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n e w s l e t t e r

Revalidation

What will it mean for members of the BGS?

The General Medical Council (GMC) first started to talk about the idea of revalidation for doctors in the mid-1990's. It was thought that the traditional way of doctors being put on a register and then practising for the next 30 years of their professional life without checks on their fitness to practise was no longer tenable.

The Bristol scandal was beginning to unfold and there was pressure for the profession to change. The public were surprised to know that doctors did not already have regular checks on their practice.

Appraisal for doctors had already been introduced, and it was thought that if appraisal were made more robust, that would suffice. The profession, the GMC and departments of health began work on introducing a system of revalidation based on appraisal. There were some philosophical disputes as to whether appraisal was summative

and developmental or could be formative and judgemental about a doctor's practice, or should be a mixture of both.

This debate was overtaken by the case of Harold Shipman, the doctor who was convicted of killing his patients with drug overdoses. Dame Janet Smith's Inquiry into the Shipman case looked at the ways the profession was regulated, in order to prevent a further "Shipman"-like incident. She was highly critical of the proposals for revalidation, opining that they were not robust enough.

The Government's response to the Shipman Inquiry resulted in the 2007 White Paper: *Trust, Assurance and Safety - the Regulation of Health Professionals in the 21st Century* and the GMC was obliged to respond by introducing more robust proposals for revalidation of all doctors.



Revalidation

Revalidation is the process by which doctors will, in future, demonstrate to the GMC on a regular basis that they remain up to date and fit to practise.

Revalidation will have three elements designed to:

- ◆ Confirm that licensed doctors practise in accordance with the GMC's generic standards.

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for better health in old age

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- ◆ Confirm that doctors on the GMC's specialist register or GP register continue to meet the standards appropriate for their specialty.
- ◆ Identify for further investigation, and remediation, poor practice where local systems are not robust enough to do this or do not exist.

All licensed doctors will need to demonstrate to the GMC that they are practising in accordance with the generic standards of practice set by the GMC as described in Good Medical Practice. For most doctors, they will need to do this every five years. This is the process known as relicensing.

Relicensing

In order to relicense, doctors will need to collect a folder of information about their practice. This will include, for example, information about appraisal, CPD, audit, and patient and colleague feedback.

Relicensing will have three main elements:

- ◆ Participation in annual appraisal within the workplace (based on the doctor's folder of information).
- ◆ Participation in an independent process for obtaining feedback from colleagues and, where applicable, patients.
- ◆ Confirmation from the 'Responsible Officer' (usually the Medical Director, but that is not yet finalised in England) in their local healthcare organisation that any concerns about their practice have been resolved. The Responsible Officer will provide a recommendation to the GMC, on the basis of which the GMC will make a decision whether the doctor's licence should be renewed.

Most doctors already participate in

annual appraisal and obtain feedback from patients and colleagues. Relicensing will build on what they are already doing. Licences were issued by the GMC in November 2009. All BGS members should have received a letter about their licence. Their information is held electronically on the GMC register

Recertification

The second element of revalidation is recertification. This will apply only to those doctors who are on the GMC's specialist register or GP register. These doctors will need to demonstrate, through re-certification, that they continue to meet the particular standards that apply to their specialty or area of practice.

Work is being undertaken through close co-operation between the GMC, the medical Royal Colleges and the Academy of Medical Royal Colleges.

Doctors on the specialist register or GP register will not go through two separate processes, once to relicense and once to recertify, there will be one process.

The GMC have designed a framework covering the generic standards in Good Medical Practice, Research and Management. This covers 4 domains, namely, domain 1 – knowledge, skills and performance; domain 2 – safety and quality; domain 3 – communication, partnership and teamwork; and domain 4 – maintaining trust

The Federation of Physicians (including RCP London, RCPSG and RCP Edinburgh) has been meeting with the Specialist Societies in Medicine to devise a generic list

The important thing to note is that revalidation covers what you actually do.

of the evidence, which will need to be collected by ALL physicians to demonstrate that they are competent in their specialty. This will map against the GMC framework. The BGS has decided NOT to add more requirements to this generic list

but will be issuing guidance to the membership of the sort of evidence they might collect - for instance, participation in CPD is required. A geriatrician who is doing the unselected acute medical intake will need to show CPD in general emergency medicine but also CPD in topics specific to the care of older people.

It is envisaged that there will eventually be an electronic system to generate the portfolio. In addition, the requirements will develop over time.

What does this mean for BGS members?

The important thing to note is that revalidation covers what *you actually do*. If you are a stroke physician, then you will have to demonstrate competency in stroke, if you do specialist continence clinics, then you need to demonstrate competency in that, if you don't do the general medical intake then you may not need to show you are up to date in dealing with unselected medical emergencies.

Multi source feedback and feedback from patients is mandatory - there are examples of questionnaires on the Royal College of Physicians website www.rcp.ac.uk.

Doctors outside the system

For doctors who are working outside of a managed organisation special arrangements will have to be made. This particularly applies to locum doctors who will need to be clear about the arrangements for their revalidation.

Stop Press - Update!!

As a member of the Academy of Medical Royal Colleges Steering Group on Revalidation, representing the Royal College of Physicians and Surgeons of Glasgow, I have had a hand in developing the standards that have been submitted to the GMC. All the work on standards has been co-ordinated by Ian Starke on behalf of the Federation and I believe he has done a spectacularly good job.

The standards have been signed off by the GMC in the last few weeks and will now go out for consultation in the near future. It is my understanding that the systems for appraisal and the collection of relevant information (e.g. audit and quality data) may be different in each of the UK countries but the result and standards will be the same. BGS members should not be put off by what now looks like a revalidation industry covering many issues. The process is likely to be incremental and won't start before 2011. The key data required will be proof that the doctor has kept themselves up to date involves participation in clinical governance; multi source feedback from colleagues and patient feedback. Thus apart from MSF the requirements are not greatly different from now. With regard to CPD it is likely that with the fullness of time you will be required to have more CPD involving some form of on line self assessment, but no exam is envisaged at the present time.

In Scotland the Health Department have embarked on a training programme to produce some 600 secondary care appraisers modeled on the Scottish On-line Appraisal Resource (SAOR <http://www.scottishappraisal.scot.nhs.uk/>), a GP appraisal system developed by NHS Education Scotland who also developed the e-portfolio now being used for core medical training. To this will need to be added the information detailing specialty requirements as outlined by Colleges.

Prof Paul Knight
Director of Medical Education (Associate Medical Director)
Royal Infirmary, Glasgow

You need to be collecting evidence for your appraisals, as in the past and also be sure to do MSF and patient feedback questionnaires - the BGS is recommending these be done twice in a 5 year cycle.

Conclusion

As the work with the Federation continues, we will keep you apprised of any developments. The question remains whether revalidation is going to make a substantive difference without making people feel vulnerable, but if it makes people more reflective about their behaviours and more receptive to patient feedback, it can only be a good thing.

Do contact us at the BGS if you have any queries and look at the GMC website www.gmc-uk.org.

Linda Patterson
BGS Topic Lead
Recertification and Revalidation

Editorial



Although the Christmas season is generally a quiet time for NHS related business, the last few weeks have seen a flurry of good news stories, at least as far as geriatrics is concerned.

The focus on care home medicine continues, this time endorsed by Sir Michael Parkinson, the government's National Dignity Ambassador, on Radio 4 (http://news.bbc.co.uk/today/hi/today/newsid_8453000/8453388.stm). As is so often the case, it is only once people have to face up to the realities of care of older people in our society in the context of a loved one becoming more frail or having contact with the NHS, that they really start to 'get it'. This is particularly true of senior doctors who aren't geriatricians! In Sir Michael's case, it was his experience of seeing his mother being subjected to undignified care in a care home that made him realise the importance of having a positive attitude towards frail older people. Whilst it would be inappropriate to take undue advantage of the misfortune of others, it is worth making the most of such moments of revelation in attempts to improve services. As I am starting to appreciate in my own attempts to improve services, the evidence based approach is not necessarily stronger than the emotion based approach. Often both are necessary.

New National Clinical Director for Older People in England

Another good news story is that the Department of Health (DH) has appointed David Oliver National Clinical Director for Older People's care in England, taking over from Ian Philp – a challenge for anyone. I am sure David will continue in his own indomitable way to push the case for better

care for older people – although I was reminded by our President elect that suggesting the BGS might have any influence over DH matters is perhaps a little naive! Congratulations David – and commiserations to your colleagues in Reading who will have to cover you! Also, welcome news is the appointment of Professor Alistair Burns to lead on dementia care. A formidable duo.



As the financial squeeze hits and activity is being scrutinised, be careful about accepting or making snap judgments based on small samples!

The fact that DH sees the importance of such a role is encouraging, and perhaps there is additional reason for some cautious optimism. Many of our England members will have had some contact with, or may even have led, one of the Partnerships for Older People Projects (POPP) schemes. The national evaluation (carried out by the PSSRU, a well respected health services research unit) has reported back on the outcomes from these schemes. They were many and varied, but together have highlighted the importance of preventative, multidisciplinary care – and have suggested that health and social care services need to work together in order to improve outcomes – what a revolutionary concept!; Whilst some of the claims from the POPP schemes might be rather bold and a tad overstated (one scheme apparently reducing emergency admissions by nearly 50% - which would be a world first!), the enthusiasm surrounding these schemes is again something to exploit and build upon.

Revalidation is coming your way!

Linda Patterson and Paul Knight have provided a helpful overview on revalidation and work is in progress within the BGS to try and identify some of the metrics that might be helpful. I suspect that some metrics of interest, especially for any involved in acute work, will be process measures such as

discharge rates, length of stay and readmission rates. A word of caution – for such metrics to be reliable and meaningful, they need a little bit of scholarly appraisal. For example, we recently looked at discharge and readmission rates for older people from our Acute Medical Unit. In order to obtain reasonably tight confidence intervals which allowed comparison from one consultant to another, we found that a sample size of at least 200 was needed to estimate the discharge rates to within 5 per cent

and readmission rates (again to within 5 per cent) needed at least 160 discharges. As the financial squeeze hits and activity is being scrutinised, be careful about accepting or making snap judgments based on small samples!

Good luck!

Simon Conroy

President's column

This will be a challenging year for the care of old people. After the general election there will be perhaps hundreds of new MPs at Westminster, many of whom will not be well versed in elderly care.

The financial freeze will hit hard: there will be threats to services and staff, with challenges for the ways in which we work. As Geriatricians, we are used to working in difficult circumstances. We must expect more bed closures, more work in the community, reductions in staffing levels and much more emphasis on prevention, quality and efficient working. We can learn much from each other by sharing ideas for good practice and by learning how we are all responding to the lean years ahead.

BGS Manifesto

In order to ensure that Parliamentarians are better informed about what the BGS is and what we do, Iona-Jane Harris is preparing a short manifesto which will be sent to all political candidates. This will feature in the newsletter. In 2010 we will be extending our involvement with MPs and will keep you updated on developments.

Care Homes

We are making prevention and Care Home

medicine our two main current priorities. The Policy Committee is working on ideas for improving preventative care and Ian Donaldson is co-ordinating these initiatives.



Care homes continue to be in the news. The Care Quality Commission recently published “The quality and capacity of adult social care agencies” (www.cqc.org.uk/newsandevents/newsstories). It provoked a journalistic storm: *The Times* thundered about thousands being condemned to live in squalid conditions. *The Guardian* spoke of this “shocking... scandalous... disgraceful report”. No newspaper picked out the many positive developments: the year on year improvement in care home standards; the facts that 17 per cent of homes are rated as excellent and 60 per cent as good; that 67 per cent met or exceeded standards; that the number of “adequate” homes fell from 25 per cent to 17 per cent. There have been major improvements in record-keeping, medications and staff supervision. There is much more to be done but we owe it to our colleagues who work hard in residential and nursing homes to champion their many successes.

Society Guardian

A national conference sponsored by the Guardian newspaper provided the opportunity for me to gently castigate the press for lazy journalism and the relentless re-enforcing of stereotypes. I was able to emphasise some of the many improvements in care homes and gave examples of exemplary practice. The day before the meeting, Gerry Robinson's first television programme on dementia care was broadcast. He described a broken system, with demoralised staff working long hours for poor pay. He underlined the lack of training and pointed out the staff in dementia care homes are not valued and are often ignored. As more geriatricians become involved in nursing home medicine, these deficiencies should be mitigated – particularly if we can help improve training. There are lessons to be learned from hospices, which enjoy highly positive attitudes from the press and the general public. I am sure that we can help ensure that those in their twilight years can enjoy uniformly high standards of care – and that the media will celebrate stories of outstanding care and facilities

This conference also gave opportunities for people to be aware of the existence, role, commitment and enthusiasm of the BGS. David Oliver spoke with style and conviction on age discrimination in research funding, denial of diagnostic work-ups and sub-optimal treatments. Des O'Neill (in his capacity as President-elect of EUGMS) lectured with his usual élan about embracing complexity, celebrating the demographic dividend and exhorting societies to avoid the temptation to impose simplistic solutions (which are invariably wrong) on the ageing population.

The Secretary of State for Social Services, Phil Hope, emphasised the key importance of prevention, support for carers, integrated working and the training of the social care workforce – all of which harmonise with the values and aims of the BGS.

South Asian Geriatricians

It was gratifying to see the *Independent* newspaper paying tribute to the pioneering work of doctors from India, Pakistan, Sri Lanka and Burma in improving the care of old people in

the UK. In a project supported by the BGS and the British Association of Physicians of Asian Origin, the Open University (OU) has produced an oral history project, which is now in the British Library archive.

In the early 1970s, 60 per cent of consultant geriatric posts were filled by overseas doctors. By their dedication and determination these doctors helped to transform the care of elderly people, who were previously considered as second class citizens. At that time, many UK graduates had little enthusiasm for a career in geriatric medicine – how things have changed! We are greatly indebted to our Asian colleagues.

One of the outstanding pioneers was Babi Das Gupta, who developed an astonishingly successful unit at Scunthorpe General Hospital. In the *Scunthorpe Telegraph*, he explained how he was attracted by his grandfather's philosophy of looking after all people equally – the battle against ageism has not yet been won but we salute the enormous contribution made by our South Asian colleagues. (For a full copy of the OU report, contact Lauren Hardy on 01908 655 614; to learn more about this project visit www.open.ac.uk/hsc/research/.../germed).

BGS Intelligence

It would be useful to have a repository of statistics on ageing and elderly care. Such a resource should be easily accessible on line and be helpful to clinicians, researchers and journalists, who could then quickly find all the information they need. Such a site would also further heighten the profile of the BGS among the general public.

