



Editor: David Oliver

# BGS

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n e w s l e t t e r

## Commissioning



using a frailty based model for commissioning in Wales

**F**railty is a complex multiple system decline characterised by instability in the presence of an environmental stress.

Recent thinking emphasises the advantages of timely comprehensive multidisciplinary assessment, either allowing early intervention, which maintains patients in a community setting or alternatively, reducing length of hospitalisation and expediting discharge. Patients themselves prefer this and while it does sometimes mean greater risk in the community, this should be acceptable if it is based on an informed decision taken by the patient.

It may be opportune to base the method of commissioning health care in this group on care pathways derived from the frailty concept. This will complement contemporary work into chronic conditions management, intermediate care and the co-morbidity syndromes and disability encountered in the elderly.

### Potential risks

Work done by Kaiser Permanente in the United States has grouped potential patients into a relatively stable base population at which health maintenance and prevention can be directed. This is overlaid by a more vulnerable group with chronic disease and disability, who are at risk of destabilisation and finally, a smaller group who are defined as frail and who for the most part are either institutionalised or who require high

community care input. Frailty is in fact a marker of dependency risk.

The level of assessment and intervention should increase from surveillance of the stable to targeted intervention, treatment and if needed, institutionalisation of the very dependent. This will require simple assessment tools useable by



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for better health in old age

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unskilled workers for case finding, which could feed into rapid response assessment and community intervention. Hospitalisation or care home placement would be the final stage and only after all other interventions were exhausted.

**An integrated approach**

Elderly services in Gwent are developing such a model, which cuts across divisions between health and social services and primary and secondary care. This is supervised by programme organisers and is overseen by a multidisciplinary board with representatives from health, social services and the voluntary sector. The service is jointly run by health and social services and has a joint budget. There is a single point of referral and a rapid response time in hours. There are links with A&E, Medical Admissions Unit and integration

with out of hours, intermediate care and 24 hour community nursing services. Input is limited to a maximum of 14 days and is community based. Discharge is to the GP. There is a community hospital facility with inpatients and a virtual hospital of patients in their own homes. This is supported by a daily virtual ward round, multidisciplinary meetings and hot clinics. Future plans will shape the hospital community pathway and elderly medical social care workforce to support this model.

I would like to acknowledge that this paper is based on presentations by Sinead O'Mahony, Ed Wilkins and Pradeep Khanna

**Anthony White**  
 Consultant Physician in Elderly Care  
 North Wales NHS Trust



**Call for abstracts**



**Abstracts are invited for the British Geriatrics Society Scientific Meeting in Harrogate from 7 - 9 October.**

Use this opportunity to showcase your hard work. Abstract submission system opens from 9 a.m. on 1st May until 15 June at 5 p.m.

The online abstract submissions system may be accessed either through the homepage of the BGS website: [www.bgs.org.uk](http://www.bgs.org.uk) or direct from <http://bgs.ascensiondesign.co.uk>

If you have any difficulties submitting your abstract, please contact the Abstracts Manager, Mrs Joanna Gough on 0207 608 8574 or email her at [scientificofficer@bgs.org.uk](mailto:scientificofficer@bgs.org.uk)

Note a new Survey category under the Clinical Effectiveness section. See page13 for more detail.

# Editorial



I recently returned from an intermittently sunny Bournemouth and a lively successful BGS conference in an excellent venue.

The main programme was varied and interesting and was preceded by a Wednesday afternoon joint session on Dementia, organised with partners from the EUGMS – very topical in view of the recent long awaited launch of the national dementia strategy (see Duncan Forsyth's view on page 17). Also, see a pair of excellent state of the art review articles around dementia care - references in box below.

## How to get more delegates and members?

The only regret about the Bournemouth meeting was that the number of delegates could have been higher (486 - down from our heyday of 600-ish). How much of this was due to the time of year, or travel to the south coast, I am not sure. I realise that shift work, tight job plans and limited study leave budgets all have an impact on attendance, but the meeting is a principal income generator and showcase for the Society and research by its

members, as well as an important chance for us to network, exchange ideas and support one another and, of course, to gain speciality-specific

CPD. My own view is that we need to push much harder to attract both interested doctors from allied specialities and a much larger number of professionals from nursing, pharmacy and the therapies, both to the Society and to the meetings, and it would be good to know if people agree, or have ideas for upping our attendance.

## Dignity in Nursing Care

Soline Jerram's commentary in this issue on the latest Nursing and Midwifery Council guidance on dignity points up the fact that we need professionals with specialist skills in the care of older people from all the disciplines. Though, on a personal note, with regard to the NMC, I do feel we now have more than enough resources to describe what dignified and undignified care is and need to move towards solutions – one of which has surely got to be around adequate staffing levels and skills-mix. Education and awareness raising can take one only so far, but if someone's drowning, the appropriate response is to throw them a lifeline, not to describe the water.

## Public Relations

Speaking of marketing, awareness-raising and greater engagement, I am delighted to announce the appointment of our first ever press, public relations and parliamentary affairs officer, Iona-Jane Harris (See article on p 28), who was appointed from a field of over 140 applicants and started in April. As a consequence of her appointment, we will now be in a stronger position to engage with the media both proactively and reactively and push the cause of better specialist care for older patients.

## Commissioning

In this time of recession, the days of large tranches of money coming from the English Department of



1. Burns, A and Robert, P: The National Dementia Strategy in England BMJ 2009;338:b931, doi: 10.1136/bmj.b931 (Published 10 March 2009)

2. Burns A and Iliffe, S: Alzheimer's Disease BMJ 2009;338:b158, doi: 10.1136/bmj.b158 (Published 5 February 2009)

3. [http://www.rcplondon.ac.uk/news/news.asp?pr\\_id=443](http://www.rcplondon.ac.uk/news/news.asp?pr_id=443)  
[http://www.bgs.org.uk/Publications/Compendium/compend\\_4-8.htm](http://www.bgs.org.uk/Publications/Compendium/compend_4-8.htm)

4. <http://www.telegraph.co.uk/news/newsttopics/howaboutthat/5114055/Putting-on-make-up-could-help-prevent-accidents.html>

<http://news.bbc.co.uk/1/hi/england/7983045.stm>

Health earmarked for specific services are over, following the massive additional investment made by the Labour government in the Health Service. We are also gradually moving away from a target-driven culture to other “levers” to improve access and quality. So when it comes to delivering new and improved services for instance, on the back of the stroke or dementia strategies, then local commissioning is now seen as the engine of change. For most of us clinicians, phrases such as “world class commissioning” can seem like confusing or platitudinous management-speak – what does it mean? And will it actually force commissioners, for once, to prioritise services for older people? “We will believe it when we see it” – many will say. So in this issue we have provided an introduction to the concept (see paper by Graham Mulley, page 8, and progress made in Wales by Antony White, page 1).

### Falls and Bones

In addition to my BGS role, I have recently taken over Finbarr Martin’s work at the Department of Health, specifically around commissioning of falls and bone health services, and we are due to launch a commissioning toolkit to be presented at all SHAs in England in May and June – watch this space. This might give a better notion of how commissioning might drive service improvements. And we know from the latest RCP national audit on falls and bone health<sup>3</sup> that we still have a long way to go in providing the truly “comprehensive services to reduce falls and fractures” envisioned in the 2001 NSF.

### Ethics and Law in the care of older people

At the Bournemouth Meeting, two sessions which attracted large numbers of delegates and a great deal of interest were around physical restraint use and around the new deprivation of liberty safeguards to support the code of practice for the Mental Capacity Act (which came into force on April 1). I know that there has been a lot of interest in the guidance on Advance Care Planning in which the BGS played a major role<sup>4</sup>. The care of frail older people raises complex ethical and legal dilemmas daily, for those of us at the coalface, and the interest in these sessions flagged up just how keen people are for more information and support. For those especially interested, there are a number of part time Master’s Programmes in Healthcare ethics and law around the UK, as well as some shorter courses, and several of our members have undertaken them. But the BGS ethics SIG (which ran the sessions in Bournemouth) would welcome

more active members so please get on board. Contact them through the editor.

