



B G S

n e w s l e t t e r

Spring Meeting Telford

- conference report

The Spring meeting was held in the new Telford Conference Centre. The realisation that the proposed venue would not be fully completed by the April deadline would have fazed lesser mortals but not so this organising Committee, chaired by Prof Peter Crome!

With over 650 registrations and 530 delegates, the attendance reflected a well balanced programme with a number of eminent speakers and offering 'something for all'. A little disappointing was the dwindling attendance toward the very end of the

meeting - reflected in the Society Dinner on the Friday and particularly on the Saturday.

Early arrivals on the Wednesday were rewarded by an excellent symposium on 'New Insights in Vascular Disease'. Presentations were a blend of cutting edge



Prof Peter Crome and part of his organising committee

science applied in the context of changing clinical practice. Clearly there is much more to ACE inhibition than Angiotensin 11 receptors!

Thursday included sessions on Stroke and Social Exclusions. I attended and enjoyed the session on stroke. Powerful evidence was presented for the meticulous control of physiological parameters such as blood pressure and oxygen levels and glucose in early stroke. Clearly a 'touch of hyperglycaemia' must be taken much more seriously!! ➤

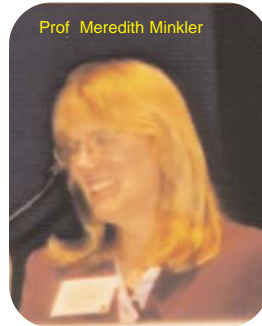
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President: Prof Cameron Swift, PhD, FRCP **President Elect:** Prof Robert Stout, FRCP
Honorary Secretaries: Dr Chandni Vellodi and Dr Kevin Kelleher **Meetings Secretaries:** Dr Juanita A Pascual and Dr Janice O'Connell
Honorary Treasurers: Dr Robert J Shepherd and Dr Ian Sturgess **Administrative Director:** Richard Lynham **Sub Editor:** Recia Atkins

Enabling the Elderly

Meredith Minkler, Professor of Health and Social Behaviour, School of Public Health, University of California at Berkeley gave the first of the guest lectures. She emphasised the value of health promotion in the elderly [and the young]. The importance of 'enabling the elderly' in delivering this strategy was emphasised and cultural differences apart, Prof Minkler's message was powerful and apposite.



The afternoon commenced with a clinical update session. Many of us were disappointed with the cancellation of the first paper on Assistive Technology in older people's homes. Great tribute to Peter Crome's nocturnal stamina in stepping in at the last minute and giving us a flavour of the challenges [trials and tribulations!] of establishing a modern cohesive geriatric service in the locality - which left some of us with a curious sense of *deja-vu!*

Evidence Based Prescribing

A notable highlight of the afternoon was the the guest lecture by Professor Rosanne Leipzig, New York. Prof. Leipzig is Professor of Geriatrics at Mount Sinai and is a leading

expert on evidence based prescribing. Her lecture reinforced the complex and meticulous requirement of evidence based practice, using the treatment of adult macular degeneration and the treatment of rheumatoid disease as illustrations.

The afternoon concluded with the first of the meeting's SIG's, Ethics chaired by Karen Le Ball, and a session on *pain and arthritis*



including an interesting paper given by an orthopaedic surgeon, Charles Wynn Jones.

Following a choice of two early evening symposia on the 'Diagnosis of Parkinsons Disease' and the impact of COPD – 'Very Vicious Circles', the delegates were entertained at Weston Park Country House.

Focus on Stroke

For the enthusiastic, the Friday session opened with a breakfast symposium outlining the results of LIIFE entitled, 'Improving Outcomes in Hypertensives' - the session included a presentation from the Stroke Association by its Director of Public Relations entitled, 'What a stroke means for an elderly patient'

The clinical update sessions followed with an emphasis on neurological disorders and a continuing focus on stroke. This included two papers on the relationship between sleep disordered breathing and stroke – both papers delivered by the same author and with a delightful Irish flavour.

Audit of Drug Prescribing

There was also an oriental flavour to the morning in the useful presentation given by Dr CFK Mok and colleagues from Hong Kong, reminding us of the potential value of developing a Medication Appropriateness Index in facilitating audit of drug prescribing.

Professor Carole Hackney's guest lecture was a blend of anatomy, which rang 'distant bells' for some of us, and an update on the latest in the science. The speaker's style reflected strong empathy with her patients and the deaf as a group. I particularly enjoyed the tale of 'Lord Jack Ashley and the supermarket counter cashier'. ➤

Mouths, Hearts, Bowels and Bladders

The afternoon sessions included a clinical update session with an initial focus on Periodontal Disease in the elderly and an interesting presentation by A Coull et al. on educating and empowering elderly patients in the management of their ischaemic heart disease using 'surrogate' lay health mentors as advisors.

The afternoon's SIG on Bowel and Bladder included an in-depth presentation by Kate Williams, a Senior Nursing Fellow from Leicester, on establishing a community based nurse led incontinence service – more of the same please.

Eyes, Minds and Bones

The remaining afternoon sessions considered varying aspects of 'Clinical Practice'. Amongst the topics covered were addiction in the elderly by Professor Ilana Crome and the psychosocial impact of cataract surgery by Dr G Karimova and colleagues from Sunderland. The remaining clinical practice presentations revolved around falls, metabolic bone disease and further encouragement on the benefits of exercise.

The afternoon concluded with a debate on regulating the professions, chaired by Alison Norman, Director of Nursing and Operations, Christie Hospital in Manchester with eminent contributions from Graeme Cato, Vice Principal of Kings College; Linda Patterson CHI and Consultant Physician, Care of the Elderly. Prof Bob Stout, our President in waiting led the discussion.

Psychology and Sociology

The meeting concluded on Saturday with a Joint Meeting between the Geriatrics section of the RCM and PRIAE. Professor Peter Crome representing the Geriatrics and Gerontology section of the RCM and Professor John Cox, President of the Royal

College of Psychiatry, chaired the meeting. The multidisciplinary theme covered topics from Mental Health in the Community to Racism in Health. This was clearly an excellent and well thought out symposium. Unfortunately its timing precluded as full an attendance as its content deserved.

Presentations

One hundred and five abstracts were assessed by the Scientific Committee and 96 were accepted for presentation, with 29 accepted for platform presentation. The content was good but skill in presenting oral and poster presentations remains a challenge. Some presenters are clearly not aware of the importance of maintaining eye contact with the audience!

The 'Meet the Professors' surgery is a successful new innovation lead by Professors Ford and Jackson. This session is highly recommended for aspiring researchers - young and old - with evidence in Telford of its increasing popularity.

Special General Meeting on the Structure of the BGS

The President explained the need for fundamental changes to the BGS' managerial and operational structure. Prof Swift gave details of the two main drivers for change.

The first related to the charitable status of the Society and the view expressed by the Charity Commission that the current structure with business conducted through a large Council, and responsibility divided between Council and Executive Committee was unacceptable.

The second related to the politics of devolved government with each of the four countries developing its own Health structure, Health Minister and potentially diverse health policies. This would result in increasing demands for geriatricians in ➤

the four countries to engage with their respective country's politics and policies. The importance of ensuring the Society's continued central role in advising and influencing policy within the devolved government status of the UK was stressed as fundamental to its ethos as the *British Geriatrics Society*.

The President Elect, Prof Robert Stout, then explained the logic behind the structuring proposal. The proposals developed by the Executive Committee and accepted by Council were as described in the last Newsletter [also available on the Society's Web page].

Representation

There followed a constructive debate with the representatives from Wales and Scotland emphasising the importance of ensuring appropriate representation of the Celtic countries in ensuring a truly *British Geriatrics Society*. Representatives from the Midlands and the South West felt that England needed more representation commensurate with its larger population.

Following a show of hands there was strong support given to the proposals but it was agreed that further consideration would be given to the English representation prior to the Annual General Meeting in October. It was also agreed that England, as the larger partner, would need support in establishing its Council as proposed under the re-structuring arrangements.

Extra-Curricular Activities Including the Society Dinner

Thanks to the organisers for two interesting evening functions. On Thursday, we enjoyed the Edwardian Country House experience at Weston Park. We were greeted with champagne and the echoing strains of a string quartet, before receiving a buffet in the conservatory. Guides were on hand to explain the story of the family and the paintings and furnishings of the house.

