



BGS

n e w s l e t t e r

Dr “Bobby” Irvine CBE 1920 - 2002 – the BGS pays tribute

We all called him “Bobby”. It seemed to fit, somehow, with his larger than life personality, his boyish laugh and his sense of fun.

It was easy to forget that he was an eminent physician and a deeply religious man.

Educated in Winchester, at King’s College Cambridge, and at Guy’s, Bobby kept friends and colleagues from all these stages of his life into old age. His marriage to Peggy, whom he met when she was a nurse at Guy’s, was a long and happy one and their three sons and four daughters kept in regular touch with them even when the family were scattered all over the globe. It was Catherine, their

daughter who was a practice manager in Guernsey, who organised the family gatherings, especially after Bobby and Peggy retired to Guernsey (where Peggy had been brought up). He was very proud of his 17 grandchildren and, at the last count(!) 3 great grandchildren.

After serving in the RAMC as a Regimental Medical Officer between 1945-47, Bobby returned to medical posts at the Brompton and at Guy’s and later moved to Newcastle-on-Tyne in 1952, as a senior registrar in general medicine. At that time, 40 applicants competed for each consultant post in general medicine and even excellent candidates like Bobby were unable to find appointments.

Like several other outstanding physicians, and after an energetic apprenticeship in the specialty under Dr Elunet Woodford-Williams in Sunderland, Bobby made the decision to move into geriatric medicine. On his appointment to Hastings, he transformed the service there from a primarily longstay one to a unit with active acute and rehabilitation wards and a day-hospital.

Bobby was committed to teaching, and became the first clinical tutor to Hastings, helping to establish its postgraduate centre and regular clinical meetings. Senior registrars from other centres were invited to give lectures, spend the night at his home, and perhaps see something of the working of the innovative orthopaedic-geriatric ward. There, he and his orthopaedic colleague, Michael Devas, combined their expertise to ensure that patients recovered as quickly as possible from their hip

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specialist medical society for health in old age

fractures. They achieved discharge rates unheard of at that time.

Co-operating with colleagues in other disciplines gave Bobby his keenest pleasures at work, and resulted in some of his most enduring publications. With the therapists and social worker in Hastings Day Hospital, he published "The Older Patient", which was still in print after 20-odd years. He represented the British Geriatrics Society in a combined report with the Royal College of Nursing, "Improving Geriatric Care in Hospital", in 1975 and its sequel in 1987. He was in demand to provide chapters in a number of textbooks of geriatric medicine and was adviser to the Department (DHSS) on geriatric medicine from 1982 -5. Despite the volume and quality of his work for the specialty, Bobby was genuinely surprised to be asked to become President of the British Geriatrics Society from 1981-1984. He filled his role with distinction and his customary bonhomie, and his career was crowned by the award of the CBE for "services for elderly people".

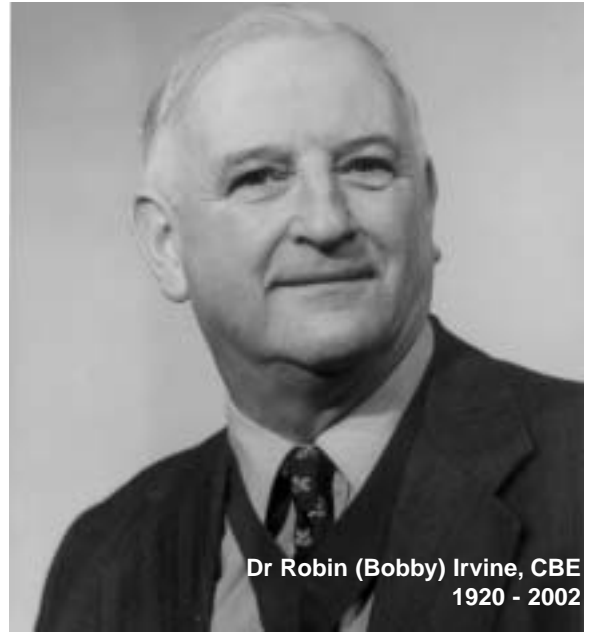
It was typical of Bobby that he chose to leave his cancer untreated, and to die from that, rather than from his multi-system atrophy, which involved untreatable Parkinsonian symptoms. His last Christmas letter (and he knew it would be his last), was full of thankfulness for his many blessings at work and in his family life and friendships, and he was sure he would see his dear Peggy again. A great man.

Marion Hildick-Smith

I first got to know Bobby when together, we mounted an exhibit on the geriatric day hospital at the BMA Annual General Meeting in Bristol in the early 1960s. He remained a most supportive friend and colleague. St Helen's Hospital in Hastings became one of the small number of places of pilgrimage for visitors from home and abroad, studying the new specialty for geriatrics. Beneath his outgoing and ebullient exterior, lay a very modest man. He went out of his way to acknowledge the contributions of nurses, social workers and other colleagues, to the success of the Hastings Unit.

He was one of the "greats" of British geriatrics, and was much loved.

Prof John Brocklehurst



Dr Robin (Bobby) Irvine, CBE
1920 - 2002

I was privileged to visit Bobby's unit in Hastings on two occasions; the first was to see the workings of the geriatric/orthopaedic service which Bobby had pioneered with his colleague, Michael Devas. It had seemed too good to be true with the rapid rehabilitation and early discharge of elderly patients after surgery. My observations convinced me that the scheme did indeed work well.

My first memory is of the remarkable team work of physician, surgeon, nurses, therapists and social workers. The next is of the good humour and happiness of the team (and patients) and the laughter that was heard so frequently.

Another is of a visit as a member of an SAC inspection team charged with assessing the quality of training for junior medical staff. Once again I was very impressed. This was, of course, all expertly supervised by Bobby himself. On this visit I stayed in the Irvine household and enjoyed the warm hospitality provided by Bobby and Peggy, his charming wife.

A favourite recollection of my stay with them concerns when we were preparing to leave for the hospital after breakfast. Before setting out, Peggy "inspected" Bobby and spotted a rather large dark stain on the end of his tie. When Bobby saw this, he immediately opened a drawer, took out a pair of scissors and snipped off the last few inches of the tie. We then sallied forth without further problems.

He was a large man in every way - physically, intellectually and as a "character". He loved life and people, and it was impossible not to feel better for being in his company. He brought many good things into the lives of his colleagues and friends.

James (Jimmy) Williamson

.....from our colleagues in New Zealand

Members of the New Zealand Geriatric Society wish to add their tributes to the late Dr Bobby Irvine who developed a particularly close relationship with geriatric medicine in this country.

This started with his friendship with Dr Ron Barker in the early 1970's. Dr Barker was a pioneer New Zealand geriatrician who later became Director General of Health. Following the initial contact, four New Zealand senior registrars trained at the Hastings unit, Jonathan Baskett, John Campbell, Tudor Caradoc-Davies and Dick Sainsbury. For 6 of 10 years, in the 1970's and 1980's, the Hastings senior registrar position was occupied by a New Zealand advanced trainee and Bobby therefore had a very important role in the establishment of the discipline in this country.

In 1984 Bobby visited New Zealand as the major invited speaker for the National Conference organised by the New Zealand Geriatric Society and the New Zealand Association of Gerontology. Bobby made many friends in New Zealand,

in addition to those that he trained. Those of us who worked with him were privileged to gain an excellent training in the field. The particular strengths of the Hastings unit were the orthopaedic-geriatric service and service innovation, as Hastings had one of the first age related services in the United Kingdom. The close linkage with psychogeriatrics was also a major feature. Ward rounds with Bobby were always a pleasure. He treated patients with dignity and compassion, and was genuinely their friend. He was a good teacher and a superb entertainer. He had an unnerving habit of appearing to be asleep during a clinical presentation, only to wake up at question time and ask a searching question. He was a firm believer in interdisciplinary team work. His skills in people management were demonstrated at the end of every ward round when he would observe, in a loud voice near the nurses station, "don't you think these are the most marvellous nurses you have ever worked with?". Bobby will be sadly missed in New Zealand, but his imprint is indelibly printed on geriatric medicine in this country.

Richard (Dick) Sainsbury
President, NZGS

Dr Bobby Irvine - Personal Reflections by Peter Greenfield

I first met Bobby Irvine in 1959, within a week or two of entering general practice in Robertsbridge, East Sussex. My partner had asked Bobby to undertake a domiciliary visit to one of his patients, and I was told that it would be "good for my education" to accompany this relatively new and enthusiastic consultant from Hastings. This I did, and I can still recall the impression that the occasion made on me. Having hitherto been used to being at the bottom of the rigid hospital medical hierarchy which existed in the 1950s, I was amazed to find that Bobby, although a consultant, and 11 years my senior, treated me as an equal from the start. We were on first name terms after two minutes, and at the end of the visit I found that he was as keen to hear my views as to express his own about the patient in question. To someone as raw to the profession as I was, this did wonders for my morale and self esteem!

During the 1960s I came to know Bobby even better, not only through the medium of DVs, but more particularly because I gradually took over my partner's role as part time medical officer to Bobby's long-stay geriatric unit at Battle Hospital. Around 1965, I was formally appointed to the post, and this coincided with the retirement of the matron and the administrator of the hospital - hence allowing Bobby to "import" senior staff of various disciplines from his flourishing geriatric unit at Hastings. Over the next year or so I was privileged to witness at first hand, the metamorphosis of a gloomy former workhouse, with its stern discipline and custodial philosophy, into a vibrant high morale unit, managed on a multidisciplinary basis, and from which patients could on occasion be discharged alive! All this, by common consent, was happening as a result of Bobby's commitment, single mindedness and drive, laced with good humour and

courtesy. I know now, of course, that this phenomenon was occurring in other parts of the country, but it was little short of miraculous to me, and an object lesson in what good geriatric medicine could achieve that I never forgot.

When for reasons quite unconnected with geriatric medicine, I decided in 1969 to apply for a job at the former DHSS, I needed to let Bobby know of my intentions. "Oh dear," he said, "Are you sure this is a good idea?" After explaining my thinking he said, "Don't do anything more until I have had a word with a friend of mine in DHSS." I agreed, and within a couple of days he rang me back to say that jobs in the Department were quite good, and could even be interesting! The friend he had spoken to was Surgeon Rear Admiral Jack Holford, and little could I have guessed that within 3 years I would succeed Jack as the medical "man in the Ministry", dealing with old age care - and even becoming a member of the BGS!

Many will remember Bobby's achievements on the national and international stage, but I will remember him as a good friend who had a major influence on my medical career, and to whom I am eternally grateful. It was an honour to have known a man with such a kindly, supportive and gentle manner at the personal level, yet who could be so persistent and persuasive with managers, officials and authorities in his efforts to improve the lot of older people. The medical world will be the poorer for his loss.