### The rise and role of the regulators

Also in Bournemouth, we enjoyed an excellent talk from Prof Martin Marshall on the sometimes confusing role of regulatory bodies in healthcare. This was highly topical in view of the report on the Mid Staffordshire trust and other fairly recent public enquiries such as the one on Clostridium at Maidstone and Tunbridge Wells (HCC website under re-construction, so references cannot be provided at the time of going to print). We also had the recent Panorama Programme on the sometimes poor quality of home care services contracted out to private companies. (We have all heard patients reporting poor as well as good experiences with home care and this programme – uncomfortable viewing – showed us why). And as I write the verdict from the Gosport War Memorial Inquest is about to come in. There was an enlightening piece in the BMJ 2007 on the history of public enquiries in NHS and UK social services. But a common feature of such enquiries seems to be the narrative of problems being flagged up repeatedly by frontline staff and not acted upon. There was, to my mind, an excellent letter in the Times by John Spivey FRCS, stating that the NHS rewarded and promoted staff who reported only good news up the line – the “don’t bring us problems, bring us solutions” culture, meaning that those in senior positions were often shielded from day to day operational problems and tended to “manage upwards”, in looking for their own career progression. It is also interesting to note that the HCC had given Mid Staffs a decent report, just as Ofsted had for Haringey social services in 2007, leading one to wonder whether inspections tend to be superficial. Still, in one of the regular re-organisations that seems to occur in quangos including regulatory bodies, the Healthcare Commission and CSCI have now merged to become the Care Quality Commission (CQC), with the complaints function being taken over by the Ombudsman and it was heartening to see the announcement that CQC plan to toughen up inspection standards for care homes. I will do my level best to interview someone from CQC for the next newsletter. If any members have questions they would like me to put, then please let me know.

### Jumping for Joy

Finally, on a more light-hearted note, two stories caught my eye recently. Firstly, the headline that “putting make up on can prevent accidents in

elderly women. And no, it wasn't published on April 1 (well, not in the newspaper at least). The study led by the research communications director from the cosmetics giant L'Oreal (a conflict of interest perhaps?) found that older women who applied make-up in the morning stood straighter and had fewer falls than those who did not.

Dr Patricia Pineau, of the University of St Etienne in France, claimed that the findings could help prevent many debilitating accidents. Her team studied 100 women, aged between 65 and 85, as part of a study originally intended to measure the effect of wearing make-up on self esteem. The women were fitted with belts to measure their posture and were given special insoles to test their centre of gravity. The team concluded that those who wore even a small amount of make-up appeared to be more stable on their feet.

"They held themselves differently to those who did not wear make-up," Dr Pineau was quoted as saying.<sup>5</sup>

My second heartwarming story was about 97 year old George Moyes undertaking his first skydive from 10,000 feet with a maximum speed of 120MPH to raise money for the RNLI.<sup>6</sup>

"It was the first time but it won't be the last," he said afterwards "I do not sit around, I get about, I go for a walk every day and I do my own cooking, washing, ironing, everything," he said. "I have just been lucky to be so agile." And on the basis of finishing right where I started, the man in question was from Bournemouth, though I am pleased to say he didn't attribute his successful ageing to regular applications of mascara.

David Oliver

# President's column

The BGS Spring scientific meeting in Bournemouth was a triumph. The conference centre was superb, the ambience friendly and the quality of the lectures and presentations was of the highest order.

I wish to thank Michael Vassallo and his team for all the hard work in planning such an excellent meeting, and not forgetting the team of Hampton Medical Conferences who so ably ensure that we are fed, watered and shepherded around to where we have to be!

Everyone I spoke to was pleased with the conference. The interactive sessions were deservedly popular and the talks given by high profile speakers were first rate.

I received a lovely letter from Dr Arnold who

organised a previous conference at Bournemouth 40 years ago. Things were different then: there were just over 100 delegates, mostly

male and many from the Indian sub-continent (the enormous contribution to British Geriatrics by our Asian colleagues has perhaps not received the recognition it deserves). Many brought their wives and they enjoyed a lively social programme (even senior members of the Society escaped the lecture rooms for a cream tea in Dorset - no CPD forms to sign in those days!) Many geriatricians then were single handed and worked in poor quality accommodation with inadequate staffing levels. They arrived at the venue battle-fatigued and an important aspect of the conference was to refresh front line staff and give them energy to continue their vital work - at least until the next meeting in



six months' time.

The scientific meetings have grown in size and stature and feature updates and relevant science as well as new ideas for improving practice. They show the spirit of the BGS at its best. If you have not got into the habit of attending them regularly, do consider making these events an important part of your academic year. The next meeting will be in Harrogate from 7th to 9th October; why not put the date in your diary now?

### Where are we going?

The opening session was an opportunity for me not only to welcome everyone (especially overseas visitors, from 25 countries) but also to outline strategic plans for the next two years. In essence, I would like to increase the profile of the Society; forge closer links with charities; combat the anti-medical social model of elderly care; build on the talents and skills of younger members and strengthen the relationship between the four countries and the regions and the Society's centre at Marjory Warren House. We should be more vocal in championing the highest standards of care for old people, promoting dignity and combating injustice and inequality. I am also working towards a more federal model of running the BGS, with key people acting as leaders across a range of topics. Already a dozen people have offered their services - I will write more on this in the next issue.

### Geriatrics in a cold climate

The financial crisis may present us with the biggest challenge that our specialty has faced for some time. In Bournemouth, Prof Allen McLean from Notre Dame University in Sydney pointed out that the current health budget could not sustain the big cohort of old people. His interesting cost analyses showed that a Mediterranean diet is much more effective than statins or aspirin in preventing heart attacks. Also, if people aged 64 worked for one more year, this would add ten percent to the GDP. Prof Martin Marshall (standing in at the last minute for Baroness Barbara Young) said that health funding will be stable for the next two years, but after that there will be major changes. This will mean cuts in staff and services and acceleration in the move away from hospitals to community care.

We should begin to think seriously about the threats that this will pose to elderly care and ways in which they could be mitigated. The Policy Committee will be debating this subject but we need as much help as possible if we are to develop

coherent strategies for coping with the inevitable cut-backs. Please contact me if you have any suggestions.

### EUGMS

The first day of the Bournemouth conference was triple badged, with the International Association of Geriatrics and Gerontology (IAGG) and the European Union Geriatric Medical Society (EUGMS) sharing the session with the BGS. The afternoon was devoted to advances in dementia. It was interesting to learn that one third of non-demented subjects have the same number of plaques as those with dementia. Perhaps the plaques are innocent bystanders? The tauists are currently in the ascendancy.

You might wish to view the EUGMS website. The next meeting is in Glasgow, on end of life care - the date for your diary is 17-18 September 2009.

### BGS Wales

My first presidential visit was to Wales. I was delighted to be invited to the national meeting in Aberystwyth in March. I received a warm welcome and was impressed with the commitment, energy and enthusiasm of the younger members, as well as the senior Geriatricians. Welsh Geriatricians have made - and continue to make - a huge contribution to services and research, as well as being key figures on the national scene. The close links with Age Concern Wales and the Welsh Assembly are to be applauded.

Professor Bim Bhowmick OBE is working hard in retirement and has set up a model system of community care. He assesses about 1,400 elderly people each year and is able to prevent a thousand hospital admissions. He liaises closely with GPs, has helped health and social services to combine, and ensures that politicians, managers and clinicians are aware of his pioneering initiatives. It is fitting that Bim's developments recently received a prestigious Bupa Foundation award. Pradeep Khanna is also very active in community Geriatrics in Gwent. The plan is for every SpR in Wales to be trained in community geriatrics in Gwent for six months

### Professor John Pathy

It is with sadness that we recently heard of the death of John Pathy (obituary is on p32). John made a truly astonishing contribution to geriatric medicine. His text book is internationally recognised. He had a passion for research and influenced countless trainees. He chaired Age

Concern Wales for 25 years - and even ran a smallpox unit in Cardiff! The BGS office in Wales is named after him, as is a day ward at Rookwood hospital. I greatly enjoyed examining the Diploma in Geriatric Medicine with him: he had a gentle style and wore his learning lightly. He was active and productive to the last. May he rest in peace.

### Congratulations

To John Campbell, whose superb studies on falls have been acknowledged by the Royal College of Physicians of London, by conferring upon him an Honorary Fellowship. An accolade for John and his family, Otago University, New Zealand and Geriatrics generally.

Congratulations too, to Roger Briggs, emeritus professor of Geriatrics at Southampton, on

receiving the President's medal at the dinner in Bournemouth. Roger has nurtured numerous trainees, done excellent research on dementia and other neurological diseases, runs the Southampton Ageing project and always promoted Geriatrics. My pleasure in presenting him with a medal was exceeded only by his surprise in being publicly honoured.

