dementia

Available support for people with dementia and their carers, including post-diagnostic support and advice, personalised services, peer support, housing support, housing-related services and telecare

The impact of dementia on the assessment and management of other illnesses

The impact of dementia on rehabilitation, e.g. in stroke and orthogeriatrics

The effect of treatment of other illnesses on dementia

The effect of drug treatments for dementia on other illnesses

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Psychiatry of Old Age - section 42

To know how to assess and manage older patients presenting with the common psychiatric conditions, and to know when to seek specialist advice

Knowledge

Major psychiatric conditions and illnesses: depression, delirium, dementia, anxiety and paranoid states

Clinical Pharmacology, therapeutics and pharmacy for older people with psychiatric conditions

Ethics and Medico-legal issues

Organisation of old age psychiatry services

Psychiatric assessment methods and tools

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Specific Learning Methods

- General medical take
- Specific teams e.g. Psychiatry outreach, DADOT
- Placement – a minimum of a four week attachment or equivalent

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Optional higher level curriculum competencies in dementia and psychogeriatric services - section 49

Delirium, incidental cognitive impairment, chronic cognitive impairment (dementia, MCI) and cognitive decline in the presence of an intellectual disability

Knowledge

Biological substrates involved in delirium and dementia

Assessment tools for delirium and dementia

Complications of delirium

Pharmacological management of delirium and dementia

Non-pharmacological management of delirium and dementia

Legal issues of capacity and consent in delirium and dementia

Differential diagnosis of cognitive decline in people with pre-existing intellectual disability

Atypical presentations of dementing illnesses in people with pre-existing intellectual disability

Assessment scales useful to measure cognitive status in people with pre-existing intellectual disability

Common co-morbidities that might affect management of dementia in people with pre-existing intellectual disability

Specialist services available for people with pre-existing intellectual disability

The impact of cognitive impairment on the assessment and management of other illnesses

The impact of cognitive impairment on rehabilitation, e.g. in stroke

The effect of treatment of other illnesses on cognitive impairment

The effect of drug treatments of cognitive impairment on other illnesses

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Specific Learning Methods

- Core curriculum targets
- A minimum of a six month attachment to include 1 month acute assessment, 2 month memory clinic attachment, 1 month assessment and management of inpatients and sessional attachments with community teams

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Assessment strategy

Capabilities in Practice (CiPs)

‘A unit of professional practice identified as a task or responsibility to be entrusted to a learner to execute unsupervised once sufficient competence has been demonstrated’

In the literature referred to as Entrustable Professional Activities (EPAs)

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Assessment tools – remain the same

Supervised Learning Events (SLEs):

- Acute Care Assessment Tool (ACAT)
- Case-Based Discussions (CbD)
- Mini-Clinical Evaluation Exercise (mini-CEX)

WPBAs:

- Direct Observation of Procedural Skills (DOPS) - formative
- Multi-Source Feedback (MSF)
- Patient Survey (PS)
- Quality Improvement Project Assessment Tool (QIPAT)
- Teaching Observation (TO)

Supervisor reports:

- Multiple Consultant Report (MCR)
- Educational Supervisor Report (ESR)

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Internal medicine stage 1 will normally be a three year programme that will include mandatory training in geriatric medicine, intensive care, outpatients and ambulatory care.

Internal Medicine curriculum 2018 (page 3)

https://www.jrcptb.org.uk/sites/default/files/Internal Medicine stage 1 curriculum FINAL 221217.pdf

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Geriatric medicine

With an increasing elderly population it is essential that all trainees in IM have adequate exposure to and experience of geriatric medicine. It is felt that a four month attachment to a team led by a consultant geriatrician during the training programme is an absolute minimum.