Postscript
In a letter to Dr John Dall, written just eight days before his death, Dr Irvine recalled his work with Michael Devas, saying, "I should be happy to be remembered as the physician who had the privilege of working with Michael Devas on the invention of geriatric orthopaedic collaboration. He was a great man."

Dr Bobby Irvine

co-pioneer of geriatric orthopaedics in Hastings



The development of geriatric-orthopaedics, the system of interdisciplinary care of older people with hip fractures, was revolutionary in its time.

It was pioneered in Hastings by Bobby Irvine in collaboration with the orthopaedic surgeon, Michael Devas. It was to become the benchmark for the care of older patients with hip fractures. The principle of interdisciplinary care driven by regular meetings of senior specialists, of which this initiative was the first major example, has also provided the inspiration for developments in other areas of care, notably cancer services.

On Dr Irvine's arrival in Hastings, he had 300 patients under his personal care, in four hospitals. Many of these patients would not have been expected to leave hospital.

Many years later, he pointed out with justified pride, that one of the younger, "chronic sick" patients he had inherited had not only been discharged to live independently in the community, but was subsequently employed as a porter by the hospital in which he had been a patient. This well exemplified the complete change in society's attitudes towards the disabled in general, and older people in particular - from paternalism to a striving for dignity and independence. This change had depended on pioneers from the 1940s, notably Marjory Warren, but was underpinned by the geriatricians of Bobby Irvine's generation.

Bobby's great successes in Hastings were built around collaborations borne of his generosity, ebullience and sheer stature, both physical and personal. He had an uplifting presence. It was

perhaps important that he and Michael Devas were appointed around the same time, but it says much for the personalities and innovative flair of both men that they were quick to appreciate the advantages, to both their services, of joint working. This is now so much the norm, particularly in such areas as cancer care, that it is hard to remember that in 1959, when Drs Irvine and Devas started geriatric-orthopaedics, such collaborations were anathema to many. By his enthusiasm and commitment, Bobby Irvine championed multi-professional interdisciplinary care. Nurses of all grades were encouraged and enabled to contribute to the assessments of his patients at a time when nursing and medical hierarchies tended to be very separate.

"This well exemplified the complete change in society's attitudes towards..older people - from paternalism to a striving for dignity and independence."

Hastings had one of the first geriatric day hospitals. Again, it is easy to forget that the early day hospitals pioneered approaches to interdisciplinary rehabilitation between medical, nursing and therapy professions that are

now taken for granted. It says much that in remembering the revolution in geriatric nursing practice that occurred during his career, Bobby particularly singled out the importance of removing the restrictions to visiting times in elderly care wards.

Under Bobby Irvine's leadership, the unit in Hastings became both nationally and internationally recognised. Prof Ian Philp, now DOH National Director for Older People's Services, came from Scotland to work with Dr Irvine at an early stage in his specialist training, and two academic units in New Zealand are led by men who came to spend formative years in Hastings.

Stuart Bruce
Consultant : Hastings Hospital

Editorial



page

It is fantastic to read such warm tributes for a man of the stature of Bobby Irvine.

It serves to remind us how one person's vision and drive on behalf of older patients can be translated into ideas and systems of care that spread far and wide. I'll return to that theme.

The notion of "merit" is also elucidated further in this month's newsletter with some further light thrown on this potentially thorny subject. The Department of Health has marked our cards on imminent changes to this system next year.

Whilst working in the geriatric field, one's inclination and motivation is to find ways to advocate for one's patients. Day to day work can crowd in and leave little time to think of strategies that will enable one to improve the older person's lot, especially in the health sector.

Traditionally many advances and improvements came about through the drive, ambition and altruism of individual practitioners or their departments. They advocate their innovative practices through scientific bodies such as the British Geriatrics Society and, in theory, these are then copied and become "best practice" on a regional or national level.

However, with health service reforms come ambitious targets to be achieved on behalf of the older patient. New bodies have come into existence to drive workforce development to accomplish such targets. Workforce Development Confederations (WDC's) are with us in England to contribute to this agenda in 2003, and service plans influenced by National Service Frameworks will be written.

These are the planning opportunities that must be influenced by geriatricians on their patients' behalf. Are you up to speed locally on how such service targets will be delivered? Is your voice being heard?

A paper on WDC's is published on page 22. I hope it will prove useful.

Special Interest Groups

I would be grateful if members could remember to complete the survey form on the back of the Newsletter postage label this month. Our President Elect, Dr Playfer has seen the increasingly important role played by the Special Interest Groups (SIGs), in the Society's scientific sphere of operation. Presently, the SIGs operate relatively autonomously from the main BGS - at least from an administrative perspective, and Dr Playfer is anxious to establish the extent of members' interest in the existing SIGs as well as where gaps may exist e.g a Stroke SIG, for example?

BGS On-line Forum

In addition to this printed version of the newsletter, we have been publishing an on-line version since September. Our President, Prof Stout, is keen to promote use of the on-line newsletter, with a view, in the medium term, to saving printing and postage costs. More recently the website www.bgsnet.org.uk carries a discussion forum where members may air their views on a number of themes. The forum is passworded, so please go on line to register and to let us have your views. Among the "themes" currently available is that of the NCSC on cognitive impairment and again, the thorny issue of "merit awards". Please make your views known.

BGS Officers

The offices of **Deputy Hon Secretary** (in which capacity I am currently privileged and cursed to serve) and the **Scientific Meetings Secretary (Spring Meeting)** - currently Dr Juanita Pascual's domain - become vacant in October this year. If you have the enthusiasm and talent for organisation (see page 13), or you have a colleague who you think fits the bill (and you can persuade him/her to stand for one of the positions), the BGS would like to hear about it!

Kevin Kelleher
Deputy Editor

President's column

In this letter I discuss two matters which were debated at recent meetings of the Executive and Council. Both of these are of interest to members and I would be happy to receive your views.



Aberdeen

Before dealing with my two main themes, I want to mention the most attractive programme put together by the organisers of the Aberdeen Meeting. Aberdeen is an interesting and hospitable city and I hope to see as many as possible of you there in April.

The Name of the Society

Both the Past President and the Honorary Secretary wrote about the name of the Society in the last edition of the Newsletter and suggested that we should consider a change of name. They made the point that the word 'geriatrics' is viewed in some quarters in a rather negative way and this may be reflected in some people's attitudes to our Society. Hence the desire to look at alternative names.

It is important to remember that as recently as 1998 the name of the Society was carefully considered, and a referendum of members was held. While this produced a majority in favour of a change of name, there was no consensus on an alternative name, and it was therefore decided to continue with the present name. The Executive and Council took the view that it was not good for the Society to appear to be preoccupied with its name. It might suggest a lack of self confidence and even lead to ridicule. They did not wish to consider a change so soon again and I would suggest that at least a decade should elapse between consideration of changes of name. There are other points in favour of continuing with the present name. The name 'British Geriatrics Society' has a long and distinguished history and the Society is held in high regard. It is similar to the name of most of the

national societies worldwide. Whatever negative connotations were attached to the word 'geriatrics' seem to have reached a peak five to ten years ago and are much less prominent today. This is because our speciality has a high reputation built by the efforts of members of the Society.

The term 'geriatrics' was devised by Ignatz Leo Nascher (1863-1944), an American physician. In 1909 he created a special branch of medicine which he called 'Geriatrics', derived from two Greek words - *geras* (old age) and *iaticos* (relating to the physician). Much of the negative connotations come from misuse of the word to describe an older person as 'geriatric' or, even worse, 'a geriatric'. This is not only insulting and demeaning, but is etymologically meaningless.

Our reputation derives from our actions, not from our name. Our reputation is high in the medical world, and always has been high in the lay world. Our task is to further enhance that reputation and the esteem of the Society. For decades members of the Society have been warning the Government and the public of the implications of our ageing population. Little notice has been paid to us but the recent problems with pensions have suddenly thrust this issue into the limelight. We should take this opportunity to make it widely known that older people will need not only pensions but also high quality health and social care, something that the speciality of geriatric medicine has been endeavouring to deliver for over half a century.

The Executive also felt that, as we are a Society devoted to the problems of old age, it is particularly important that we are a modern organisation. We will be looking at our corporate image, including our publications and letterhead, and will be adopting the most modern methods of electronic communication. This is the subject of my second topic.

An eNewsletter

The Newsletter is one of our most successful and popular activities and it is widely welcomed and read by members. It is an attractive production and credit goes to successive Honorary Secretaries who act as editors, and to those in the office who produce it. It is, however, expensive. The Society

spends about £20,000 per year on the printing and postage of the Newsletter. Until recently this was covered by sponsorship. Sponsorship of all types is becoming much more difficult to obtain. This is because of the economic climate, the fact that following mergers there are fewer pharmaceutical companies, and the flow of new drugs from the pharmaceutical industry is decreasing rapidly. The cost of the Newsletter is now borne entirely by the Society. For exactly the same reasons the Society's finances are under pressure. We are in balance now but there is no room for complacency and we must make all savings that we can. Substantial savings would be made if the Newsletter were to be available only in electronic format. The process would be that members would receive an email to indicate that the Newsletter has been published and a password that would lead them to a special section of the Society's website. The Newsletter would be on the web in full colour, and of course could be downloaded and printed as members wished. An electronic Newsletter would be more up to date and could contain more pages and hence more information than the printed version. All editions of the Newsletter from March 1999 to the

current issue are on the BGS website and I encourage you to look at them. A number of societies already use such a system, including the Royal College of Physicians of Edinburgh and many government documents are now available only in electronic format. As I have mentioned the savings would be considerable and if these savings are not made, the costs will continue to have to be borne by members' subscriptions. A decision to move to an electronic Newsletter has not yet been made but Executive and Council have decided to look into this and to seek members' views. I would encourage you to let us know what you feel about this suggestion. I would urge you to visit and register on the discussion forum on www.bgsnet.org.uk to let me know your views.

Au Revoir in Aberdeen ...

I look forward to seeing as many of you as possible at Aberdeen in April. You may wish to use the opportunity to discuss one or both of these issues with me then.

Bob Stout
President

Continence Care

National Sentinel audit



Representatives from the British Geriatrics Society have been actively involved in a project of the Clinical Effectiveness and Evaluation Unit, under a grant provided by PPP

Initially headed by Dr Jonathan Potter and now by Dr Adrian Wagg, this two year project aims to set the foundations for a National Sentinel Audit of Continence care for older people. This audit will cover both urinary and faecal continence.

Workshops and Delphi exercises have already taken place and have resulted in the publication

of "Bowel Care in Older People" by the CEEU, available from RCP Publications Department, and the drafting of a pilot audit questionnaire. It is intended that the pilot will run in March 2003 in the care home, secondary and primary care environments.

As a separate piece of work in collaboration with the Health Services Research Unit of the University of Kent, the project is examining the views of older people, of their use of continence services.

The results of these separate pieces of work will be combined to form the National Audit in partnership with CHI to run from April 2004.