The data would come from multiple sources. I only recently discovered the NHS Information Centre, which has some useful information on elderly care, and the US-based John A Hartford Foundation (Bandwithonline.org), which provides instructive charts, graphs census information and links to other databases.

If you are interested in helping to set up and develop this new BGS resource, do get in touch.

Adieu and welcome

We are sorry that **Sarah Allport**, our Committees

Secretary, has left us. She has taken up a new role at the Dunhill Foundation after nearly five years at the BGS. The huge numbers of thank you messages from many BGS members testify to the high regard in which she is held. She worked tirelessly and efficiently, was unfailingly cheerful and made life much easier for me and many others. Her work on distinction awards and promoting the Society has been greatly appreciated. We wish her well in her new post.

Mark Stewart joined the BGS as our Committee Secretary in the new year (see page below). Coming from a background of professional associations, he is well versed in the dynamics of committees. I am sure you all join me in welcoming him to the ranks of Marjory Warren House and in wishing him a long and satisfying sojourn with us.

Graham Mulley



Introducing the BGS' new Committees Secretary - Mark Stewart

Mark Stewart joined the BGS at the beginning of January as the new Committees Secretary. Mark has held a number of committee related roles, most recently with the Engineering Council UK and the Association of Accounting Technicians.

Taking up his position at the BGS Mark said: "I am delighted to be joining the team at Marjory Warren House. The care of the older person has touched my own family life recently with a parent who has entered residential care. I am therefore hoping to make a real and lasting contribution to the work of the Society. I am looking forward to meeting all the members of my committees as the 2010 meetings programme unfurls."

Mark is responsible for providing secretariat support for the following committees: England Council, UKMC, Policy Committee, Education and Training Committee, Finance Committee, Age and Ageing Editorial Board and the Older People's Specialist Forum. He will also be undertaking additional project work such as revising the 2000 report on the Health and care of older people in care homes.

Our new Committees Secretary is married with two teenage children and, when he is not operating the family taxi, his spare time interests include astronomy and collecting first editions.

Mark may be contacted by email: committees@bgs.org.uk or by phone: 020 7608 8575.

RCP London National Survey on the Impact of Consultant Input into Acute Medical Admissions Management - Can you help?-

Acute medicine has developed over the last decade in response to the increasing number of medical admissions, concerns over quality of acute care and other pressures including the European Working Time Directive.

The Royal College of Physicians (London) is undertaking a study aiming to describe any correlations between different levels of physician cover for acute medical admissions and patient outcomes such as length of stay, readmission rate and hospital mortality and to audit the patterns of service provision against recommendations in national guidelines such as NICE CG50. Also included are some questions specifically related to care provision for frail older people. A pilot study conducted in 2008 showed that the proposed methods are feasible and produced some interesting initial data on correlations between patterns of cover and patient outcomes.

The aim is now to scale up the study to a National survey throughout England.

Chief Executives of all Trusts with Acute hospitals received a letter in November asking them to nominate one person from each hospital in the Trust, who can complete the online survey.

If you would like to take part on behalf of your hospital you can either:

- ◆ Approach your Chief Executive directly to offer to be the nominated person
- ◆ Contact the study Project Manager, Marie Keetley: marie@phassociates.com or Tel: 0208 504 1082 for a copy of the letter and to find out if a nomination for your hospital has already been received.

Commissioning



For a long time, geriatricians have been trying to influence how services are delivered locally.

As complex as the commissioning cycle might appear – with a mix that includes benchmarking guidance, eligibility criteria, streamlined pathways, key performance and quality indicators, financial profiling and continual review – it is essentially about ensuring that the right patient gets the right treatment from the right clinician, in the right place at the right time and for the right price.

To get involved successfully, one needs to understand the pressures and priorities of commissioners, and where the local weaknesses are. Clinicians have solutions to quality and efficiency that commissioners may not realise.

In November 2009, the BGS staged a one day workshop to familiarise participants with various mechanisms for commissioning health services for older people and to examine how they are being used against the changing backdrop of delivery routes, resources and venues.

With increasing demands for quality and efficiency, what the workshop showed was that there is considerable knowledge and forward thinking within the BGS membership that commissioners and managers would like to hear about, particularly as they seek to match the competencies of World Class Commissioning.

Partnerships

In a series of breakout sessions, delegates were given snapshots from different perspectives on successful commissioning, but a common thread running through all the sessions was the notion of “partnerships”.

Speaking of the partnership between geriatricians and PCTs, **Eileen Burns** reported that in Leeds, geriatricians had been assisting with the commissioning process since 2000 - beginning with

a secondment examining the potential benefits of a secondary care geriatrician working with newly developed intermediate care services in the community.

Since then, geriatricians have been involved in many developments including a falls service, rapid response, community matrons, joint care management and an integrated continence service. Inroads are also being made into links with specialist nurses. Work continues to get dedicated proactive input into care homes, a falls service redesign to broaden its scope and, despite some early anxieties, better governance with regular community audit meetings, morbidity and mortality reviews etc. While the approach continues to have its frustrations, the benefits are considerable.

“There has historically been an adversarial climate around money issues,” said Eileen, “but as we are employed half by each side we have managed to not be seen as having an axe to grind one way or the other. We are seen as being even handed by the PCT, as advocates for older people. While there is plenty of information coming our way from the acute side, getting hold of data from the PCT has, until recently, been a struggle. We actually brought some data to them to show how change could demonstrate benefits.”

NHS Quality Frameworks

Drawing on another common theme, **Jonathan Potter** said that while there was divergence in policy from country to country across the UK, a framework with three universal sets could be identified, namely:

- ◆ Advice - National Operating Framework, NICE guidelines and quality standards
- ◆ Implementation – Commissioning, Quality Accounts, NHS Institute, Clinical Excellence Awards
- ◆ Assessment – Care Quality Commission, National Clinical Audit, Quality Observatories, NPSA.

The National Quality Board (NQB) came into being post-Darzi. Its role includes aligning the national system around shared goals for improving

quality. Importantly, it also advises Ministers and the DoH on priority areas for improving quality and this tops the agenda.

Over the coming years quality, innovation, productivity and performance will dominate all elements of the framework structure. As well as delivering quality, new developments have got to be cheaper. NICE Quality Standards and registration requirements will push high quality care through all the structures.

How does this affect the clinician? Making a difference to quality works when one has a champion who is prepared to take the lead on service improvement. It works when one uses all the levers that will drive change both nationally and locally. Get to know your managers and commissioners. Gather local metrics that can be monitored frequently to support the case for change and to show that change is happening.

Commissioning by psychology

Paul Knight was in more philosophical (and warlike) mode on how services might best use the commissioning culture. Quoting from several military strategists including Machiavelli and Sun Tzu on *The Art of War*, Paul said: "If you want to overcome things, you have to overcome a lot of innate conservatism. People are comfortable with what they do. As you plan, consider, what it is you actually want to achieve? Is it new? Can you make it seem new? Does it resonate with current political thinking and targets? Do you have 'facts' to back up your assertions? Can you 'produce' some?"

"Gather intelligence – don't look for it in the *BMJ*. Find it in *Health Service Journal* because that's what your managers will be reading. You need to know their language.

Engage the main players. Bring them onside. If you don't get 100 per cent of what you want don't get in a huff. Consider what of your plan is reconcilable with the direction they seem to be taking. You may manage 75 per cent and still be able to make things work. Be assertive, not angry. Say you're angry without behaving angry. Think on your feet. Bluff.

Think again, when it doesn't quite go to plan. Back

to Sun Tzu: 'Military tactics are like unto water; [...]Water shapes its course according to the nature of the ground over which it flows'.

Gather intelligence - don't look for it in the BMJ. Find it in the HSJ because that's what your managers will be reading. You need to know their language.

"The people who tend to be successful in driving through service development are those who can change their plans in accordance with what might be deliverable."

"It's hard work. Don't be rebuffed at your first attempt. How you put your argument

across may vary with your audience so have different ways of expressing it".

A commissioning toolkit for falls and fractures

Giving a very practical example of effective commissioning was **Finbarr Martin** who said: "It is important to get over to commissioners and managers the things clinicians take for granted". In respect of falls and fractures, since the National Service Framework of 2001 and the NICE guidance CG21 of 2004 and TA87 of 2005 there has been sufficient policy to know what should be happening. We now have the emerging powerful information from the National Hip Fracture Database and with pressure from the BGS, the British Orthopaedic Association, Help the Aged and the National Osteoporosis Society, we now have the Dept of Health commissioning toolkit for falls and fractures and have been able to harness the potential of the Payment by Results best practice initiative.

The toolkit is not about new evidence. It has pulled together existing guidance and standards, stakeholder and expert opinion, with the intention of giving more clarity on priorities and making progress through four cascaded objectives. All the objectives relate to guidance or policy and offer opportunities for integration with long term care and social care strategies.

Data - essential to quality and efficiency

Emphasising the importance of supporting data, **Jugdeep Dhesi** gave a further practical example of how South London geriatricians extended the reach of geriatric medicine to improve outcomes for older people having elective surgery. Again, under the heading of forming partnerships, they engaged with a wide range of stakeholders (including surgeons, anaesthetists, nurses, therapists, hospital managers, social workers and intermediate care

teams) to set up a new high quality service with the aim of reducing waiting times and mortality and improving patient and staff satisfaction.

Data collection was an essential means of demonstrating the need to redesign the service. The results of their efforts is that a CGA clinic now sees approximately 600 surgery patients a year. The geriatrician led team liaises with the patient, their GP, surgeon and anaesthetist, to see what can be done to optimise the patient prior to operation; what the possible post-op complications might be; and what junior doctors can do to treat these. A letter is then sent to the patient and all professionals involved in their care. There is a twice-weekly geriatrician ward round on all surgical wards to ensure early identification of any post-op complications. A geriatrician leads the MDT meetings on each surgical ward for all staff and all patients (not just those aged over 65) are reviewed.

Blinded by traditional boundaries

Practical advice on engaging in the commissioning process came from **Peter Murdoch** who advised:

- ◆ Make clinical voices part of the planning and

decision-making process and use them to get support of public and politicians.

- ◆ Agree a shared vision and values – if you have consensus around what you are trying to achieve you can go forwards and do practical things.
- ◆ Communication is vital, both within and between key agencies and stakeholders.
- ◆ Link your shared desired outcomes to national measures – i.e. reducing A & E attendances
- ◆ Older people are the largest group of service users – if you get care right for them you will get it right for almost everyone.
- ◆ Analyse what is needed and don't be blinded by traditional boundaries: what are the prime needs; and where do people need to be? - What are the most appropriate settings?
- ◆ You have to break down barriers to have a new whole-system approach and may have to develop new care pathways.
- ◆ Focus on the basics – quality, experience, value for money.
- ◆ Robust data is all-powerful – it will show you where changes need to occur. The information is in the system but needs to be uncovered. For example, look at hospital admissions by long-term

Integrating health and social care commissioning in Northern Ireland

With increasing dependency come increasing social care costs that may be invisible to health care providers. Health care interventions, on the other hand, may be completely inaccessible to social care providers. For example, according to the National Audit Office, the costs of stroke to the social care budget are 40% higher than healthcare, while informal personal and family care costs are even higher still.

Northern Ireland has for many years had a legally integrated framework for health and social care. Historically, this has not led to practical integration at commissioning or local level as the funding streams have tended to remain distinct, with the larger Trusts being exclusively based around either acute hospitals or community services. Recent major organisational change is increasing integration across the health and social care trusts at the level of delivery, with common budgets for health care, domiciliary care and care homes. However, the balance of commissioning between the single regional board and the local health and social care groups is unclear, while primary care commissioning has not been introduced.

The integrated care team I work with exists entirely within social care and meets every week. Social workers and care coordinators bid for money because their client needs more looking after. These professional staff have not previously had easy access to health systems, while their clients'

increasing levels of dependency have not yet reached the crisis point which would cause a referral to emergency services. My involvement has led to earlier assessment, treatment and rehabilitation which is often enough to avoid, prevent or delay increasing dependency.

Integrated commissioning across the whole system could prevent avoidable dependency and avoid a premature commitment to high cost long-term packages, leading to better individual outcomes and less cost. But there are potential pitfalls. Integrated commissioning brings the risk that health and social care will be fighting for a slice of the same cake; GPs have had little if any involvement in these discussions; and the development of community services may lead to an accelerated decline in assessment and rehabilitation facilities unless this is addressed on a system wide basis.

There are obstacles to be overcome. There's little evidence base behind integrated health and social care commissioning. Although there are a number of successful local initiatives, not a lot is happening at the whole system level. Health and social care information systems aren't linked.

To many, integrated commissioning seems a strange system – but that doesn't mean it's not worth doing and my experience is that its biggest champions are social workers and their clients.

Ken Fullerton

A series of common-sense collaborations and free personal care at home for the most frail, has seen a 35 per cent reduction in acute bed days, and a fall too in the use of care home care

conditions and look at admission rates by local areas. Identify where problems are occurring.

- ◆ Reporting mechanisms are an incentive for continuous improvement.
- ◆ Set realistic goals and plan properly to achieve them.
- ◆ Support clinical staff and others in change process
- ◆ Ensure consistency of quality and experience – guidelines for all staff help

mould a common approach.

“Better can be cheaper”

Speaking under this rather attractive title, **Colin Currie** illustrated the post-code lottery with a report that a 2006 multi-agency inspection of services for older-people across the three regions of Tayside showed significant divergence in the probability of multiple admissions of over 85s per 1000 of population. While in Angus the figure stood at 50 per 1000, in Dundee it was 71. And in Edinburgh, in the Lothians, the number was higher still, at 83. And great divergence was seen in other key indicators, such as occupied bed-days for multiple admissions of over 75s.

A similar postcode lottery is apparent right across England. The probability of multiple admissions of over 75s ranges from 2.5 per cent to 9.5 per cent across English PCTs with the number of resulting bed days from less than 1000 to more than 3000 per annum.

For decades, organisational, political, financial, cultural and professional divisions between health and social care have delayed and fragmented care and made collaboration difficult. Neither the acute nor social sectors take ownership of the care of older frailer people. The postcode lottery is intolerable because it costs so much, some of that money is grossly inefficiently spent – and now we have an ageing population and shrinking budgets too.

There are many little ‘projects’ but they don’t seem to get us very far. Instead of limited, single-diagnosis schemes for a multi-pathological population we should

be developing effective collaborative care at system level. Most old people live at home and want to stay there. And better care at home for those most at risk of unnecessary acute or care home admission could save a lot of money.