Internal Medicine curriculum 2018 (page 33)

https://www.jrcptb.org.uk/sites/default/files/Internal Medicine stage 1 curriculum FINAL 221217.pdf

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Geriatric Medicine Curriculum

- Purpose statement October 2018
- Only allowed 8 CiPs – mapped to more detailed syllabus
- The fate of stroke medicine
- “No optional grids”
- Curriculum has to be risk assessed for equality and diversity

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Geriatric Medicine specialty CiPs (all trainees)

1. Performing a comprehensive assessment of an older person, including mood and cognition, gait, nutrition and fitness for surgery in an in-patient, out-patient or community setting
2. Managing complex common presentations in older people, including falls, delirium, dementia, movement disorders, incontinence, immobility, tissue viability, and stroke
3. Managing older people living with frailty in a hyper-acute (front door), in-patient, out-patient or community setting
4. Managing and leading rehabilitation services for older people, including stroke
5. Managing community liaison and practice
6. Managing liaison with other specialties, including surgery, orthopaedics, critical care, oncology, old age psychiatry
7. Evaluating performance and developing and leading services with special reference to older people

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Geriatric medicine specialty CiPs (themed for service)

1. Able to manage older patients presenting with fracture and is able to provide a comprehensive orthogeriatrics and bone health service
2. Able to assess patients with urinary and faecal incontinence and is able to provide a continence service for a specific patient group in conjunction with specialist nursing, therapy and surgical colleagues
3. Able to confidently manage ill or disabled older people in a hospital at home, intermediate care and community setting and is able to provide a community geriatric medicine service
4. Able to manage patients with a wide range of movement disorders at any stage and is able to develop a specialist movement disorders service for older people
5. Able to assess patients presenting acutely with stroke and TIA including suitability for cerebral reperfusion treatments and their subsequent ongoing medical management within an organised stroke service

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A. Capability in practice (CiP) leading to a 'trusted decision'	B. Descriptor (key observable activities, tasks and behaviours)	C. Evidence	D. Relevant competencies from the current specialty curriculum
1. Performing a comprehensive assessment of an older person, including mood and cognition, gait, nutrition and fitness for surgery in an in-patient, out-patient or community setting	• Demonstrates the ability to take a comprehensive history incorporating physical, social, cognitive and functional elements • Demonstrates the ability to communicate effectively with patients from diverse backgrounds and with special communication needs such as hearing, visual and speech impairments and confusion and mental health issues • Demonstrates diagnostic skills – particularly in the context of complex multisystem pathologies and associated social and psychological issues • Demonstrates the ability to perform functional status evaluation • Demonstrates the ability to use CGA to develop individualised management plans • Champions the value of CGA	CbD Mini CEX SCE ACAT MCR MSF	• Knowledge of factors influencing health status in older people, and measures employed in measuring this • Models and concepts of frailty • Evidence base for CGA • Awareness and recognition of age discrimination within healthcare systems and strategies to combat this • Knowledge of the range of agencies that can provide care and support, how they can be accessed, and financial support available • Is familiar with safeguarding legislation and actions needed when caring for vulnerable adults

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Current curriculum area	New curriculum	Possible impact/comments
Delirium	IM CiPs 1-3,5; Ger Med CiP 2	The content will remain unchanged? Unlikely to have impact
Dementia	IM CiPs 3,4; Ger Med CiPs 1-6 Higher level grid will be incorporated into main curriculum	There will need to be some additional components to the core syllabus – but there is already a lot of overlap. New requirements may include: - Assessment tools for delirium and dementia - Complications of delirium - Legal issues of capacity and consent in delirium and dementia - Ordering appropriate investigations - Appropriate prescribing of drugs - Providing leadership and advice to staff unfamiliar with caring for patients with cognitive impairment A greater focus on delirium and dementia in the core curriculum is clearly justifiable given the change in demographic of our patients.