On Friday, the Spring Meeting Dinner was held at RAF Cosford Aircraft Museum. Menacing V2 rockets towered over us as we toured the museum, before settling down to dinner under the wings of vintage aircraft. After the prize-giving, we boogie-woogied the night away to the big band sound of the Squadronaires.

Luminaries

Going clockwise, Prof Bob Stout pays tribute to Prof Graham Mulley on his retirement as Editor of Age & Ageing; Prof Oliver James receives the President's Medal; Dr Clare Fallon receives the Elizabeth Woodford Williams Prize; and on behalf of Dr Aamir Qureshi, Prof Gwyn Seymour accepts the Elizabeth Brown Prize

Thanks

Our thanks and congratulations to the local Committee for an excellent meeting, to Hampton Medical Conferences, the BGS's event organisers and to the pharmaceutical companies who once again, provided generous support.

Dr Ed Wilkins

Princess of Wales Hospital
on behalf of the Executive Committee



Editorial

page

The Reformation - that period in the history of the British Geriatrics Society for which 2002 will be always etched in our memories continues apace.

Following the Extraordinary General Meeting at Telford, the question of English representation on the BGS UK Management Committee has been debated further. Why 3 English representatives and not 4, you may ask – others have! Well, it's 3 to match the number of representatives from the Celtic fringes (I jest) and not 4 to fit in with the current NHS Regions in England. After all, by the very nature of such things, one may find Region numbers changing – has not history taught us this?

A Brave New World...

For the first time in BGS history our election system is changing. Our first combined postal and electronic ballot, administered by the Electoral Reform Society, takes place this month for the next President Elect and Deputy Treasurer. Too late for individual nominations on this round, but in the future nominations will be open to all full members. So, rejoice all those who like me have waited for this day.



The BGS Needs You

While our new management procedures bed down, willing and able volunteers are sought to serve on our Standing Committees with effect from the Annual General Meeting in October (see page 15).

Yet Another Successful Spring Meeting

Telford now joins the ranks of Cardiff and Warwick. The programme was full and diverse, and from breakfast to dinner kept our 500 plus delegates well and truly occupied. Well done to Peter Crome and his merry band.

Positive Views from our Next Generation of Geriatricians

To be seen and heard is indeed an achievement due, in no small part to the enthusiasm and commitment of our Trainee representatives (see page 8). What attracts and repels the next generation into and from geriatric medicine leaves us with food for thought. The influence of a committed colleague can clearly be crucial (page 12).

And, Looking to the Future

Workforce planning was the topic explored on the Council Study Day in May. Alistair Main's programme started with an up to date result of the current NTN and consultant recruitment survey. A great big thanks to all of you who provided the much needed data (more on page 9).

From Bournemouth to Yorkshire

The NSF for Older People continues to provide a platform for much debate and innovation (see pages 16 and 20). Have other keen readers of the classified ads careers sections noticed the handful of Consultant posts being advertised with Intermediate Care as the key agenda? If new posts are being created around the NSF agenda, do let us know at the BGS. Good news is worth sharing.

Chandi Vellodi
Editor

President's column

“Training remains a powerful instrument for the raising of standards of care in a sustainable manner. Opportunities have been lost within the England NSF with respect to these issues.”

An extraordinary general meeting

I would like to thank members for turning out in such strength to the Extraordinary General Meeting of the Society in Telford. Your office bearers and Council were anxious to ensure a free and open exchange of views about the restructuring proposals. The result was one of the best BGS General Meetings I can remember. Your unequivocal support for the new structure was a great encouragement. At the same time, your suggestions for modification were invaluable and have promptly been acted upon.

Gathering of past presidents

It was a great pleasure to meet with John Brocklehurst, Jimmy Williamson, John Dall, Marion Hildick-Smith, Michael Denham, Peter Millard, Brian Williams and Bob Stout at HQ on 21st May and to tele-confer with George Adams, Bobbie Irvine and Arup Banerjee before going on to a “working” lunch and feedback on matters BGS. We were, of course, conscious of the gap left by the late Fergie Anderson in an otherwise complete dynasty! There was considerable interest in the exploitation of the premises at Marjory Warren House.

Health policy, workforce development and sustainability

I recently had an informal meeting with the

Director of Health & Social Care at the King's Fund. We discussed our shared interest in what it takes to translate the policies of successive governments (transient almost by definition) into sustainable benefit for the well being of older people. She had recently presented an impressive paper reviewing the case for legislation against age discrimination^[1]. While accepting the difficulties of both defining and implementing any legislation, the point was well made that such discrimination was probably less likely to diminish with no statutory framework than with one. Legislation may be one route to sustainability, but the problems of definition and the costs of implementation often limit its impact. We both felt, however, that workforce development was a fundamental consideration in the long-term viability of any standard or innovation. This would certainly square with over half a century of experience of this Society. The BGS over the years has sought to respond to ageism and neglect through a sequential process of translating innovation into professional practice and practice into sustainable service models. Through collaboration with the Medical Royal Colleges, the associated and necessary skills have been built into established training curricula with the resulting recruitment growth, career structures, accountability for standards of practice and most recently specific governance criteria. “Training” has been and remains a powerful instrument for the raising of standards of care in a sustainable manner. I have suggested elsewhere^[2] that opportunities have been lost within the England NSF with respect to these issues. Its drive for inclusiveness (everyone an expert) is not well balanced with incentives ➤

to professionals to commit themselves to careers specifically in the care of older people. Very little is said about this important aspect. Even if “hearts and minds” are indeed won, the phenomenon is likely to be transient without long-term career structures and human resources to provide sustainable expression to any such new-found commitment.

Returning to sustainable change through health policy, I would also have to acknowledge that the original explicit concerns voiced in the initial BGS Press Release about the mechanisms and criteria for monitoring the implementation of NSF standards and the flow of funds still remain. The Commission for Health Improvement (CHI) will now acquire much of this monitoring role, (at least with respect to standards) and faces a daunting task. (The BGS will, of course, through its Interim Administration for England, seek to work closely with CHI as well as with the Department of Health and to collate and report data on the outworking of the NSF). In Scotland and Wales a less explicit approach to policy change for the care of older people has so far been followed and there is currently no defined initiative in Northern Ireland. If, however, political explicitness represents a shift from the sustainable to the transient, the preference of some colleagues in these parts of the UK for this less rhetorical approach is understandable.

It seems more vital than ever, therefore, for specialty societies (in the UK and internationally) to remain active and influential in the areas of workforce development and training and to continue to press for accreditable qualification programmes of high standard and career status in this field, both in medicine and the allied professions. We were very pleased last year to do some joint work with the Royal College of Nursing on Nurse Specialists and are now involved in discussions with representatives of the Royal College of General Practitioners on GP Specialisation (for which the catalyst effect of the NSF should, of course, be acknowledged). In considering the required workforce size we were grateful recently to Dr Alastair Main for compiling an excellent Council Study Day on 10th May on the topic of workforce planning (and for continuing to shoulder the task of heading up the Workforce Planning Group).

Prof Cameron Swift
President

References:

- [1] Robinson J (2002) Age Equality in Health and Social Care. London. Institute for Public Policy Research
- [2] Swift CG (2002) The NHS English National Framework for Older People: opportunities and risks. Clinical Medicine (Journal of the Royal College of Physicians of London) 2: 2, 139-43

POUR LE MERIT

In support of Marjory Warren House

The Honorary Treasurer wishes to acknowledge the persistent efforts of Dr Ronnie Barber in Bristol, for continuing to send in donations raised from the local membership in the South West Region, in support of the premises fund, and of course, to recognise the generous support of the donors themselves.

Letter from the Trainees' Committee

Trainee Representatives on BGS Committees

In the past eight months, trainees' representatives have been initiated into the complex world of meetings. Apart from improving our vocabulary of managerial speak and our understanding of spin, we have been trying to make sure your views are represented at these meetings. In particular, we have focussed on

☞ Assessments - proposals for more formal methods of assessment are underway, including knowledge based exams, 360 degree assessments/appraisal.

☞ Stroke - its development as a subspecialty of GIM.

☞ Workforce planning - methods to improve enthusiasm for geriatrics amongst high quality SHOs, the needs of and for flexible trainees, the role of community geriatricians.

☞ Research - ways to ensure that SpRs are involved at an early stage in their training in research, ways to make sure this is appropriate to the trainees' interests and needs, improving the academic status of geriatrics and increasing interest amongst funding bodies.