Adrian Wagg
Chairman : CEEU

Intermediate Care

the Aussie approach

A visitor to Australia will see interesting modern cities, efficient societal infrastructure, beautiful and varied landscapes, incredible wildlife.



Kookaburra and kangaroo are frequently seen **but a kangaroo is not just a kangaroo**; there are over 50 species including big reds, eastern greys, western greys, whipped tail wallaby, quokka and musky rat kangaroo. **Neither is Intermediate Care just Intermediate Care.**

In understanding the Australian scene, it is important to be aware of Australia's history. The early pioneers settled in separate, remote areas of a large continent, developing different political processes and virtually separate countries. The decision to form a Federation of States was made on 1st January 1901. The Centenary of the Federation of the Commonwealth took place in 2001. Australia is seen overseas as a unified country, which it is in a global and sporting context, but internally the states work with separate parliamentary systems; different political groups are in power and have different political health agendas. This is coordinated by the Commonwealth Health Minister and the State Health Ministers at the Australian Health Ministers Advisory Council (AHMAC). Certain aspects of health care delivery are Commonwealth funded while others are funded by the State's budget. In Aged Care, the Commonwealth supports "the care" of older people through nursing homes, hostels, community aged care packages, Home Aged Care Services and the Aged Care Assessment Teams/Service (ACAT - ACAS). ACAS are the gateway to accessing the services and perform Case Management function. The States provide "treatment" services to older people through hospital services including geriatric medicine. Some provide acute health care to older people on the same hospital site as mainstream secondary health services. Others have a more sub-acute approach; often the hospitals will be on separate sites. The service delivery is therefore dependent upon the style of geriatric medicine

encouraged within the State. This affects the need for Intermediate Care.

Intermediate Care in Australia has been subject to the same discussions as that in the UK, in that Intermediate, Interim, Transitional, Step-Down Care are often used synonymously but describe different components of service to complete the spectrum of health care services needed to maintain older people's health and care in the community. Thus there is confusion over nomenclature and service style.

The Spectrum

Services that have moved towards the acute end of the spectrum, need a sub-acute style of unit delivering "rehabilitation" with a multi-disciplinary team aiming to help people recover and return to their own home. With the sub-acute style of geriatric medicine, the need is for a care whilst waiting for a permanent hostel or nursing home to be found. The latter has tended to be the usual model within Queensland and is called **Interim Care**.

The AHMAC has a reference group working on the interface of aged and acute care that is currently seeking feedback on definitions of **Sub-Acute Care** and **Transition Care**.

Sub-Acute

Sub-acute care is goal orientated, individualised, inter-disciplinary care that aims to help people regain function and return them to their usual place of residence. It is available to patients of acute facilities on a short term basis, either as an inpatient or on an ambulatory basis. Sub-acute patients generally require an assessment or supervision of their care plan by a specialist medical consultant (geriatric medicine), up to 2-4 hours per day of therapy services e.g. physiotherapy, occupational therapy, access to ancillary or diagnostic services such as laboratory, radiology, pharmacy, nutrition.

Transition

Transition care comprises a lower intensity of services for people who are either awaiting placement or require more time to recuperate, no longer in need of high level nursing/consultant care/intensive therapy, but who may still benefit from low level therapy and support. Transitional care recipients are generally those discharged from an

acute facility and having been assessed by the Aged Care Assessment Service. Transition care aims to maintain physical and cognitive function with up to 2-4 hours per week of therapy. Care can be provided either in the facility or in the community and can be overseen by a General Practitioner¹.

The over-arching principle is to have the right patient in the right place at the right time at the right cost. A study of these issues is currently being undertaken by the AHMAC as a national survey of hospital geriatric services. A previous study was performed in 1992 and will allow for comparison and service planning².

Intermediate care, Aussie style, namely sub-acute and transition care, will be more like the kookaburra than the kangaroo, less variants, with the intermittent flashes of brilliance.³

A more detailed paper on intermediate care, Aussie

style, may be published to www.bgsnet.org soon.

Dr P Goldstraw
BGS Member: Australia

Acknowledgments and Disclaimer

My thanks to the Australian Society of Geriatric Medicine (ASGM) Secretariat, to colleagues in Queensland and around Australia who have provided formal and informal information. Views expressed here amount to a personal opinion and does not represent the views of the ASGM.

References

1. ASGM Newsletter December 2002
2. Gray L. Professor of Geriatric Medicine, University of Queensland, Personal Communication.
3. Simpson & Day. Field Guide to Birds of Australia. *The Blue Winged Kookaburra of Queensland, Northern Territory and Western Australia has a brilliant blue flash on the wing.*

BGS Spring Meeting

9-12 April in the Granite City (Aberdeen)

The Granite City prepares for the National BGS Scientific Meeting on 9-12 April, at the Aberdeen Exhibition and Conference Centre.

As April is mere weeks away, the final touches are being made to an outstanding programme for the forthcoming UK Scientific Spring meeting (details and on-line registration facility at: www.bgs.org.uk/meetings/meetdate.htm). The varied programme promises to encompass a wide range of topics (identified within the CPD programme) and will surely whet the appetite (literally and metaphorically!) of all those who plan to attend.

The scientific programme boasts keynote addresses by Professor Stuart Ralston on “**The Genetics of Osteoporosis**” and Professor Gordon Lowe on “**Secondary Vascular Prevention in Older People**”. In addition, Professor Sir Graeme Catto will give a “**View from the GMC**” and there is an informative session on

“Reflections on Geriatric Medicine and Government” with views from all four corners of the U.K.

There are four clinical updates in two parallel sessions (one each on Thursday and Friday) with four Special Interest Groups holding sessions on Friday morning. Free communications, poster viewing and four sponsored symposia complete the programme on the 10th and 11th.

The scientific programme is brought to a close on the Saturday morning with an excellent session by our colleagues in the Department of Rehabilitation Medicine on “**Seating, Posture and Spasticity**” followed by presentations on community aspects of geriatric medicine, which has a distinct multidisciplinary flavour. This will also be of special interest to our colleagues in general practice, nursing and allied health professions.

The social programme kicks off (or should that be “tees” off?) with a **golf tournament at Newburgh-on-Ythan Golf Club**, a traditional seaside links course, on Wednesday afternoon. A

Civic Reception, hosted in the v.uk Aberdeen Art Gallery, follows on Thursday evening. Places are limited at this function, so early booking is essential. For those with boundless energy (and good co-ordination), an invigorating **Scottish ceilidh** has been organised after the Civic Reception at a nearby hotel. The **Gala Dinner will take place at the Ardoe House Hotel**, one of Aberdeen’s finest, on Deeside. With superb cuisine and fine wines, this promises to be a most enjoyable way to spend a Friday evening.

The **Woodend Department of Medicine for the Elderly celebrates its 50th year in 2003** and we feel this exciting programme befits our “Golden Jubilee”. We would recommend early registration and hope that specialist registrars and other staff, are encouraged to support the conference. We look forward to welcoming colleagues from the United Kingdom, and beyond, to what will be an excellent meeting.

Donald Newnham

Regional specialty advisors

to the RCP London



In the November issue of the newsletter, we published guidelines set down by the College regarding regional specialty advisors (RSA) to the RCP London.

There are however, a number of specific points to be made, and some BGS internal issues to be addressed.

1. The term of office prescribed by the College for an RSA, be it Service or Training, is three years. It has been drawn to our notice that there are several regions where the incumbent has served substantially longer, with no new mandate. The regions concerned are therefore invited to go through a formal process of either appointing a new RSA or re-appointing the existing RSA, at the earliest opportunity. Where by due process an RSA is re-elected to serve a further term, a total of six years (two terms) is considered to be the maximum period anyone should hold office.

2. Whilst it is the College that invites the Society on behalf of the specialty of geriatric medicine to nominate potential advisers, the Society's regions

are free to recommend to the College that, because of the workload in the region, there should be a Service and a Training Adviser and accordingly, to nominate two RSAs (Service and Training), unless of course, this is already the case.

3. In the past the Society has left it entirely to the Regions as to how they chose their nominees. However, the time has come to provide for continuity across the country and with this in mind, Regions are asked to adhere to the procedure set out in the recommendations below.

4. Appreciating the difference between RSA Service and RSA Training: there are important nuances that have to be taken into account when appointing an RSA.

RSA Training, and RSA Service & Training - combined role. Where the RSA is solely concerned with training, or will fulfil the combined role of both service and training, the final appointment is made by the College in consultation with the regional Postgraduate Dean. It therefore behoves the Society's regional officers to discuss any candidates put forward by the membership with the PGD to ensure that the person/s concerned are suitably qualified, before proceeding to a ballot and making a nomination to

Recommended Procedure for nominating RSAs

years advertise the intention to nominate replacements for the incumbent RSAs; this can be locally or through the BGS Newsletter. The call for nominations should give members in the Region four weeks notice to submit recommendations. Recommendations can only be made with the consent of the candidate.

◆ Where there is more than one recommendation a ballot must be held to select the final person of choice. Any proposals for an RSA Training or RSA Service & Training should, as explained above, be discussed with the regional PGD, before proceeding to a ballot. The ballot may be effected by post or at a regional meeting; if the ballot is held at a regional meeting, all members of the Region must have due notice of the meeting and the intention to hold the ballot at the meeting. The ballot paper should

◆ The Regions must every three

provide for a transferable vote, i.e. where there are more than two candidates, the electors must be asked to express a first and second choice. In the event of a tie, there will be a recount based on the second choices. In the event that there is still a tie between two or more persons, the regional chairman shall have a second or casting vote.

◆ It is recommended that the members of the Region be informed of the role of the RSAs so that they can exercise their judgement in nominating or support a candidate.

◆ Where the nomination of an RSA is one requiring consultation with the PGD, and in the hopefully unlikely event that no consensus can be reached locally, the matter should be referred to the Registrar at the College, copied to the BGS office, and arrangements will be made to discuss the matter with the Registrar at a meeting of the Joint BGS/RCP Geriatrics Committee.

◆ It has to be stressed that the final appointments are made by the College.

College, i.e. it is preferable for the Society to make a nomination that has the support of the PGD. Whilst it is possible that there may be physicians who are not members of the Society who are able to fulfil the training aspects of the role, we understand that the College would feel more comfortable with an RSA who can speak with the authority of the Specialist Society, i.e. a member of the Society.

Where with RSA is solely concerned with Service, it is the College's

expressed hope (cited in their guidelines) that the RSA 'will be the same person as the Specialist

Society's representative'; if it transpired that the appointed individual was not a member of the Society, the College would expect the Society to elect its own local representative, and in this less than ideal situation, the two service representatives would need to work closely together. Anyone serving as an RCP RSA must belong to the College as a collegiate member, affiliate or Fellow.