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JOINT TRAINING PILOT

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Classic model

Patient with BPSD

Brought in to ED by family

Referred to medicine for “?UTI”

Admitted to geriatric medicine – assess/ treat any physical precipitants

Ongoing challenging behaviour – referred to liaison psychiatry but deemed not “medically fit”

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Classic model

- Patient with BPSD
- Brought in to ED by family
- Referred to medicine for “?UTI”
- Admitted to geriatric medicine – assess/ treat any physical precipitants
- Ongoing challenging behaviour – referred to liaison psychiatry but deemed not “medically fit”

- Patient with BPSD
- Family ask GP to review
- GP refers to old age psychiatry inpatient unit
- Psychiatrists carefully titrate medication against symptoms, receives specialist nursing input
- Concerns raised that patient’s heart rate increased (?infection) – discussed with medical SpR and sent to ED

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Geriatric medicine curriculum

To know how to assess and manage older patients presenting with the common psychiatric conditions, and to know when to seek specialist advice		
Knowledge	**Assessment Methods**	**GMP**
Major psychiatric conditions and illnesses: depression, delirium, dementia, anxiety and paranoid states	SCE, mini-CEX, CbD	1
Clinical Pharmacology, therapeutics and pharmacy for older people with psychiatric conditions	SCE, mini-CEX, CbD	1,2
Ethics and Medico-legal issues	SCE, mini-CEX, CbD	1,3,4
Organisation of old age psychiatry services	SCE, CbD	1,2,3,4
Psychiatric assessment methods and tools	SCE, mini-CEX, CbD	1
Skills		
Diagnostic skills	SCE, mini-CEX, CbD	1,2,3
Drug and non-drug interventions	SCE, mini-CEX, CbD	1,2,3
Team and leadership skills	MSF, ACAT	1,2,3,4
Cognitive and mood assessment	SCE, mini-CEX, CbD	1,2,3,4
Appropriate referral to other specialists	SCE, mini-CEX, CbD	1,2,3
Assessment and documentation of mental capacity	SCE, mini-CEX, CbD	1,3
Behaviours		
To develop a positive approach to the investigation and management of psychiatric conditions in respect of older people	MSF, CbD, ACAT	1,2,3,4
To work collaboratively with other specialists, particularly old-age psychiatrists, and agencies to manage the older patient with mental ill health	MSF, mini-CEX, CbD	1,2,3,4
To take account of a patient's family, cultural and religious background bettering order to enable the management of the psychiatric health of the individual patient	MSF, mini-CEX, CbD	1,3,4

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Current old age psychiatry curriculum

Intended learning outcome 1	
The doctor will be able to perform specialist assessment of patients and document relevant history and examination on culturally diverse patients …	
1a Clinical History	**Assessment methods**
Skills Make a basic physical examination, be competent in the diagnosis and management of physical illness at a basic level and take this into account when planning individual management. Also recognise and manage the complex interaction of mental and physical problems in old age	ACE, Mini-ACE, CBD
1b Patient examination, including mental state examination and physical examination	**Assessment methods**
Knowledge	
Skills Able to identify psychopathology in all clinical situations, including those that are urgent and/or complex Assess and diagnose patients with multiple and complicated pathologies	ACE, Mini-ACE, CBD ACE, Mini-ACE, CBD
Intended learning outcome 15	
Develop appropriate leadership skills	
Intended learning outcome 15	**Assessment methods**
Take into account in service design and delivery the relationship between physical illness and disability in late life	Mini-PAT, DONCS, supervisor's report

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Proposed old age psychiatry curriculum