We have identified a couple of issues that we feel need to be addressed.

Changing Structure of Committees

The impending changes to the national BGS committees is going to result in the structure of the trainees' Committee changing too. A well considered change should reinforce our representation on important bodies to ensure

that our views continue to be a driving force for change in geriatrics. We will be thinking about this before the next newsletter and will put it forward for discussion with you all.

Better Communication

While we feel that communication between trainees has improved, there may be more we can do. All members of the committee write their own version of the meetings they attend (versions reflecting the trainees' perspective rather than formal minutes!). We e-mail these to regional representatives where we have addresses. We rely on these representatives to relay the information to you and then to send us feedback. If you are not receiving this information please let us know.

They do listen!

We continue to be surprised at how welcome we have been made to feel at all meetings, how interested in our views the other members of the committees are, and how seriously they are taken. In particular, we feel that together with the Training and Scientific committees we are making headway with regards 'the SpR and Research'. National guidelines will be issued by the Scientific Committee on 'Research in Training' and will be published in the next issue. The Research Surgery went very well at the meeting in Telford with 30 SpRs attending a meeting hosted by four research-active geriatricians (two professors, a successful research active NHS consultant, and me!). The feedback we received from that meeting was very positive, and we plan to make this a permanent feature of the national BGS meetings.

We hope to continue writing updates for you in each newsletter and to communicate by e-mail. We look forward to seeing people at the next BGS meeting (we will be arranging a 'pub visit' at that time!)

Jugdeep Dhesi

On Behalf of the Trainees Committee
Jugdeep.dhesi@kcl.ac.uk

- Your Representatives -

Council - Cath Church and Jugdeep Dhesi
 Executive Committee - Cath Church and Stella Barnes
 Training Committee - Jon Trembl and Cath Church
 SAC (BGS/RCP) - Cath Church
 Medical Specialties Board - Cath Church
 Finance Committee - Richard Frearson
 Joint Specialty Committee (BGS/RCP) - Jugdeep Dhesi
 Scientific Committee - Jugdeep Dhesi

Workforce

Increasing demands on our time: something has to give!

Everyone wants more consultants - it has to be more than a shout for preservation or expansion of the species.

This comment to me from an influential source in the Department of Health (DoH) served to remind me that it simply ain't enough to say: "Dr Bloggs is retiring. Let's get another Dr Bloggs (or indeed two Dr Bloggs!)"

Consultants are extremely expensive. Traditional ways of working and professional boundaries are being challenged in the new NHS Workforce culture and in the new arrangements recently set up by the DoH.

On 23rd May, members of the BGS Council met for a timely debate, prompted by a position prepared by your Workforce Committee in March, available on the BGS website and referred to below. In essence it painted a gloomy picture but, for solutions, looked inwards ("We need to alter what we do and attract people to our specialty") as well as outwards ("we need more consultants and therefore more registrars"). The Study Day attempted to achieve a positive balance to the arguments by examining pragmatic solutions (there is no guarantee of extra trainees)

In the first session, Alistair Main presented the messages from the up-to-the-minute NTN and consultant recruitment surveys (see Box 1) and went on to describe the new Workforce planning arrangements (see position paper on the BGS website).

Box 1

The power of information (hopefully!)

The Workforce Committee was able to add weight to the arguments for more NTNs by two recent surveys: of NTNs and of consultant recruitment (Spring 2002). These surveys are still to be completed but four clear messages emerged:

- ① One reason why the WNAB fails to award new NTNs is that the specialty has recruitment difficulties. The NTN survey blew away this widely held notion. All but 3 of 392 posts were filled last year.
- ② Some areas have considerable consultant recruitment problems and the most prevalent reason is a shortage of trained registrars. (Three regions had more than 10% consultant vacancies).
- ③ We were able to show a sharp rise in the number of new consultant posts (41 in the last year) with further pressures on us as consultants, especially if new posts cannot be filled (20 of 41 in the last year).
- ④ Visiting trainees (VTNs) form a significant number and should be encouraged to stay (many do).

The outcome of this year's bids will be known over the summer and will be reported in a future Newsletter. Though by nature an optimist, I am aware that the larger political agenda dominates. So although we have made the arguments, and have the additional clout of the NSFOP, last year's new NTNs were awarded to politically sensitive specialties such as psychiatry (though they can't recruit) and anaesthetics (manning ITU) and the 'waiting list' related shortage specialties such as radiology and pathology.

Judy Curson, (Associate Dean from the Medical Workforce Review Team, formerly SWAG, which advises on specialty distribution of new SpR numbers), described the advantages of being part of a National Service Framework (NSF): It suggests a service model (important in arguing for more staff); The NSF for Older People has an influential National Director (Ian Philp); older people's services and the acute medical take are political priorities. She went on to describe the factors which are taken into account when deciding trainee numbers, the likely impact of the European Working Time Directive (EWTD), and an increase in part-time working. To bridge the obvious shortfall in the ➤

Box 2

Bridging the Gap (Judy Curson)

☞ Length of training – consider the necessity of out of programme working and whether this could be replaced with a course in research skills and critical appraisal. Also do part time workers need to train as long as full timers.

☞ Rethink immigration rules to encourage VTNs to stay (quite a large resource in our specialty).

☞ Consultant retention, possibly offer a reduced number of sessions post retirement.

☞ International recruitment drive perhaps through a fellowship scheme.

☞ Expand the role of other professional staff.

☞ Make more use of staff grade and associate specialists especially in shift systems.

near future, she offered practical advice (Box 2).

Cath Church (current Chair of the SpR Group) gave her views on the attractions and detractions of geriatrics as a career (see page 12).

Brian Wood, recently appointed as a consultant, described his experiences (good and bad) of seeking consultant posts and what shaped his final choice. These ideas were further expanded in Workshop 3

The afternoon was devoted to constructive debate around four themes highlighted in the March position paper. These themes and the conclusions of the debate are summarised in the theme boxes.

Something has to give (or give up!)

Even if consultant numbers increase substantially in the future, there is no quick fix for now. Should we continue to spread the bread ever more thinly? Should we abandon some of our current work (e.g. acute medicine of younger age groups) or should we withdraw from or fail to develop specialist input into community, intermediate and long term care? Should we be much more bold in deploying 'consultant' tasks to others? ➤

Theme 1 – TIME TO RETHINK WHAT WE DO?

It was envisaged that consultants in the future would be providing support and advice as part of a care team. Features of a new system of working could be:

☞ Selective assessment – with GPs and nurses flagging up areas for consultant involvement.

☞ More nurse involvement in evidence based care.

☞ More patients seen in primary care settings facilitated by greater use of technology.

☞ Flexibility to encourage recruitment and retention of community workers.

☞ Other specialities encouraged to share acute general take.

☞ Disciplined management of outpatients.

A new system will require a change in culture to encourage teamwork, feedback, appraisal and greater delegation. The skills base in teams will need to be developed to encourage consultants to delegate responsibility. New ways of working will need to be trialed to map the extent to which consultant involvement is necessary. A new culture could allow clinical directors more scope for maintaining standards of behaviour and conforming to a business plan.

Recognising that there is a recruitment problem in general practice, it will be necessary to determine whether there are enough GPs with a specialist interest in older people and develop a postgraduate competency test for those interested in working in this field.

Theme 2 – IMPACT OF THE EWTD

It is clear that the very sizable consultant expansion necessary to allow cover set up using current models of working is unobtainable. This is accelerated by the changing culture of the medical profession and a move away from long working hours. Creative implementation of the EWTD may involve:

- ☞ Improved cover arrangements between medical specialties.
- ☞ A review of traditional roles and work patterns, for instance trainees on quiet night call rotas.
- ☞ A greater range of staff could be involved ie. nurse practitioners, staff grades and researchers.
- ☞ Team responsibility rather than individual responsibility.
- ☞ Workload organised into sessions as in anaesthesia.

Challenges Identified

- ☞ Maintaining continuity of care under a shift system.
- ☞ Small units may not be legal unless they can provide a certain minimum level of cover.
- ☞ The BMA is clear that is illegal to work beyond the stated hours.
- ☞ Current distinction awards system rewards effort over and above the normal call of duty.
- ☞ Need to equate with the public and government agenda of responsibility for patient care.