Richard Lynham
Administrative Director

These recommendations supersede the November Newsletter in that it had initially been thought that the regional officers could select whom they considered to be the most suitable person for the nomination as an RSA, but it is now apparent that this did not meet with the wishes of many members and hence the system set out in this article should now be the norm.

BGS RETIRED MEMBERS MEETING

BGS members who have retired from active practice of geriatric medicine may be aware that there has been an annual BGS retired members meeting, arranged by one or more retired members. The meeting usually consists of a social event combined with a lecture.

At date of publication fourteen couples and six singles have booked for this year's BGS retired members meeting at the Castle Hotel, Windsor on Friday 25th and Saturday 26th April 2003.

To reserve your accommodation, telephone Reservations at **Castle Hotel, Windsor** (Tel: 0870 400 8300). Ask for and say that you are booking for the British Geriatrics Society meeting. You will need your credit card number. No deposit needed. Cancellation up to 24 hours before the meeting will not be charged.

Accommodation is based on dinner, bed and breakfast and costs:

£88.00 for a single room for one night; £176.00 for two nights.

£163 for a double room for one night; £326 for two nights.

Rooms can be occupied from 2:00 p.m. on the day of arrival. The full programme and list of events will be sent out in March. The programme will include:

Friday 26th April at 17:15: Evensong at St George's chapel (gather outside the castle gates), followed by Chris Foote on "The Tale of a Peddling Physician - Care in the Chilterns" and then dinner together in Sandringham Suite.

Saturday 27th April from 09:00-11:00: John Hebbert on "Belle-Isle en-Mer and John Hunter's service there"; Wilfred Fine on "Leriche, my wife and the rabbit's foot"; and Donald Portsmouth on "BESO in Zambia: commissioning a new 20 bed hospital in Lusaka"

Saturday afternoon: Visit to Eton College – time to be arranged.

Saturday evening: 18.30 p.m. Nick Coni on "Medicine in the Spanish Civil War". Followed by dinner.

Please register your interest with Professor Peter Millard at 12 Cornwall Road, Cheam, Sutton SM2 6DR. Tel: 020 8642 0040. Email: peter.millard@tinyworld.co.uk

In memoriam

Dr Glenn Foubister 1935 - 2002

It is with regret that the Society must report the passing of Dr Glenn Foubister, a man respected and greatly liked by those who worked closely with him. We were all saddened that his evident enjoyment of his retirement and increased opportunities for playing golf were cut short so soon after his retirement.

- Dr M W Pearson

Merit awards

the road to hell is paved with good intentions

Members have asked that we publish again, the procedure followed by the BGS in making recommendations to ACDA; this could of course be changed in the future.

The comments apply solely to England and Wales; similar systems are in place for Northern Ireland and Scotland.

The key point that has to borne in mind is that the Society is discouraged from putting up more than **twelve** names, which means that with the best will on earth the BGS cannot do justice to all the deserving members that it would like to support. There are 14 regions of the Society in England alone, plus Wales. It is quite conceivable that each region could put up three names deserving of recognition, and it is a heartbreaking process to have to pare all the nominations down to a short list of just twelve final names for England and Wales in total.

The Society goes about the process:

- ◆ By inviting the Father Figures in each region in the autumn of each year to put forward their recommendation in respect of members in their region.
- ◆ This list is then reviewed and pared down by a committee, comprising the President, the immediate Past President, the President Elect and the chairman of the Joint BGS/RCP Committee.
- ◆ There follows a consultation with the Royal College of Physicians (London) who have a similar system of inviting recommendations from across the two countries.
- ◆ The Society may then amend its original list to ensure that in respect of geriatric medicine, the same recommendations are made to ACDA by both the RCP (London) and the Society; however the Society's list will always include more geriatricians than can be accommodated by the RCP, who are constrained in respect of the total number of names that they can put forward covering all specialties.
- ◆ By this stage, early November, one will also

know who has been successful in the previous round of awards, so that names carried forward on the BGS list from the previous year can be removed and new names added to within the 12 allowed.

◆ Having reached a final list, the BGS office will then proceed to get updated CVs and citations in the prescribed ACDA format from the individual doctors and from the Father Figures respectively; the whole lot is then sent to ACDA under a covering letter in time for the deadline of 31 January.

The BGS and RCP are not the only routes to a successful award; recommendations have in the past been made by the regional health authorities and are now being made by the individual hospital trusts direct to ACDA; these have in the past, and may again in the future, succeed where the BGS and the RCP have failed.

The Society has been asked whether it would provide additional citations to support recommendations from individual trusts. After careful consideration, it has been decided that this would not be appropriate as it blurs the main recommendation of the Society agreed with the RCP, and risks to devalue the citations provided by the Society.

As indicated above, the BGS is deeply conscious of the fact that any system that involves an elimination process cannot be perfect, but the BGS is not responsible for the fact that there is not the funding to go round to support all the merit awards one would like to see made. The officers concerned with administering the agonising process go to great lengths to be as fair as possible in narrowing down the number of candidates to the shortlist of 12.

Richard Lynham
Administrative Director

Since this article was written, there has been an extensive exchange with the English members of the BGS Council and it seems likely that procedures will be changed to provide more transparency in the initial stages of the process, effected in the Regions.

BGS officers

nominations invited



DEPUTY HONORARY SECRETARY

- Deadline for nominations: Friday, 2 May 2003

to succession as Honorary Secretary.

- ◆ Commission articles and edit the BGS newsletter (6 issues a year).
- ◆ Liaison with external organisations; Department of Health, Royal Colleges, other specialist medical societies, voluntary organisations and allied professional groups.
- ◆ Liaison with the BGS Secretariat to help with enquiries from the press and public.
- ◆ With the other senior officers the Hon Secretary will have a key role in strategic planning. Both the Hon Secretary and Hon Deputy Secretary can expect to be involved in key projects during their term of office.
- ◆ The BGS Office reports to the Hon Secretary.

Term of office

Subject to endorsement by the membership at the AGM in

Duties

Below is an outline of some of the duties of the **Honorary Secretary**. The **Honorary Deputy Secretary** will be involved in some of these activities during the two-year period prior

October, the **Honorary Deputy Secretary** will serve for 2 years followed by another 2 years as **Honorary Secretary**.

Committees

- ◆ Both the Hon Secretary and the Hon Deputy Secretary attend the UK Management Committee (6 meetings a year).
- ◆ Other standing committees including Finance, Policy and Training are divided between the two positions (4 meetings a year for each committee).
- ◆ The Hon Secretary is also a member of the RCP & BGS Joint Geriatrics Committee.

All meetings take place in London.

Appointment process

Nominations should consist of a statement (no more than 150 words) setting out your suitability for the position. Please email this to Louise-Wykes@bgs.org.uk by Friday 2 May 2003.

Appointment will be by a postal ballot of the UK membership.

SPRING MEETINGS SECRETARY

- Deadline for nominations: Friday, 6 June 2003

Meetings Secretary is responsible for the educational content, social and financial aspects of each meeting. The term of office is 3 years from October 2003.

Duties

- ◆ Provide advice to the local organising committee about the scientific programme and organisational aspects of the meeting; this is likely to involve attending some or all of the local organising committee meetings and participating in site visits to the venue.
- ◆ Liaise with the CME Director and the Autumn Meetings Secretary to ensure continuity in the Society's rolling CME programme.
- ◆ Co-ordinate the involvement of SIGs and Sections.
- ◆ Liaise with the Conference Organisers (Hampton Medical), in particular identifying opportunities for

The BGS Spring Meeting is a three-day event usually held in mid April each year. Venues are currently booked for 2004 in Derry/Londonderry, 2005 in Birmingham and 2006 in Newcastle. The Spring

sponsorship, and being available throughout the meeting to provide advice and help where necessary.

- ◆ Assist with the adjudication of abstracts for the meeting.

Committees

- ◆ Academic & Research Committee (4 meetings a year in London)
- ◆ UK Management Committee (6 meetings a year in London). As a member of the UK Management Committee the post holder will be a director of the Society, and is expected to participate in the wider aspects of running the Society.
- ◆ Abstracts Adjudication Panel for each Spring Meeting (one meeting in January in London, usually on the morning before the Academic & Research Committee).

Nomination process

Nominations should consist of a brief CV and a supporting citation from the relevant regional or national branch, sent to Louise-Wykes@bgs.org.uk by Friday 6 June 2003.

The UKMC will vote on the nominations received at its meeting on 17 July 2003.

RESEARCH FELLOWSHIP**NEUROLOGICAL IMPAIRMENT IN OLDER PEOPLE**

Research into Ageing is delighted to announce the availability of a research fellowship in neurological impairment in older people fully sponsored by the Barnwood House Trust. Outline applications are invited from individuals with a medical qualification, from a profession allied to medicine or from post doctoral researchers ready to embark on an independent research career. Funding is available for three years and the total cost should not exceed £150,000 or £175,000 for applicants with a medical qualification. The deadline for outline applications is **30 May 2003**; the decision will be made end of Nov 2003 for start any time in the following calendar year.

OTHER FUNDING OPPORTUNITIES

Research into Ageing supports research into the biology of ageing and diseases and disabilities associated with older people.

Research into Ageing**Help the Aged**

Examples of topics we support are cellular ageing processes, dementia, vision, hearing, falls, mobility, osteoporosis, stroke, incontinence, wound-healing, depression and diet. We do not normally fund cancer research. Applicants may be any nationality, but the project must be carried out in the UK. In 2003 Research into Ageing will fund in excess of £3 million worth of bio-medical research and we anticipate further growth in 2004. The following awards are currently available:

PhD studentship

Incontinence research funding scheme

Research fellowships

Programme grants

HOW TO APPLY

Please find further information about the research funded by Research into Ageing and outline application forms for the Fellowship in Neurological Impairment and for the other funding schemes available to download at our website www.ageing.org Telephone enquiries to Ian Jarrold, Project Administration Officer on 020 7843 1572.

**Research into Ageing
is a special trust within
Help the Aged**

Research into Ageing, 207-221
Pentonville Road, London N1 9UZ

HEALTH PROFESSIONALS INTERNATIONAL

Health Professionals International is a retained search company currently on assignment for some District Health Boards in **New Zealand**, **searching for Physicians** in the following areas:

**Geriatric Medicine
Rehabilitation**

The ideal candidate will have the training and qualifications required to be recognised by the NZ Medical Council and practicing currently as a geriatrician or rehabilitation physician in the United Kingdom.

Full relocation and excellent salary package provided for a minimum two-year commitment. Permanent relocation an option if desired.

This is an excellent opportunity to develop professionally, be involved in the strategic planning of services within this region and experience living in New Zealand.

For further information, please contact:

Darryl Cooksley

Phone: +1 917-577-4877

or email: darryl@nyheadhunter.com

**SUN, SEA, SAND AND
SOME GREAT PUBS**

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at mutual convenience.