Seamless, accessible and flexible health and social care is rare in England. But it has to be provided, and there are grounds for hope. Despite the complexities of joint commissioning they are doing it in Camden where occupied bed days for over 75s are down 16 per cent. Torbay’s care trust structure, with effective local health and social care teams, has cut bed days by 24 per cent - a good example of cost-effective system-wide care. And in the Isle of Wight, a series of common-sense collaborations and free personal care at home for the most frail, has seen a 35 per cent reduction in acute bed days, and a fall too in the use of care home care.

Abridged from the full report by

Recia Atkins

www.bgs.org.uk/Publications/commissioning/commissioning_index.html

Index of Commissioning Workshop Sessions

Each session is outlined in greater detail than appears here, on the BGS website www.bgs.org.uk/Publications/commissioning/commissioning_index.html. Copies of the powerpoint presentations supporting each session may also be downloaded.

Should you wish to attend a future commissioning workshop which the BGS might arrange, please register your interest by email to: scientificofficer@bgs.org.uk

- ◆ NHS Quality Frameworks - *Jonathan Potter*
- ◆ Better can be cheaper - from postcode lottery to cost-effective, system-wide care - *Colin Currie*
- ◆ Using Payment by Results to Commission Better Quality Clinical Care - *Eileen Robertston*
- ◆ What makes a successful bid for a new clinical service? Top tips for developing a service - think, plan, engage, rethink, go again - *Paul Knight*
- ◆ Practice based Commissioning, Delivery? Conviction, Courage and Culture - *Eithne Cummins and Agnes McAuley*
- ◆ Can Geriatricians help PCT's Commission World Class Geriatric Services? - *Eileen Burns*
- ◆ Integrating health and social care commissioning - the Northern Ireland Experience - *Ken Fullerton*
- ◆ A Commissioning Toolkit for Falls and Fractures - *Finbarr Martin*
- ◆ Using geriatric medicine to improve quality and efficiency of elective surgery in South London - *Jugdeep Dhese*
- ◆ Service Development in Forth Valley and Use of Multi-Agency Data - *Peter Murdoch*

Interface Geriatrics

- a BGS event exploring new models of care for frail older people -

endorsed by the British Journal of Hospital Medicine, the College of Emergency Medicine and the Royal College of General Practitioners

Our ageing populations will naturally lead to an increase in age-related illnesses and greater numbers of frail, older people to be cared for in the community.

Soon people over 65 years of age will outnumber those under 16 and the oldest old, the over 85s, are the fastest growing sector of our population. With the continuing emphasis on care for those with long term illnesses to be as close to their homes as possible, such responsibility will rest initially with primary and community care teams, although help will undoubtedly be required from our specialist secondary care colleagues in geriatrics and old age psychiatry. However, as the nature of primary care has changed dramatically over the last 10-15 years, so too has the acute care of frail older people.

Previously, much of the acute care and rehabilitation of older people was delivered in acute hospital settings. Now, acute care is delivered predominantly in acute medical units (AMUs), often over very short time periods, with on-going rehabilitation provided in a variety of community settings, including intermediate care schemes (home based or residential) and community hospitals. Some older patients with complex needs, who would previously have been managed in hospitals by geriatricians, may not receive the specialist geriatric component of comprehensive geriatric assessment (CGA), even though they may still access other aspects of care (physiotherapy, occupational therapy etc). The consequence of this change in health care delivery is unclear, but in some centres the outcomes for frail older people attending AMUs and being discharged back into the community setting are worrying – up to 55 per cent are re-admitted and 26 per cent die in the following 12 months¹.

Whilst there is welcome and long overdue renewed interest in community geriatrics, it may be difficult to persuade both hospitals and primary care trusts to invest in such services. Why would an acute hospital want to fund a scheme which ultimately might lead to a reduction in 'business'? And why would a PCT want to invest in a post when the postholder will be spending half their time working in the hospital. One solution would be to develop services which are jointly funded by the PCT and the acute hospital trust and which can jointly benefit both parties. Such is the rationale behind interface geriatrics; geriatricians working at the front door (either the emergency department or the acute medical unit or both), identifying who needs to be admitted and for how long and who would be better served by a community-based multidisciplinary team. These same geriatricians should be part of this team to ensure an integrated approach.

An Australian trial has shown that a CGA approach spanning primary and secondary care can reduce readmissions by about 25 per cent²; similar UK studies are underway.

The community role of the geriatrician, working within a multidisciplinary team, can not only be linked into early expedited discharge support from hospital. More importantly, they may be able to reduce the need for access to acute care settings and unnecessary admissions, as has been shown by several of our colleagues in recent years⁴. Of course, avoiding admissions or readmissions is fine, but the real aim is to improve the quality of care for frail older people. Appropriate resource utilisation and allocation is more important than reducing resource use. These arguments are the currency of the day and may be helpful to colleagues trying to develop services in this challenging economic climate.

So maybe a fusion of community and acute geriatric medicine - the interface geriatrician, is one way by which care for older people can be improved, whilst keeping both commissioners and providers happy, especially GPs! **A conference specifically focused on Interface Geriatrics, and organised by the British Geriatrics Society will be held on the 5th March 2010.** The conference will be of great relevance to all health professionals involved in the care of older people in the community and will include speakers from both primary and secondary care. The event is being supported by the British Journal of Hospital Medicine, the RCGP and the College of Emergency Medicine. We look forward to seeing you there!

For more information about Interface Geriatrics and to book a place visit: www.bgs.org.uk

Louise Robinson
Simon Conroy
Jay Banerjee

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Tribute to a friend and mentor Professor Jerry Morris, CBE (1910 - 2009)

Jerry Morris's life and his death at 99 were noted in the November issue of *BGS News*. He was a friend and mentor for half a century and I am pleased to have been asked for some recollections.

Recently qualified and with ideas for research, I had asked to see him. I came one sunny day in 1961 to his MRC Social Medicine Unit at the London Hospital. He said 'let's talk among the people of Stepney', and off we went to a local park, he still wearing his white coat. I warmed to this lovable, shrewd, passionate and compassionate man. And so he remained until his short illness and death last autumn.

At his suggestion I first went to learn some psychiatry (so it was largely his doing that I eventually became a psychiatrist). In 1964 I joined him as lecturer in social medicine, and there followed some life-changing, and always lively, years. On my arrival he set me a test. Waiting on my desk was that week's *Lancet*, with a note attached to one paper: 'What's wrong with this?' With trepidation I read – and, thank God, found the error of logic that he had spotted. He was still posing questions in his hundredth year – on politics, books, theatre and people. I in turn over the years, faced with a dilemma, would quite often ask myself a question: What might Jerry have done?



A founder of chronic disease epidemiology, and of health services research, he was to the good effects of exercise what Richard Doll was to the bad effects of smoking. Among his many studies those of London busmen became especially famous: the sedentary drivers had much more cardiovascular disease than the active conductors. Always, his research was linked to policy and action. His book 'Uses of Epidemiology' changed professional outlooks.

A man of the left who grew up in poverty in Glasgow, he advised governments (and declined a peerage), and sat on key bodies: the Seebohm Committee which established today's social services, the Royal Commission on the Penal System, the Black Committee on Health Inequalities, and work with the Sports Council were just a few. Policy on ageing was a special

interest: at 96 he co-authored a paper which meticulously calculated the minimum income needed for healthy living in old age. It is pleasing that the last honour he received was from our Society – our medal 'For Relief of Suffering'.

Tom Arie
Professor emeritus of Health Care of the Elderly
Nottingham University

Stroke Matters

The latest issue of **Stroke Matters** is now available - featuring all the news from the UK Stroke Forum Conference, December 2009.

Produced by The Stroke Association, Stroke Matters is a quarterly e-publication for professionals with an interest in stroke. The publication promises to deliver interesting and accurate news on stroke issues, carefully selected by an expert multidisciplinary editorial board comprising of leading stroke specialists.

The latest issue is now available. To subscribe for free, please visit www.stroke.org.uk/strokematters and complete the online subscription form.

In the news

The AGS/BGS "Blue Book" Clinical Practice Guideline on Prevention of Falls in Older Persons has now been updated and can be found on the American Geriatrics Society website: www.americangeriatrics.org/education/prevention_of_falls.shtml

The Department of Health has recently published the National Evaluation of the Partnerships for Older People Projects www.dh.gov.uk/en/SocialCare/Deliveringadultsocialcare/Olderpeople/PartnershipsforOlderpeopleProjects/index.htm

Delivering quality and value for hip fracture patients



Hip fracture remains the most serious consequence of a fall and the commonest cause of accident related death in older people.

The numbers of hip fractures has been rising by 2% annually from 1999 to 2006 and is predicted to continue rising¹. Ten per cent of people will die within the first month after a hip fracture and after one year, a third would have died^{2,3}. Less than 50 per cent will regain their former level of independence and up to 20 per cent of people will require some form of continuing care^{4,5,6}. There have been guidelines for many years advocating the evidence base for timely and coordinated multi-disciplinary management that improves outcome for these patients, but the figures have not improved over the last few years. (The Scottish Intercollegiate guideline network (No. 56)⁷ Hip

Fracture Management was published in 2002 and the first blue book, the Care of Fragility Fracture Patients⁸ from the British Orthopaedic Association guidelines all have similar themes as to the best practice into hip fracture care.

The profile of hip fracture care in England has been raised with the publication of the Department of Health's prevention package⁹ for older people containing guidance on managing hip fractures. With the introduction of the best practice tariff in April 2010 for patients with hip fracture, all Trusts will need to review the pathway of care for these patients in order to ensure the full tariff. At the time of writing the indicators are: Time to surgery as defined by Arrival in A&E (or diagnosis if an inpatient) to start of anaesthesia and Involvement of an (ortho)-geriatrician. This is to include all of the following domains:

- ◆ Admitted under the joint care of a Consultant Geriatrician and a Consultant Orthopaedic Surgeon
- ◆ Admitted using an assessment protocol agreed by geriatric medicine, orthopaedic surgery and anaesthesia
- ◆ Assessed by a Geriatrician in the perioperative period
 - Geriatrician defined as Consultant, Non consultant career grade, or ST3+
 - Perioperative period defined as within 72 hours of admission
- ◆ Postoperative Geriatrician-directed: Multiprofessional rehabilitation team and Fracture prevention assessments (falls and bone health)

These tariffs will be reviewed for 2011 following the publication of the NICE guidance for hip fracture care which are expected in autumn 2010.

How does a Trust actually implement and improve the pathway?

In 2006 the NHS Institute for Innovation and Improvement published a *Focus on* document¹⁰ that highlighted the large variation both in the length of stay and mortality after hip fracture with indicators on how to improve the quality and value of care to these patients. The document was designed by undertaking site visits to both high and less well

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performing Trusts and the team spent time observing, watching, listening and looking at the flow and process of care and drew up an optimal pathway which was published in the document. This was tested at sites.

Over the last year the NHS Institute has been working with ten NHS Trusts in England on the rapid improvement programme for orthopaedics promoting the findings from the *Focus On* document. The aims of the programme were to work with an individual Trust on a service improvement programme for a 12 week period. It included providing participating trusts with a full insight to the key findings in the *focus on* document, a practical knowledge of the pathway supporting toolkit and service improvement tools. The programme has allowed participants to hear from colleagues who have shifted their orthopaedic service and provided time for networking, discussion, debate and planning. The learning has been shared and adopted through regional network meetings.

The teams worked with the Trust over a period of 12 weeks. The Trusts were challenged to look at the pathway of care for hip fracture and to identify the problem areas. A multi professional team and steering group were established and objectives and timescales were agreed.

As part of the assessment the team “walked the patient pathway”. Representatives from the multidisciplinary team went from the Emergency Department to the discharge lounge, questioning staff on the way and the processes used in the care

of hip fracture patients. The team gained valuable insight into the current pathway and bottlenecks and this led to ways of thinking differently and understanding the roles of each department. It was found that one can never assume one knows what goes on in one’s own hospital or department.

The main issues identified in all trusts were:

- ◆ Fast track to the appropriate ward from the Emergency Department
- ◆ Early involvement of the Geriatrician and Anaesthetist
- ◆ Optimisation of patients for theatre within 48 hours
- ◆ Mobilisation post surgery
- ◆ Early conversations with Social Services & Primary Care regarding discharge
- ◆ Collection of data to understand where there were bottlenecks

Many generic solutions were found and included:

- ◆ Standardisation of patient information and the setting of an Estimated Date of Discharge, ensuring this is communicated to the patient and carer as well as within the team.
- ◆ Dedicated unit or area for admission and ongoing treatment of patients with hip fracture. All the team understands the pathway and works to a common goal.
- ◆ In order to facilitate rapid admission, some Trusts have established an ambulance service pre-alert in association with fast tracking through the Emergency Department
- ◆ Anaesthetic guidelines for hip fracture surgery have ensured a consistent approach and reduced

Hip Fracture	Before Programme										After Programme									
	A	B	C	D	E	F	G	H	I	J	A	B	C	D	E	F	G	H	I	J
ED Pre-Alerts	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Fast track adm within 2 hrs	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Dedicated ward Unit for #NOF	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Access to Theatre 24 hrs	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Mob 12 - 18 hours post op.	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Pred. LOS on adm.	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Discharge Planning	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Trauma Coordinator Role	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Orthogeriatrician Input	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Integrated Pathway	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
StD. Prot. for Anaes	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Std. Prot. for Pain Mngt	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Std. Assess. of falls and bone health	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Monitor Metrics	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Clinical Leadership	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■

Figure 1
Self reported improvements in areas of the pathway monitored over the 12 week improvement plan

- no protocol or plan in place
- a protocol or plan available but not implemented
- fully implemented

wait for theatre.

- ◆ Trials of senior orthogeriatric review have been used resulting in business cases for permanent appointment.
- ◆ Review of theatre lists has led to establishment of daily trauma lists (including weekends) or dedicated slots for hip fractures allowing patients to access theatre more rapidly.
- ◆ 7 day therapy input and training of non-therapy staff to ensure patients are mobilised over weekends and bank holidays.
- ◆ Key measures for improvement have allowed teams to identify on a weekly basis where the pathway needs to be reviewed.

Despite only focussing on 3 or 4 areas of the pathway that were particularly difficult, significant gains were made throughout the patient journey leading to improved quality of care, reducing waits for surgery and reduced length of stay (figure 1). All Trusts that implemented the Rapid Improvement Programme showed significant improvements in their pathway of care for these hip fracture patients.