Theme 4 – IMPROVING RECRUITMENT

How to increase the number of NTN's?

- | | |
|---|---|
| <ul style="list-style-type: none"> ☞ Review immigration laws with a view to encouraging VTN holders to stay. ☞ More flexibility in recycling numbers for out of programme trainees. ☞ Tackle Deanery bureaucracy especially with regard to delays in advertising posts. ☞ Facility for obtaining additional NTN's for staff grades in funded posts. | <ul style="list-style-type: none"> ☞ Greater use of appraisal to assess competency rather than time bound training. ☞ Ensure that geriatric medicine is incorporated into undergraduate training, ideally followed by an attachment to geriatrics as an SHO. Trainees are most likely to come into contact with a geriatrician during GIM training. |
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Theme 3 – IT'S A BUYER'S MARKET

How to attract consultants?

- ☞ A genuine commitment to being flexible, other consultants in the department may have to change their job descriptions to accommodate a new appointment.
- ☞ Balance between creativity and service delivery – there is a recommended limit of 7 sessions.
- ☞ Develop best practice in recruitment including well co-ordinated visits
- ☞ Genuine commitment to continuing medical education and professional development.
- ☞ Resource and infrastructure including support personnel, space and child care arrangements.
- ☞ Ability to change contract over time, flexible remuneration and decent on call profile.
- ☞ Personality profiling and proper induction to ensure that new appointees will fit in.
- ☞ A job description with a commitment to geriatrics, but with the opportunity to develop sub-specialty interests. External peer review from college advisers is variable. The BGS could encourage other sources including peer review of job descriptions.
- ☞ Map how other organisations deal with these issues.

What do our members feel?

The Workforce Committee is keen to hear from you about any workforce issues - solutions as well as problems! Please e-mail the BGS with your comments or contact me directly:
alistairmain@compuserve.com

Alistair Main
 Chair BGS Workforce Committee

Geriatric Medicine

what attracts doctors to the specialty

“Geriatric Medicine (Geriatrics) is that branch of general medicine concerned with the clinical, preventive, remedial and social aspects of illness in older people. Their high morbidity rates, different patterns of disease presentation, slower response to treatment and requirements for social support call for special medical skills” - *Official BGS definition of geriatric medicine.*

The Goal

In the new SpR curriculum for geriatric medicine, it states that “*at all times, Geriatricians will aim to maximise the functional independence of older people in their care.*”

There are many challenges that face us in the specialty, not least that of the impact of increasing numbers of elderly in the population, and recent national initiatives such as the NSF. We need to think carefully about how to attract doctors to our specialty.

Influences

Once the initial year as a pre-registration house officer (PRHO) is complete, most doctors work as senior house officers (SHO) and aim to obtain the MRCP. Plans and ideas change throughout this time before people settle on a definite career path. The following reflect some of the influences when doctors choose geriatric medicine and, from my own experience, are in order of importance!

A Geriatrician’s Enthusiasm

I was attracted to the many personalities that I found within geriatric medicine and was particularly impressed by their approach to both patients and colleagues.

“In Geriatrics, it is about looking at a person rather than just a condition” -

as a colleague of mine said recently. The whole

ethos of our specialty, with its holistic approach, attracts many doctors.

Why this Specialty?

It is obviously a hospital specialty, which is an attraction to those of us who don’t wish to work in primary care. There are opportunities to practice in both acute and long-term care (for example, rehabilitation, palliative care and continuing care). The majority of geriatricians train in general internal medicine (GIM), and there are still those who enjoy the challenge of practising general medicine! Geriatricians have a great breadth of knowledge which is vital in view of the multiple pathologies, co-morbidity and atypical presentations that we are faced with. For many, it is an attraction to have a broad base of general medical knowledge and be able to treat a range of conditions. This goes back to the ethos of treating the patient rather than a particular condition. The counter-balance is the relatively new development of subspecialty interests. This is now a big attraction to the specialty. Not only do geriatricians have a broad base of knowledge, they are also able to subspecialise in areas such as stroke, falls and orthogeriatrics. Geriatric medicine also offers opportunities to work in a wide variety of clinical settings, for example, wards, day hospitals and outpatient clinics.

Teamwork

Our specialty provides the opportunity to work as part of a team, not just with fellow doctors, but with other members of the multidisciplinary team. There are opportunities to gain leadership and management skills, and also the experience of being led by others in the team.

Ethics

Geriatrics offers ethical challenges, for example decisions regarding resuscitation or withholding and withdrawing treatment. Again, the geriatrician treats a person rather than an illness or condition. ➤

But...

Putting aside the merits of choosing our specialty over other branches of medicine, one cannot fail to recognise the demerits.

There are still issues over how our specialty is perceived. Geriatric medicine has never been a particularly “sexy” specialty. This perception may be changing, partly owing to the development of subspecialty interests. Geriatric medicine is sometimes seen as being “less academic” than other specialties. There are concerns at the lack of research opportunities for Geriatrics trainees at present. This is being addressed.

The impact of the European Working Time Directive on our training is an issue for all specialties but geriatric medicine in particular. Service delivery often impacts on training and acute medicine is often to blame for the lack of time that trainees have available to spend in Geriatrics itself. Although the development of subspecialties is a positive one, not all of the training posts are able to offer training in these areas.

‘Soft Option’

Controversial as this observation may be, could it be that some doctors see Geriatrics as a soft option? Maybe they feel that it is less

competitive than other specialties, and a chance to get out of doing too much work/research.....

More Pros than Cons

Geriatric medicine provides unique opportunities and challenges and there are many reasons why doctors are attracted to it. I certainly feel that there are far more positives than negatives. To be honest, I have been left wondering why anyone wouldn’t want to be a geriatrician!

One of the things that I have realised is how important my exposure to Geriatrics was as a PRHO and SHO. I probably underestimated just how much this influenced my decision to enter geriatric medicine. For this reason, I feel that exposure to our specialty at an early stage in training (even as a medical student) is essential.

We don’t want to attract just anyone to our specialty, we want to attract the best.

The challenge for us already practising Geriatrics, is how to do it!

Council Study Day Report by
Dr Catherine Church
Teaching and Research Fellow
in Stroke Medicine
Wansbeck General Hospital

An Honour and a Challenge from Europe

Congratulations to Dr Ian Hastie of St George’s Hospital in London, who has been elected President of the Geriatric Medicine Section of the European Union of Medical Specialists (EUMS).

One of the main functions of the EUMS is to deal with the training of specialists across Europe. Each member country has only two representatives on the body.

Dr Hastie has served as Secretary of the Section since its inauguration four years ago and will therefore have few illusions as to the challenge presented in the EUMS ideal of progressing towards a degree of uniform training across Europe.

Our best wishes to him for a fulfilling term of office.

The work of the BGS

Summary of Council Meeting held in May

NSF in England

☞ The Department of Health Liaison Group met in May to discuss progress with the NSF.

☞ A small group within the BGS would be appointed to form an NSF Focus Group for England to monitor progress and co-ordinate BGS involvement.

BGS Future National Structure

☞ The number of English representatives on the UK Management Committee will be increased to three.

☞ An Interim Administration (IA) to establish a Council for England will be appointed. The current Council representatives for England will continue to represent their regions and confer with the IA.

Elections

☞ A combined postal and internet ballot of UK membership will take place in July 2002, to elect the next President Elect and Deputy Treasurer. The election will be managed by the Electoral Reform Service.

☞ Nominations have already been received from regional branches for the 2002 election but future nomination will be open to individual members. Where there are more than two candidates a single transferable voting system will be used.

Regional Constitutions

Work on the regional constitutions will begin once the new national structures are in place.

Policy Committee

The new Standards of Care for the BGS compendium will be finalised in June.

Scientific Committee

☞ The BGS has matched Research into Ageing funding for a two-year Clinical Fellowship to start Autumn 2002.

☞ The Research Database will be expanded to include publications.

Clinical Practice Evaluation Group (CPEG)

☞ With co-ordination by CPEG NICE

consultations are increasingly being dealt with by the special interest groups.

☞ Plans for new work include a possible national audit of intermediate care and the presentation of audit work at BGS meetings.

Training Committee

☞ The NTN survey for March 2002 shows that there are no persistently unfilled posts. It was previously thought outside the Society that there were unfilled NTNs and that in consequence there was no need to allocate more NTNs to geriatric medicine. The Society is now able to demonstrate that this was an incorrect perception and to put the case for having more NTNs.