To develop the ability to carry out comprehensive assessment and treatment of patients with physical health problems		
Knowledge	**Assessment Methods**	**GMP**
Recognise that good health includes both physical and mental wellbeing and social, sexual and spiritual aspects	SCE, mini-ACE, CbD	1, 4
Factors influencing health status in older people	SCE, mini-ACE, CbD	1,2, 3
Models and concepts of frailty	SCE, mini-ACE, CbD	1,2,3,4
Recognition, diagnosis and management of Delirium.	SCE, CbD	1,2,3,4
Be aware of and recognise age discrimination within healthcare systems, and the role that individuals and services can play in combating this	SCE, mini-ACE, CbD SCE, CbD	1,2,3,4 1,2,3,4
Have knowledge of the range of agencies that can provide care and support both in and out of hospital and how they can be accessed	SCE, mini-ACE, CbD	1,2,3,4
Be familiar with safeguarding legislation and actions needed when caring for vulnerable adults		
Be familiar with ethical issues such as decisions regarding life-prolonging treatments, Resuscitation decisions, Consent procedures		
Skills		
Assess the physical health of patients on admission and at appropriate intervals thereafter, including the assessment for the presence or absence of illness, injury or disability, and any of the following – receiving a medical history, making a functional enquiry, undertaking a physical examination, arranging blood tests and other investigations for the presence of an underlying physical cause, as necessary.	SCE, mini-ACE, CbD	1,2,3, 4
Recognition of acute illness (the 'deteriorating patient'): this includes measuring physiological parameters, using NEWS (National Early Warning Score) system, making the 'first response' to an acute illness, and using effective communication and resuscitation techniques.	SCE, mini-ACE, CbD SCE, mini-ACE, CbD	1,2,3,4
Monitor and provide treatment for long-term conditions in collaboration with specialists including the awareness of all medicines prescribed for the patient.	SCE, mini-ACE, CbD	1,2,3,4
Delirium, Falls, Immobility, Incontinence (urinary and faecal) assessment and management	SCE, mini-ACE, CbD, Mini-PAT SCE, mini-ACE, CbD	1,2,3,4 1,3, 5
Communicate effectively with patients from diverse backgrounds and those with special communication needs such as hearing, visual and speech impairments and confusion and mental health issues	SCE, mini-ACE, CbD	1,2,3,4
Diagnostic skills – particularly in the context of complex multi-system pathologies and associated social and psychological issues.	SCE, mini-ACE, CbD	1,2,3,4
Functional status evaluation, including assessment of basic ADL and IADL, social support, mental health and cognitive status, mobility including gait and balance, and nutritional evaluation (assessment scales) used to assess functional status	SCE, mini-ACE, CbD	1,2,3,4,5
Know 'when and how' to refer to other health professionals. In particular, be aware of clinical 'red flag' symptoms and signs that should prompt referral to specialists and facilitate recovery from physical illness or injury for instance by liaison with specialists who provide the services needed by the patient for physical healthcare.		1,2,3,4
Assist and guide Core trainees in assessing and managing patients with physical illness		
Behaviours		
To develop a positive approach to the investigation and management of physical health conditions in respect of older people	MSF, CbD, ACAT	1,2,3,4
To work collaboratively with other specialists, particularly geriatric medicine, and agencies to manage the older patient with physical ill health	MSF, mini-CEX, CbD, mini-PAT	1,2,3,4, 5
To take account of a patient's family, cultural and religious background bettering order to enable the management of the physical health of the individual patient	MSF, mini-CEX, CbD	1,3,4

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Current training model

Returns to “normal job” in hospital

Sits in/ observes some memory clinics, basic experience on inpatient unit

Geriatric medicine trainee – working in hospital

Runs memory clinics, some inpatient placements

Phones (or delegates to more junior trainees) GP or medical SpR for advice about physical health problems