Welcome to Iona-Jane Harris, who has just started work as the BGS Press, PR and Parliamentary Affairs officer. She will be visiting the four nations and the regions and will make a huge difference to the promotion of our Society and the skills, enthusiasm and values of its members.

Graham Mulley

# Stroke

## a tale of two National Health Services

The hearse like hospital car crept down our mother's street and returned her to us. The two front steps were now another challenge. Only eight weeks ago, all this had been routine.

That was before a cerebral haemorrhage and resulting homonymous hemianopia cut off half her world and transformed daily activities into a series of complex projects, requiring strategic planning.

The Occupational Therapists accompanying our mother were attentive. 'Now Irene, can you find your lounge?' 'Of course,' she replied, as if it were a silly question. It was coming back to her now. They practiced walking, getting in and out of bed and on and off the toilet. The poor women were given a compulsory tour of family photographs. 'Irene is special,' said one of the good ladies, 'She is positive and has great faith.' 'Will she be able to cook?' I ask. I had lost half a stone since my mother's admission and I was fading away! The girls went through the care package options and help

with activities of daily living.

This was the NHS at its finest - caring, holistic and realistic. In no other part of the world, would there be such an attempt to rebuild this disabled, elderly widow's life. In other countries, we would have lost thousands of pounds on hospital care and rehabilitation, over and above the distress of caring for a stroke victim.

How treatment has moved on! We had already visited this scenario fifteen years ago with our father. Things were very different then. Dedicated stroke units were rare and my father was admitted to a general medical ward. As he deteriorated we had to bring intense pressure on the doctors to organise a brain scan. As a stroke victim my father had "not for resuscitation" written in his case notes. At ward rounds a cursory nod was commonplace for the stroke victim. He survived, rehabilitated himself, stopped taking the Phenytoin that had been prescribed for a 'twitching' episode, returned to driving and had a further thirteen years of good life.

My mother on the other hand was in a stroke unit from the beginning. At her bedside there was a

**This is the personal experience of Dr Sureshini Sanders. Dr Sanders works as Hospital Practitioner for care of the elderly at St John's in Livingston and as a general practitioner in a practice within the catchment area.**

traffic light system, which let all care staff know the stages of her physical limitations. She had a scan within an hour of admission and a detailed medical explanation of her condition. I have no doubt that the overwhelmingly informative, positive, caring, attitude of the doctors, nurses and rehabilitation team, played a crucial role in her early recovery.

'Well, I can just stay now,' she proclaimed. 'No mummy, remember this is just a home visit.' The night before in hospital, she had asked me for 'the

answers'. 'What answers? What are you talking about?' I was worried she was becoming confused again. 'The lady next door has failed and can't go home'. Then it dawned on me that she meant the mental function test that was prerequisite for discharge. I felt like a conspirator in a crime. Would her sentence be diminished because of my answers?

The home visit came to an end. Mummy headed for the steps. She remembered, good foot to heaven, bad foot to hell. How could she forget? She had heard it all before fifteen years ago. To nearly lose one parent with this condition was bad luck but two was sheer carelessness! My mother waves at us from the car and my sister and I arrange our widest smiles. 'Dad. You can come back for her another day but not today', I mumble to myself.

**Sureshini Sanders**

# Commissioning



one head of the hydra

**T**he concepts of 'contracting', 'purchasing' and 'commissioning' were introduced into the NHS in the late '80s and early '90's

From a service based on need and which provided care without too much emphasis on cost, the introduction of business management concepts turned the National Health Service into a "market" with a "purchaser-provider" split - the intention being to encourage competition among providers, reduce cost to HM Treasury and improve quality and responsiveness.

In 1991, health authorities and GP "fundholders" became the gatekeepers to all purchasing but it was only in the late 1990's that the NHS adopted primary care led "commissioning" as a more sophisticated and strategic activity - one that encompasses assessment of health needs, buying services to meet those needs, and a range of strategic efforts to improve health (Ovretveit,

1995). A strategic activity it may be, but commissioning is still a work in progress with many "commissioners" still being trained in what the concept involves.

## Is commissioning simply "contracting"?

No. It's a bewildering, multi-layered process with many objectives which involve large-scale system transformation. In apt business-speak for a business model, the "bottom line" is to achieve highest quality at minimal cost.

## Changing culture

By putting primary care at the heart of commissioning, the perceived domination of acute hospital Trusts has been challenged. Its themes include a move away from the hospital model towards community care, which is what service users say that they want and which is believed to be cheaper. It continues the erosion of centralised national policy in favour of local decision making. It encourages the development of partnerships between primary care trusts, local authorities and health professionals. There is also greater awareness of prevention.

Learning from the USA, and initiatives such as Permanente, a major US Health Maintenance Organisation, commissioning ideally involves an element of identifying and managing people with long term conditions before those conditions become crises leading to hospital referrals. The arrival of walk-in clinics and poly clinics, the expansion of community teams (GPs with Special Interests, nurse specialists, community matrons, case managers) are all initiatives born out of this aspect of commissioning. At the same time, financial inducements and penalties have been introduced to reduce prescriptions.

### The Commissioning Cycle

**Planning:** Assessing needs and priorities; engaging the public; setting goals and health outcomes.

**Execution:** Designing and implementing care pathways around these needs; contracting from a plurality of providers.

**Management:** Policing the system - ensuring that it works; Identifying gaps; Managing demand and performance; Governance;

**Monitoring:** Evaluate service models and measure health outcomes.

### Commissioning - the NHS' "core weakness"

While the NHS could not continue to swallow unchecked, the resources of the Treasury, the jury is still out on whether "commissioning" was the right process to achieve the first part of the highest quality for minimal cost equation. Primary Care Trusts - the commissioning teams, are not all fully trained, may not have the necessary expertise and

they are not always engaging with the public or front line...in short, World Class Commissioning remains an aspiration.

### What should the BGS be doing?

We should use every opportunity to champion the needs of old people, especially those who are frail, which is why the BGS Wales Strategy of using a frailty based model for commissioning seems particularly effective (page 1).

We will be devoting a UKMC meeting to this topic and then organising a study day on commissioning for old people. We hope to welcome senior people from the DH (the Director of Commissioning has already indicated a willingness to discuss things with us and we will use this opportunity to gently remind him of the central importance of elderly care in the NHS).

We need lead geriatricians on Commissioning in all the regions and the four countries (taking account of the different situations in the latter). These leads will need to become familiar with health economics. We will then publish and publicise best practice guidelines amongst those who would do the commissioning.

The Policy and UK Management Committees will be considering these in greater depth over the coming year and we would welcome the views of our members

**Graham Mulley**  
President

Reference: Smith, J: A commissioning taxonomy for the NHS in England, Presentation at an ESRC Managing Scarcity Seminar. December 2005

## Commissioning in Cymru, Northern Ireland and Scotland:

**Cymru/Wales** (see page 1)

### Northern Ireland

In Northern Ireland, a major review of Health and Social Care has been under way for the last two years. Due to political changes, the Commissioning side of this has been slow to develop. On 1 April 2009, the four former Health and Social Services Boards were replaced by a new single Health and Social Care Board (<http://www.hscboard.hscni.net/>). Membership of this Board has not yet been finalised. In addition, a number of Local Commissioning Groups have been set up, but it is not clear what their role in Commissioning, as opposed to that of the Board, will be. As such, Commissioning in Northern Ireland is best described as "work in progress". - **Ken Fullerton**

### Scotland

Essentially we don't have commissioning in Scotland. There is no purchaser/provider split, but we find it easy to meet with government officials, having met with the Health Minister very recently. - **Paul Knight**

# Specialist Certificate Examination

## in geriatric medicine - the latest news!

**T**he first Specialist Certificate Examination in Geriatric Medicine (SCE) was held on 4th March.

Geriatric Medicine was the second medical specialty to hold an SCE. Gastroenterology held the first SCE in June 2008. The examination was conducted as a computer based test and 15 candidates sat the exam at 7 Pearson Vue test centres around the UK.

The examination consisted of two 3-hour sessions, during each session candidates answered 100 best-of-five questions. All 200 questions were new (i.e. had not previously been tested), and had been written specifically for the SCE. Questions had been standard set before the exam by the Standard Setting Group, using the modified Angoff's method of criterion referencing to produce a pass-mark which for this examination was set at 59.4%.

All 15 candidates passed the examination (mean score 69%). Congratulations to all concerned!