Key factors for success in all Trusts were the people. It is clear that there is a need to have both clinical and managerial engagement and that the organisation wants to change and sets realistic goals. Without these factors the sustainability of the improvement programme is limited. Ensuring the baseline data and tracking the data in real time

allows the improvements to be rapidly demonstrable and gives positive feedback and encouragement to the team. In addition it will identify areas of difficulties that the team will need to concentrate on. The National Hip Fracture Database will provide the evidence for the best practice tariff and can provide monthly trends of preference for individual Trusts with comparative data from the SHA and England.

What does it mean for the geriatricians?

The hip fracture patient is often one of the frailest patients admitted acutely. For years they have been neglected. With the introduction of best practice tariff commissioners will have to ensure the involvement of our services – a welcome move forward and one that is long overdue. By using the principles of the key characteristics of the Focus on Document together with development of pathways of care significant improvements in hip fracture care can be made. The evidence from the Rapid Improvement Programme is that pathway change in a few areas can lead to wide ranging improvements to care. Many of these changes will be led by the geriatricians. Let us strive to improve the quality of care for the vulnerable group and at the same time see financial reward.

E Aitken, P Roberts

Clinical Leads, Orthopaedic Rapid Improvement Programme, NHS Institute for Innovation and Improvement

Doctors in difficulty

The London and KSS deaneries fund the Mednet service for doctors in difficulty. The following link www.londondeanery.ac.uk/var/career-planning-personal-development/MedNet can be used for further information on their services. A brief summary of the service is provided below:

MedNet is a confidential Consultation service **for doctors by doctors** at Tavistock & Portman NHS Trust and at South London & Maudsley NHS Trust. Funded by the London Deanery, it provides doctors and dentists with confidential consultations, advice about their careers, emotional support, and when needed, access to other expert help. This may include more specialised psychotherapeutic interventions (which embrace all the mainstream modalities of psychotherapy), or specialised psychiatric advice.

MedNet is staffed by Consultant Psychiatrists in Psychotherapy, who have seen over 750 doctors face-to-

face in the last ten years. Treatment interventions are tailored to the individual practitioner in the context of a supportive relationship.

To access MedNet, practitioners, of any grade or specialty, must live or work within the area covered by the London Deanery and KSS Deanery. The service is confidential and well respected. The service deals with a wide range of problems including anxiety, depression, relationships at work/home, burnout and work/life balance, bullying/harassment at work, obsessive compulsive disorder, anger management, bipolar illness, personality difficulties, communication difficulties, adjustment difficulties, isolation/racism/migration, social phobia, examination stress, inquiry/clinical incident stress, NCAS/GMC involvement, trauma, past or recent bereavement/loss.

Sue Morgan
Chair, SASG Group

Staff Grade and Associate Specialists



update

Funding for Continuous Professional Development Breaking the boundaries of CPD

Following recommendations made in the Tooke Report on Modernising Medical Careers (MCC) £12 million of funds have been made available to SAS doctors to acquire consultant level competencies. These may be used to support an Article 14 application for entry onto the specialist register or to improve or expand an individual's practice.

The deaneries have responsibility for overseeing the allocation of funds. The London Deanery has been particularly active and has funded many projects.

Frontier Project – London Deanery

The project aims at *Breaking the boundaries in Continuing Professional Development* for SAS doctors and was launched last Autumn at a meeting in central London by Elisabeth Paice, the Project Sponsor and Associate Dean, Tony Rao. Tony is a Consultant Psychiatrist and has the responsibility for delivering the initiative. He was selected for his track record of leading and improving a large training scheme, as well as his personal insight (both his parents worked in the SAS grade). In addition, the Deanery has employed 2 SAS advisors who work part-time on an annual contract for the project, as well as involving their Trust liaison deans.

To ascertain the training needs of SAS doctors, the Deanery conducted a survey. A program of free activities was then designed to meet these needs. Please visit www.frontier.londondeanery.ac.uk/. Included are sessions commissioned from the college on teaching, appraisal, job planning and maintaining a portfolio. The Deanery keeps in regular contact with all SAS doctors employed in the London Region via its website, e-mail database and SAS leads in each Trust.

Joint Venture

The London Deanery wished to develop specialist training days for SAS doctors. The new format was developed by me in a joint venture with the BGS. The

day was divided with morning sessions delivering clinical CPD (epilepsy and therapeutic sessions) and the afternoon devoted to generic issues affecting SAS doctors (job planning and mentoring). The event aimed to deliver first class CPD whilst providing opportunities for SAS doctors to share their knowledge and skills. This was achieved by 3x 20 minute talks followed by 30 minute panel discussions. The format proved extremely successful with SAS doctors presenting alongside experts in the field and benefited from active participation from the floor. Special thanks to everyone who helped make the day a success but in particular, thanks to the speakers from the BGS (Simon Conroy, Jagdish Sharma, Aza Abdulla), Consultant Neurologist Bridget MacDonald and the SAS presenters (Jumoke Abili, Meng Aw-Yong, Anthea Mowat and Prem Ohri). The day has paved the way for other specialist days.

New from other regions

Deaneries in other regions have funds to distribute but there appears to be a wide variation in what is being currently offered. There is concern that some deaneries are less proactive in supervising the distribution and spending of funds and are forwarding these to Trusts to manage. If you have not been advised of funding in your area, contact your local deanery. In some cases, information may be available on their website.

Recurrent funding

Recurrent funding depends on demonstrating a successful outcome to the first wave of expenditure – it is important for us all to take full advantage of this opportunity. There is funding available for more substantive educational activities such as MSc or secondments to learn new skills.

Sue Morgan
Chairman
BGS Staff and Associate Specialist Grades
Group

Retired Geriatricians

Do you remember these faces? Then perhaps you should be joining us at the 2010 BGS Retired Members Group Gathering which will be held on Sunday, 23 - 24 May at the 4-star St Michael's Manor Hotel, Fishpool Street, St Albans AL5 4RY

Tel: 01727 86444

www.stmichaelsmanor.com/private.asp



This is a first class hotel. A short walk (10 minutes) from town and the cathedral. All rooms are John Lewis furnished, en suite and with all the usual facilities one might expect from a 4-star hotel. There is excellent parking and well tended grounds.

We have reserved 10 rooms at £125 a night and 7 rooms at £145. Breakfast is included and it is the same price for double or single occupancy .

Extras - evening meal on Sunday and Monday . Cost of this without wine will be circa £25 - £30 a head per night.



By arriving on a Sunday and leaving on a Tuesday we have negotiated the weekend rate, enabling the hotel to host a wedding function on Friday and Saturday. Book now as we have undertaken to release all rooms in February / March and the price may go up for late bookings

Booking a room: Credit card needed. Telephone reception: 01727 864444. Ask for a booking under the BGS Retired meeting on 23rd-24th May block reservation. Choose price of room - £125 or £145; give credit card details, telephone number and email. Confirmation will be by email. Rooms may be cancelled up to two weeks before arrival date.

When your reservation has been confirmed by hotel, please email me phmillard@tiscali.co.uk to confirm your attendance of the BGS Retired Members' Group meeting.



National Audit of Dementia - Care in General Hospitals

The Royal College of Psychiatrists has been working in partnership with the Royal College of Physicians, the Royal College of GPs, the Royal College of Nursing, the BGS and the Alzheimer's Society to develop a national audit of the care of people with dementia in general hospitals across England and Wales.

The admission of dementia patients to general hospitals has been identified as a time of high risk and can often lead to deterioration in health. Consequently, improving the consistency and standards of care that dementia patients receive in general hospitals has been recognised as a great priority.

The audit will identify areas of good practice in general hospitals and compare performance against national standards. This will support participating hospitals to identify areas for improvement which should lead to the provision of better services for dementia patients - a main objective of the National Dementia Strategy in England and the National Dementia Plan for Wales.

The programme aims to involve all general acute hospitals across England and Wales and will generate national data relating to the structures, policies and training that support the care of people with dementia, and the quality of admission, assessment and discharge

A sample of hospitals will also participate in an enhanced ward-level audit. This will gather information about the ward environment and ward organisation and information will be collected from staff, carers and patients concerning their experiences in relation to dementia. Staff from participating hospitals will also be trained to carry out structured observations relating to the quality of the care transactions between staff and patients.

Data collection begins in spring 2010. If you would like more information on this project, please visit our website www.nationalauditofdementia.org.uk or contact the project team on 020 7977 4976 or agandesha@cru.rcpsych.ac.uk.

Middle Eastern Promise

Although Prof Peter Crome is no stranger to the Middle-East Academy of Medicine of Ageing (MEAMA), an invitation to speak at their Congress on Age, Ageing and Alzheimers (MECAA) was a new experience for me. Having left our British November nights behind, we arrived in the Lebanon to be greeted by Dr Abyad who gave a warm welcome to all the international speakers in English as well as Arabic.

As founder of both the Middle-East Journal of Age & Ageing and the Middle-East Network on Ageing research his organisational skills were clearly on display with a breadth of program from the potential of stem cell research to the cost



Address by the Lebanese Secretary of State

effectiveness of home care provision in the Middle East.

Uninterrupted sunshine outside did not distract us from parallel scientific and health care system programs. Day one offered us the “greying Middle East”, its challenges together with governmental and non governmental solutions. This was pitched against a comprehensive analysis of cognitive disturbance from prevention through to end of life care. Prof Baeyens raised the importance of creativity to the older person and the need to select activities which maintain self esteem, though I question his view that ‘we all strive for happiness’. When the health risks of obesity were discussed, the ‘considered’ benefits of fasting appeared to open research possibilities.

The focal point that evening was the arrival of the Lebanese Secretary of State for Health. His interest in the care of older people was clear and pressing given the current lack of state Lebanese health care for this cohort. Traditional family loyalties are cherished by many but significant gaps exist for those who are childless, divorced or otherwise neglected.

On day two, we heard comparison made between developed and developing countries health care systems

and their experiences of long term care beds. This raised the question, at what point is palliative care initiated and continuing restorative treatments abandoned? Prof Giovanni courted controversy by analysing the mortality reduction with antihypertensives including an analysis of the HYVET trial. This was followed by overviews on stroke, heart failure and mood disorders in chronic illness. The mortality risks with antipsychotics were discussed with the equally unacceptable risks associated with physical bed restraints.

That evening we were whisked away from worldly matters up over the city of Tripoli to dine on a healthy Mediterranean meal. The lack of alcohol led one of our Italian friends to suggest this was a critical part of the Mediterranean diet. After many courses and sweet fruits to finish, he appeared outwardly satisfied.

The final day concentrated on successful ageing, nutrition and the concept of quality of life. Although numbers reduced for Friday afternoon prayers multi disciplinary team work and gender specific medicine were not ignored. Limited sun exposure in some women was part of this discussion and how best to strengthen bone. A break away group then headed for the old souks and a climb to the historic castle sighting snow



Peter Crome, on watch for conference dodgers

capped mountains. We could see the city under construction with the re-awakening of its financial services. Our mini-bus even managed a sing-along though the harmonies did not quite make it. On departure, tributes were paid to the many who had given freely of their time and facilities to make the congress a success, especially to Dr Abyad, ‘Shoukran’ (Arabic for thank you).

Owen David
BGS Meetings
Secretary

To find out more:
<http://www.meama.com/secondconference/index.htm>
<http://www.mejfm.com>
<http://www.me-jaa.com>



Making our voice heard

BGS PR update

As the media continues to focus on the implications of our ageing population, the BGS has been contributing to public debate.

In December, Graham Mulley and David Oliver addressed the Guardian's Older People and Ageing Britain Conference 2009. Graham Mulley participated in a panel debate on the role of supported housing and how we care for older people, while David Oliver discussed the challenges for services for an ageing population and how they will have to adapt. Another BGS member, Desmond O'Neill, provided an overview of what is happening in other countries, in his capacity as President Elect of the EUGMS. Professor O'Neill also took part in an Economist Intelligence Unit webcast on the future of ageing.

The BGS' opposition to age discrimination in the NHS was noted on the Parliamentary record during a Westminster Hall debate on age discrimination in healthcare, which was secured by Paul Burstow MP in December. In the course of the debate, Greg Mulholland MP, Liberal Democrat Shadow Health Minister, referred to the findings of the BGS/Help the Aged survey of geriatricians' views regarding the prevalence of ageism in the NHS.

We have received attention in the national consumer and trade press. We issued a joint press release with the Royal College of Physicians (RCP)

relating to the findings of recent research into continence and linked to the launch of the 2010 national audit of continence care. The

Daily Express, the *BMJ* and the *Nursing Times* reported on the findings, including a quote from Jackie Morris in her capacity as BGS dignity lead. Following interest in the research, Adrian Wagg has written further articles for publication in the *National Health Executive* and *Nursing Times*.

After presenting the results of the BGS pilot audit of intermediate care services at Harrogate, Duncan Forsyth and John Young were interviewed for a feature in the *Health Service Journal*. They highlighted the importance of data collection and the need to develop standards for intermediate care.

We collaborated with the RCP on another joint press release, this time focusing on research, published in the December issue of *Clinical Medicine*, which looked at geriatricians' involvement in care homes and the level of PCT commissioning for care homes. The findings were picked up by the magazine *Community Care*, which highlighted that care home residents lack access to specialist doctors. The Care Quality Commission is now looking at the data in the context of their ongoing review of the healthcare needs of care home residents.

Iona-Jane Harris
PR and Parliamentary Affairs Officer

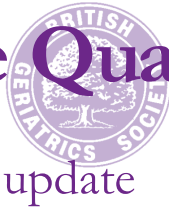


Social Care TV

Social Care TV (www.scie.org.uk/socialcaretv) is a first for social care; the broadband service is a window into the world of good practice from the Social Care Institute for Excellence and other organisations. The web pages feature engaging films that link through to related guidance and advice, multimedia and e-learning resources. The aim is to stimulate debate about the big issues in the sector with social care staff, managers, commissioners and trainers.

Because it is a TV service, users can relate to it in a way that is not always possible with the written word. The clever technology means that staff can keep ahead of developments and share good practice to improve care and support. We all want to improve care provision – this is another, exciting way of doing it.

Care Quality Commission



update

The BGS interviewed Mr James Rentoul of the Care Quality Commission (CQC), asking how its programme might impact upon the care of older people.

The Care Quality Commission is the independent regulator of all health and adult social care in England. Our aim is to make sure better care is provided for everyone, whether that's in hospital, in care homes, in people's own homes, or elsewhere.

Our vision is of high quality health and social care which supports people to live healthy and independent lives; helps people and their carers to make informed choices about care; and responds to individual needs.