Old age psychiatry trainee – mainly working in community

Does own home visits

Talks to colleagues – sends some emails until someone replies

Minimal geriatric medicine exposure

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Pilot training model

Geriatric medicine training

Old age psychiatry training

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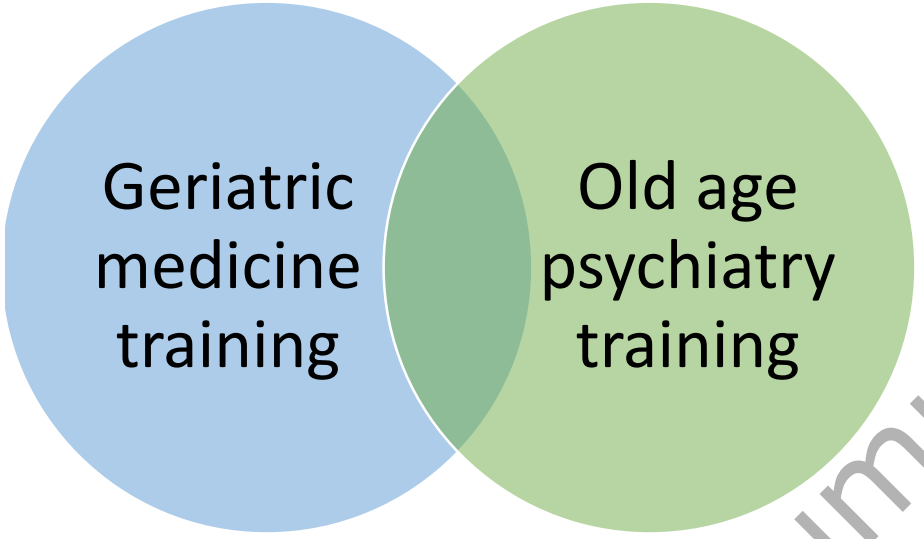
Welch (2019) BMC Med Educ; 19:283

Pilot training model



Aims
To link old age psychiatry and geriatric medicine higher trainees to attend and participate in each others' clinical experience
To foster a joint way of learning and working together
To allow trainees to fulfil curriculum competencies that are otherwise difficult to achieve

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Welch (2019) BMC Med Educ; 19:283

Methods

5 trainee pairs formed in 2017-18 academic year

Geriatrics ST3-ST7; old age psychiatry ST4-ST6

Group meetings during the year to discuss progress

Old age psychiatry trainees shadowed geriatric medicine trainees/ attended activities geriatric trainees were able to help facilitate

e.g. specialty referrals, stroke, Parkinson's, outpatient clinics, ward rounds

Geriatric medicine trainees shadowed old age psychiatry trainees/ attended activities old age psychiatry trainees were able to help facilitate

e.g. memory clinics, psychotherapy, home visits, complex care units

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Methods - evaluation

Feedback provided informally at group discussions

Feedback collected formally through trainee surveys pre- and post-pilot

Anonymised reflections collected from trainees

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Survey - results

Likert scale questions of confidence in competencies

Grouped into geriatric medicine/ old age psychiatry/ both

Wilcoxon signed rank sum test

	Geriatric medicine			Old age psychiatry		
	Pre-pilot (median score)	Post-pilot (median score)	p-value	Pre-pilot (median score)	Post-pilot (median score)	p-value
Geriatric medicine competency questions	4	↑ 5	<0.001 *	3	↑ 4	<0.001 *
Old age psychiatry competency questions	3	↑ 4	<0.001 *	4	4	0.08
Competency questions pertaining to both specialties	4	↑ 5	<0.001 *	3	↑ 4	0.003*

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Reflections – general

*Attendance at this clinic demonstrated the potential benefit of **collaborative working** between geriatricians and old age psychiatrists.*

Geriatric trainee, ST5

*There are **gross similarities** between the patients and problems that both specialties face, but both have a **slightly different focus**.*

Geriatric trainee, ST5

*My **team** found his input quite beneficial and [his] team felt the same when I shadowed him.*

Old age psychiatry trainee, ST5

***Patients** are better managed when there are good links between specialties.*

Old age psychiatry trainee, ST5

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Reflections – geriatric trainee knowledge

*It was particularly interesting to learn of the **infrequency** of which psychiatrists prescribed **sedative medication** for management of agitation …. I felt that members of the MDT were generally more comfortable in managing such symptoms than staff within secondary care and that there was less pressure to prescribe sedative medication for management of complex patients.*

Geriatric medicine trainee, ST5

*Doses of **acetylcholinesterase inhibitors** can be escalated when symptoms of [Behavioural and Psychotic Symptoms of Dementia (**BPSD**)] exist rather than commencing antipsychotics.*