For further information, please
contact either Dr S Barber
(Email:
doctorbarber@hotmail.com) or
Evelyn Cervan (Tel: 00 350 79700
or Email: e.cervan@gha.gov.gi)

DELAYED DISCHARGE

Tackling Delayed Discharge and Promoting Independence

2 April 2003

Savoy Place, London WC2

Contact: Neil Stewart Associates, P O Box 39976, 2nd Floor, 1 Benjamin St, London EC1M 5YT. Tel: 020 7324 4330. Email: info@neilstewartassociates.co.uk. Online registration: www.neilstewartassociates.com/sh 128

JOY OF AGEING

AC Comfort Lecture

22 April 2003

Royal Society of Medicine, London

Contact: Anke Muller, Academic Dept, Royal Society of Medicine, 1 Wimpole St, London W1G 0AE. Tel: 020 7290 3941. Email: geriatrics@rsm.ac.uk. Online registration: www.rsm.ac.uk/geriatrics

VIENNA CONGRESS

6th Vienna International Congress in Geriatrics

22-24 May 2003

Vienna, Austria

Contact: Ilse Howanietz, Ludwig Boltzmann Institute for Interdisciplinary Rehabilitation in Geriatrics, Apollogasse 19, A-1070 Vienna, Austria. Tel: 00 41 1 52 103 5770. Email: ilse.howanietz@sop.magwien.gt.at

GETTING STARTED WITH RESEARCH

A free conference for SpRs in geriatric medicine

30 May 2003

Southmead Centre for Medical Education, Bristol BS10 5NB

Contact: Dr Susanne Sorenson, Research into Ageing. Email: Ssorenson@ageing.org

SCOTLAND - RCP(E) SYMPOSIUM ON GERIATRIC MEDICINE

28 May 2002

Sessions to include: Improving outcomes in heart disease, bacteriological challenges, nutrition

Queen Mother Conference Centre, Edinburgh

Contact: Ms Eileen Strawn, Education & Standards Dept, RCP Edinburgh, 9 Queen St, Edinburgh EH2 1JQ. Tel: 0131 225 7324. Website: www.rcpe.ac.uk Email: e.strawn@rcpe.ac.uk

PSYCHOGERIATRICS

Affective, Behaviour and Cognitive Disorders in the Elderly

3rd Bologna International Meeting

10-21 June 2003

Bologna, Italy

Contact: G&G International Congress Sri, Via G, Squarcina, 300143 Rome, Italy. Tel: + 39 06 5043441. Email: congressi@gegcongressi.com/abc de

MORE MEETINGS, JOBS & ON-LINE DISCUSSION

Visit www.bgsnet.org.uk

for details of

- ◆ conferences
- ◆ jobs in sunny places

Download full versions of some of the articles featured in this newsletter and make your views known in the on-line discussion forum

PARKINSON'S DISEASE

BGS Parkinsons Disease Section Conference

15 July 2003

RCP (London)

Examines the four phases of management in PD - diagnosis, maintenance, complex and palliative.

Contact: Sally Bradley, Medical Education Partnership Ltd., 53 Hargrave Road, London N19 5SH. Tel: 020 7561 5400 Email: info@mepltd.co.uk

BGS SIG IN GASTROENTEROLOGY & CLINICAL NUTRITION

Annual meeting

13 June 2003

**Marriott St Pierre Hotel & Country Club
Chepstow, South Wales**

Includes session on 'The Effects of NSAIDs on the Gut', a guest lecture and a free paper session presented by members of the group.

CME approval applied for.

Cost £50 - includes evening buffet and overnight accommodation on the Thursday, with meals provided on Friday.

Contact: Send cheque for £50 drawn to "British Geriatrics Society" to: Dr Nadim Y Haboubi, Nevill Hall Hospital, Brecon Road, Abergavenny NP7 7EG. A programme will be sent to you. Registration is limited to 30 places allocated on a first come first served basis.

Between two stools

psychogeriatrics

A report on psychiatric services for older people in general hospitals makes recommendations to improve the care of older people.

Those interested in psychiatric illness in older people need look no further than the wards of a general hospital to find high levels of psychiatric morbidity. Dementia, delirium and depression are particularly common, and in some general hospital wards, over 70% of patients have a diagnosable psychiatric illness.

What are psychiatrists doing about this? Old age psychiatry, like many parts of the NHS, has become increasingly community focused, possibly to the detriment of general hospital inpatients. We set out to determine what old age psychiatrists think about their services to older people in general hospitals through a postal survey.

We found that psychiatrists are kept busy by general hospitals, with a quarter of all referrals to old age psychiatry from this source and referral rates rising. Most services operate a traditional, sector-based service model, often based away from the general hospital site, with assessments provided almost exclusively by doctors on a consultation basis, relying on general hospital staff to detect and refer appropriately. However, some services are provided on a more proactive basis, with general hospital based liaison psychiatry staff (including

psychiatrists, psychiatric nurses, occupational therapists and others) developing educational programmes for general hospital colleagues as well as assessing and managing referrals. Shared care wards, jointly operated by geriatricians and psychiatrists to meet the needs of patients requiring both physical and psychiatric care, were also described.

Are psychiatrists happy with their current services?

It seems not; over two thirds described their service to general hospitals as being poor or needing improvement. Although many wanted to adopt general hospital based liaison psychiatry models, important barriers to service development included a lack of interest from mental health trusts managers, and the separate managerial arrangements of acute and mental health trusts.

What benefits can liaison psychiatry services offer?

We found that those psychiatrists operating a liaison model were able to respond more quickly to referrals, meaning less time spent waiting for assessments.

This may be explained by a perception that community referrals should be assessed more urgently, as patients are in more danger than they would be on general hospital wards, although the vision of a junior hospital doctor bearing down on a delirious patient with a large syringe of haloperidol casts doubt on this.

There are other potential benefits from liaison psychiatry.

One American study has shown that the introduction of a liaison psychiatry service reduced the overall length of stay by two days. If this could be reproduced in the NHS the potential cost savings are large. Most importantly, the overall quality of patient care should improve as the



general hospital skills mix more accurately reflects the needs of patients.

Where do we go from here?

There is pressure for change from psychiatrists, who feel they could do better but are frustrated in their attempts to improve matters. Our report makes a range of recommendations across policy and planning, service models and care pathways, training, and research and development, and we need to build partnerships with clinical and managerial colleagues to implement these recommendations.

Interested readers can download a copy of our report from the Internet, and anyone wanting to hear more can attend the second annual conference on Liaison Psychiatry for Older People in Leeds on 12th and 13th June 2003. At our first conference

last year, delegates asked where the geriatricians and managers were, so come along and bring a colleague!

The report – “Between Two Stools: Psychiatric services for older people in general hospitals” can be downloaded from:
www.leeds.ac.uk/medicine/divisions/psychiatry/research/oldliaison_br.htm

Further information about “Liaison Psychiatry for Older People: Directions and Developments 2003”, including a downloadable registration form, can be found at:

www.leedsmentalhealth.nhs.uk/andrewsims/

John Holmes
Senior Lecturer in Liaison Psychiatry of Old Age
University of Leeds



PARKINSON'S DISEASE ACADEMY - Master class series

The PD Academy is a series of Master Classes in the management of Parkinson's disease.

It was developed when the Parkinson's Disease Section of the BGS, responded to a need for a course for senior medical staff who wish to receive further education and training in Parkinson's disease and its management. We believe this to be an innovative approach, and it is proving very popular. In addition to clinical skills enhancement, it offers mentorship and support, and aims to promote best practice and fulfil the clinical governance agenda in this disease area.

The aims of the programme are to: -

- ◆ enable geriatricians and general practitioners to further develop effective clinical management skills and to provide access to opportunities for personal development and learning in the management of Parkinson's Disease;
- ◆ enable participants to develop skills in the application of a disease management model in Parkinson's Disease;
- ◆ provide opportunities for participants to develop clinical skills across organisational boundaries;
- ◆ enable participants to critically evaluate the relationship between clinical management, the National Service Framework (NSF) for Older People and the forthcoming NSF for long term medical conditions and neurology (scheduled 2004);
- ◆ enable participants to relate theory in Parkinson's

- management to practice as leaders of service development and delivery in their own local areas; and
- ◆ to understand and fulfil the clinical governance agenda in Parkinson's disease

The first course was held in Cornwall in September 2002, and concluded in London in January 2003. The second commenced in February at the Royal College of Physicians (London) and will conclude in Grantham in June 2003 (11th & 12th). A third will take place in Cornwall in September 2003 and will conclude in London in January 2004. The course is run in two modules, Module 1 in September 2003 will look at initial diagnosis and maintenance issues in Parkinson's Disease. Module 2 in January 2004 will take participants onto Complex management of Parkinson's Disease and will also focus on palliative care issues.

The faculty is comprised of experienced geriatricians, neurologists and clinicians from other relevant disciplines. Between modules participants will be mentored and undertake further learning through experiential visits with their mentor and through regional master class workshops. We are grateful for the assistance of Pharmacia through the provision of an unrestricted educational grant to establish this project.

Email Doug MacMahon : dgmahon@hotmail.com

National Care Standards Commission

on incidental cognitive impairment

Some members are concerned that the designation of some nursing homes as specialist EMI homes limits the choice available for older people looking for nursing home placement, even if their cognitive decline is incidental to their current frailty.

There is some anecdotal evidence that people whose physical health needs far outweigh their mental health needs are being directed to care in EMI specialist homes when mention is made of cognitive failure or dementia, as part of the information sharing with the home or Social Services; often the reason cited by care managers or nursing home managers is that non-specialist homes are not allowed by the new National Care Standards Commission (NCSC) to care for people with a diagnosis of dementia (even when that is not the main management issue).

In order to address this concern, the Policy Committee sought clarification from the NCSC. The following is the content of that body's reply, written by Heather Wing, Director of Adult Services on 2nd October 2002:



"Firstly, can I reassure you that the NCSC has no policy which requires persons suffering from dementia to be 'streamed' as you put it, into specialist dementia accommodation. Such a policy would fall outside the NCSC's remit.

Decisions about where service users are placed in care homes are taken by persons outside of the home e.g. families, funding authorities, and wherever possible, with the active involvement of the service user. The NCSC has no such involvement in this process.

However, all registered persons must be cognisant of the relevant legislation which

governs the day to day running of care homes, as well as the national minimum standards relating to such services. The legislation and national minimum standards are both produced by government, and are binding on all registered persons and the National Care Standards Commission.

The legislation makes only one reference to dementia sufferers and this is set out in the NCSC (Registration) Regulations 2001, Schedule 7 paragraph 6(c), where dementia is identified as a specific category which must be applied where this is relevant. Thus, if an applicant for registration specifies that they intend to offer care to people with dementia, assessment of the service to be provided, then the service will be registered as such and the category of dementia will be shown on the registration certificate.