The date for next year's examination has not yet been finalised but it will almost certainly be held in March again. As soon as the date is confirmed, I shall publicise it through the usual BGS and JRCPTB channels and the information will be available on the MRCP(UK) website. Please note that at this stage the Federation proposes to hold only one diet (one exam sitting) each year for all medical specialties. This has very important implications for trainees.

At least one candidate experienced problems booking in to the nearest Pearson Vue centre to sit

the recent SCE and had to travel to another centre. These concerns have been fed back to the Federation who in turn have liaised with Pearson Vue. To reduce the chance of this happening in future, the SCE Project Manager emphasises the need to book early for the SCE and not to leave it to the last minute. Changes are also being made to the SCE registration period to improve the situation.

Two other significant bits of news:

### Retakes/Resits

I am pleased to say that in response to feedback (in particular from trainees) the Federation has changed its policy on the question of free resits/retakes.

The Federation writes:

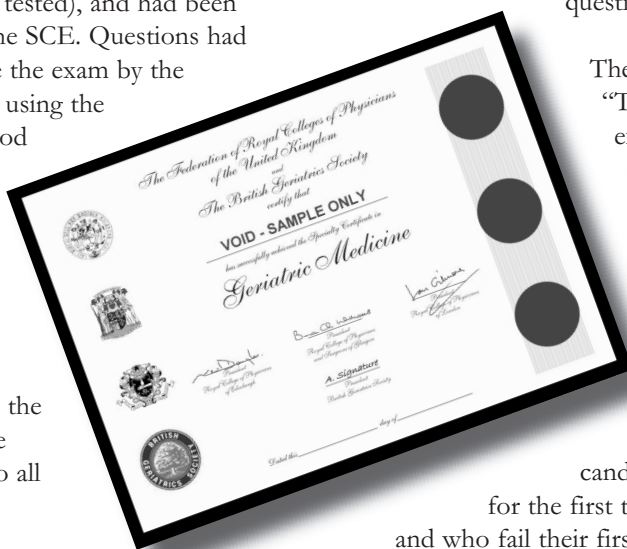
"The Federation has re-examined the option of offering retakes free of charge and has agreed to introduce a second sitting free of charge to candidates who fail their first attempt during 2008 – 2010.

Therefore, all candidates who take the exam for the first time in 2008, 2009 or 2010 and who fail their first attempt will automatically be offered a retake at no extra charge. This offer will apply to all candidates, both in the UK and overseas. It will be backdated and made available to all candidates who have already taken the examination and did not pass".

This is something the BGS, and in particular our trainees, have been pressing for for sometime so although this decision has come late in the day persistence has clearly paid off!

### Postnominals

The Federation has agreed to grant the postnominal: Cert.RCP(UK) (Specialty) to all



candidates who pass the SCE. We therefore have definite confirmation that the Federation's original proposed postnominal 'Diploma' will not be used.

Only UK trainees who go on to attain their CCT will be able to upgrade/convert this to MRCP(UK) (Specialty).

I shall ensure any news of further significant changes is disseminated through the usual channels to colleagues and trainees.

**Oliver J Corrado**

Lead Physician SCE Geriatric Medicine

## Changing PACES (PACES clinical skills assessment)

**Attainment of the MRCP(UK) diploma – which includes the PACES clinical skills assessment – remains a mandatory part of physician training in the UK and is vital to career progression in many other parts of the world.**

PACES was introduced in 2001 and has proved a successful and deliverable examination, with over 30,000 candidates taking the examination since that time.

Changes to UK curricula in Medicine, the advent of new standards for postgraduate assessments in the UK, and feedback from examiners, patients and candidates have led to review of the examination. As a result, important changes will be introduced in October 2009. The main aims of the changes are to further standardise candidate experience, enhance the assessment of communication, and develop the standard setting methodology, but still maintain basic format and deliverability.

In October, the content and structure of one of the five Stations, Station Five, will change. The four five-minute encounters – which currently have mandatory system content of locomotor, dermatology, ophthalmology and endocrinology - will be replaced by two ten minute encounters. The emphasis will now be on the demonstration of integrated history taking, physical examination, communication and problem solving skills, rather than on "spot diagnosis" and knowledge assessment. System content is not now limited to the four specialities currently represented – offering the opportunity for content relating to under-represented specialties such as haematology, acute medicine, and elderly medicine to be incorporated.

Secondly, the methods of marking candidates and determining the pass standard have been revised. The principle behind these revisions relates to the need to ensure that a passing candidate has attained the required standard in all of the clinical skills assessed, rather than being able to compensate for poor performance in one skill, for example communication, with better performance in another, for example physical examination. Seven core clinical skills, based on the current PACES Anchor Statement Skills and Good Medical Practice, have been defined, and examiners will assess candidates on each of these skills using a three point marking scale of Satisfactory, Borderline and Unsatisfactory. The pass mark will initially be based on the total test score, but a final pass standard, based on performance in each skill, will be introduced in late 2010.

If you are an examiner, or supervise or teach trainees about to sit PACES, please familiarise yourself with the changes on the MRCP(UK) website. (<http://www.mrcpuk.org/Pages/Home.aspx> ). DVDs for examiners and candidates will be released in the summer.

**Andrew Elder**

Chair, MRCP(UK) Clinical Examining Board  
Consultant in Elderly Medicine  
Edinburgh

# Jungle geriatrics

## what's a geriatrician doing in the jungle?



**Y**ou may ask! As an ST4 in Geriatric Medicine, this was my second trip, in February 2009, to the jungle in Peru's Amazon basin.

The first was in June 2007 after hearing about the Amazon Hope Medical Project run by Scottish charity, The Vine Trust. For the last 5 years the charity has been sending one, and occasionally two, medical and dental teams per month down an Amazon tributary to work alongside local medics, nurses and dentists delivering health care to the poorest of river communities in this remote region. Living on one of the Trust's two ex-Royal Navy boats, in somewhat surprising comfort, provides ample opportunity to enjoy the scenery and jungle environment in this beautiful region, which is untouched and virtually unseen by tourists. The medical and dental teams run clinics for the villagers providing basic, predominantly primary, health care. The villagers, quite literally, hear

through jungle drums that the medical boat is in town. There is more than adequate supply of medications, including antibiotics, analgesia, anti-fungals, creams, anti-hypertensives and diabetic medication, which is sourced by the charity from the USA and is provided, together with health care, free of charge to villagers who would not normally benefit from any local health care services. Clinics run for a proportion of the morning and afternoon but leave plenty of time to relax, explore the jungle villages, have a South American style siesta and play football and volleyball against the usually very competitive villagers. On village walks, we were often fortunate enough to be invited into people's houses which proved to be a fascinating insight to their lifestyle, or to be shown their diverse variety of tropical pets ranging from monkeys and parrots to ocelots.

So, it all sounds great but you still might ask, what's a geriatrician doing there - especially in this harsh environment where few people survive to their 7th or 8th decade? For me, this particular project has been an excellent opportunity to develop both personally and professionally. It has provided opportunity to develop clinical and diagnostic skills, predominantly on careful history-taking and examination in an environment without the luxury of extensive batteries of investigations as in hospital. Working through an interpreter, an indispensable member of the on-board multi-disciplinary team, also developed skills of focussed



history taking and concise explanation. Additionally, knowing that I was the only medic the patient would see for several months facilitated decisive, definitive decision making, skills entirely applicable to my UK training.

Overall, I found the whole experience on each trip to Peru thoroughly enjoyable and extremely valuable. The working environment on board the boat is relaxed, supportive and the Peruvian staff are extremely appreciative of the efforts of UK medics' visits. There is an atmosphere of mutual learning, culturally as well as professionally. I found myself particularly deficient at salsa dancing much to everyone's amusement but soon proved myself in an Orcadian strip the willow. So, who can go on the boat to Peru? The answer is anyone with two

weeks of annual leave, enthusiasm and general medical skills who wants to contribute to this project and experience the challenges of working in an environment different from that of a UK hospital. Geriatricians are particularly well placed as general physicians with team-working skills, adaptability and excellent clinical diagnostic skills. It's an unforgettable experience in a beautiful place with an opportunity to make a real impact on the lives of villagers in rural Peruvian communities. For more information contact the Vine Trust on [health@vinetrust.org](mailto:health@vinetrust.org), visit [www.vinetrust.org](http://www.vinetrust.org) or contact me at [Karen.leckie@ggc.scot.nhs.uk](mailto:Karen.leckie@ggc.scot.nhs.uk)

**Karen Leckie**  
ST4 Geriatrics

Southern General Hospital, Glasgow

## CALL FOR ABSTRACTS (Clinical Effectiveness Surveys)

The Clinical Practice and Effectiveness Committee which adjudicates abstracts submitted in the clinical effectiveness category for presentation at BGS Scientific meetings has issued the following guidance on acceptable criteria for survey. The Committee hopes that this guidance can

help to improve the quality of survey abstracts which, to date, have suffered a high level of rejection at the adjudication stage.