Geriatric medicine trainee, ST5

*Although dementia diagnosis is often referred to old age psychiatry, the process is no different to that encountered by geriatricians and **geriatricians should feel more confident** (and should be supported) in making these diagnoses as well.*

Geriatric medicine trainee, ST5

*It was interesting to see the different dynamics of a **home visit** compared to a clinical setting. It highlighted how complex elderly psychiatry needs can be, especially when **two people in a household** are affected by mental health issues.*

Geriatric medicine trainee, ST5

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Case example …

Creative commons

"Fred"

Resident in traumatic brain injury unit

Previous subarachnoid haemorrhage

Recent progressive memory loss and behavioural difficulties

Early dementia diagnosis to enable support and pragmatic approach to investigation and treatment

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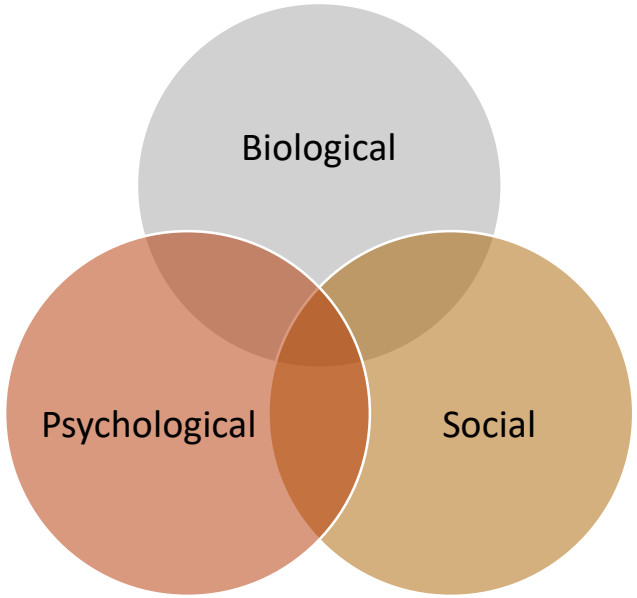
Case example …

Creative commons

"Bill"

Psychotherapy sessions alongside drug treatment for depression



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MDT

Inpatient mental health services – complex care unit

Only one voluntary patient – remainder either MHA or DOLS

Complexities of managing patients with complex behavioural and Psychotic symptoms of dementia

Difficulties surrounding discharge and finding appropriate long-term care facilities

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To discuss…

- How timetables were set up
- How trainees in a pair worked in partnership
- Experiences and reflections of psych trainees

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Example of a timetable set up for geri trainees

	AM	PM
Monday	Outpatient clinic/psychotherapy	Home visits
Tuesday	Home visits	Tribunal
Wednesday	Outpatient clinic	Home visits
Thursday	MDT ward meeting	Ward reviews
Friday	Outpatient clinic	Home visits

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Example of a timetable set up for OA psych trainees

	AM	PM
Monday	Ward round	Seeing referrals from other wards
Tuesday	Stroke emergency on call	Stroke emergency on call
Wednesday	Outpatient clinic	Outpatient clinic
Thursday	Medical SPR on call	Medical SPR on call
Friday	Ward round	Seeing referrals from other wards

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Some deviations from the typical timetable….

- Occasionally, in the absence of an OA psych trainee counterpart, geri trainees would shadow consultants or another trainee in the study.
- Timetables would be “stretched” due to study leave, AL, clinic cancellations etc.
- One psychiatry trainee was a dual working age and old age psychiatry trainee thus arrangements were made for her to shadow another psych SPR in another pair.

