Document 1

Clarification of training requirements for higher specialist trainees in Geriatric Medicine in Community Practice Including Continuing, Respite and Intermediate Care

As a consequence of the ageing population in the UK and increasing pressures on acute hospitals there is a renewed emphasis on shifting the balance of care to the community and providing care closer to home in a more patient-centred way. This has led to closer joint working across primary and secondary care, with social care and the third sector. Many initiatives have evolved into novel services involving Geriatricians in new roles in the community. This has created a breadth of new community training opportunities.

Services providing Comprehensive Geriatric Assessment in the patient's home have been developed in an effort to avoid unnecessary emergency hospital attendances. These are evolving at different rates. Trainees should gain experience of different approaches, assessing the sick elderly patient at home, investigating and providing treatment and supporting patients and their carers by liaising with social care and voluntary sector services.

Community Hospitals may provide facilities for step-up care from the community and step-down care from acute hospitals. They may serve other roles including slower stream rehabilitation, palliative care, interventional procedures such as IV fluids, antibiotics, and other treatments. They may provide short-term respite admissions. Different models of supervision exist involving GP's, hospital based teams and community Geriatricians. Trainees should try to gain experience as to what these facilities can provide and how they can develop to support the changing provision of healthcare for the elderly closer to home.

In most areas, general practitioners take responsibility for patients living in nursing and residential homes. You should be aware of how the ongoing medical care of such patients is organised and the opportunities and limitations of looking after patients in this setting. Some GPs organise care by performing regular visits to the homes for which they have responsibility.

All geriatricians should have the knowledge and skills required as defined in the core curriculum competencies. Trainees wishing to develop a special interest in community practice may wish to dedicate more time in the training programme to develop the more advanced competencies outlined in the optional higher level grid

The core and optional higher level grids from the 2010 curriculum are as detailed below. Community practice is a mandatory subspecialty experience and trainees should be expected to undertake a specific attachment to intermediate care and community schemes of at least 3 months whole time equivalent duration, either as a single block or over a longer time period. The attachment in community practice should include experience in a variety of settings such as community hospitals, hospital at home schemes, domiciliary assessments, day hospital, interface geriatrics/front door frailty models, continuing care, care home visits. SLEs should be completed to aid reflection and to evidence acquisition of competencies

Document 1

Core curriculum competencies in Community Practice Including Continuing, Respite and Intermediate Care

To have the knowledge and skills required to assess a patient's suitability for and deliver care to older people within intermediate care and community settings, working with multidisciplinary teams, primary care and local authority colleagues.

Knowledge
Basic Biology of Ageing
Frailty
Major Geriatric Syndromes and Illnesses
Clinical Pharmacology, therapeutics and pharmacy for older people
Rehabilitation
Health promotion
Models of intermediate care/community geriatrics including evolving role of day hospitals and care home medicine
Understanding of the various agencies involved in community care
Opportunities provided by assistive technologies eg Monitoring devices, technology assisted living
Evidence base for intermediate care and community practice
Ethics and Medico-legal issues
CPR decisions
End of Life Care including advanced care planning
Relevant National Publications including Guidelines on Continuing Health Care
Relevant National Publications including Guidelines on Respite Care
Understanding of Care Home Structures, Regulation and Inspection
Role of Independent Sector within intermediate and long term care

Skills
Establish Diagnosis/Differential Diagnosis
Recommend pharmacological and non-pharmacological interventions
Provide medication review
Provide team leadership
Manage time effectively (personal/team)
Manage problems safely within a non-hospital setting
Identify opportunities to prevent ill health and disease in patients
Identify opportunities to promote changes in lifestyle and other actions which will positively improve health.
Provide palliative care when appropriate – liaising with relevant agencies
Guide and support patients/staff/relatives/carers through advanced care planning – "what if scenarios"
Liaise effectively with GPs including joint management of cases

Behaviours
Develop an approach to care that crosses the traditional division between primary and secondary care
Recognise the importance of geriatrician involvement in intermediate care
Recognise the role of the geriatrician in education and management of community staff

Ability to work flexibly and deal with tasks in an effective fashion
Appreciation that small changes in disability can improve quality of life
To work in an empathetic and ethical framework helping patients and relatives/carers to understand and accept or reject medical investigations and treatments
To recognise the value of a structured, active approach to care in care homes
Recognition that the patient's wishes are important
To strike the right balance between opinion-seeking, discussion and decisive management of patients

Specific Learning Methods
Attachment to Intermediate Care and Community Schemes
Visits to Care Homes and Continuing Care Hospitals
Visits to Community Services
Attendance at a Continuing Care Assessment Panel
Short attachment to Primary Care
Performing/Taking part in medical home visits

Optional higher level curriculum competencies in Intermediate Care and Community Practice

To be able to confidently diagnose and manage ill or disabled older people in intermediate care or community settings for those with a special responsibility for this type of care. Additional competencies required for this higher level grid are:

Knowledge
Evidence regarding suitability and effectiveness of different forms of supported care for older people (including retirement villages, highly sheltered housing, and care homes with or without nursing, both general and with specialist designation
Current national publications regarding intermediate care
Current national publications regarding end of life care
Regulatory bodies with responsibility for care homes
Understand the role of commissioners of care for English services
Understand regulation regarding medicine administration in care homes
Models of medical care for care home patients including knowledge of evidence base
Knowledge of pressure relieving and other specialist equipment and their uses.
Knowledge of criteria for continuing care assessments

Skills
Excellent risk assessment and management skills in identifying most appropriate place of care
Excellent communication skills in sharing with patients and their carers decisions about place of care in the light of risk assessment
Extended skills in medication review in those with frailty and life limiting conditions
Excellent communication skills including verbal and written timely communication
Appropriate use of facilities
Multidisciplinary team leadership
Developing community and intermediate services for older people
Effective interagency working; with social services and the voluntary sector including older people's representative groups
Excellent influencing skills in joint working with providers and commissioners of community services for older people

Document 1

Behaviours

Works in a context of mutual respect with other health and social care colleagues
Works in a context of recognition of the older person as central to decisions about their future plan of care whether in their own home or other community setting
Facilitates the sharing of relevant information with appropriate regard both to patient confidentiality and to the important role of carers

Specific learning methods

Experience (minimum 4 months full time or equivalent part time)
Sessional or full-time attachment with intermediate care services at home or in institutional settings both at nursing and residential levels
Leading a MDT for at least 10 meetings, leading at least 5 complex case conferences and undertaking solo at least 10 home visits to assess older patients
Attachment to a primary care team and consultant geriatrician with a special responsibility for community and intermediate care
Attachment to a public health service or commissioners organising and funding care for older people including that in community settings
Accompany a community geriatrician or GP (or both) on proactive planned visits to care homes (minimum 10 visits)