A good survey should:

- ◆ Answer/inform specific questions on a specific theme relating to evidence-based practice, health care policy or resources affecting older people
- ◆ Lead to a clinical effectiveness strategy such as guideline or good practice guidance development, practice change implementation or formal audit
- ◆ Look at clinical practice across regions/units
- ◆ Have a nationally generalisable message
- ◆ Clearly state who or what is being surveyed (providers, patients, carers, health or social

care databases etc.)

◆ Clearly state the survey methods:

- Questionnaire or interview - describe (a) evidence-base, (b) content and structure, (c) result of feasibility pilot, (d) method of administration (e) how non-responses are dealt with
- Database - describe (a) background to database, (b) how data is collected, (c) how your survey accessed the database

- ◆ Describe sampling methods and any potential bias
- ◆ Have a response rate greater than 40%
- ◆ Discuss response rate and implications for bias from non-responses

An audit would differ from a survey in that it would:

- Include external and internal standards
- Form part of an audit cycle
- Demonstrate an improvement in quality
- Demonstrate a change in practice
- Evidence in following through on results

Proposed abstract headings for the 'Survey' subcategory:

- Background and aims
- Sampling methods
- Results
- Generalisable conclusion and further work

# Lifelong learning

## are we meeting the needs of the older adult?

The inquiry into the “future for lifelong learning” (IFLL2009) was established in September 2007 and is due to produce its main report in June 2009.

It was sponsored by the National Institute of Adult and Continuing Education (NIACE), with an independent Board of Commissioners. The goal of this initiative is to offer an authoritative and coherent strategic framework for lifelong learning in the UK.

The changing demographics and its likely impact are the subject of many publications and discussion. People will be spending far longer in the period known as the ‘3rd age’ - a concept, developed in the 1970s to describe the phase of life extending from 50-75 years old where employment rates decline as people retire, and before health and disability impose serious constraints on lifestyle. In the 1980s this age was seen as a time where people could exert

greater control over their lives, free from the responsibilities of employment and bringing up children. There are also far more people living in the ‘4th age’, recognised as individuals aged 75+ in the final stages of life, who depend on others to cope with aspects of their day-to-day life.

These changes call for a re-evaluation of our healthcare priorities, starting with the methods and emphasis of education. The inquiry advocates challenging, in particular, our policy of education being directed primarily at young people, as prerequisites to achieving and maintaining paid employment. Whilst we must not underestimate the importance of economic productivity, such exclusive focus for education is shortsighted in the face of these well known demographic trends.

### Purpose of learning

According to the IFLL report, learning helps individuals build three types of capital:

- ◆ **Identity capital:** To develop a sense of identity and confidence in one’s own knowledge and abilities. This will become increasingly important as individuals spend a greater proportion of their lives in retirement, since an individual’s occupation generates a significant proportion of their sense of identity.
- ◆ **Human capital:** This form of learning develops vocational skills. As the number of people in the 3rd age increases, understanding the learning needs of the voluntary sector increases the bank of useful skills at the community level.
- ◆ **Social capital:** Skills which enable individuals to interact successfully with others, to maintain and enhance relationships, and to pass on knowledge to the next generation. These skills promote an individual’s emotional (and therefore more than likely also their physical) wellbeing.

On the national scale, lifelong learning:

- ◆ Maintains the skills base of the population to maximise economic productivity and to facilitate international competitiveness.
- ◆ Secures transmission of knowledge and skills between generations and creates strong inter-generational relationships.

### References

Mc.Nair, S (2009) ‘Demography and Lifelong Learning’. Inquiry into the future for Lifelong Learning. Sourced at: <http://www.niace.org.uk/lifelonglearninginquiry/docs/Demography-Lifelong-Learning.pdf>

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Office for National Statistics. (ONS 2009a) Latest on Fertility. Sourced at: <http://www.statistics.gov.uk/cci/nugget.asp?ID=951>

Office for National Statistics. (ONS 2009b) Latest on Ageing. Sourced at: <http://www.statistics.gov.uk/cci/nugget.asp?ID=949>

HM Government (2008) Delivering Digital Inclusion: An action Plan for Consultation, London, Communities and Local Government Publications.

Life Academy (2009). Sourced at: [www.life-academy.co.uk](http://www.life-academy.co.uk)

◆ Promotes citizenship and the integration of newcomers into society.

### Policy approach

In order to respond to demographic change we must consider a shift in policy, recognising that learning should continue throughout life, and we especially need to support the older community in this. We also have to re-consider the content of learning. Some form of curriculum could be developed for the 3rd and 4th ages to help people adapt better to life changes, improving sense of self and general wellbeing, alongside vocational learning to maintain paid employment.

### How do learning motivations change as individuals get older?

The NIACE survey data shows, unsurprisingly, that those who continue to learn are less likely to be learning for employment needs, and more likely to cite personal and social motivations. Learning for personal development and intrinsic interest in a subject increases with age, as does the importance of meeting new people, demonstrating the role of employment in maintaining social relationships. NIACE data supports common expectations of what older adults may wish to learn, the main subjects being: IT skills, cultural subjects, foreign language and health. Information and communication technologies account for the largest group of older learners (40% of those learning over age 55). These subjects, however, may simply represent what is available through formal routes for this age group, and do not necessarily accurately reflect their learning needs. Routes of access to education are changing, and a very large proportion of adult learning takes place informally, without recourse to formal courses and without direct intervention by teachers. This makes data collection difficult, and it is suggested that a significant proportion of education carried out by older adults will not be accounted for in NIACE data. In particular, less conventional topics may be accessed through informal educational routes e.g. the internet. Internet from home helps to overcome the problem of physical access which will be an issue for some people, however, access to computers falls with age with only 37% of people over 65 having

access to the internet in comparison to 67% for the general adult population (HM Government, 2008). Any future shift to internet learning must include individuals who do not have access to the web.

### Proposed curriculum for the 3rd age

Whilst society devotes much attention to young people entering the workforce, very little is spent on helping to prepare people exiting the labour market and entering the age of active retirement. Key areas for learning include health and finance, information and communication technologies, citizenship and volunteering as well as learning to maintain one's sense of identity. Also, as life expectancy increases, larger numbers of people in the 3rd age are taking on the role of carers for elderly relatives or spouses. Little training is available to help them with this role. A major challenge is how to deliver this information. One way to support learning is through pre-retirement courses (Life Academy 2009). These programmes have existed for decades, however their quality has been found to be uneven and access is limited. More recently new programmes have been developed aimed at specific topics such as financial literacy and health literacy.



### Curriculum for 4th age

Education and learning plays a particularly important role in the 4th age. Whilst these people are only a small percentage of the population, their numbers are rapidly increasing. For the majority, time is spent living in their own homes with their partner or children, with only 20% of people over 80 living in residential homes. Learning can encourage independent living, and helps to improve one's sense of autonomy where both may be severely constrained. Learning in this life phase can play an essential part in delaying the onset of extreme dependence. Many of the learning needs will overlap with those in the 3rd age, including managing health needs and staying physically and mentally active to maintain a sense of wellbeing. However, people's physical location and the level of support they require will influence their ability to access education. Often, the learning materials and/or teaching staff have to be brought to the learner. In residential care, what is available will

depend on the priorities of the manager and may not necessarily meet the needs of the residents. The report suggests that this is an area with great scope for future research.

### The challenge of lifelong learning

The overall goal of the Inquiry is to offer an authoritative and coherent strategic framework for lifelong learning in the UK. The challenge of a rapidly growing population in the fourth age is to develop a relevant curriculum, and establish appropriate working relationships between educational agencies and the health and social care ones without whose cooperation it is difficult to make any provision.

However, we do know that the overall effect of demographic change is likely to be a growing but ageing population, with a workforce increasingly dependent on immigration, a growing retired population, and an increasingly unpredictable lifecourse for many people. The report suggests this poses three risks which policymakers need to consider:

- economic tensions: as a shrinking number of economically active people support a growing number of retired dependents, exacerbated by uneven distribution of income and wealth, which makes it easier for some people to take advantage of new opportunities than others;
- cultural tensions: as new patterns of migration challenge the sense of identity of communities and the security of immigrants;
- personal well-being and health tensions: as the loss of the traditional anchors of identity in work and family undermine people's confidence and wellbeing.