☞ Work with the regional committees to develop a strong research infrastructure continues.

☞ Dr Margaret Roberts will represent the BGS on the Stroke Sub-specialty Advisory Committee of the JCHMT.

☞ The Training Committee will be looking at the training requirements of intermediate care.

CME

The CME website (provided free of charge by Novartis) will include an electronic assessment tool.

Multidisciplinary

There was a meeting with representatives from the allied health professions on 16 May. An educational conference is being planned for 2003, and links with CPEG are being explored.

Health Advisory Service (HAS)

The Society had withdrawn as a corporate member from HAS.

Trainees' Report

☞ Discussions with the SAC continue, regarding suitable assessment methods.

☞ The impact of shift working on training is a concern amongst trainees.

Louise Wykes
Committee Secretary

FUTURE COMPOSITION OF BGS STANDING COMMITTEES

Academic and Research Committee	Policy Committee	Finance Committee	Education and Training Committee
3 England ¹ 1 Northern Ireland 1 Scotland 1 Wales 2 Section Representatives ² President 2 Meetings Secretaries Trainee 2 Age & Ageing CPEG	2 England ¹ 2 Northern Ireland 2 Scotland 2 Wales President President Elect Honorary Secretary Trainee	3 England 1 Northern Ireland 1 Scotland 1 Wales Treasurer Treasurer Elect President Deputy Hon Secretary Trainee	21 Regional Representatives UEMS Lead Dean 2 Trainees SAC Secretary Workforce Group President Deputy Hon Secretary
¹ 6 English representatives for the first year to allow current English Committee members to finish their term of office. ² To rotate between the four sections.	¹ 3 English representatives for the first year to allow current English committee members to finish their term of office.		



The work goes on

Volunteers wanted!

There will be several vacancies on the standing committees effective from the Society's AGM in October. Taking account of the future structure of the Society, these need to be filled in relation to the agreed national representation from the four countries of the UK.

The intention is that in future the national councils will put forward candidates to fill these posts. However as the national councils do not yet formally exist, members interested in serving on the standing committees are asked to notify

the BGS office by 31 August. The office will notify the respective national chairmen (in the case of England, the chairman of the Interim Administration), of the nominations and these national officers will confer locally. The preferred choices will be ratified at the Society's AGM in October.

Do not be put off by the new procedure, your Society needs you!

Richard Lynham
Administrative Director

Vacancies on BGS Standing Committees - October 2002

Academic & Research Committee (formerly Scientific Cttee) - Two new members are needed, one each from N. Ireland and Wales	Finance Committee - Five new members are needed, two from England, one each from N. Ireland, Scotland and Wales	Policy Committee - Four new members are needed, two from N. Ireland, one each from Scotland and Wales
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NSF one year on - a celebration of progress in the North and Yorkshire

The Northern and Yorkshire Modernisation Board (Task Force) for Older People held a meeting on Friday 26 April 2002 at the Stadium of Light in Sunderland.

The meeting was to celebrate the progress achieved in improving older people's services and provide a platform to plan further development and collaboration. There were 340 delegates from a range of health and social care backgrounds, including geriatricians, allied health professionals, social care workers and managers. The meeting also included an exhibition of 29 current Local Implementation Team (LIT) projects, stands from voluntary agencies such as the Stroke Association and Dementia North and from four pharmaceutical companies who partly sponsored the day.



Dr Peter Belfield, Chair Northern & Yorkshire Regional Modernisation Board for Older People spoke of progress made with the NSF, the Regional approach of learning from best practice, and the need to maintain momentum at a time of organisational restructuring. He

emphasised the use of "patient stories" to illustrate standards in the NSF, team working and the role of consultants. He highlighted a recent survey from Age Concern and the BGS on implementation of the NSF which had shown reasons for both optimism and

reasons for concern (available at www.bgs.org.uk).

Ageism - it's still out there!

Gordon Lishman, Director General, Age Concern England, spoke about some of the ageist practices that still exist. Age Concern is involved in many partnerships especially in the area of minority ethnic groups, mental health and intermediate care. Mr Lishman stressed the importance of keeping the focus on older people during times of change and like Dr Belfield, advocated using anecdotes about the experiences of older people constructively, to bring about change and improvements to the service.

Bedblocking - that old chestnut

Professor Ian Philp, National Director of Older People's Services referred to the BBC NHS Day and the danger of service improvements being hi-jacked by an inappropriate focus on 'bed-blocking'. He outlined some of the means to ensure progress: champions, advocacy organisations, the Modernisation Agency, NICE and development focused PCTs. Although money had not been ring-fenced, delegates were assured that funds were available for improved older people's services. One year on, the key aim survives, of delivering person centred care.

The plenary lectures were followed by workshop sessions on each of the NSF standards and on medicines management. The presentations on offer included: challenging age discrimination, the single assessment process; intermediate care - the Hartlepool multi-link scheme; stroke - getting evidence into practice; and falls prevention. Colleagues described how they

had tackled difficult issues, followed by an opportunity to discuss common problems and to share learning.

Local Implementation Teams (LITs)

Throughout the day, there was a poster exhibition of work from LITs. Over 29 initiatives and services were displayed, encompassing health promotion, intermediate care, domiciliary care and community working. The stands were well attended with very valuable contributions from the voluntary sector. All this gave an excellent opportunity for networking, sharing of written materials and exchanging ideas.

Effective Partnership

Philip Lewer, Group Director Health and Social Care, Calderdale Metropolitan Borough Council chaired the afternoon session, overcoming the post lunch dip by enthusing about his experience of life in a progressive Local Authority, where there is a real partnership with the local Health Service.

Different folks, different strokes

Professor Pieter Degeling, Professor of Health Management and Director, Centre for Clinical Management Development, Durham University, spoke of a research and development project focusing on the culture change issues that need to be addressed in order to pursue the modernisation agenda. Professor Degeling illustrated the cultures in different professional groups such as medical, nursing and management and how they contribute to the decision-making process. Progress with the modernisation agenda requires a culture change to embrace the broad skills mix involved in whole systems working.

Innovation and Partnership

The afternoon presentations included: user involvement in developing a stroke service; a consultation and information service for Bradford's Asian Elders; collaborative methodology to improve dementia services; an update on the integration of community equipment; details of a new long term care service; as well as workshops on shared learning and the 'supporting people' agenda.

Dr Belfield closed the meeting by encouraging participants to reflect on the progress to date and to use the learning shared at the meeting within their own localities. The Regional Modernisation Board has a work programme over the next year which includes the development of learning sites in each Strategic Health Authority, the launch of the dementia collaborative, a support team to review implementation of Standard 5 on Stroke Services and support of work on continuing care.

Louise Wykes
BGS Office and

Peter Belfield
Consultant Geriatrician

Further details of the workshops and exhibition stands with principal contacts can be found on **win.king@doh.gsi.gov.uk** who is the key support to the Northern & Yorkshire Regional Modernisation Team.

Other contacts in Northern and Yorkshire are: Jean Tottie, NSF Project Manager. Email: **jean.tottie@doh.gsi.gov.uk**

Peter Belfield, Consultant Geriatrician at **peter.belfield@leedsth.nhs.uk**

See the Northern and Yorkshire Excellence website for details of the programme of work at **www.nyx.org.uk/modernprogrammes/olderpeople**

Tackling the Crisis in Care Homes

No funding strategy will succeed unless it enables skilled, accountable professionals to work effectively together in partnership across the sectors within a single, planned defined service.

This was the view put forward by Professor Swift at the ‘Tackling the crisis in care homes’ forum, organised by Simon Burns MP (Conservative) on behalf of Dr Liam Fox, Shadow Secretary of State for Health at Portcullis House in London. The forum was attended by care home owners, organisations representing care home owners, the BMA, Help the Aged, Age Concern, the King’s Fund, the Association of Retired Persons, Directors of Social Services Departments, and the Small Business Federation.

The forum was designed to stimulate debate concerning the loss of care home beds and the ongoing “bed-blocking” crisis. Dr Fox announced that care of the elderly and age discrimination in terms of access to medical treatment were at the top of the Shadow Cabinet’s health agenda.