By high quality care, we mean care that is safe, has the right outcomes, including clinical outcomes. For example, do people get the right treatment and are they well cared for? Is it a good experience for the people who use it, their carers and their families? Does it help prevent illness does it promote healthy, independent living? Is it available to those who need it when they need it? And does it provide good value for money?

We are currently consulting on our five year strategy (2010 – 2015) and our strategic priorities are:

- ◆ Ensuring care is centred on people's needs and protects their rights
- ◆ Championing joined-up care
- ◆ Acting swiftly to help eliminate poor quality care
- ◆ Promoting high quality care
- ◆ Regulating effectively in partnership

The details of the consultation are available on our website www.cqc.org.uk.

Our main activities are:

- ◆ Registration of health and social care providers to ensure they are meeting essential common quality standards



James Rentoul, Care Quality Commission Director of Regulation & Strategy

- ◆ Monitoring and inspection of all health and adult social care
- ◆ Using our enforcement powers, such as fines and public warnings or closures, if standards are not being met
- ◆ Improving health and social care services by undertaking regular reviews of how well those who arrange and provide services locally are performing and special reviews on particular care services, pathways of care or themes where there are particular concerns about quality
- ◆ Reporting the outcomes of our work so that people who use services have information about the quality of their local health and adult social care services. It helps those who arrange and provide services to see where improvement is needed and learn from each other about what works best.

Do you have any special reviews coming up over the next twelve months?

Following consultation the CQC Board has agreed seven topics for reviews and studies for 2009/10. These are meeting the healthcare needs of people in care homes; ensuring services for people who have had a stroke and their carers; meeting the physical health needs of those with mental health needs and learning disability; supporting families with disabled children; commissioning, health promotion and health inequalities; ensuring Social Services responds to people's first contact with them; and managing the impact of financial downturn on the quality of care.

All the above topics include older people issues in varying degrees, depending on the topic. We will be consulting on the list of topics for 2011/12 soon. Some of the future topics include Nutrition and Dementia, which are highly pertinent to the older people agenda.

Is there a role for the CQC to encourage PCTs and local authorities to commission appropriate services for frail older people?

CQC is very keen to ensure high quality outcomes

for all, particularly those who may find themselves in vulnerable situations due to their age, disability, ethnicity or other reasons. We have the remit of assessing commissioning arrangements by PCTs and Local Authorities and we will use this remit to ensure that the services are being commissioned in a way that produces high quality outcomes for vulnerable groups while maintaining dignity, safety and human rights for these groups in all care settings. For PCTs our assessment of commissioning will include performance against national priorities for the NHS set by government and World Class Commissioning guidance. Our assessments of councils will be based on the outcomes that have been commissioned for people who use services and will incorporate findings about the quality of care in regulated services commissioned by councils. Findings of our assessments of commissioning will also feed into Comprehensive Area Assessments.

As a joint regulator of health and social care, how do you think the CQC can play a part to encourage greater service integration and more joined up care pathways?

One of our strategic priorities is to champion joined up care which indicates our strong commitment to this important area. We are very keen to use the care pathway approach towards provision and commissioning to ensure that people using the services do not face challenges and disjointed care due to gaps in services. We are already working on looking at the care pathway for people who have had stroke, which is very relevant to older people agenda. Our view of joined up care pathways is one that aims to join up services to achieve the best outcomes for people and meet their needs. We are working with NICE to develop national quality standards for Dementia and Stroke, based on the respective care pathways.

How will you encourage higher standards in care homes and hospital settings?

Promoting high quality care and acting swiftly to eliminate poor quality of care are two of our strategic priorities. The Care Quality Commission has launched guidance for all health and adult social care providers on meeting new essential standards of quality and safety, that will apply across the care sector. Providers must show they are meeting essential standards as part of a new registration system which focuses on people rather than policies, on outcomes rather than systems. The essential standards relate to important aspects of care such as involvement and information for people, personalised care and treatment, safety and

safeguarding. Subject to legislation, the new registration system comes into force for NHS trusts on 1 April 2010 and for adult social care and independent healthcare providers on 1 October 2010. CQC will continuously monitor compliance with essential standards as part of a more dynamic, responsive, robust system of regulation accompanied by new enforcement powers. CQC's guidance is focused on outcomes - the experiences people have as a result of the care they receive - rather than on systems and processes. It was widely consulted on earlier this year and places the views and experiences of people at the centre of the regulatory system. We are keen to hear from local groups who can provide us with local intelligence which will help us in targeting the poor performers. We have provided a specific mechanism through which local groups can provide us with this information and this is available on www.cqc.org.uk/getinvolved/viewsfromlocalgroups/whocansendusinformation.cfm

How do you determine who is responsible for the provision of care in the care home setting? For example, if care home residents are not receiving appropriate health care will you determine if this is the responsibility of the care home provider, the PCT, individual clinicians or care home staff?

We believe providing care that meets the needs of people in any care setting is everyone's responsibility. The care home provider and the Registered Manager would be expected to ensure that the service provided by them is fit for purpose. They also have a duty to work with others in ensuring that people in their care have access to high quality services and these services provide high quality outcomes. If CQC finds that the care home is not meeting the requirements of registration to make it fit for purpose, we will use our enforcement powers to bring about improvements. In the extreme case where we feel the safety of the people using the service is at risk, we may consider cancelling the registration and closing it down.

With the ongoing shift towards care closer to home, how will you regulate people receiving health and social care in their own homes?

From April 2010 all services that provide personal care in any care setting will have to register with the CQC to ensure that they are fit for purpose. The essential standards for safety and quality that were referred to earlier will equally apply to services provided to people in their own homes. We are also working with skills councils and other professional bodies to ensure that the staff

providing care in people's homes are appropriately skilled and competent to provide a service that meets people's needs, including maintaining their dignity. Safeguarding people who use services in all care settings is of paramount importance to us and we will use all our powers to ensure that this applies to people who receive health and social care in their own homes too.

Do you use information collected by other audits, for example those conducted by the National Audit Office or the Royal College of Physicians?

Yes we do.

Iona-Jane Harris

BGS PR and Parliamentary Affairs Officer

Nursing by degrees

“you need knowledge to care”

The recent announcement regarding the changing requirements by the Nursing Midwifery Council (NMC) to move towards a degree level registration by 2013 has received a mixed reception.

Ranged against those who believe that we will lose the essence of the “caring role” are those who see a need for a modern educated workforce which is robust and grounded to face a new age of healthcare. The NMC have reviewed the standards of education. These will be out for consultation next year. They require that nurses are educated to deal with greater complexity that leads to a degree level education. In no way does this undermine the skill and expertise, knowledge and experience of nurses on the register who do not currently hold degrees and they will not be required to attain a degree to remain on the register.

Following the commentary has been enlightening in seeing the old debates surfacing about nurses as mini doctors or “too posh to wash”. In my view, it is all rather ridiculous. The first undergraduate programme for nurses was

introduced in Edinburgh in 1960, some 50 years ago. Wales introduced an all-graduate profession in 2006; I do not recall the cries of horror about that. No one seems to have objected to the all graduate profession of speech therapy, physiotherapy or occupational therapy in the last few decades or in midwifery last year. So why is there such a concern about nursing? Nurses are the single biggest employed workforce in the NHS, predominately female and they provide a constant role in the delivery of healthcare to patients. Is there a gender issue at play? New role developments such as Nurse Specialist and Consultant posts have provided a new pathway for senior clinical nurses. Currently we have 60 posts within the speciality across the four countries of the UK. These posts expect nurses to hold a degree. We need to have robust career

structures in place if we are to retain and sustain the profession.

The concern about denying a potentially “good bedside” nurse access to training will be negated by developing a range of access courses to enable individuals to attain appropriate qualifications to gain entry to a degree programme. Most recently, many nurses have topped up their university diploma to



degree level, which is the current requirement. I think we underestimate people's potential and we need to be realistic in the fact that we will need a new hybrid of "nurse" or health worker who is more flexible and can support and lead changes we will see in healthcare services. The economic outlook is bleak. Reform will be continuous and radical change will be needed to sustain the workforce and demands for care. Nursing will be at the heart of that and will require a highly educated and skilled workforce to adapt to the economic pressures and to contribute some of the solutions. We cannot afford to look back as a profession to what went before. We have to look forward and be

prepared for a new world of new opportunities and challenges.

The best comment on the nurse degree debate came from my 85 year old aunt who recently spent two weeks observing the NHS from her hospital bed. A retired nurse, politically astute and well versed in current affairs, she said of the critics of the intention to turn nursing into an all graduate profession, "They can say what they like, you need knowledge to care." I think that sums it up.

Deborah Sturdy RN MSc (Econ)
Nurse Advisor Older People
Department of Health

Nursing - a world away from the "routine rounds"

I have been following with interest the debate in the press on the NMC recommendation that all new nurses will be required to be educated to degree level by 2013.

I trained in the 1980s and did not progress to higher education until later in my career. The world was much simpler then. The training was good but focused on learning by rote and obedience and much of the care was routinised e.g. back rounds, fluid rounds. I don't feel that this culture adequately prepared me for the ever developing complexities of health care where a questioning attitude and an understanding of complex principles are crucial to the role of a nurse seeking to apply best practice.

I work in a hospital as well as the community and for nurses, higher levels of skills in many areas are now required. Nursing is about the whole care of patients rather than just their personal care. In relation to older people today, this means that it is necessary to have a comprehensive understanding of multiple co-morbidities, pharmacology for non medical prescribing, psychology, technology, complex legal principles (e.g. Mental Capacity Act), funding issues (e.g. CHC) in addition to being a good communicator, negotiator, educator, empathiser and advocate.

Much of the debate has focused on the 'too posh to wash' side of this argument but I believe that this is another discussion. The role of caring and providing personal care in society is not valued as it should be. The care of our frailest older people with the most complex of conditions is often delegated to the people with the lowest levels of training and expertise who are often working without adequate clinical leadership or supervision. The growing awareness of vulnerable adult abuse in institutions such as hospitals and care homes and the investigations carried out in these areas have repeatedly shown that clinical leadership, training and supervision are key areas to providing high quality care. This is more to do with the value that, as a society, we vest in caring as a skill than it

has to do with basic training.

In my hospital and community work, I do not experience nurses being averse to providing the care that is needed by individual patients, whether they are educated to degree level or not. In my student training with district nurses, there were many patients who were provided with weekly bathing by the team, but at some point this became a 'social' rather than a 'health' need and so was no longer seen as part of the nursing role. These 'health' and 'social' distinctions are divisive, unclear and not particularly helpful as people can rarely be easily classified into one or another category or system.

I work with many excellent nurses without degrees. However, many of them, have had to take on additional study to prepare themselves for their role and for the needs of the patients on their caseload, while juggling the demands of work and families. The response of academic institutions to this proposal is key to ensuring that nurses can access modules at degree level which will support them in improving their clinical nursing expertise, rather than amounting to academic 'hoop-jumping'. Equally valuable, is the importance of the clinical placement with access to practical training, role modelling, mentorship and time with patients in a structured, learning environment. The aim of this proposal is to improve quality – I hope that it does but it seems that this measure alone will not be sufficient to achieve what is hoped for. It must be complementary to a radical review of the workforce and changes in the ways that we think about, and value care.

Nursing as a profession, is something to be proud of and value. Florence Nightingale has been quoted many times in this debate but I'll finish with Gordon Brown's description of nursing - "something that we do with our head, our hands and our heart, all at once, and this, for me, sums it up perfectly".

Aileen Fraser
Nurse Consultant

All graduate nursing profession - the devil in the detail

“They can say what they like, you need knowledge to care.’ I think that sums it up.”, says Deborah Sturdy in the lead article on the issue of introducing an all graduate nursing profession by 2013.

How could I possibly disagree with that? I don't. It is with relief that at last a plan has been formulated to allow nurses within the UK to stand equally with our overseas counterparts and be able to demonstrate that our training programme is as robust and grounded as theirs. However the devil will be in the detail. As a Registered Nurse (RN) who qualified via the “traditional training method” (a waged student) I would add a word of caution to the debate.

The argument here cannot be about whether a degree programme is a good thing or not, it has to be about whether that programme reflects the needs of our client group and whether those individuals who are the best potential recruits into the profession are equipped educationally to get a place in one of our academic institutions.

To illustrate my point, at 23, I was considered a mature student. I passed all of the required assessments as I progressed through my training, including the academic ones. But the skills I found myself calling on most were not those acquired through academic study. They were the skills gained during my earlier career in the retail industry and during my time as a volunteer, both with the Police and as a volunteer ambulance association (the latter job included mopping floors in a home for the elderly at weekends).

Gaining knowledge is not simply a process of absorbing text and being able to cite a reference (although these abilities can be useful when trying to make a point). Knowledge, as we know, is gained from all manner of experience. I remember as a child sitting in the “day room” of a home for the elderly and hearing a gentleman's memories of what it was like to be in the trenches in the Great War. Even now, the hairs on the back of my neck rise despite his version being edited for the ears of a 9 year old.

Throughout my career I have held many responsible posts. I am pleased to say that my managers have all appeared happy with the care I have provided and with my contribution to the developments in those environments. However, should I apply to train as a nurse now I would not qualify. I would fall at the first hurdle of the application process.

I do not know the proportion of individuals on my intake who would have been considered “mature students” but on reflection, I would guess that it was a third. The majority of those have gone on to provide excellent care as RN's. My concern would be that now, with the introduction of an all degree profession, those excellent nurses would never be

recruited. Their skills, talent, knowledge and ability to empathise would be lost to the nursing profession.

It would be interesting to look at the comparison between recruitment from the mature age group now, as opposed to 20 years ago. It also has to be said that the loss of a waged programme would have deterred this group. Who would risk their home and livelihood on a vocation in the current climate by giving up a secure income for a bursary with no guarantee of employment at the end?

Two points were raised with me recently, the first understandably, was the anxiety raised by a nurse with similar training to my own, that she may be forced into taking a degree programme simply to stand still and secondly, by a senior nurse who observed that realistically, it is very difficult in practical terms to differentiate currently between a degree and non-degree qualified nurse.

RCN Chief Executive & General Secretary, Dr Peter Carter said: 'This is not about restricting entry to the nursing profession, in fact we must ensure that the door to nursing continues to be as wide as possible...we need a nurse education system which encourages the best entrants to pursue a career in care.'

I echo Dr Carter's comments. Let's find a way to wedge this door open and develop radical programmes which will allow us to educate our successors to use all of their talents.