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Experiences of psych trainees in geri settings

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Psych SPR shadowing geri SPR

Differences noted between geri and psych wards	
Geri ward	Psych ward
Bigger wards	Smaller wards
Staff wear uniforms	Staff don't wear uniforms
All patients are reviewed in 1 days	A few are reviewed in 1 day
Reviews involved patient and doctors (sometimes nurses)	Reviews have nurse, doctors, social worker, family, care coordinator, OT, physio and pt
A review lasts up to 15 min	A review lasts up to an hour
Everyone will be standing	Everyone will be sitting

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Psych SPR shadowing geri SPR

<u>Falls management on geri wards</u>

1. History and eyewitness account
2. Causes – cardiovascular meds, arthritic changes, postprandial hypotension, carotid sinus syncope, neurocardiogenic syncope, valvular heart disease
3. Physical examination
4. OT and physio assessment
5. Exercise program and vit D supplements
6. OT/physio home assessment for aids etc
7. Discussion in morning meeting - ?referral to hospital social services for care home transfer etc.

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Psych SPR shadowing geri SPR

<u>Falls management on psych ward</u>

1. History and eyewitness account.

2. Causes – psychological/attention-seeking, violence/aggression, mania, depression, psychiatric meds (dementia meds, antipsychotics etc), UTIs, dehydration, uncontrolled DM, poor vision, dementia.

3. Discussion in morning huddle – nurses, doctors, OT and physio.

4. Consider boundaries setting and distraction measures.

5. Referral to falls clinic or referral letter to geri doctors to review on the ward.

6. Discussion again in morning huddle – home visit to assess for aids or refer to social services (not part of mental health service) to assess patient on ward.

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A case of a swollen joint during consultant's ward round……

- A swollen ankle.
- Consultant asked "which type of arthritis is commonly associated with metabolic syndrome?"
- My list of causes of swollen ankles:
  - falls
  - not elevating feet
  - cellulitis
  - DVT
  - heart failure
- Actual cause was gout!

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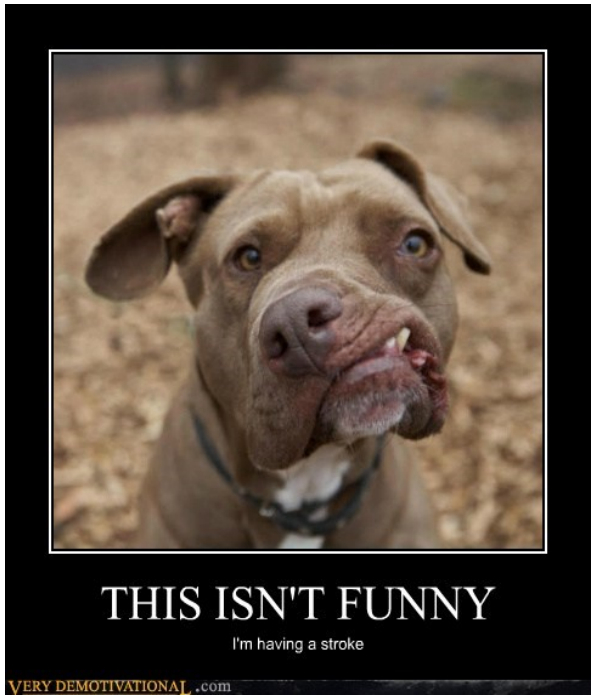
When a stroke is not a stoke….

- Shadowing SPR on call for stroke emergencies.

- Asked to see a lady with a swollen face – turned out to be angioedema!
- Asked to see another lady who became unconscious in a a supermarket – turned out that she had experienced a heat exhaustion!

- Interesting to see how so many illnesses can be confused with strokes.



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Reflections of the psych trainees

- *I found this experience useful in refreshing my skills in physical health in old age.*
- *I was surprised to know that elderly patients with significant co-morbidities can undergo major operations.*
- *One tends to forget stroke mimics when working in psychiatry. It is common to see suspected stroke cases.*
- *When working in old age, one tends to forget all causes of fevers.*