Professional Qualifications

Professor Swift argued for a recognised single common sphere of expertise and training in the care of older people, with clear standards of qualification across the professions working in primary, secondary and social care (including the private sector). Delegates from the care home sector admitted that there is a poor perception of staff working in care homes because they generally have vocational as opposed to professional qualifications.

Nursing Care and Assessment

Care homeowners expressed their concern at the low set fees of nursing care, and the fact

that the funding mechanism does not take account of the intensive care demands of clients with dementia.

A representative from Age Concern reported that the Age Concern helpline has received numerous complaints about the level of assessment.

The majority of the Directors of Social Services (DSS) object to the government’s proposal to fine poorly performing authorities, saying that fines would not provide an incentive for authorities to achieve excellence. Most directors also appear not to favour unified budgets because of “risks and liabilities involved”. In their view any additional investment in long term care should involve a partnership between companies, voluntary organisations and care homes.

Professor Swift stated that the funding and management arrangements imposed by successive politicians has proved profoundly divisive at the levels of professional practice, the NHS and social services, primary and secondary care and the statutory and private sectors. There is a lack of strategic thought and planning on best care and best professional practice across these sectors. Individual needs and “appropriateness” require expert and well organised decision making. Physicians working in the acute sector at present, for example, are under ever greater pressure to discharge patients prematurely. What is needed is the development of local, timetabled, costed plans based on estimated population needs, with projections over time. Such plans require a unified budget, but only if the required increases in spending are recognised and some form of protection of the funds guaranteed.

Annette Guerda Fischer
BGS Office

Medical Ethics

Spring Meeting Parallel Session

Resuscitation. Who decides? Central ethical issues are consent, capacity, involving patients' wishes and improving diagnosis of 'dying'.

So said Dr Stephen Burton, Consultant Psychiatrist, South London and Maudsley NHS Trust, to a large audience at the Telford Spring Meeting parallel session.

Existing guidelines to help us formulate our policies include the report on the BMA's Consent Working Party and the Mental Health Act 1983 Code of Practice, "Decisions relating to cardiopulmonary resuscitation" (BMA, RCN and Resuscitation Council, March 2001).

Dr Burton stressed the importance for all doctors to assess the capacity (competence) of their patients to decide on their treatment, and for this assessment to be done as soon after admission as possible. From his experience a full history is not always taken at the time of admission and severe cognitive impairment can be missed. Doctors should give patients sufficient information to help them come to decisions for themselves.

Consent must be Voluntary

The Mental Health Act says 'consent is voluntary and continued permission of the patient to receive a particular treatment based on an adequate knowledge of purpose, nature, likely side-effects and risks of treatment including likely success and any alternative to it. Permission given under any unfair or undue pressure is not consent.'

Incapacity is not being able to take in and retain the information pertaining to the decision, especially not knowing the likely consequences of having the treatment or not. It is also, not being able to believe the information, which is the case with a lot of patients, and not being able to weigh the information in the balance. Any assessment as to an individual's incapacity has to be made in relation to a particular treatment.

Patient's Best Interests

We treat patients without consent when we are acting in their best interests but a future contentious issue is the suggestion that the courts may be better placed to make some of these decisions. Our decisions should be transparent and fully documented and should take account of the Human Rights Law which will become increasingly important. Fear of litigation is not the best starting point for clinical decisions. The remedy to this is the adoption of best practice guidelines.

Routine Assessment of Competence

Consent is the important issue. Adults should be presumed to be competent if not otherwise proved. Information must be given and its retention and patient's understanding of the issues tested. Competency needs to be part of routine assessment of a patient, if for no other reason than their ability to consent to treatment.

Dr Jane Liddle
Secretary/Treasurer
Medical Ethics Special Interest Group

Intermediate Care

in the Bournemouth and Christchurch Area

The controversy and ongoing debate over the definition of “Intermediate Services” is delaying its implementation in many areas.

Guidance from the Department of Health on the development of Intermediate Care was released in January 2001, followed shortly by further advice in the delayed National Service Framework for Older People (NSF). We chose to take advantage of the new opportunity for resources and describe here our experience of developing Intermediate Care services for local people over the last two years.

There had been significant pressure to change the existing service arrangements for older people within Bournemouth and Christchurch, coming from the fronts of

- ✎ a local population with one of the highest proportions of older people in the UK;
- ✎ an increasing pressure on local acute services;
- ✎ Bournemouth Primary Care Trust (PCT), established in October 2000, had as one of its top priorities the development of services for the elderly;
- ✎ the Royal Bournemouth and Christchurch Hospitals NHS Trust “Bridges Project” had identified a number of areas in which admission and discharge arrangements for patients needed improvement;
- ✎ Bournemouth Social Services had established that it had a high number of admissions to long term care, compared with the rest of the country;
- ✎ there were many “champions” within individual organisations (see Box) who believed that services for older people should be developed to the highest possible standard.

Consultant-Led, Single Point Access to a Central Multi-Agency Group

Key stakeholders from these relevant organisations met at a workshop in June 2000, prior to the launch of the national guidance, where all parties agreed to the principles of a new model of service for frail vulnerable people. The service would be consultant-led, ensuring the quality of the medical element, with a single point of access to a central multi-agency group, the Community Assessment and Rehabilitation Team (CART). The focus would be on prevention and ‘crisis-avoidance’, providing real alternatives to prolonged admissions to the acute Trust. It was agreed that the initial emphasis would be on creating high-quality Intermediate Care *services*, rather than just the provision of Intermediate Care *beds*.

In setting up CART, stakeholders considered it important to follow three guiding principles. Firstly, each of the organisations should feel ownership of the team. Secondly, the role of the new team should complement existing services, filling unmet need rather than adding a new layer of service. Thirdly, the service should be centred around the user, providing all aspects of care following referral rather than passing a patient from one service to another, thus minimising communication problems and disputes regarding service responsibilities between different agencies. Financial support for the project would be multi-agency, and the project would commence in a limited area defined by general practitioner (GP) practices. The catchment population for the initial model scheme was around 30,000, covered by 21 GP principles from 5 practices.

CART commenced duties with a supported discharge service in December 2001, and began a rapid-response service to help prevent unnecessary admissions in February 2002. Each

month, the team receives around 20 referrals for supported discharge, and 10-15 requests for the rapid-response service.

Multi-Disciplinary Secondments

The CART team staff are permanently seconded by their employing organisations, and comprise the newly-appointed consultant geriatrician, team



co-ordinator (a head occupational therapist), 1.5 WTE occupational therapists (OT), OT technical instructor, 1 physiotherapist, G and E grade nurses and 6.5 WTE community support workers. This new team of generic health and social care assistants provide care within patients' homes in such a way as to reduce the number of visits from different agencies. Their multi-disciplinary training was accomplished through a novel programme created in conjunction with Bournemouth University.

The consultant post was a new development, with the main role being to ensure that all frail elderly people cared for in the community have access to the same high-quality comprehensive geriatric assessment and interventions as they would have received within the 'conventional' hospital-based service. The post has enabled much improved communication between the acute sector and primary care, plus improved liaison with nursing/residential homes and other allied health professionals. Five sessions are dedicated to community cover, but the consultant's base is within the acute Trust, facilitating CPD and education.

In addition to providing these services, we secured four 'step-up' beds in an independent residential home, allowing a more supported setting. Linking with an established seven-bedded residential rehabilitation facility run by social services has further added to our range of facilities. We were recently successful in a bid to the Department of Health for £131,000 capital funding to increase this bed complement to sixteen; all the therapy input for these beds will come from staff in the CART team. This allows physiotherapists and OT's to work with the same patient both in the residential unit and after they return home, achieved by integrating existing therapy staff into the team.

Bournemouth is one of the pilot sites for NHS 'Care Direct', providing a one-stop referral point for access to social and voluntary agency support. We have developed close links with a nominated care manager within this team to allow closer working relationships and now have a weekly liaison meeting with the Care Direct team.

The local charity 'Help and Care' has been intimately involved with the planning of the new Intermediate Care services from an early stage. Their involvement underpinned our successful application for a national grant from Help the Aged, enabling Help and Care to second a member of staff to our team for two years. This worker liaises with clients directly to take on support and advocacy issues and to link in with other voluntary agencies. Help and Care are also developing a service users' forum to advise and comment on the current service and future service developments.