We need to ensure that anxieties are addressed and that the educational process reflects the needs of our ever developing health service. Phrases like “with early opportunities for postgraduate achievement” www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_108370.pdf may serve to help in the recruitment of undergraduates from schools and colleges but they may not prove enticing to a wider group of potential nurses. Many nursing skills are inherently practical, this should not be forgotten in the new courses and time must be allowed for proper course development.

Proven ability in these skills, as well as academic understanding needs to be assessed before a rapid scramble up the career ladder can be taken.

I fear the need to have courses up and running by September 2011 may be too short a period to allow for a full consultation with those nurses who know what is needed, those who work at the sharp end and ultimately will have to guide the practice of their newly qualified colleagues.

Aidan Dunphy RN
Older Persons Research Nurse
(working toward a degree)

BPOP Guidelines



best practice in acute care for older people

The Older Adult R&D Team at City University, London, has published a set of evidence-based guidelines for the acute care of older people that are primarily targeted at nurses but also have relevance for other clinicians.

The evidence-based best practice statements are a resource for staff who work with older people, all or some of the time in general acute service; to support and guide their own practice, and to help them explain to others what best care for older people involves. They update the 2001 Standing Nursing and Midwifery Advisory Committee (SNMAC) evidence-based principles, standards and indicators for nursing care of older people in the acute phase of illness, published at the same time as the National Service Framework for Older People. Their relevance is heightened by the policy context of improving patient experiences, because of their explicit aim to do just this.

The best practice statements are based on the findings from a systematic review aimed at finding out about the acute care experiences of older people and relatives¹. The review's findings highlighted the value that older patients and their relatives place on the relational rather than the technical aspects of care, and the important role that all acute care staff, have in:

Maintaining identity: "see who I am"

Patients want healthcare professionals to know what is important to them, and relatives want

healthcare professionals to value what they know about the patient.

Creating community: "connect with me"

A connected and two-way relationship with staff gives patients and relatives the reassurance that staff will care for them and meet their needs.

Sharing decision-making: "involve me"

Patients and relatives want to understand what is happening, and to be given ongoing involvement in decision-making.

The review illustrates that these three key messages have particular relevance for older people with dementia and/or delirium; with difficulties communicating, hearing or understanding; from ethnic minority groups, especially where there is a language difference; with low functional ability/high physical disability; and for people not accompanied by relatives or others. It is probable that the key messages also hold particular relevance for people at the end of life, but the dearth of research here meant that this possibility could not be explored.

These findings reinforce the importance of relationship-centred care in which the quality of engagement between patients, staff and practitioners is paramount in promoting the wellbeing of all involved². A best practice statement is included for each of the three key messages and they also provide an underpinning philosophy for all the best practice statements. Other best practice statements are based on existing systematic reviews, clinical guidelines and consultation with an expert panel. These statements cover:

- ◆ Caring for people with mental health needs
- ◆ Caring for people with palliative care needs
- ◆ Caring for people at end of life
- ◆ Meeting needs for nutrition and hydration
- ◆ Promoting continence
- ◆ Promoting mobility and preventing falls
- ◆ Preventing and managing pressure ulcers

The guidance comes in the form of a CD and a

Reference List

1. Bridges J, Flatley M, Meyer J. Older people's and relatives' experiences in acute care settings: systematic review and synthesis of qualitative studies. *International Journal of Nursing Studies* 2010; 47(1):89-107.
2. Nolan MR, Brown J, Davies S, Nolan J, Keady J. *The Senses Framework: improving care for older people through a relationship-centred approach*. 2006. Sheffield, University of Sheffield.

booklet. The best practice statements are set out in full on the CD, along with links to videos of patient stories and to other resources. The booklet includes ideas for individual nurses and nursing teams to work with the best practice statements to identify existing good practice and to articulate the support they need to maintain and build on this. The CD and booklet have recently been distributed with the journals *Nursing Standard* and *Nursing Older*

People. The material, including a link to the systematic review, can also be accessed on www.city.ac.uk/bpop. Spare copies of the CD can be requested from me (contact information below).

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Training matters!

SpR/StR update

2010 is a very important year for training in geriatric medicine and other medical specialties.

I was appointed Chair of the SAC in Geriatric Medicine in June 2009, taking the mantle from Prof Steve Allen. Steve has been an outstanding chair, his negotiating and leadership skills are second to none and I am only too aware that he will be an incredibly difficult act to follow.

Chris Turnbull's tenure as Secretary of the SAC has also come to an end. In this Newsletter Chris has written an article on 'Project 2010' (the new curriculum in Geriatric Medicine) and whilst this rewrite was very much a team effort on the part of the SAC and the specialty as a whole, without Chris's drive, enthusiasm, and tenacity this project would have struggled to get off the ground and certainly would not have been delivered to PMETB on time. Chris has been replaced as Secretary by Brendan Martin who is based at Hairmyres Hospital, East Kilbride.

The SAC has three trainee representatives. Peter Burbridge continues to provide splendid support in this capacity and we welcome two new members: Thomas Jackson (Chair of the Trainees' Committee) and David McGhee. Thomas and David replace Zoe Wyrko and Adam Gordon, Zoe and Adam have worked tirelessly on behalf of trainees and have helped our specialty get a reputation with the JRCPTB for being one of the most vocal!

On behalf of the SAC may I once again thank Steve, Chris, Zoe and Adam and welcome Brendan, Thomas and David.

In this article I intend to focus on what I believe are the 'hottest' topics affecting training at present.

Structure of SAC Meetings

Our specialty is very fortunate in being in the unique position of having SAC meetings immediately preceding our specialty's Education and Training Committee (ETC) meetings. This facilitates the rapid dissemination and discussion of training matters within all deaneries and nations. In October 2009 the JRCPTB proposed a change to the structure and frequency of SAC meetings, which would have greatly impaired the SAC's links to the ETC. Our specialty (as well as a few others) objected to these proposed changes and whilst we await a final decision I am pleased to say we have been at least partially successful as no change in the structure or frequency of meetings is planned for 2010.

Specialty Certificate Examination (SCE)

In order to become SAC Chair I relinquished the role as Lead Physician for the SCE. I am pleased to say that Dr Mike Vassallo has been appointed as Lead Physician for the SCE. Mike was Secretary of the Exam Board and has an excellent knowledge of the exam and worked very closely with me on it. His appointment will ensure a smooth transition of the process and I wish him every success.

Our first SCE was held on 4 March 2009, 15 candidates sat the exam and all passed. The next

SCE will be held on 24 March 2010, the format will be the same, 200 best-of-five questions divided into 2 papers, taken on line, on the same day at one of the Pearson Vue centres. Once again may I remind trainees and trainers that at least for the foreseeable future there will be only one diet (one exam) per year.

The SCE is mapped to the curriculum. Questions are very much clinically related and cover topics which trainees encounter in their everyday clinical and sub-specialty practice, but when structuring regional teaching programmes trainee reps might want to ensure regional teaching programmes include aspects of gerontology and ageing physiology as in my experience these are often poorly covered by structured teaching sessions.

The exam Blueprint is available in the SCE 'Regulations' section on the MRCP(UK) website or on page 11 of the following link: www.mrcpuk.org/SiteCollectionDocuments/SCERegulationsGeriatricMedicine.pdf

Trainees who have (or register for) an MRCP(UK) account can gain access to 5 sample exam questions.

Professor Marion McMurdo and colleagues at the University of Dundee have developed a free online educational resource (Educational Resource on Ageing (ERA)) in collaboration with the National Initiative for Care of the Elderly in Toronto which may help trainees prepare for the SCE and other related exams. They have generated a bank of best-of-five questions based on common clinical scenarios. At each log-in, questions are viewed in random order and once a section has been completed the correct answers are provided with an evidence-based web link to support further reading around the topic.

Stroke Training

As Chris Turnbull describes in his article, the Geriatric Medicine curriculum now includes an expanded grid of competences for stroke training. The Stroke sub-SAC have revised their curriculum as part of Project 2010. Trainees and trainers need to be aware that for trainees to be fully accredited in stroke medicine (as well as Geriatric and General (Internal) Medicine) it will necessitate an additional year of training in a dedicated stroke training post, thereby increasing the overall 'registrar' training time from 5 to 6 years.

Registrar Recruitment

Geriatric Medicine is one of the 5 partner medical specialties (the others being cardiology, diabetes and endocrinology, gastroenterology and renal medicine) participating in JRCPTB's national 2010 registrar (ST3+) recruitment process.

This process will be coordinated by JRCPTB using a single national web-based application portal, using a standardised application form for all medical specialties but with shortlisting and interviewing being undertaken at deanery/regional level. The principles are very similar to those used for the national recruitment to CMT posts. Applications open on 26 February 2010, with interviews held from 29 April – 17 May.

Geriatric Medicine will include available vacant posts in England, Wales and one or 2 (non run-through) posts in Scotland. Our intention in Geriatric Medicine is to have a standardised 3 station OSCE based approach to test (amongst others) candidates' communication skills, aptitude for the specialty and awareness of the common ethical principles which underpin our specialty.

Dual Training in Geriatric and General (Internal) Medicine

Dual training (and therefore CCTs) in Geriatric and General (Internal) Medicine has been reinstated as of August 2009.

Some trainees are affected by this transition period. It is extremely important that those trainees who registered with the JRCPTB between August 2007 and July 2009 in Geriatric Medicine with a Level 2 credential in GIM request to transfer to dual CCT training. The first step in this process is to complete the 'Request to Transfer' form on the JRCPTB website. To avoid problems please read and follow the JRCPTB's guidance on the transfer process closely.

Curriculum

This is perhaps the 'hottest' of all the topics I have discussed and has major implications for both trainees and trainers (assessments and the time required to undertake them), but for obvious reasons I shall leave discussion of this to Chris in his article.

Finally our President Elect, Finbarr Martin suggested to me that colleagues would welcome advice on how they might be more involved in training in Geriatric Medicine at regional/national

level so here goes:

1. Complete all the mandatory training courses on 'educational supervision/appraisal', 'equality and diversity' and 'employment law and selection'.
2. Get a good local reputation for supervising and supporting trainees, not only as an educational and clinical supervisor but perhaps (with the agreement of School Directors/Deanery) helping support 'doctors in difficulty' requiring remedial or targeted training.
3. Strongly consider obtaining a qualification in medical education such as a Certificate/Diploma/Masters. There are many opportunities to do so either face-to-face or by distance learning. At present person specifications for 'senior' training posts include these as a 'desirable criterion' but I

can see this becoming obligatory in future.

4. There are a number of opportunities to be involved in undergraduate and postgraduate training. Almost all trusts have College Tutor, Foundation Training Programme Director, and Undergraduate Tutor posts. If this is the direction you want to follow then apply! They are extremely rewarding and provide an excellent platform for those wanting to pursue a career in medical education

I hope this article has been of some interest. My intention is to provide regular updates on training in future Newsletters, and Mike Vassallo will also contribute articles on the SCE.

Oliver J Corrado
Chair, SAC Geriatric Medicine

Project 2010

A New Geriatric Medicine Curriculum

A new curriculum for Geriatric Medicine specialist trainees has been written and presented to the Postgraduate Medical Education and Training Board.

We are awaiting final confirmation on what amendments will be required but the comments below about the major changes to the curriculum below are unlikely to be affected.

PMETB has expanded its standards for medical curricula to 17 and has asked for curricula to be brought up to these standards by 2010. Introduction is for those starting higher specialty training in August 2010. It is important that all trainers and specialty trainees starting in 2010 are aware of the important changes so that they can update what they teach and learn respectively.

These changes are in addition to those important changes brought in with the arrival of specialty registrars (StRs) in 2007 such as workplace based assessment for registrars, the Specialty Certificate

Examination (SCE) and the e-portfolio with which many of us will now be becoming familiar.

The additional standards require further evidence on the validity of the assessment methods particularly the "high stakes" examinations such as MRCP and the SCE.

Standards for supervisors, assessors and examiners

There is increased emphasis on the standards expected of educational supervisors, assessors and examiners in supervision, assessment and giving feedback.

Certificates of Eligibility for Specialist Registration (CESRs)

Trainees who start after ST1 will not be able to obtain a CCT but will be able to obtain a CESR via an accelerated CESR route. Details at www.pmetb.org.uk

Dual recognition in G(I)M and Geriatric Medicine returns

Importantly StRs will again be able to obtain dual CCTs in Geriatric and General Internal Medicine

Importantly StRs will again be able to obtain dual CCTs in Geriatric and General Internal Medicine (G(I)M which many were unhappy to lose with the arrival of the single CCT in 2007.

(G(I)M which many were unhappy to lose with the arrival of the single CCT in 2007. A new curriculum for General Internal Medicine has been written and existing trainees not on dual training will be able to “map across” to the dual CCT programme by applying to the Joint Royal College of Physicians

Training Board (JRCPTB) and going through a deanery based review of their “Acute Medicine” training to identify any gaps that need filling. More details of this process can be found on the JRCPTB website www.jrcptb.org.uk. In future all Geriatric Medicine trainees will be expected to dual train in G(I)M.

Stroke training

There is a considerably expanded core stroke training grid for all trainees to reflect the increased knowledge and skills required for managing stroke patients. For those trainees wishing to achieve CCT level training in stroke, an additional year of fulltime stroke training will be required which will result in a 6 year training programme for these people. There is a separate curriculum for stroke CCT level trainees.

Core competences

The former generic curriculum for physicians has now been integrated into the Geriatric Medicine curriculum in the form of core competences. As all Geriatric Medicine trainees will be expected to dual train in G(I)M, trainees will be glad to hear that the core competences for the two specialties are identical. However, in order to cover the additional core competences of leadership (the importance of which was emphasised by Lord Darzi) and because of the importance of service development in Geriatric Medicine, a new grid on “Evaluation of performance and developing and leading services” is included. An increased emphasis on health inequalities, especially ageing, is evident throughout the curriculum.

Additional core grids

With the arrival of national dementia strategies, a new grid on dementia is included. PMETB insists that anything that is assessed or examined should be found in the curriculum. The new curriculum contains additional grids on homeostasis (including fluid balance and temperature regulation), nutrition and tissue viability, all of which emphasise the

importance of these topics for geriatricians. In order to recognise the fact that in most areas continuing care has moved to community settings, the continuing care and community with intermediate care grids have been merged.

Optional higher level grids

Recognition of the additional knowledge required of geriatricians who develop a special interest is now acknowledged in the curriculum. Optional grids which detail the additional experience and knowledge required in some of these areas are now included in the curriculum: orthogeriatrics and bone health; falls and syncope; movement disorders; dementia and psychogeriatric services; continence and community with intermediate care. These grids have been produced by senior members of the relevant sections or special interest groups of the BGS. The additional training required is expected to be obtained during experience “out of programme” which requires prospective approval for the individual trainee by PMETB after approval by the programme director (deanery) and JRCPTB.