There is no requirement for people with dementia to be cared for in specialist dementia accommodation, but if the provider decides that the individual's needs can be best met in such an environment, then the NCSC has no power to either prevent this or require this.

Additional impetus for decisions to cater for such people may be drawn from the National Minimum Standards – Care Homes for Older People, which states as follows:

Standard 4 – Outcome

Service users and their representatives know that the home they enter will meet their needs

- 4.1 The registered person is able to demonstrate the home's capacity to meet the assessed needs (including specialist needs) of individuals admitted to the home
- 4.2 All specialised services offered (e.g. services for people with dementia or other cognitive impairments, sensory impairment, physical disabilities, learning disabilities, intermediate or respite care) are demonstrably based on

current good practice and reflect specialist and clinical guidance

Care Standards 7 – 11

In the introduction to the **Health and Professional** the document states that:

“the proprietor/manager and relevant professional staff within the home should be party to that full assessment (carried out by others) and only accept a new resident if they feel that the home can adequately meet the needs of the prospective resident as determined through that assessment”

Standard 11.9

states that:

“the changing needs of service users with deteriorating conditions or dementia – for personal support or technical aids – are reviewed and met swiftly to ensure the individual retains maximum control”

Standards 27-30

In the introduction to **Staffing Standards 27-30** the document states:

“Residents with dementia also require care from appropriately skilled staff – and so on. In determining appropriate staffing establishments in all care homes and nursing care homes in particular, the regulatory requirement that staffing levels and skills mix are adequate to meet the assessed and recorded needs of the residents at all times in the particular home in question must be met”

Standards 19-26

In the introduction to **Standards 19 – 26 Environment** the document states:

“People with dementia have particular needs for the layout of communal space and associated signage which aid their remaining capacity. Other older people however could find some of these features patronising”

It is perhaps in view of the above references to

the National Minimum Standards, that some registered person have decided not to operate separate facilities for persons suffering from dementia, although I am not aware that the Commission has any evidence to support this at this time.

You state in your letter that there seems to be a view that this specialist accommodation has come about because of some specific NCSC policy, and I trust that the above assists you to understand our position. However, it would be helpful to have further information from you as to who holds the ‘view’ you refer to, so that we might have a dialogue with these person to clarify our position.” - Letter ends



Thus it seems that there is no requirement from the Commission to stream people into diagnostic groups. Rather there is a perfectly appropriate expectation that older people should only move into a home which is able to address their needs adequately.

Care homes will therefore need to demonstrate to the NCSC during inspections, that they have the skills, expertise and time to care appropriately for any individual.

It is important to recognise that because of ignorance or fear, many homes may quote the NCSC excuse as an attempt to refuse admission of a resident. It is still up to the home to decide whom they accept as a resident, so whilst this explanation from the NCSC is helpful, it may not result in any practical local changes.

The Policy Committee would be pleased to hear of members’ experiences regarding this issue or any other apparent difficulty to do with the care standards commission. Dialogue with the NCSC is commencing and it would be nice to have examples to consider.

Please contact Louise Wykes at the BGS office, email: Louise-Wykes@bgs.org.uk if anything in your experience would contribute to this dialogue.

Gill Turner
Policy Committee

Trainees' Column



As most of you know, the new curriculum for geriatric medicine was launched by the JCHMT in December 2002.

Much of the new curriculum is similar to the old but the learning objectives of our training are now clearly specified, as is the knowledge and skills required for achieving these objectives. The next step is to establish methods for the assessment of knowledge and competence and these are currently being explored and piloted by the JCHMT in a number of different specialties.

European Working Time Directive

As all of you know, the impact of the **European Working Time Directive** is resulting in changes to our working patterns and the introduction of shifts for many of us. Although we have received some informal feedback on this, the Training Committee is currently working on a questionnaire to try to obtain more formal feedback from trainees on the impact of shifts on training.

Stroke Medicine

Stroke Medicine is now a recognised sub-specialty. The British Association of Stroke Physicians (BASP) has recently formed a new Trainees Group which met for the first time at BASP's annual conference last month. The Chair for this group is Jo Kwan (jk@1to1.org) and both Jo and I are keen to improve links between BASP and the BGS at Trainees level. If you are a geriatrics trainee and are interested in stroke medicine, please do contact Jo or myself via email for further information.



Cath Church

Constitution

With the help of Richard Lynham, we have altered the wording of the **BGS Trainees Group Constitution**, essentially to allow a little more flexibility in the structure of the Trainees' Committee itself and in our representation on other BGS committees. We hope that you as

Trainees will approve this so that it can be in place in October 2003 when we elect a new Trainees' Committee.

Aberdeen

Our next Trainees' meeting will be held during the **BGS Spring Meeting in Aberdeen**. I hope that many of you will be there to discuss the above issues and any others that arise! I have invited Jo Kwan along to this meeting to discuss issues relating to stroke medicine, so

do bring your questions along! The **Research Surgeries** will take place once again during the Spring meeting. These surgeries have been very successful to date and provide you with the opportunity to discuss research issues. So again, I would encourage you to come along with your questions.

And finally, please do keep in contact with your BGS regional representatives who often feed back to me, and with whom I am in contact regularly with updates from my trips to London. And if you haven't done so already, please visit the Trainees' website (bgstraining.org.uk) where you'll find the names and email addresses of the representatives and Trainees' committee. See you in Aberdeen!

Cath Church

Chair, Trainees Group

Cath Church (c.j.church@newcastle.ac.uk)

A career in geriatric medicine?

providing information to medical students



We have been working on updating the BGS careers page on the BGS website (our work is almost finished and will be on the website very soon).

As part of this work, we designed a simple questionnaire which we circulated to medical students. Our aim was to find out a little more about where students would go in order to get advice on their future careers. We administered the questionnaire to 45 2nd year (Newcastle) and 23 4th year (Liverpool) medical students at hospital based careers fairs.

The results of the survey (summarised on this page) suggested that both a brochure and a website would be useful, but that those organising careers fairs would need ready access to a brochure. It would be useful if such a facility could be available on the website. Also, we need to keep medical schools informed, and link to the BMA careers website, as well as the RCP website.

It would be helpful if you could feed your comments to Cath (c.j.church@newcastle.ac.uk). The more we hear from you, the more useful we can make the website.

Cath Church and Chris Turnbull

Question: 'If you were looking for information on a specialist career, would you look...'

At a careers fair	Yes – 56	No – 12
By contacting a specialist society	Yes – 14	No – 54
By contacting a Royal College by phone	Yes – 18	No – 50
By contacting the BMA by phone	Yes – 16	No – 52
By speaking to a friend	Yes – 60	No – 8
By speaking to a tutor/supervisor	Yes – 66	No – 2
By use of a website	Yes – 62	No – 6

Question: If you use the Internet, which website/s would you use to find information on a specialist career?

Unsure	- 35	Hospital/NHS	- 4
BMA	- 13	University	- 2
Royal College	- 4	GMC	- 1
Specialist society	- 7	Deanery	- 1
DoctorsNet	- 1		

Question: Would you like to receive a brochure...?

Yes – 62 No – 6

What sort of info would you like a brochure/website to tell you?

Job availability/competitiveness/prospects	- 25
Salary	- 22
Training structure	- 25
Job hours	- 20
Training length	- 15
Exams/Qualifications	- 17
Best hospital/place to work in	- 11
Application info/how to get into the specialty	- 19
Part-time opportunities	- 9
Opportunities for women in the specialty	- 5
Opportunities for research	- 2
Adv/Disadvantages of the specialty	- 1
Type of character suited to the job	- 1

Question: Any other suggestions regarding sources of careers information for undergraduates?

Don't know	- 21
Med school lectures/seminars	- 20
Library/books	- 5
Named contacts/hospitals	- 4
Brochure	- 3
Med school website	- 2
Other websites	- 3
Student/Careers BMJ	- 4
Career choice computer programme	- 0
Overseas Doctors information	- 0
Meet junior doctors	- 1

Workforce Development

Confederations - its influence in England

In March 1999, the House of Commons Health Select Committee recommended that there should be a major review of Workforce planning in the National Health Service.

The Government accepted this view and set out a number of key principles which should govern the review.

1. The NHS and the NHS Executive must be clear about service needs and the skills and staff required to deliver those services efficiently and effectively.
2. Thinking about services, workforce and resources should be done together to ensure plans and developments are consistent and co-ordinated.
3. There should be an appropriate mix between central (top down) and local (bottom-up) planning.
4. Planning should cover the whole health care workforce looking across sectors: primary, secondary and tertiary, employers: public, private and voluntary and staff groups: nurses, doctors and dentists and other professionals and other staff, and should take account of revolving roles.
5. Workforce planning arrangements should reflect clear and agreed responsibilities and accountabilities with effective performance management systems.

The outcome resulted in the establishment of 27 (now 24) Workforce Development Confederations in England.

The relationships of Workforce Development Confederations (WDCs) to existing and emerging bodies e.g. primary care trusts (PCTs) and Strategic Health Authorities (StHAs) is complex and a report can be reviewed at www.wdc.nhs.uk

The Executive of the British Geriatrics Society has received a paper on the 21st March 2002 from the BGS Workforce Committee analysing the current workforce issue for geriatrics in the UK in the light of previous publications and with added commentary.

However, the essence of this article is to point out to working geriatricians, members of the BGS, how best to benchmark current workforce issues in the specialty and influence the decision making process which plans for future upward pressures in health and social care in relation to older people.

Targets

With this in mind national targets for older people have been set which are informed by the National Service Framework document (NSF) for older people.

Examples of such targets are as follows:

1. Improve the quality of life and independence of older people so that they can live at home wherever possible, by increasing by March 2006 the number of those supported intensively to live at home to 30% of the total being supported by social services at home or in residential care.
2. By December 2004, all assessments of older people will be given within 48 hours of first contact with social services and all assessments will be completed within 4 weeks, and 70% within 2 weeks.
3. By December 2004, following an assessment, all social services for older people should be provided within 4 weeks, and 70% of services within 2 weeks.
4. By December 2004, all community equipment for older people (aids and minor adaptations) provided by Social Services will be delivered within 7 working days.
5. Each year there will be less than 1% growth in emergency hospital admissions and no growth

- in re-admissions.
6. 80% of people with diabetes will be offered screening for early detection of diabetic retinopathy in a systematic programme which meets national quality standards by 2006.
 7. Intermediate care capacity expanded to meet the NHS Plan targets of an increase in the number of intermediate care beds by 5000 and the number of people benefiting from intermediate care by 220,000, in 2004 compared to 2000.
 8. Service capacity increased in other key services which support people at home so that in 2006: 30,000 more people a year receive care packages involving 5 hours or more a week of home care; 500,000 more pieces of community equipment are provided; there are 6,900 more extra care housing places - to contribute to an increase of 6,000 and the number of people in care homes supported by councils over the 3 years to 2006. By 2006 councils increase their intermediate care places to benefit an extra 70,000 people a year.
 9. An additional 130,000 carers a year receive services in 2006, using the increased investment in the existing carers special grant.
 10. As a result of investment in extra capacity in the introduction of reimbursement of the NHS by councils, delayed transfers of care reduce to a minimal level by 2006 and by April 2004 all general hospitals caring for people with stroke to have a specialised stroke service. By April 2005, an integrated fall service should be established across all local health and social care systems.