The report further opines that lifelong learning cannot solve all the world's problems, but it can contribute to reducing all three of these risks.

**Holly Kilim**

5th Year Medical Student

**Martin Curtice**

Consultant in old age psychiatry

## **BupaFoundation** The Medical Research Charity

### **Bupa Foundation Awards 2009 - Call for entries.**

The annual Bupa Foundation Awards, now in their 30th year, are made to healthcare and medical professionals in recognition of excellence in healthcare. Current award categories are:

- Care Award – for excellence in the development of care for older people;
- Research Award – for the best emerging medical researcher in the UK;
- Epidemiology Award – for excellence in the epidemiological study of human disease;
- Clinical Excellence Award – for work that demonstrates an improved clinical outcome for patients;
- Health at Work Award - for excellence in occupational medicine;
- Communication Award – for effective communication between health care professionals and patients;
- Patient Safety Award – for outstanding contribution to patient safety.

Awards are £15,000 each, divided into two parts: £5,000 will be paid direct to the individual or team members and £10,000 will be for use to further the award winners' research. Applications are open to healthcare professionals who are resident and working in the UK.

**Closing date for entry is 1 July 2009**

For full details visit: [www.bupafoundation.co.uk](http://www.bupafoundation.co.uk)

For an application form please call: 020 7656 2246 or E-mail: [iona.chessells@btinternet.com](mailto:iona.chessells@btinternet.com)



# The National Dementia Strategy

## Will it improve dementia care?

**T**he National Dementia Strategy - will it improve dementia care? Yes, if geriatricians and neurologists, and not just old age psychiatrists (OAPs) engage with it!

It was unfortunate that the sound bite from the launch of the National Dementia Strategy (NDS) was, 'a memory clinic in every city', for to many clinicians a clinic means bricks and mortar, walls and a roof. So, not too surprising that the next sound bite that I heard was, 'memory clinics are unproven in their effect on dementia care'. Ah, so sad that those (hospital-based) making these comments neither appear to have read the NDS in

its entirety nor to have understood the concept of virtual clinics. The NDS is about team work and patient centred care, not bricks and mortar, OAPs understand this for they are used to working outside the institute (I believe it's called the community or 'real world') and taking the service to the patient.

The aim of the NDS is to ensure that significant improvements are made to dementia services across three key areas: improved awareness; earlier diagnosis and intervention; and a higher quality of care. The NDS identifies 17 key objectives which should result in significant improvements in the quality of services provided to people with dementia and should promote a greater understanding of the causes and consequences of dementia (Box 1). This resonates with our own publication 'Delirious about Dementia' and the importance of geriatricians engaging in identifying patients with cognitive impairment, typing the cognitive impairment and referring the sufferer and carer on to support services.

The objectives of the NDS can not be faulted and geriatricians must not shirk from their responsibility to be engaged in the process, for dementia is core to our practice whether or not we run a memory service. Whether we are confined to the acute hospital or out in the community, dementia sufferers and their carers will be ever present, the NDS offers us a chance to improve the care of both sufferer and carer. The potential benefits of improved dementia care to the system are: a reduction in the number of crisis admissions; a reduction in the number of delayed discharges; easier transfer of dementia sufferers to care home placement, which in themselves will reduce the costs of dementia care. Surely, just from an acute hospital perspective, the NDS offers an unrivalled opportunity to improve the care of those who are most at risk of a complicated and unnecessarily long hospital stay (any hospital management team that does not recognise this must itself be cognitively impaired!).

Of course improving dementia care will not be without cost and so the economic impact of

### Box 1: Key objectives of the National Dementia Strategy

1. Improving public and professional awareness and understanding of dementia.
2. Good-quality early diagnosis and intervention for all.
3. Good-quality information for those with diagnosed dementia and their carers.
4. Enabling easy access to care, support and advice following diagnosis.
5. Development of structured peer support and learning networks.
6. Improved community personal support services.
7. Implementing the Carers' Strategy.
8. Improved quality of care for people with dementia in general hospitals.
9. Improved intermediate care for people with dementia.
10. Considering the potential for housing support, housing-related services and telecare to support people with dementia and their carers.
11. Living well with dementia in care homes.
12. Improved end of life care for people with dementia.
13. An informed and effective workforce for people with dementia.
14. A joint commissioning strategy for dementia.
15. Improved assessment and regulation of health and care services and of how systems are working for people with dementia and their carers.
16. A clear picture of research evidence and needs.
17. Effective national and regional support for implementation of the Strategy.

implementing the NDS is modelled over 5 years, i.e. several fiscal spending rounds.

So, get engaged, if you aren't already. Ensure all your patients (inpatients and outpatients) have their cognition assessed; type the cognitive impairment; seek to stop or slow down the rate of cognitive decline (e.g. treat hypothyroidism, modify vascular risk factors, consider cholinesterase inhibitors); refer those with dementia to the appropriate support services; lobby your hospital to develop liaison mental health teams; lobby your acute hospital to improve awareness of delirium and dementia and get your hospital management to

understand the financial benefits of so doing; strengthen links with your old age psychiatrists; and work with your PCT(s) to improve the long-term care of care home residents.

And remember, you have a 1:4 chance of developing a dementia and a 1:3 chance of caring for someone with dementia, so making the NDS work is in your own interest too!

**Duncan Forsyth**  
Consultant Geriatrician  
Addenbrooke's Hospital

## Dancing with Dementia

### Dance Fever hits Lindfield Care Home!

With the success of 'Strictly come dancing', members of Lindfield Care Home's Richmond Suite in Worthing - a home to people with dementia, are throwing a few 'cha cha cha' moves themselves. The project is run in partnership with Worthing Council, Guild Care and 'fit as a fiddle'. Each week members put on their dancing shoes and shimmy their way into the lounge.

Laughter can be heard throughout the home, as members of all capabilities are involved in the sessions. This method provides a fun introduction to physical activity for members who have undertaken little previous exercise along with those who perhaps thought their dancing days were over. The benefits are not just physical, but also social and emotional, with its success demonstrating increasing participation and community spirit within the home each week.

Even the staff want to learn new moves, Leonie Haines the community dance artist, has provided a day workshop, so staff are able to deliver a flavour of the sessions in the future. Leonie Haines said, 'The response by staff and members has been brilliant, everyone has been extremely receptive and it is a pleasure to lead the sessions.'

"This is great fun", enthused Nell, "I've never laughed so much".

"This will give me an appetite", declared Bertha.

"What fun we're having", said Kathy.

"We are delighted to be able to have helped Lindfield organise these sessions," comments Julian Stevens of Worthing Council, "and it was only possible thanks to the financial assistance we received from fit as a fiddle."

The fit as a fiddle programme, is supported by The National Lottery through the Big Lottery Fund and is designed to help older people to live healthier, more active and fulfilling lives. The programme will be working in partnership within the community to deliver a range of courses to older people throughout the south east in physical activity, healthy eating and healthy lifestyles.

For more information including high quality visuals, please contact Tory Lawrence: Healthy Lifestyle Co-ordinator on 07901 635 033 or [tory.lawrence@acwestsussex.org](mailto:tory.lawrence@acwestsussex.org)

## Fit as a Fiddle, dancing with dementia

'Fit as a fiddle' is a national programme supported by the National Lottery through the Big Lottery Fund and delivered by Age Concern. It aims to improve the health and wellbeing of older people, promoting physical activity, healthy eating and developing 'active networks' for the over-50s.

In partnership with Guildcare's Lindfield Care Home and Worthing Borough Council, who have both embraced the project. Leonie Haines the community dance artist, led the sessions which took part at the home's Richmond Suite, where members could become fully involved in the project.

### Who is it for?

The active network is aimed at over-50s who are currently not undertaking much exercise and have an interest in dancing.

### Why we set up the project

Many residents in the scheme would like to do some form of physical activity, but did not have the confidence or opportunity to do so. The activity gets the residents of the Lindfield Care Home interacting together, which will help to develop a stronger community within the home. There are varying

each other; to provide a wider range of activities, rather than just your traditional activities for older people and to provide sensory stimulation through the various types of equipment used and music they use to listen to in their younger years.