Flexibilities remain

The curriculum retains the flexibilities for trainees making good progress to count up to one year out of programme following prospective approval towards their training. Out of programme experience could be in research, education or management to Masters level, a related specialty such as neurology, renal medicine, oncology or in one of the special interest areas referred to above.

A new ARCP decision grid

The increased emphasis on workplace based assessments, the SCE and the incorporation of the core competences requires a new decision grid to use at annual reviews of progress with training. This grid will rapidly become of everyday importance to all trainees and trainers. The grid is compatible with the G(I)M grid but at dual ARCPs it is still necessary to check progress against both grids. Dual recognition of appropriate workplace based assessments is still allowed, saving unnecessary duplication. The new workplace based assessments e.g. CbD, AA (audit assessment) and TO (Teaching Observation) are of most value as formative rather than summative assessments.

Conclusion

The new curriculum takes account of the additional knowledge and developments in the specialty over the last few years. It also recognises the importance of demonstration of competence

Supervisors are expected to demonstrate their competence, not only by having the necessary knowledge and teaching skills, but also in appraisal and assessment of trainees

through assessment. Supervisors are expected to demonstrate their competence, not only by having the necessary knowledge and teaching skills, but also in appraisal and assessment of trainees.

Trainees will have to work hard throughout the training programme in order to acquire the knowledge, skills and attitudes required but also to

provide the necessary evidence of this acquisition. We hope that this will mean more assurance of a high standard of care for our patients over the longer term. Finally, the curriculum is always developing as the specialty advances so there will be annual updates to recognise these changes!

Chris Turnbull

Former Secretary of the SAC in Geriatric Medicine and Chair of the Curriculum and Assessment Groups of the SAC

Presenting a poster at a BGS Scientific Conference - A medical student's perspective -

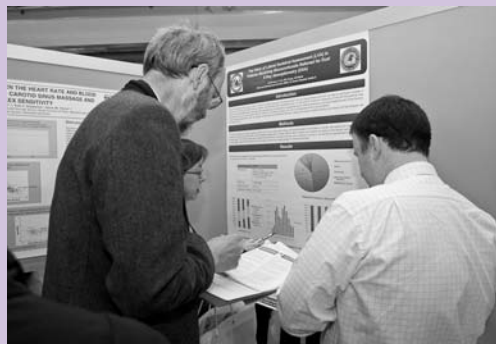
During a Special Study Module in our first year of clinical medicine at Leicester University, we were involved in the process of a clinical audit entitled, "Appropriate Prescribing in Older Patients".

The research plan and initiation came courtesy of Dr Simon Conroy, who was the clinical lead for the Special Study Module. This was our first such research project and it gave us the chance to develop skills not necessarily formally taught, such as data analysis.

After submitting our abstract to the BGS, we were both thrilled to be informed that it had been accepted for presentation as a poster at the Autumn 2009 meeting. Feeling both excited and intimidated, we did not know what to expect, other than the fact that we would be

presenting to high profile clinicians and academics. The process of presenting the poster turned out to be nerve racking but exhilarating. The experience was fantastic and was made easier by each assessor's friendly and approachable manner and also interest in our work.

We must acknowledge that if we had not secured the medical student and junior doctor grant, none of this would have been possible. It led to our meeting



many influential and knowledgeable clinicians. Not only did we get to present our poster, but it was of great interest to be present at the many lectures and other scientific presentations over the two days. Witnessing the arena where future ideas and plans for medicine in the elderly are set out has inspired us both to take our precious experience further and, subsequently, we wish to be a part of much more clinical research.

We believe that geriatric medicine will play a large part in our medical career, regardless of our final choice of specialty. During the conference, we were asked the question 'how could geriatric medicine be made more attractive to medical students?' Many medical students start their careers with a strong attraction to the "blood and gore" of surgery or the adrenaline rush of the emergency department, but we feel it is not until one has exposed oneself to an array of experiences that the subtleties of medicine become clear. For

us, this whole process has more than highlighted the importance of elderly care.

We would like to take this opportunity to say a big thank you to all at the British Geriatrics Society for your generosity, warmth and support.

James Dearman and David Clutton
Medical Students
University of Leicester

NATIONAL GERIATRIC MEDICINE TRAINEES WEEKEND

**Educational and Social weekend for StRs/SpRs
Manchester, Saturday 27th and Sun 28th February 2010**

**Day Venue : Manchester Royal Infirmary, Oxford Road, Manchester
(1.5 miles south of city centre in University campus);
Evening venue: drinks reception and dinner in Central Manchester
Yang Sing, 34 Princess St, Manchester, M1 4JY**

Come and meet your colleagues for a great social weekend and also benefit from sessions on:

- ◆ the specialty certificate exam (SCE) and practice questions
- ◆ consultant interview workshops
- ◆ continence - how to assess and how to treat
- ◆ improving your CV
- ◆ dizziness - how to assess and how to do a Hallpike manoeuvre properly
- ◆ training issues with SAC chair
and more

Cost: The meeting including venue and lunch both days will be free of charge thanks to financial support. However, there is some cost involved if you attend the dinner - £30.

Register online or download the registration form and send it together with your cheque (if you are attending the dinner) drawn in favour of British Geriatrics Society if you wish to attend the dinner. You may also pay online.

Any questions: please send to davidjahearn@gmail.com

We look forward to seeing you in Manchester!!!

END OF LIFE CARE

Achieving the end-of-life care pathway - what works?

King's Fund Event

London, 17 March 2010

This conference will feature a series of practical workshops, which will focus on the following elements of the end-of-life care pathway.

- ◆ Identifying people who are approaching the end-of-life
- ◆ Assessment and care planning
- ◆ Co-ordination of care
- ◆ Delivering high quality services
- ◆ Last days of life
- ◆ Care after death

Website: www.kingsfund.org.uk/learn/conferences_and_seminars/endoflife_care.html

The BGS regrets that owing to restrictions on space, we are not always able to publish all events we have been asked to publicise. Please visit the Notices section of www.bgs.org.uk for details of more events, courses related to geriatric medicine and for downloadable programmes and registration material

BGS REGIONAL AND SIG MEETINGS

BGS Cardiovascular Section
1 - 2 July. Download card registering interest from the BGS website

BGS Wales
4-5 March (Wrexham); 2 - 3 Sept (Haverford West); 3 - 4 March 2011 (Glan Clwyd); 1 - 2 Sept 2011 (Cardiff)

BGS West Midlands
30 March, Birmingham Medical Institute

More details on:
www.bgs.org.uk/Notices/regional_sig_meetings.htm
Regional Officers, please contact editor@bgsnet.org.uk to publicise your region's meetings.

OSTEOPOROSIS

**Osteoporosis and Other Metabolic Bone Diseases
A course for specialist trainees**

17 - 19 March, Oxford

Download programme and registration from the BGS website [Notices/non_bgs_meetings]

VISUAL PROBLEMS

**Visual Problems in Older People
an Royal Society of Medicine Event**

23, March, RSM London

Download programme and registration from the BGS website [Notices/non_bgs_meetings]

BIRMINGHAM MOVEMENTS DISORDERS COURSE 17 - 19 MARCH

This course is aimed at specialist registrars and new appointed consultants in neurology and geriatrics. The first half deals with hypokinetic movement disorders, in particular, Parkinson's Disease. The second half concerns hyperkinetic movement disorders.

Download programme and registration from the BGS website [Notices/non_bgs_meetings]

BGS OFFICERS - VACANCIES

BGS President Elect

Expressions of interest are invited for the post of President Elect, to take office from November 2010. Nominations to reach the BGS CEO by 31 March 2010.

Nominations Procedure:

Prospective candidates (who must be full members of the Society) are welcome to self-nominate; there is no requirement to apply via your Region or Council. The only requirement is that a nomination must be supported, in writing, by at least five other members who are eligible to vote at an AGM of the Society.

Along with the written statements of support, the candidate must submit a statement of consent, in writing, to the effect that: "I, (name) do hereby consent that my name be put forward for nomination to the post of President-Elect of the Society for the period 2010-2012".

A detailed job description may be found on the BGS website (homepage). The statement of consent and supporting signatures must be received by the Chief Executive, at the registered office of the Society, **no later than Wednesday 31 March 2010.** Late or incomplete nominations will not be accepted. Submissions via email are acceptable. Should there be more than one nomination, a ballot will be held. All successful nominees will be encouraged to submit a statement supporting their nomination, not to exceed one A4 page in length, together with a photograph, which will appear with the ballot paper. Full details concerning a ballot will appear in a future issue of the Newsletter and the website. All email submissions should be sent to: alex.mair@bgs.org.uk and any queries should be directed to the Chief Executive at this address.

BGS Deputy Meetings Secretary/Spring Meetings Secretary

Nominations are invited for the post of Spring Meetings Secretary - to preside from Spring 2011 and Spring 2012 as Deputy Meetings Secretary and then, as Meetings Secretary over the Autumn 2013 and 2014 meetings (4 meetings). Nominations to reach the BGS CEO by 31 May 2010

Meetings Secretaries are responsible for the scientific content, social, planning and financial aspects of the meeting over which they preside. The Spring Meetings Secretary works closely with the local organising committee to construct the scientific content of the meeting, working in conjunction with the Academic and Research Committee and the Director of Continuing Development.

Providing administrative support to the Meetings Secretary is the BGS professional conference organisers and the Scientific Officer at the BGS office.

A more detailed job description may be found on the BGS website (homepage).

Nominations Process: Nominations should consist of a brief CV, together with a statement from the nominee supporting their application, not to exceed one A4 page in length. In addition, there must be a supporting citation from the relevant region or national council. Nominees may also consider submitting a photograph of themselves. These should be sent to alex.mair@bgs.org.uk to arrive no later than 31 May 2010. Submissions via email are perfectly acceptable. In accordance with the Society's rules, the United Kingdom Management Committee (UKMC) will make the appointment, by secret ballot should there be more than one applicant. Such appointment will be subject to endorsement by the membership at the AGM to be held in November 2010

Chairs (or two Co-Chairs) of the BGS Primary and Continuing Care Special Interest Group

Nominations are invited for the post of Chair (a co-chairing arrangement is possible) of the BGS Primary and Continuing Care Special Interest Group.

The Primary and Continuing Care SIG plays an important part in shaping BGS policy and championing community geriatrics. SIG members work in primary care settings, in continuing care and in the newer interstices between primary and secondary care, such as intermediate care, interface geriatrics and other domains of community geriatrics.

More detail about the Primary and Continuing Care SIG may be found on the BGS website (homepage) or please contact Alex Mair. The closing date for nominations is Wednesday 31st March 2010. Nominations should be sent to alex.mair@bgs.org.uk

'Nil by Mouth'

should be a last resort rather than the first option

Nil by mouth - a last resort. This is the central message from a Working Party report published by the RCP (London) and the British Society of Gastroenterology

Entitled, 'Oral feeding difficulties and dilemmas: A guide to practical care, particularly towards the end of life', it has been prepared in response to continuing unease about the lack of consensus, including among doctors, about when artificial nutrition and hydration is appropriate.

Its authors (a multidisciplinary team of healthcare professionals with an interest in nutrition matters, medico-legal experts and patient representatives) have reviewed the clinical and ethical arguments surrounding the tube feeding of those patients who, often near the end of life are experiencing swallowing difficulties either as a result of neurological illness or other substantial disabilities.

The ultimate aim of the report is to improve care by providing healthcare professionals, patients, their families and carers with practical advice that has a sound legal and ethical basis, and to prevent distressing and complicated disagreements.

The Working Party invited a wide range of stakeholders to submit views during the course of the work. Among the evidence they took were reports of poor practice involving the withdrawal of feeding, as well as its inappropriate continuation. There were also reports of substantial disagreements between health professionals and family members when patients were unable to articulate their wishes.

On the basis of this, the group's final recommendations are that:

- ◆ Oral intake, modified as necessary, should be the main aim of a nutrition strategy at the end of life. Even if a patient is deemed to have an 'unsafe swallow', a risk management approach may offer them the best quality of life; 'nil by mouth' should

be a last resort, rather than the initial default option. Where tube feeding is necessary, this should be additional whenever possible and done with clear clinical objectives in mind.

- ◆ To ensure patient centred decisions about artificial nutrition and hydration are being taken, there needs to be a clear agreement about the aims of any regimen. Such decisions should never be based on the convenience of staff or carers, nor should artificial feeding ever be required as a criterion for admission to any kind of institution providing care.

- ◆ All Trusts and care homes should ensure there is sufficient staff, especially at meal times, to assist and feed those patients who require a longer time to eat an adequate meal.

- ◆ When oral feeding difficulties occur, a nutrition support team, ideally but not inevitably led by a doctor with special expertise in nutrition, should be made available to work with patients and their families.

Dr Rodney Burnham, Co-Chair of the Working Party said: "This report brings considerable and much overdue clarity to a very challenging area. Feeding difficulties can create great uncertainties and even confusion among healthcare professionals, as well as patients and relatives. The College expects it to become an invaluable resource for those who are trying to grapple with these difficult issues."

Dr David Sanders of the British Society of Gastroenterology said:

"The British Society of Gastroenterology is strongly supportive of this timely and critical report. This report not only provides an evidence base for our practice but is also a valuable 'working manual' for clinicians from all disciplines dealing with these highly emotive clinical problems. This report is further strengthened by the fact that it was an all inclusive working party which encompassed many disciplines and societies."

Copies of the report are freely available for download in the members' section of the website, or for sale in hard copy or pdf format to non-RCP members through the College's online bookshop.

BGS Scotland

50th Anniversary

Although the BGS was constituted in 1948, it was not until 1960 that BGS Scotland, as it has come to be known, was founded.



Oswald (Ozzie) Taylor Brown - appointed the first geriatrician in Scotland and the first President (Chair) of the Scottish Branch of the British Geriatrics Society

The forming of the branch with a separate constitution probably has its roots in the creation of separate Secretary of State for Scotland in 1926. Separate from the other Ministers of State in Westminster, this individual had control over Scottish policy on health, social welfare and housing (now devolved to the Scottish Parliament) and thus the Scottish Geriatricians at the time did not heed the instruction to create a regional group without a constitution and no right to contact

National Bodies or engage in local negotiations.