Current mathematical modelling of trends is arrived at centrally and can be based on historical trends which may be imperfectly understood.

However, once arrived at they are handled on a sectoral basis now that Strategic Health Authorities (StHAs) are almost completely coterminous with WDCs nationally.

Local Development Plan

Each "player" be it Trust, secondary or primary, is obliged to detail their workforce projections into a Local Development Plan ("LDP") which outlines the workforce, doctors, nurses and professionals allied to medicine etc. which will be required to deliver on national targets as set. These plans include the pressures placed by current and future demography.

The new system has been designed by a project board involving representations from PCTs, Trusts, Workforce Development Confederations and Strategic Health Authorities with input from local Government. It is intended to be a radical departure from an established practice, which was widely believed to be unsatisfactory.

For the new system to work better, however, it will need more than careful design - they will also need practice and behaviour to change. The period in which plans are developed is a critical test of the new system. A fundamental change in relationship between PCTs and trusts, strategic health authorities and Department of Health is needed.

The new planning system is based on a single 3-year "local delivery plan" (LDP) which covers NHS and joint NHS/social care priorities. This change reinforces previous guidance simplifying the planning system for social care.

Local delivery plans will need to be developed by primary care trusts (PCTs), and strategic health authorities (StHAs), and for trusts in critical areas such as "access". Work on "access" is almost complete.

Roles and responsibilities

The following sections sets out the high level roles and responsibilities for organisations under the new planning framework.

Department of Health

- ◆ Set priorities, targets and planning framework
- ◆ Allocate capital and revenue funding
- ◆ Provide developmental support to StHAs
- ◆ Sign-off StHA local delivery plans

Strategic Health Authorities

- ◆ Establish and oversee an effective planning process, involving all key stakeholders, local government and other agencies
- ◆ Ensure that overall plans will meet nationally set targets, including overall financial balance within the StHA
- ◆ Ensure coherence between and adding value to local plans
- ◆ Manage StHA-wide and supra-StHA issues
- ◆ Ensure SLAs/contracts are consistent with local delivery plans, and are signed-off by March 31st
- ◆ Ensure that planning takes account of

anticipated change such as the new financial flows system or new NSFs

- ◆ Sign-off PCT local delivery plans, and trust plans for critical access targets

PCTs

- ◆ Lead production of integrated whole systems local delivery plans
- ◆ Represent the NHS in broader local planning arrangements and partnerships with key local stakeholders
- ◆ Ensure effective stakeholder involvement in planning processes – as a minimum PCTs' local delivery plans should:
 - be signed-off by the PEC and Lay Board
 - demonstrate that clinicians and front line staff have been engaged in the development of plans and support proposals
 - demonstrate that provider organisations have been engaged in the development process and are supportive of planning proposals
 - demonstrate the contribution of local government and other key non-NHS partners
 - involve local communities and the voluntary sector in the development of plans
- ◆ Develop credible profile trajectories for delivery of targets
- ◆ Ensure flexible arrangements to handle anticipated changes such as the new financial flows system or new NSFs
- ◆ Provide NHS Trusts and social service partners with open book access to information
- ◆ Negotiate provider SLAs/contracts, ensuring that agreements are in place to underpin plans by March 31st (PCTs and Trusts will be held jointly accountable by StHAs for the delivery of robust plans)
- ◆ Resolve commissioner/provider disputes at a local level, and jointly with trusts alert StHAs at the earliest time where dispute cannot be resolved.

NHS trusts

- ◆ Provide PCTs with open book access to information as part of the planning process
- ◆ Actively support PCTs in developing plans, so

that they represent provider as well as commissioner intentions and actions

- ◆ Produce trust plans for relevant targets (access, workforce)
- ◆ Ensure that provider SLAs/contracts are agreed and in place to underpin local delivery plans by March 31st.
- ◆ Resolve commissioner/provider disputes at a local level, and with the PCT(s) alert StHAs at the earliest time where disputes cannot be resolved.

Social Care

- ◆ Lead production of local delivery plan section for relevant priority area(s)
- ◆ Provide PCTs with open book access to information for relevant priorities
- ◆ Actively support PCTs in developing plans for the delivery of robust local delivery plans
- ◆ Ensure appropriate social care input to allow provider SLAs/contracts to be agreed
- ◆ Resolve disputes at a local level, and with the PCT(s), alert StHAs at the earliest time where dispute cannot be resolved.

Councils with social services responsibilities and PCTs will need to jointly agree their contributions to achieving targets. Local delivery plans must record the contributions of both the PCT and council. Local agreements will need to be consistent with Best Value requirements for councils.

To date the emphasis has been on capacity around "access" issues i.e. waiting times, transit times and A&E. But local delivery plans will need to be done for older people, amongst others, by the end of March 2003.

Local delivery plans will need a standard format to facilitate aggregation at StHA and national level. A standard national template has been designed, consisting of two main sections. The first section is a strategic executive summary. A national format for this section of LDPs will not be prescribed, however, as a minimum the management summary must:

- ◆ Summarise short, medium and long term service development plans and priorities,
- ◆ Summarise capital and revenue implications for those plans

- ◆ Demonstrate affordability of proposals
- ◆ Summarise how key partner organisations, front line staff and stakeholders have been engaged in the process and how supportive they are of service proposals
- ◆ Consider the strategic context both nationally and locally, lining to the NHS Plan, NSFs and partnership arrangements.
- ◆ Summarise the level and cost of service provided currently and how this will change as a result of the plans
- ◆ Provide evidence to support the use of local capacity assumptions, where these differ to national assumptions
- ◆ Describe local arrangements for monitoring against trajectories, setting out thresholds for management action
- ◆ Indicate major risks to delivery and risk management arrangements
- ◆ Set out the plans for implementing the new system of financial flows.

Once numbers required in various professional groupings have been decided upon, the Workforce Development Confederations are obliged to commission the relevant education and training with whichever body is relevant, for example, higher education institutions, deaneries, etc.

An example, pertinent here, would be organising increased amounts of national training numbers (NTNs) with deaneries to provide for increased consultant numbers.

However, it must be remembered here that there is latitude within the process to consider that much of increased geriatric workload may be dealt with (for example) by increased numbers of nurse practitioners or nurse consultants rather than medical staff.

Such considerations will almost certainly occur to some primary care trusts. The nature of new geriatric consultants and their location and focus is also available for discussion and decision i.e. whether or not they work within the intermediate care field or the notion of the community based geriatrician.

This makes it imperative that geriatricians keep apace with education and training issues for

professionals, other than doctors, who are interested in the care of the older patient.

Therefore geriatricians must learn their communication lines in their institutions to the person(s) involved in capacity planning, for example, operations manager in a trust and the commissioning managers at PCT level. Engaging at this level will ensure input into the form and function of geriatric services locally not only from a medical aspect but also involving allied professionals.

Kevin Kelleher

References

1. A Health Service for all the talents. Developing the NHS workforce
 2. Shifting the Balance of Power
 3. Improvement, Expansion and Reform
 4. Working Together – Learning Together
 5. Improving Working Lives
 6. Information for Health
 7. Funding Learning & Development for the Healthcare Workforce
- 1-7 Available at <http://www.doh.gov.uk/index.htm>
8. **Delivering the NHS Plan** sets out the full package of system reform – it is available from the DoH website at <http://www.doh.gov.uk/deliveringthenhsplan/index.htm>
 9. Improvement, Expansion & Reform: The Next Three Years is at <http://www.doh.gov.uk/planning2003-2006/index.htm>
 10. Guidance on the financial flows system is available at <http://www.doh.gov.uk/nhsfinancialreforms/financialflowsoc02.htm>
 11. A support pack will be available (including links to sources of expert advice about programme management and a new toolkit on service configuration to support hospital managers), at www.doh.gov.uk/hospitalconfiguration
 12. The Modernisation Agency has a range of support resources at its website, www.modernnhs.nhs.uk. In particular, it has developed a series of concise practical guides to modernising services, available at <http://www.modern.hmg.com/improvementguides/>

Shifting the balance of power

but where are the geriatricians?



Shifting the balance of power has brought about fundamental change to the way the NHS in England is structured. This change aims to give local people more say through Primary Care Trusts (PCTs), to get better working with local authorities and give more power to frontline staff. So where do we, the geriatricians, fit into this?

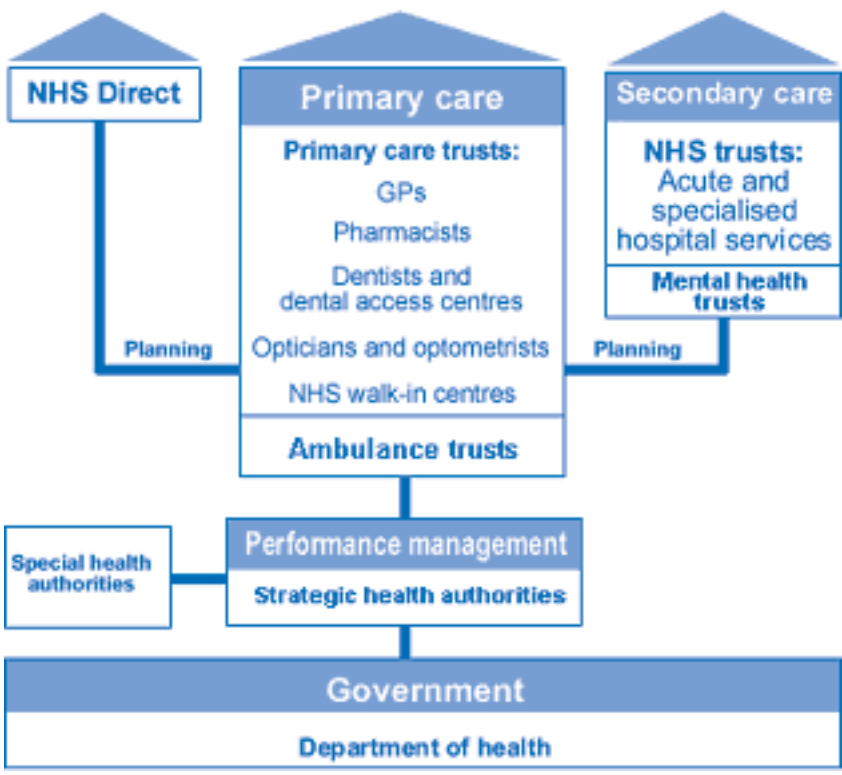
Shifting the balance of power took reform forward in April 2002 when the Department of Health (DOH) shifted power away from central government to frontline staff. This process has led to many changes in the structure of the NHS and Social Care, as shown in the diagram.

age are in this smaller box - at the side of the action. Further details can be found at www.nhs.uk

Primary Care Trusts

There are 303 PCTs in England, which are charged with modernising service delivery. They are accountable to the Secretary of State through Strategic Health Authorities (StHAs). They are to lead assessment of local needs, planning and delivery of all health services, including those provided by NHS Trusts. PCTs will therefore have a key impact on the way we as geriatricians work. They are just completing the development of three-year plans (Local Delivery Plans or LDPs) which should include improvements in services for older people and emergency care. The PCTs have been given the main commissioning role previously carried out by health authorities, and by 2005, they will control 75 per cent of the NHS budget.