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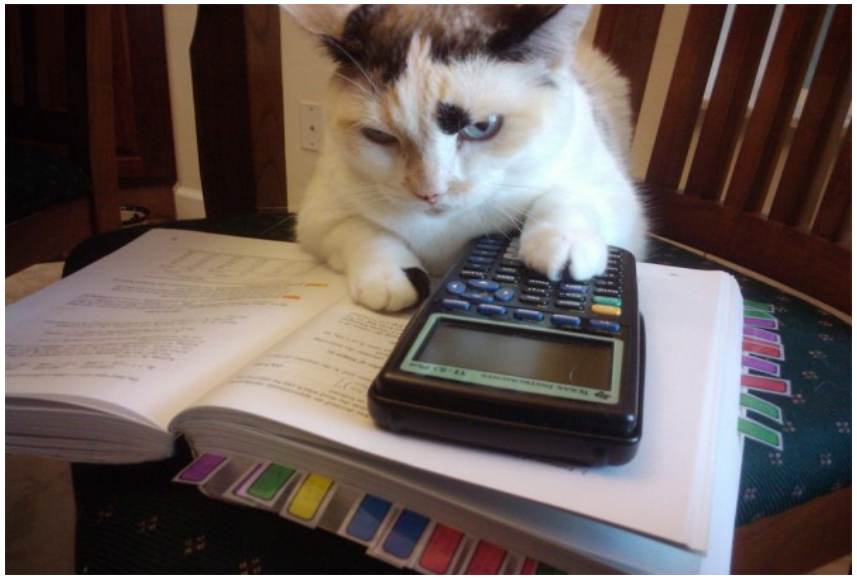
Reflections of old age consultants

- *I personally and professionally found the whole process hugely beneficial. We found there was more overlap between our roles than either party had realised.*
- *I learnt a great deal from the geri SPR.*
- *My team found it really helpful to have an opportunity to ask some medical queries about problems that we come across regularly but perhaps don't feel that confident in managing.*



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Long term benefits of the study as perceived by psych trainees

- Experience useful in sitting the geri diploma exam.
- Establishing long-lasting social networks.
- Both specialties arranging joint teaching days and conferences.
- Better understanding of the referrals system for patients.

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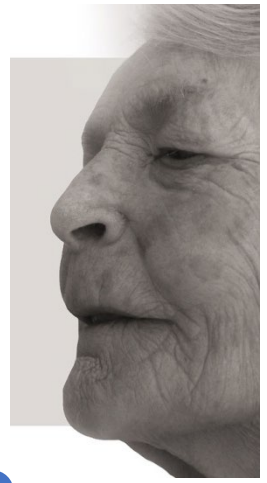
Future model?



Patient with BPSD

Admitted to specialist unit with geriatric medicine and old age psychiatry services available

Geriatricians comprehensively assess, treat physical precipitants

Geriatricians and old age psychiatrists work collaboratively in interests of patient

Old age psychiatrists review mental state, drugs, optimise pharmacological and non-pharmacological management

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Next step

- The Old Age Faculty "Frailty" paper--- is coming out soon
- The College's report Delivering the NHS Long-Term Plan's ambition of ageing well: Old age psychiatry as a vital resource---is out
- GMC pairing it down in all specialities so maybe work in progress?

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Delivering the NHS Long-Term Plan's ambition of ageing well

- Older people with mental illness have specialist and often complex needs related to medical co-morbidity and long term conditions, frailty, cognitive impairment and social needs
- The wide range of services and the variation in service models puts this growing group at risk of having their mental health and physical well-being overlooked
- An increased focus on frailty reveals that cognitive and psychological factors play a complex role in the development and outcomes of this syndrome
- There is a growing demand for services which is not matched by recruitment and retention trends

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The Old Age Faculty Position paper on Frailty

- Putting patients at the centre of all we do
- working in collaboration with others have expertise in providing high quality care and treatment for older frail people
- Old Age Psychiatrists is built in to the specifications of the Frailty Services both in the Community and in A and E which would help to take a proactive approach to frailty rather than a reactive approach
- Research into correlation between serious mental illness and frailty

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Summary

- Physical and psychiatric health problems rarely exist in isolation amongst older adults
- A collaborative training model has potential to increase links between the two specialties and improve trainee confidence
- Further work is needed to determine how this model of training can be sustainable at scale

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