The instigator of the branch was Oswald (Ozzie) Taylor Brown from the Mayfield Hospital in

Dundee who had been appointed as the first geriatrician in Scotland and was the Scottish representative on the BGS Executive in London. He gathered together like minded colleagues at Bridge of Earn Hospital, near Perth, on the 16th September 1960. A clinical and business meeting took place and the case for a Scottish Branch was agreed and a small subgroup was detailed to draw up a constitution, which was agreed the following year. Ozzie Taylor Brown was appointed the first President (later renamed Chairman) and Leslie Wilson, from Aberdeen, the Secretary. It took some considerable diplomacy from the then President of BGS, Lord Amulree, to ensure no break with the main Society.

Those of us training and practicing geriatric medicine now would find it hard to believe the stringencies that hampered proper comprehensive geriatric assessment in those days. Most consultants were single handed and operated out of facilities that nobody else wanted. Not for them the luxury of multidisciplinary teams, beds on the acute site, outreach rehabilitation from day hospital and community based teams. Thus we should be grateful for the vision of these pioneers who managed in the early years to more than double the



The BGS Scottish branch meets for the first time at Bridge of Earn Hospital on 16th September 1960. Future BGS presidents can be picked out, Ferguson Anderson (back row 3rd from left) and Jimmy Williamson (front row extreme left). In the middle row, 5th from the left is the debonair Bernard Isaacs who went on to be the first Professor of Geriatric Medicine in Birmingham. All three individuals chaired the Scottish Branch, Jimmy Williamson on two separate occasions.

number of higher specialty trainees (senior registrars), have regular meetings with the CMO Scotland and obtain membership of the National Panel of Specialists. The latter was the group of external specialists who sat on consultant appointments committees.

BGS Scotland quickly got in to a pattern of holding clinical meetings twice yearly in various parts of the country and over the last 20 years have also had joint meetings with neighbouring branches in Northern Ireland and Northern England on a regular basis. In 2009 for the first time we met with colleagues from the Irish republic near Dublin.

The branch is governed by an elected executive that has geographical representation from all over Scotland, doctors in training, non-career grade doctors and a co-opted representative from the Scottish Government Health Department. The group continues to negotiate directly with officials and ministers in the Scottish Government over a wide range of issues.

The training ground of Scottish medical politics has proved a fruitful source of clinicians who have gone on to serve the BGS nationally. With regards to its population, Scotland has been the most successful part of the United Kingdom in providing Presidents to the BGS, namely Ferguson Anderson, Jimmy Williamson, John Dall and Brian Williams. Long may it continue! We hope to see you all in Edinburgh in 2010 to join in our celebrations.

Paul Knight
Chair, BGS Scotland

Acknowledgement: *In writing this article I have relied heavily on the publication "A Short History of the Scottish Branch of the British Geriatrics Society 1960-1989", written by Dr C Joan McAlpine who was the first female chair of the branch between 1986 and 1989. I would also like to record my thanks to Joan for providing me with the original photographs for replication here.*

Dementia



ethical issues

The Nuffield Council on Bioethics was established in 1991 and seeks to examine ethical issues raised by new developments in biology and medicine.

They are funded by the Nuffield Foundation, the Medical Research Council and the Wellcome Trust. After setting up an exploratory workshop in March 2007, the Council formed a Working Party in December 2007 to examine the ethical issues raised by dementia. This timely report is based on public consultation and meetings with stakeholders including people with dementia, carers, health professionals and other members of the public.

The report entitled 'Dementia: ethical issues' was published in October 2009 and can be downloaded from www.nuffieldbioethics.org.

An ethical framework for dementia

The Council sets out 6 components to help those faced with day-to-day issues in dementia care. These include adopting a 'case-based' approach to ethical decisions. They recommend comparing 'the situation' with other 'similar situations' to find ethically relevant similarities or differences. The report suggests that with good care and support, people with dementia can expect to have a 'good quality of life throughout' the course of their illness and also highlights the importance of promoting the interests of both the person with dementia and of those who care for them. Finally, the ethical framework states that 'the person with dementia remains the same, equally valued, person throughout the course of their illness'. The framework recognises extensive changes occur in mental abilities and other functions and this may include changes to personality.

An ethical approach to a care pathway for people with dementia

The recent emphasis on early intervention and diagnosis highlighted in the National Dementia Strategy (www.dh.gov.uk - search "National Dementia Strategy") raises the issue of whether an early diagnosis may be harmful to the individual. This is more poignant given that a diagnosis may not be followed by an offer of available treatment, due to restrictive NICE guidelines on the

prescribing of anti-dementia medications, or even certain other social care resources. Healthcare professionals should seek and respect the decisions of sufferers and their families with regard to seeking an early diagnosis or not, but we should try to ensure such decisions are well informed and that they are aware of the potential benefits of early diagnosis.

The report recommends that the Department of Health (DoH) encourages more research on the reasons why there is variation between cultures in readiness to come forward for diagnosis and the role that misinformation and misunderstanding plays in these reasons. In addition, they recommend the GMC and relevant Royal Colleges promote an approach of disclosure of a diagnosis of dementia that acknowledges the role of those close to the person with dementia.

In current practice, people are sometimes presented with a diagnosis of dementia and simply told to come back in a year's time. The Council is of the view that this approach is morally wrong. Increased support, both practical and emotional, should be available and they welcome the proposal in the National Dementia Strategy to pilot models of 'dementia care advisers' to fulfil this role and aid in 'sign-posting' to suitable services.

End of life palliative care for people with dementia is often poor compared with people who do not have dementia. Both the National Dementia Strategy and the National Council for Palliative Care recognise the need to improve end of life patient care for people with dementia, highlighting the need for better links between those responsible for dementia care and those responsible for end of life care.

Dementia and society

The Council believe that for dementia to be 'truly normalised' it needs to become an accepted part of our society, in the same way that physical disability is increasingly recognised as part of the norm. They also recognise the way services are divided into 'social' and 'health' services and the detrimental effect this can have on accessing care. The method of allocating resources must be improved to prevent such unnecessary delays in the provision of care.

Making decisions

The Mental Capacity Act 2005 (MCA) provides a robust framework for supporting and protecting

Key recommendations from the report

1. People should have access to good quality assessment and support from the time they, or their families, become concerned about symptoms of dementia.
2. Many of the services needed by people with dementia are classed as 'social', which are often not available until a crisis occurs. In allocating resources, it should make no difference whether the care is classified as 'health' or 'social'.
3. Families should be treated as 'partners in care' by professionals. Trust is a key part of such a caring partnership.
4. Protecting people from harm is important, but minimising the risk of harm to a person with dementia may reduce their quality of life. 'Risk assessments' should be replaced by 'risk-benefit assessments' that take into account the well-being of the person with dementia.
5. More guidance for carers is needed on when restraint might count as 'proportionate'. Carers need more support to help minimise the need for restraint at home.
6. The UK Departments of Health should consider how all those involved in the care of people with dementia can access education and support to help them deal with the many ethical difficulties that they face.
7. The Equality and Human Rights Commission should highlight the legal duties of service providers, such as shops and restaurants, to ensure people with dementia can use their services.
8. More guidance is needed on how to apply mental capacity legislation in practice, for example, how people with dementia can be involved in decisions about their care and treatment, and how past and present wishes should be taken into account where these conflict. The process of appointing a welfare attorney should be easy and free of charge for everyone.
9. There should be more funding for dementia research, including research into how people with dementia can be supported to live the best possible lives.

References

Cooper C, Selwood A, Blanchard M et al. (2009) Abuse of people with dementia by family carers: representative cross sectional survey British Medical Journal 338: b155.



the best interests of people with dementia. The Act also makes specific provision to make 'advance decisions' to refuse treatment, even if that treatment may be life-saving. Past and present wishes should be discussed with relatives whenever

possible and the Council recommend that the Act be amended to emphasise the importance of good communication and supportive relationships with families.

It is now possible for a person with capacity to nominate a 'welfare attorney' who will be empowered to take health or welfare decisions on their behalf after they lose capacity to do so themselves. This option provides more flexibility than an advance refusal of treatment but involves significant bureaucracy and fees to register with the Office of the Public Guardian (considerably higher than the previous fees for an Enduring Power of Attorney pre-MCA). Welfare attorneys are obliged by law to act in the individual's best interests and where conflict arises between professionals and the attorney, a professional may override the attorney by applying to the court of protection. Such an intervention should only take place if the professional has grave concerns about the welfare of the incapacitated person, and not simply because they take a different view of best interests.

Dilemmas in care

Ethical dilemmas arise frequently for all those providing care for people with dementia. Education of those in professional roles is important but carers should also have access to the ongoing education needed to aid them to respond appropriately. The Council recommend that the DoH, as part of the National Dementia Strategy, consider how carers can access appropriate education and support in ethical decision-making.

The uses of restraint, including the use of medication to calm and control a person's behaviour should only be considered where it is 'proportionate' to the risk of harm without such restraint. The Council recommend that more is done by the DoH and the Office of the Public Guardian to guide carers and professionals in what is and isn't 'proportionate'.

Abuse by family and friends

A recent survey in the UK among carers of people with dementia found that 1 per cent physically hurt or hit the person they cared for and 33 per cent had screamed or swore at them within the preceding 3 months (Cooper, 2009). Although all allegations and evidence of abuse must always be thoroughly investigated, it must be recognised that abuse and neglect may be the result of unmanageable pressure on the carer.

The needs of carers

Most people would wish their carer's interests to be considered as well as their own. The autonomy of the person with dementia should therefore be seen in 'relational' terms in that it is necessary to support the whole family and social structure. Healthcare professionals should consider the needs of carers and understand that their needs are incorporated into what is in the person with dementia's 'best interests.' Confidential information may be shared with carers if it is in the best interests of the person who lacks capacity to do so. The Council believes the current Mental Capacity Act Code of Practice is too restrictive on when this may be and suggests that there should be an assumption that the carer involved in making decisions should have the same level of information as any other member of the care team.

Research

When compared with other conditions, funding for dementia research is poor, especially given the prevalence and burden of the disease. The Council recommend that major research funders develop a reasoned basis for the division of their funds between research areas and that this should lead to significant increases in research funding for dementia. The report highlights the importance of social research in dementia, aiming at providing an evidence base to underpin better ways of supporting people with dementia and their carers. Particular difficulties arise when involving people in research if they lack the capacity to consent to the research. This may be overcome by developing an advance statement on research participation and allowing welfare attorneys to consent on the participants' behalf (currently only possible in Scotland). Early diagnosis should allow dementia care advisers to discuss the issue of research and help arrange an advance decision for those that wish.

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Ethical Conundrums



Capacity

Capacity; “does the patient have capacity, doctor?” How often do you hear that question - from nurses, social workers or even surgeons (but usually only when the patient has refused consent for a procedure)?

My standard reply, “capacity for what?” is often enough to cause doubt. I follow up with “what is the decision to be made?” or “do we have any valid reason to doubt capacity?” Again this seems to cause some confusion.

The medico-legal concept of capacity arises from the principle of autonomy which then led to the development of the doctrine of informed consent. The three stage test for capacity [understanding and retaining information, believing it, and weighing it up to make a choice] was established in case law by Thorpe J in *Re C* [1994].

Then, after a long time in gestation, came the Mental Capacity Act 2005 [MCA], which built on case law and gave statutory definition to 5 important guiding principles around respect for individuals and their choices: that there is a presumption in favour of capacity; that patients should not be discriminated against on the basis of age, disability, appearance or because their decision appears

foolish; that everything possible should be done to help an individual make their own decision; that decisions made on behalf of an individual who lacks capacity for that decision should be done in their best interests; and that the least restrictive option should be chosen.

Reduced to a fixation

Yet in practice the Mental Capacity Act seems to have been reduced to a fixation on whether capacity has been assessed with less regard for the other major principles of the Act. Recently, I was asked [or rather told] to do a formal capacity assessment for a continuing healthcare funding application done by the multi-disciplinary team on behalf of a patient. The Primary Care Trust [PCT] involved was refusing to assess the application until the medical team provided a

written assessment of capacity.

So I asked the same three questions:

Question 1

“capacity for what?”

Answer given

“capacity to understand that a CHC funding application is being made on their behalf”. Question 2

“what is the decision they have to make?” Answer

“should they consent to the application for funding being made?” Question 3 “do we have any valid reason to doubt their capacity

i.e. is there any

evidence of impairment or disturbance of function of the mind or brain?” Answer “I don’t



know”. So I then asked “how did the PCT know they needed a formal capacity assessment”? Answer “I don’t know but we can’t process the application and the patient will remain in hospital blocking a bed until you sort this out.”

How did this happen and who does this bureaucracy serve? I cannot see how this serves patients’ interests. In my view the PCT is doing this to protect itself from a future financial claim. But there is a flaw in their process; because there is a very important decision to be made by or for the patient about where and how care will be provided for them. This is what we as health and social care professionals should be most interested in. What are the patient’s wishes and needs and how can we best meet them? In this context an assessment of capacity may well be necessary; if there is any evidence of impairment or disturbance of the mind or brain but not otherwise.

Secondly why has the assessment of capacity become medicalised? The MCA code of practice does not limit the assessment of capacity to medical professionals; in fact it states quite clearly that the decision maker or responsible professional is responsible for the capacity decision. My interpretation of this is that doctors should assess capacity for medical treatments and

investigations, nurses should assess capacity for nursing interventions and social services should assess capacity for decisions around place of discharge and care needs as they are the decision makers. Medical advice may be necessary for stage 1 of the test but stage 2 requires the professional to assess understanding and weighing up of the information required to come to a decision.

Often when I have been asked to assess capacity for discharge, little or no information has been provided on the alternative courses of action and the risks and benefits to the individual. What are the risks to the individual if they remain in their own home, what evidence is available that they lack safety awareness, what can be done to minimise risks, why will they be safer in 24 hour care? Why am I, the hospital consultant best placed to assess their understanding and comprehension of these facts? Why can it not be done by an occupational therapist whose core skills are about assessing function and risks, or the social worker who ultimately decides what will happen to the patient?

I would urge you to require other professionals to become more involved in the assessment of capacity. Locally we have provided practical training for occupational therapists. This has resulted in capacity assessments being completed in optimal conditions for the patient [often on home visits]. The occupational therapists are skilled in assessing function and evaluating risks, they take time to explain carefully and to demonstrate all the relevant information to the patient, and their documentation is clear. The training has had the added benefit of making them less paternalistic and risk adverse.

Finally I suggest that doctors should question the need for an assessment of capacity and I would question your responsibility to provide it for non medical decisions.

Reference: Mental Capacity

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