Expansion

Having established modern and safe Intermediate Care services to a level that all stakeholders felt was acceptable, we looked towards expanding our Intermediate Care bed base. The Royal Bournemouth Hospital recently opened a 26-bedded Intermediate Care ward providing short-term rehabilitation facilities on the acute hospital site. This has close links with CART, with consultant cover for half of the patients being provided by the geriatrician with responsibility for Intermediate Care. A member of the CART team attends the weekly case conference to ➤

Organisations involved in developing the new Intermediate Care Model

Age Concern
 Bournemouth Social Services
 Bournemouth Helping Services
 Bournemouth Central Primary Care Group
 Bournemouth North Primary Care Group
 Christchurch Primary Care Group
 Dorset Health Authority
 Dorset Healthcare NHS Trust
 East Dorset Community Health Council
 Help and Care
 The Royal Bournemouth and Christchurch Hospitals NHS Trust

ensure seamless return to the community.

All of this work carried out so far by the various organisations within the Bournemouth Health and Social Care Community has provided a very encouraging start to realising our vision of Intermediate Care. The popularity and success of the pilot scheme has been reflected by an escalating demand for the service from neighbouring localities. In order for this expansion to take place, considerable investment will be required, and we are presently in discussion with adjacent PCTs, social services, voluntary and private agencies to determine their level of commitment as future partners.

Dr Andrew Williams

Consultant geriatrician with responsibility for Intermediate Care Services

Dr Damian Jenkinson

Consultant geriatrician and honorary senior lecturer

OPPORTUNITY TO BE PUBLISHED

The National Association for Geriatric Service Providers & Educators in Texas is looking for articles for their peer-reviewed publications.

The Journal of Interdisciplinary Aging & Long Term Care (JIALTC) is published three times per year. The focus of articles is long-term care, caregiving, support systems and ageing. Two lengths of articles are published, brief (3-5 pages) and long (10-15 pages, longer considered). The brief articles are designed to provide a basic understanding of a topic. The long articles are typically those that result from research or an analysis of practice. As indicated in the title, the topics are interdisciplinary.

Journal of the Aging Family System:
 Published annually in the Summer. This

journal focuses on the issues that the average family system deals with when faced with ageing and long-term care. The articles for this publication are typically full-length (15-30 pages) papers based on research conducted by the author(s). Articles that focus on services (i.e., physical therapy procedures) but do not focus on the systemic impact will be referred to the editorial board for consideration of publication in JIALTC.

If you are interested in submitting a manuscript, being a peer-reviewer or simply have a question, please contact Tina Chang at tinachang@houston.rr.com.

Steven L. Houseworth

The National Association for Geriatric Service Providers,
www.bmhss.com

Guidelines Database



The Royal College of Physicians (RCP) has developed a comprehensive resource for identifying widely accepted clinical guidelines.

It is one of the RCP's functions to set and improve standards in medical practice. Guidelines and audit projects are considered essential in setting targets and measuring if they have been met.

Currently, much audit and guideline activity is carried out by specialist societies; it is due to this that the Clinical Effectiveness and Evaluation Unit of the RCP established a Clinical Effectiveness Forum (CEF) in November 2000. The brief of the forum is to share experience on evidence based multi-disciplinary guidelines production and co-ordinate clinical effectiveness activities to achieve greater effect. It has representation from each of the medical specialities coming under the RCP umbrella.

The first project of the forum has been the development of a central database of clinical guidelines, produced over the past five years, covering most areas of clinical practice. The database can now be accessed via the RCP website and is intended for the use of healthcare professionals.

The CEF is working towards 'kite marking' the guidelines on the database and a peer review validation process is currently being explored

using the AGREE tool.

The CEF is continually searching for guidelines that meet the inclusion criteria and currently, the database is updated quarterly.

For further details, please contact:

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Criteria for including guidelines on the database:

- ☞ All UK guidelines produced in the previous five years and relevant to the specialities covered by the RCP.
- ☞ Non-UK guidelines are included if they are of relevance to UK practice.
- ☞ A few guidelines from earlier years are included, if the relevant specialist society has confirmed their continuing appropriateness.
- ☞ Guidelines on performance or accreditation for procedures are included only if they have clear impact on clinical management of a specific condition.
- ☞ Matters of training are excluded.

Underlying values

Amulree Prize Essays

Congratulations to the winners of the Amulree essay prize. It is not the first time that medical students have concentrated on the values underpinning the practice of medicine.

The joint winners of the essay prize for medical students are Jill Tan for “Rationing and health care by age?” and x for “Elder abuse”.

Jill Tan writes about rationing, and methodically arrives at the conclusion that there are circumstances when age can be a criterion for rationing. In building her argument she examines myths and misconceptions. I felt that her best arguments tended to refute her premise! Her first major argument is that rationing, if it takes place, should be based upon the ability to benefit. It follows that age is a justifiable criterion for rationing when age is known to be a factor that influences ability to benefit. In a thought-provoking discussion of how evidence for this can be assembled she touches on the drawbacks of QALYs:

“QALYs have also been accused of discriminating against the elderly by putting different values on individuals according to life expectancy. In addition, the usefulness of QALYs may be limited by the public’s perspective of the NHS. Grimley Evans argues that most people regard the NHS as an organization which ‘will be there to do what they want when they want it’, and so the service is judged ‘on the extent to which it meets their informed desires’. Maximizing this may not necessarily lead to the same method of distributing resources as would maximizing the production of QALYs.”

Of note is the fact that there were no instances she points to where age is clearly an indicator of inability to benefit. In fact she points out that the reverse is often the case.

In building her essay, she touches on ageism. One statement in particular took my interest:

“Recent changes in the acute medical services have created an environment where ageism flourishes; a greater number of older people are being admitted to fewer beds for shorter stays.”

As I reflected on this I wondered if busy supermarkets tend to despise shoppers? Why should the increasingly efficient use of the NHS by those who need it lead to negative perceptions about those people?

Another line gave me a wry smile. Although only a youngster (age 43), I well recall the “Cinderella specialty” of stroke care only 15 years ago, and yet now Ms Tan observes:

“Wards involved in the rehabilitation of patients after they have suffered a stroke receive more compared with the geriatric general medical ward. It is believed that the reason is due to the ‘unglamorous’ image of the latter.”

How far we have come. How far we have to go.

The “fair innings” concept gets a thorough enquiry. The principle is that older people have had their share of life so it is fair to ration on these grounds. She acknowledges that these arguments have moved away from medical grounds to an assessment of public opinion. She gives us an intriguing paradox:

“In addition to my position as a medical

student, I am also a member of the public and I admit to being swayed by the filial instinct to protect my own parents from neglect. However public opinion seems to support rationing health care by age. Bowling's priority ranking study found that half of respondents agreed that the higher priority for resources should be given to the young rather than the elderly (Bowling A. Health care rationing: the public's debate. *British Medical Journal* 1996; 312: 670-674). Yet public consensus is not universal. It is divided on this controversial issue, and in contrast Hay's respondents considered increased investment in services for elderly people to be essential (Hay S. Rationing in the NHS: public does not always favour lifesaving, acute interventions. *British Medical Journal* 1996; 312:1605.).

Throughout this well argued piece I am constantly reminded of the need to examine deeply the values that we hold, and their effect upon policy and practice. The same thoughts stuck me when reading x's essay on elder abuse. In this, ageism gets a mention once again:

"A more subtle but serious causative factor for elder abuse is the growing concept of ageism, a negative view of ageing caused by lack of....accurate information. It has been shown that residential home staff who have overly negative attitudes toward elderly people are more likely to behave inappropriately toward them (Pillemer K, Moore DW (1989) Abuse of patients in nursing homes: Findings from a survey of staff. *Gerontologist* 29:314-320). In 1970, De Beauvoir in her treatise on old age, moots the possibility of an innate drive to cull the aged to make room for the young, which may seem like an extreme view to us today (De Beauvoir S (1970) *La Vieillesse (Old Age)*, transl. 1977). Penguin, London). Then again, we live in a society that uses phrases like 'rising tide' of the elderly and where a few years ago, a London hospital trust considered closing its accident and emergency department to people over the age of 70."