Fit as a fiddle in partnership with Guildcare and Worthing Borough Council are supporting 8 free sessions at Lindfield Care Home. Leonie Haines leads the sessions with support from the care staff at the home. Each week, Leonie would lead the movement sessions, incorporating various pieces of equipment to work the different areas of the body. She would explain each technique and the benefit of the movements to the residents, which enhanced their confidence and made them all feel part of the group.

As the weeks progressed, the numbers of resident involved increased, especially as laughter could be heard all around the home during the sessions. The support workers played an important part in the sessions, providing support to Leonie and residents. A day workshop was arranged for 10 staff/support workers from Lindfield Care Home by Leonie Haines supported by the fit as a fiddle project. The workshop will enable the support workers to continue the movement to music sessions once the 8 sessions have concluded.



abilities within the group and all can be involved in the activity at their own ability level.

### The changes we wanted to happen

We wanted to encourage residents to become involved in other types of physical activity; improve the quality of life of the participants through improving strength, cardiovascular fitness, flexibility and energy levels; to develop a social group that can help reduce social isolation and provide support to

them completing a workshop training day as part of the Fit as a Fiddle project. Due to the success and interest from the residents, Guildcare, Worthing Borough Council and fit as a fiddle would like to replicate this project in other homes and areas.

### Contacts

Tory Lawrence – Healthy Lifestyle Co-ordinator  
Tel: 07901 635 033

Email: [tory.lawrence@acwestsussex.org](mailto:tory.lawrence@acwestsussex.org)

### Outcomes and impacts

All participants complete a monitoring form at the start of the project and an evaluation form at the final session. A 'Fit as a fiddle' staff member visits the group to evaluate the progress of the group, speaking with the participants and instructors. The project is a supported and sociable way of introducing a different type of physical activity to an older population.

### Next steps

The movement to music sessions will continue to regularly occur at Lindfield House, being led by the staff and support workers further to

## Age & Ageing Abstracts of work presented at BGS Scientific Meetings

The abstracts of work presented at BGS Scientific Meetings is now published online. The Spring 2008 (Glasgow) meeting has been published. The Autumn 2008 (Birmingham) abstracts will be published within the next couple of months.

## BGS responses to consultations

In recent months, the BGS has responded to the following consultations:

### General Medical Council

Eligibility for inclusion in the specialist register – *Dr Chris Turnbull*

Tomorrows Doctors - *John Clague and Jane Liddle*

### Care Quality Commission

Enforcement Policy – *England Council and the Policy Committee*

Reviews in 2009/10 - *Mehool Patel*

Statement of Involvement - *Mehool Patel*

### HM Government

Preparing for our ageing society – *the Policy Committee*

### Department of Health

Developing the Quality and Outcomes Framework: Proposals for a new, independent process – *Dr Ian Donald*

End of Life Care Strategy: Quality Markers Consultation – *Dr Eileen Burns and Dr Ian Donald*

Review of Prescription of Anti-Psychotic Drugs to People with Dementia – *Dr Peter Passmore, Cerebral Ageing and Mental Health SIG*

Application for a New Medical Specialty: Acute Internal Medicine – *Dr Roger Jay*

CAF for Adults: Improving information sharing around multi-disciplinary assessment and care planning - *Duncan Forsyth*

### All Party Parliamentary Group on Parkinson's' Disease

Access to Parkinson's' Disease Services – *Dr Peter Fletcher and Dr Dorothy Robertson, Movement Disorders Section*

Dementia Care Skills - *Peter Passmore on behalf of the Cerebral Ageing and Mental Health SIG*

## Rapid Review of Medicine in Old Age

Authors: Michael Vassallo and Stephen Allen

This book has two main purposes: formative case analysis and self-assessment of medicine in old age. It presents clinicians with a series of cases on which to base discussion of the investigation and management of patients. It also provides the trainee, or established doctor, with a medium to help prepare for post-graduate examinations and clinical practice.

The authors have chosen 109 cases, a total of 250 questions/answers, illustrated by colour photographs, diagrams and tables. The cases cover the main modes of presentation of acute illness in old age, such as falls, confusion, incontinence, weight loss and immobility, with examples from all the major systems. These illustrate the complexity of diagnosis and treatment of medical illness in frail older people and the need to think widely and laterally when caring for such patients.

The questions are mostly in best-of-five format to reflect the current style of multiple choice questions used in examination, though some are open questions as the basis for tutorials. Many of the clinical stems have been expanded to improve the educational function of the book and to test more rigorously the reader's deductive thinking.

[http://www.mansonpublishing.com/med\\_titles/VassalloAllen.html](http://www.mansonpublishing.com/med_titles/VassalloAllen.html)

### Book Review:

Several accounts of geriatric medicine aimed at the medical student and junior doctor have been published recently. This book is different in that it consists entirely of interactive cases and questions.

The answers for each question are thoughtful and detailed.

The advice given is up to date and refers to national guidelines as appropriate.

This book definitely engages the 'active learner', and I recommend it to medical students and doctors of all grades who look after the elderly.

Review by: Carlo Prina, SpR, North East Thames writing for Age and Ageing 2009; 38: 249–250

# BGS Spring Meeting 2009



## Bournemouth

**T**he ideal geriatrician is someone who 'knows something about everything and everything about something', said Prof Graham Mulley as he opened his first conference since becoming president of the BGS.

He was recalling the definition as he contrasted the state of today's society with how it was a previous time it had held its Spring meeting in Bournemouth 40 years ago.

Then there were only 100 delegates and all men. By contrast today's 460 male and female attendees came from a speciality much risen in stature and now "infused with enthusiasm, goodwill and talent. Geriatrics is in good heart in Britain. There has never been a better time to be old and disabled."

Reviewing advances both at and away from the conference, Prof Mulley cited continuous improvement in presentations and posters; the impressive resources of the website and *Age and Ageing*; the number of grants, awards and prizes now stimulating scientific endeavour and the influence on the Royal College of Physicians to make age-related themes the subject of major symposia.

But there was still much to be done. We needed to raise our still low visibility: a problem to be addressed by the appointment of Mrs Iona-Jane Harris, the Society's first press, PR and parliamentary officer. The Society would also be seeking 'rising stars and leaders of tomorrow' for media training. "We need to be more vocal in

championing the values we hold dear," he added. "We're not very assertive. We need to shout about injustices and inequalities, we need to be promoting dignity and combating the negativity of the pervasive current social model."

Links with patient groups and charities needed to be strengthened and the skills of patients and their families harnessed. We needed to be more politically savvy, to nurture the talents of young members of the profession and to beef up the academic side: although there were now 53 chairs in geriatrics or related disciplines, many of them were still honorary.

Challenges for the future included the tensions between generalist and specialist geriatricians and between hospital and community. "The move to care outside hospital is now inexorable and we need to make sure geriatricians are more and more in the community."



An unexpected cloud was the downturn in the economy. "Although we might not be entering a financial ice age as the prophets of doom claim, it is bound to have an effect on staff levels, bed numbers and services. We need to think seriously about health economics and any thoughts anyone has I'd be glad to hear them."

### From beyond our shores

One measure of how far BGS conferences have come is the degree of international input nowadays: guests speakers from halfway across the world, a dozen different nationalities in the audience and a whole session on dementia given over to a joint meeting of the BGS, the European Union Geriatric Medicine Society and the Clinical Section of the European Region of the International Association of Gerontology and

**...predictors of early presentation of Alzheimer's dementia include being a male, taking anti-psychotics, and agitation - confirming what we all know, that a stropky male gets one's attention**

an Alzheimer's Disease consortium based at Toulouse University, explained there can be wide variations in definitions and approaches. The UK distinguished between different types of dementia but that was not necessarily the case elsewhere: France for example used Alzheimer's as a generic term.

Through Emma's work with the ICTUS study in Toulouse, we learnt that important predictors of early presentation of Alzheimer's dementia include being a male, taking anti-psychotics, and agitation – confirming what we all know, that being a stropky male gets one's attention!

Dr Reynish, who is now a consultant geriatrician at Victoria Hospital in Kirkcaldy, quoted President Sarkozy's words on its Euro1.66 billion programme: "The mark of honour of a civilisation is that it offers help and protection to those who with the passing of time have become imprisoned in their own lives"

Dr M Baxter from the Royal Bournemouth highlighted how various psychomotor tests might help with predicting which patients with dementia might struggle with inhalers, but Adrian Wagg in typical geriatricianly style, reminded us that the best way of finding out if anyone can use an inhaler is to try them with an inhaler!