Delivery of care



Shifting the balance of power replaced England's 95 existing Health Authorities (HAs) with twenty-eight larger Strategic Health Authorities (StHAs). Each of these has a population of around 1.5 million and the map shows which StHA you are part of. StHAs are accountable to the Secretary of State and ensure that all NHS organisations work together to deliver the NHS Plan. They are small organisations of about fifty staff and each has a policy lead for older people issues – in some this is someone with a single portfolio and in others they may also lead on other large policy areas e.g. diabetes. The StHA is charged with creating a coherent strategic framework for developing services, performance managing NHS Trusts and Primary Care Trusts (PCTs) and working with the national bodies including the Modernisation Agency; Commission for Health Improvement and the National Clinical Standards Authority. Ian Philp in his role of National Czar is visiting each of the StHAs in turn looking at good practice and

The picture deliberately shows government at the bottom of the flow of accountability with delivery of patient care by frontline staff. The large primary care element and much smaller secondary care sector are deliberately sized to emphasise importance. Most geriatricians and their colleagues in psychiatry of old

engaging in debate with local staff and leads on this policy area.

There is a real attempt at devolving power and influence to frontline staff. Regional Health Authorities have all but disappeared and the key commissioning/policy implementation bodies are

PCTs and Strategic Health Authorities (StHAs). Regional Task Forces or Modernisation Boards have been wound up and clinicians may have little input to service planning at anything other than local level.

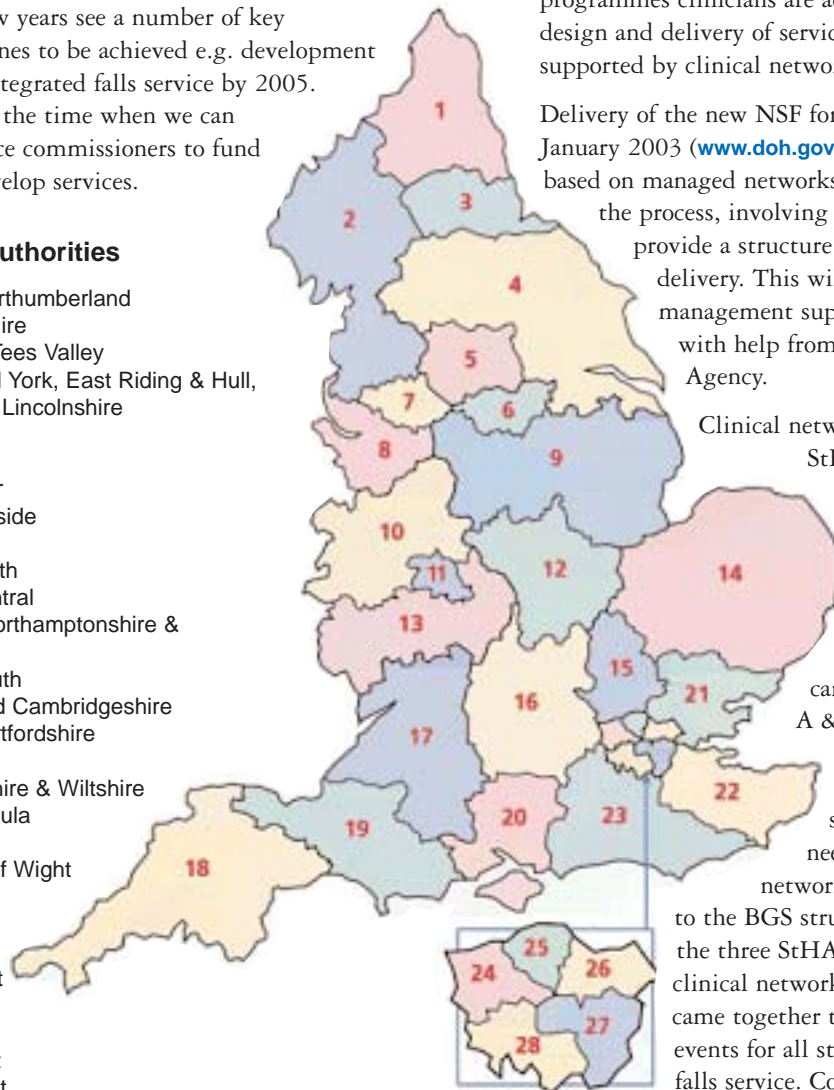
Four Directorates of Health and Social Care (DHSC) were developed to be a direct link between the DOH and StHAs but their role and function was unclear and they are only transitory bodies even by NHS standards.

All this change has led to a great deal of upheaval, many managers have moved to new posts and are finding their feet - I suspect a number of months will go by before we have clarity on which organisation is doing what.

This is an important time for geriatricians as we have to work with new arrangements and there is potential for the implementation of the National Service Framework (NSF) to stall and the risk that older people and their care will take a back seat. The NSF is two years old in March 2003, and the next few years see a number of key milestones to be achieved e.g. development of an integrated falls service by 2005. Now is the time when we can influence commissioners to fund and develop services.

Strategic Health Authorities

1. Tyne, Wear and Northumberland
2. Cumbria & Lancashire
3. County Durham & Tees Valley
4. North Yorkshire and York, East Riding & Hull, North & North East Lincolnshire
5. West Yorkshire
6. South Yorkshire
7. Greater Manchester
8. Cheshire & Merseyside
9. Trent
10. West Midlands North
11. West Midlands Central
12. Leicestershire & Northamptonshire & Rutland
13. West Midlands South
14. Norfolk, Suffolk and Cambridgeshire
15. Bedfordshire & Hertfordshire
16. Thames Valley
17. Avon, Gloucestershire & Wiltshire
18. South West Peninsula
19. Somerset & Dorset
20. Hampshire & Isle of Wight
21. Essex
22. Kent
23. Surrey & Sussex
24. London North West
25. London Central
26. London North East
27. London South East
28. London South West



How should geriatricians get involved in this New World?

At a simple level, I think we need as many BGS members as possible to influence development of services and sensible implementation of the NSF. We need geriatricians to be active in their Trusts, to work with PCTs and to ensure our services are focused on at StHA level.

At local level, geriatricians are often involved with groups on individual standards or PCT based groups called Local Implementation Teams (LITs). LITs are multi-agency and of the 35 in the old Northern and Yorkshire Region, only 28 had a clinical input and sometimes this was from a GP or psychiatrist of older age. LITs are made up of people who champion the service but often are too far removed from the executives who handle planning and finance to make a big difference.

We need to learn from other specialist areas e.g. cardiac disease and cancer. For both these major programmes clinicians are actively involved in the design and delivery of services and are well supported by clinical networks.

Delivery of the new NSF for diabetes published in January 2003 (www.doh.gov.uk/nsf/diabetes) will be based on managed networks with clinicians leading the process, involving people with diabetes to provide a structure for service planning and delivery. This will receive significant management support both locally and with help from the Modernisation Agency.

Clinical networks based on the new StHA boundaries seem a sensible way forward for older people's services. Each Strategic Health Authority has to deliver on many aspects of older people care from the trolley wait in A & E to implementation of a continuing care policy with colleagues in social services. The managers need clinical input and these networks could work in parallel to the BGS structures e.g. in Yorkshire the three StHAs could each have a clinical network that from time to time came together to put on educational events for all staff e.g. how to develop a falls service. Collaboration like this would reduce costs and allow learning

across the wider region. Finding someone at StHA level leading on older peoples services can be difficult and PCT enthusiasm is variable but persistence can pay off.

Increasingly, the link between better services for older people and the work on reforming emergency care led by Sir George Alberti is being recognised, and this can only help get planners focus on our Specialty. Four-hour trolley waits in Accident & Emergency will only be solved by a whole system approach cutting across all standards of the NSF.

Setting up a clinical network based on a StHA

How should we go about setting up networks? A possible way forward based on work we are developing in West Yorkshire is detailed below.

Aims

- ◆ Deliver National Service Framework (NSF) and key policies e.g. Free Nursing Care, Fair Access, Continuing Care.
- ◆ Deliver Reforming Emergency Care and Access agendas.
- ◆ Better outcomes for older people across social, primary, secondary and tertiary care services.
- ◆ Meet NHS Plan targets and promote excellence in relationships with Local Authorities.
- ◆ Well-managed clinical networks for service delivery, which meaningfully involve older, people themselves.

Focus

- ◆ Delivery of NHS Plan with key role for PCTs and Local Authorities.
- ◆ Practitioner-led developments with spread of learning.
- ◆ Joined up strategic leadership by Social Services Directors, NHS chief executives, and local clinicians.

Role

- ◆ Roll out/spread of good practice.
- ◆ Support the SHA lead manager for modernisation of older people's services.
- ◆ Development of simple outcome indicators, e.g. length of stay, admissions and re-admissions, levels of intensive home care, institutionalisation rates at discharge.
- ◆ Oversee focused change management modernisation work, including co-ordination resource from the Modernisation Agency (Falls Collaborative, Dementia Collaborative, Older Peoples Team, Change Agent Teams, etc).
- ◆ Oversee review of Local Implementation Teams.
- ◆ Receive and act on (as a network) regular performance monitoring reports e.g. NSF progress, LDP target progress.
- ◆ Set West Yorkshire jointly owned targets for future improvements (quantified) in care of the elderly.
- ◆ Develop alternative models to traditional secondary care and ensure good coverage of elderly care for people with mental health problems.

Who?

- ◆ Leadership from clinical champion, StHA, WY Primary Care Organisations.
- ◆ Develop case for service improvement/collaborative manager attached to network.
- ◆ Network to include key stakeholders at appropriate level in their respective organisations:
 - GPs and primary care staff
 - Consultants
 - Social care staff
 - Independent sector
 - Users and carers

Funding required

- ◆ Funding to be identified to include part time administrative/secretarial support.
- ◆ Budget for learning events, LIT development etc.

Conclusion

These are very turbulent times in the NHS in England - in chaos and turbulence comes opportunity. Let's grab it and get involved.

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PUBLICATIONS INFORMATION

The BGS Newsletter is published every second month by:

British Geriatrics Society

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