A later paragraph neatly indicates the dilemma

facing policy makers in the UK by pointing out the contrast with the USA:

"The response of agencies in the UK has been erratic. In a 1995 survey, it was found that 72% of responding social service departments, 24% of health authorities, and 22% of NHS trusts have adopted intervention policies, with fewer still earnestly monitoring cases of elder abuse. The US response has been to set up state-funded Adult Protective Services (APS) which are assigned to investigate and intervene in alleged cases of abuse. However, the agency faces problems of doctors being unaware or reluctant to utilise reporting laws; and inadequate resources. UK Law Commission proposals for the protection of vulnerable adults in 1993 (Law Commission (1993) *Consultation Paper 130 : Mentally Incapacitated* HMSO, London) were well received, but not developed and the American experience may in part have led to reluctance in pursuing a legislative route for intervention."

Every good essay needs a good ending, and both these essays had them. The issue of values arose, as the final point in x's essay:

"Finally, the most important challenge is the reconstruction of ideas about the status of elderly people. There must be an overhaul of the aspects of relationships elderly people experience within the family, in residential homes, and in other community settings. Medical and social policy is needed which addresses the question of how elderly people can live lives that are free from violence and mistreatment. This must begin from a consideration of all the conditions under which elderly people in society live, and placing abuse within that context. Then only, can we avert the appalling irony of how the amazing increase in life expectancy that has occurred in the last one hundred years, will simply become a large cohort of unprotected and vulnerable people to be abused in this century."

John Gladman

Age & Ageing Supplements Editor

Food Provision

and Residential Care

Wholesome, appealing, balanced: the challenge of food provision and the national minimum standards in residential care for older people.

This conference, held in the Stationer's Hall in London, was organised by the Royal Society for the Promotion of Health and was attended by the BGS representatives of housing associations, care homes, nursing homes, residential homes, NHS Trusts and County Councils.

The theme of the conference revolved around the challenges presented by the Care Standards Act 2000, in preventing under nourishment or malnutrition among older people in residential care.

Trish Davis, Director of Corporate Policy, Performance and Communication for the National Care Standards Commission (NCSC) outlined the provisions of the Care Standards Act as they applied to residential care, how the NCSC will operate and its inspection system – the purpose of which is to introduce a streamlined regulation system and national procedures for inspectors to ensure the relevant standards are met.

Rachael Masters, dietician, South Durham Health Care NHS Trust, informed the conference on the project 'Focus on Food', a pilot project across County Durham and Teeside for putting nutrition standards into practice by informing care home and training staff to identify and treat malnutrition.

Professor Susan McLaren, Professor of Nursing in the Faculty of Health and Social Care Sciences at Kingston University and St George's Medical School touched on how the nutritional needs of

older people are affected by physical, metabolic and functional changes, and also how culture, religious beliefs as well as social, environmental and disease-related factors have a powerful influence on a person's eating habits.

Janet Bailes, professional lead dietician, East Kent Hospitals Trust, gave a presentation on how to overcome eating difficulties by a process of screening and assessment. Very important in avoiding undernourishment, she said, is the presentation of food and portion sizes, particularly for residents with poor appetite or difficulties in swallowing food.

Steve Pepper, food hygiene consultant, gave a presentation on food hygiene and food safety. He stressed the need to maintain food hygiene standards by concentrating on personal staff hygiene, good kitchen practice (appropriate handling of different foods) and the maintenance of reliable records.

Taking a "client centred" view were Claire Rayner, writer and broadcaster, who gave the keynote address, and Dee Williams, Lecturer, Canterbury Christ Church University College both of whom dwelt on the balance needed between the resident's choice and good nutrition. While both Ms Rayner and Ms Williams advocated that where possible, residents of care homes should be encouraged to choose what they wished to eat and how they would prefer to take their meals (alone or in company), Ms Rayner pointed out that not all food choices were necessarily nutritious, toast and dripping, for example? However care homes manage this balance, said Ms Williams, mealtimes should be a satisfying experience for residents, rather than a ordeal.

Annette Guerda-Fischer
BGS Office

PARKINSON'S DISEASE

Multidisciplinary care in
Parkinson's
Disease/parkinsonianism

17 July 2002

RCP London

Topics include: dementia; mood disturbances; pain and sensory systems; and botulinum toxin.

Contact: Medical Education Partnership, 30-34 New Bridge St, London EC4V 6BJ. Tel: 020 8993 8570. Email: info@mepuk.com

PD MASTER CLASS

Preliminary announcement: Parkinson's Disease Academy

19 to 20 September 2002

St Austell, Cornwall

BGS Parkinson's Disease Section and the James Parkinson Centre in Cornwall have announced the first PD Academy - a residential Master Class, designed for consultants, final year SpRs and staff grades current running or wishing to run PD clinics. Participants will be locally mentored until the second residential 2 day module (dates yet to be agreed) in London. The cost will be £250 per person.

Contact: Dr D MacMahon, James Parkinson Centre, Camborne-Redruth Hospital, Redruth, Cornwall TR15 3ER. Email: events.redpublishing@btopenworld.com

FALLS CONFERENCE

Falls & Bone Health SIG
"Falls and Postural Stability"

6 September 2002

Kensington Town Hall, London

Deadline for abstracts: 1 July 2002

Topics include: assessment of gait and balance; Parkinson's disease and falls; and epidemiology of fractures.

Contact: HMC Ltd, 127 High Street, Teddington, Middx TW11 8HH. Tel: 020 8977 0011. Email: falls@hamptonmedical.com

STUTT GART SERVICES FOR SENIOR CITIZENS IN EUROPE

Innovative Services in Traditional Structures
2nd Congress of the Wohlfahrtswerk für Baden-Württemberg

8 to 10 September 2002

Congress Language - English, French, German

Speakers from the USA and throughout Europe will be reporting on their practical day-to-day experiences.

Contact: Ms B Steiner, Wohlfahrtswerk für Baden-Württemberg, Falkerstr. 29, D-70176 Stuttgart, Germany. Tel: +49 711/6 19 26-110. Email: barbara.steiner@wohlfahrtwerk.de

DIABETES

Diabetes Special Interest Group
Annual Meeting

13 to 14 September

Derbyshire

For further details contact:
Dr Simon Croxson, Bristol General Hospital, Guinea Street, Bristol BS1 6SY. Tel: 0117 928 6101 or email him at simon.croxson@virgin.net

REHABILITATION

Effectiveness of Rehabilitation
for Cognitive Defects

17 to 19 September

Cardiff

Contact: Ms K Giblin, School of Psychology, Cardiff University, P O Box 901, Cardiff, CF10 3YG. Tel: +44 (0)29 2087 5356. Website: www.cf.ac.uk/psych/ercd

IRISH GERONTOLOGICAL SOCIETY

50th Anniversary Conference

20 to 21 September

University College, Cork

Conference is approved for CME

Contact: Ms L Murray, 10 Beaumont Avenue, Ballintemple, Cork. Tel. 00353 21 4293918. Email: lucette@iol.ie

NEW TECHNOLOGY IN ELDERLY CARE

New Technology in Elderly Care SIG

8 October 2002

Charing Cross Hospital

Topics include: automatic fall detection and prevention systems and physiological monitoring at home.

Contact: Dr F Miskelly, Postgraduate Medical Centre, Charing Cross Hospital, Fulham Palace Rd, London W6 8RF. Tel: 0208 846 7197. Email: f.miskelly@ic.ac.uk

MAXIMISING YOUR SINGLE ASSESSMENT PROCESS

14 October 2002

London

Suitable for CME

Chaired by Dr K Kelleher and speakers including Dr I Carpenter

Contact: Ms E Woodward, The Bookings Dept. IBC UK Conferences, Informa House, 30-32 Mortimer Street, London W1W 7RE. Tel: 01932 893852. Url: www.healthcare-info.co.uk/LH1175

NUTRITION IN CARE HOMES

Nourishing Older People in Care Homes - a series of one-day courses

Taunton - 23 October 2002

Birmingham - 13 November 2002

Leeds - 27 November 2002

Cost: £125.00

Contact: Ms G Maylin, RIPH, 28 Portland Place, London W1B 1DE. Tel: 020 7291 8362. Email: gmaylin@riph.org.uk

GERIATRICS & GERONTOLOGY

International Conference

8 to 10 November 2002

India Habitat Centre, New Delhi

Separate Sessions for Doctors, Scientists and Nurses

Cost: Doctors/Scientists US\$100

Contact: Dr O P Sharma, K-49, Green Park Main, New Delhi - 110016, India. Tel: + 91-11-6865916. Email: opsharma@geriatricindia.com Website: www.geriatricindia.com

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