Nadina Lincoln from Nottingham presented work on psychomotor tests which might be useful in identifying unsafe drivers with cognitive impairment – one can only wonder how those without cognitive impairment might fare!

Finally, Dr van Munster from Holland presented some early work on understanding the genetic basis

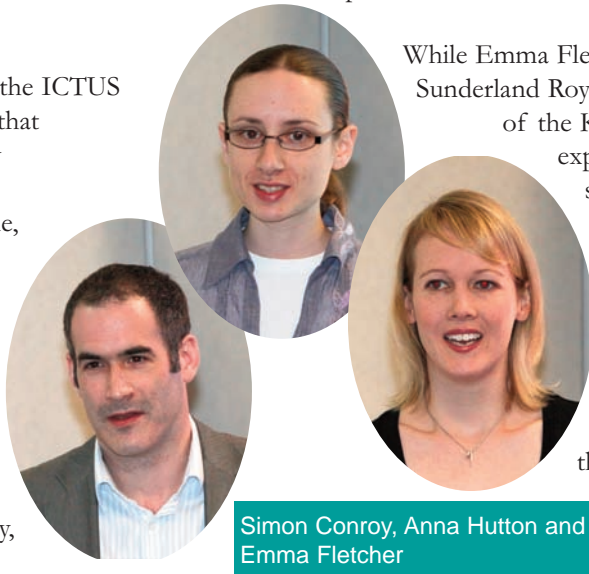
Geriatrics.

Dementia, of course, knows no boundaries: there are an estimated 9.4 million sufferers in Europe. But as Emma Reynish, who helped set up and co-ordinate

of delirium – and cleverly highlighted the importance of this work in identifying causal pathways. More to come in the future for sure.

**The human story behind research**

We saw a rare glimpse of the human story behind the bureaucracy of funding and awarding BGS fellowships. Three recipients of BGS grants/fellowships gave us an insight into how the grant had changed their lives and the direction of their careers. One clear theme that emerged from all three presentations was their appreciation of having the independence to manage their time and the variety of tasks inherent in the research process.



Simon Conroy, Anna Hutton and Emma Fletcher

While Emma Fletcher, Research Fellow at Sunderland Royal Hospital and recipient of the Kuck Fellowship could express appreciation for the support and leadership provided by her mentors, Anna Hatton, physiotherapist and recipient of a BGS/Dunhill Medical Trust Fellowship works in splendid isolation at the University of Teesside. The latter spent a year unemployed after graduation, which

put paid to her intention to go into clinical work. She found herself working as a research assistant which, together with securing the Fellowship, has set her on a path to what she hopes will be a permanent career in research.

Simon Conroy, senior lecturer at the University of Leicester, formerly one of Professor John ("Gladders") Gladman's Nottingham "wunderkinder", and recipient of the BGS/RIA Dhole fellowship, presented a witty analysis of the life lessons to be taken from doing academic research and he too expressed a heartfelt appreciation for the leadership he had received from, among others, "Gladders".

"It's amazing to think that what we're doing can change medical practice in the future.", said Emma and indeed it is amazing, but the most poignant aspect of these personal stories was the knowledge that the BGS has played a part in the development

of such confidence and passion for their careers, in these three young people.

### Boo the villain

As well as the traditional format of speaker presentations followed by questions from the floor, Bournemouth also saw the expansion of other formats aimed at increasing delegate participation: debates, workshops, a masterclass and a 'trial by jury'.

This conference saw a first when the BGS audience momentarily abandoned its habitual air of gentility and "hissed" as Dawn Garrett, Consultant nurse in Intermediate Care, Bournemouth and Poole Community Health Services, made the case for nurse led re-enablement services at home. "Who should lead?", she asked, pointing to a caricature of a white coated doctor, "Him? Who consults for 10 minutes and goes away? Her?" (pointing to a blue uniformed therapist), "with her goal orientated programme which isn't holistic? Or her" (pointing to a picture of a nurse) "available 24 hours a day, 7 days a week?" As one of the trio battling in a debate for their service to lead re-enablement services at home (Richard Day for doctors and Nicola Bryan for therapists), Dawn was obviously aiming to provoke a strong reaction from her mainly doctor audience, and she succeeded! During question time, Dr Peter Murdoch expressed good

**Leadership came from the person who in response to the patient's question: "I have a problem. Can you help?", could galvanise the intermediate care team to say, "Yes, we can!"**

natured shock at the divisiveness among the professions south of the Scottish border, but all ended with amicable consensus around Richard Day's view that leadership came from the person who in response to a patient's question: "I have a problem. Can you help?", could galvanise the intermediate care team to say "Yes, we can!"

### Entrenched attitudes

Entrenched attitudes showed in the debate: 'Complementary medicine should be used more widely in the NHS'. Speaking in favour, Dr Peter Fisher, clinical director and director of research at the Royal London Homoeopathic Hospital, outlined the latest research into the effectiveness of acupuncture for back and neck pain, St. John's wort for depression, fish oil for joint pain in rheumatoid arthritis, echinacea for reducing the incidence and duration of colds and the benefits of chiropractic manipulation.

Modern technology was now illuminating the processes by which these measures might work. "Acupuncturists used to be thought of as mad Maoists but new MRI scans show changes in brain during its use.

"Reliable, quality assured information is now available for

health professionals. There are safe and effective treatments for common conditions and they should be more widely used, especially where there is a lack of other treatments. Patients want them and if they're properly integrated they can be cost effective. Just because we didn't learn them at medical school shouldn't deter us."

Arguing against was Dr Dennis Johnston, consultant in geriatric medicine and professor of clinical pharmacology at Queen's University, Belfast, who spoke of the 'gullibility factor'. "Everyone is biased and people tend to observe what they expect." There could be a placebo effect – "and remember, sometimes things get better on their own."

The objections to complementary medicine included: absence of definable outcomes, too many disclaimers, universal diagnosis, exaggerated claims and the suggestion that conventional medicine was conspiring against it.

## BGS Spring Meeting 2009 - Prize Winners

### John Brocklehurst Prize for Best Clinical Effectiveness

Poster: Dr Sarita Bhat  
Royal Bolton Hospital

### Elizabeth Prize for best Platform Presentation:

Dr Barbara Van Munster  
Academic Medical Centre Amsterdam

### Fergus Anderson Prize for best Scientific Presentation

Poster: Dr S Brice  
Imperial College London and

S Jacobsberg  
University of Lewisham

It was also unacceptable to say that they could not hurt. There could be the direct problems of toxicity or reactions with other drugs or the indirect ones of causing a diagnosis to be missed or a treatment delayed or stopped. Despite his spirited arguments, the almost unanimous “for” vote among a small, self-selected audience at the start of the debate for the motion, remained so at its end.

### Deprivation of liberty

The Friday morning workshops were another departure from the usual format, requiring more delegate involvement. In the mental capacity one members were divided into groups, each with an expert facilitator, and given a scenario based on a real case history. The aim was to examine the concerns raised and suggest possible courses of action.

Before that, they were given an outline of some of

the issues surrounding deprivation of liberty. Prem Fade, consultant in geriatric medicine at Poole Hospital, explained that essentially there was no exact definition that could be measured by a checklist: it depended on the circumstances surrounding each individual case such as the intensity and degree of confinement, whether it was cumulative in nature and the feelings of patients themselves and their families. So in one appeal, for example, a man’s family had objected to him being kept in a care home but the court had agreed to it as the man himself was happy to be there.

Deprivation of liberty might also be lawful if it was in a patient’s best interests to prevent him harming himself or others but it had to be proportionate and no more restrictive than it needed to be. “It’s not what you do but how you do it,” said Dr Fade. Locked doors did not always signify deprivation of liberty if that meant patients

**The Quality Care Commission, the new independent regulator of health and social care in England, was only a couple of days old when introduced to the meeting by one of its commissioners Prof. Martin Marshall.**



Prof Martin Marshall

He began by outlining various types of regulation and their ways of improving patient care. One was professional: education and training, clinical audits, guidelines and peer reviews. Another was governmental: performance management and legislation. A third economic: incentives, sanctions, patient choice and competition. A fourth might be termed ‘industrial’ or organisation based. But with so many different agencies involved, he said, the field could become very cluttered and confusing.

The definition of regulation was sustained and focussed control through a system of rule making and adjudication carried out to assure the public that the regulated body was fit for purpose. “The days of saying ‘trust me I’m a doctor,’ are long gone,” he said. An increasingly knowledgeable public needed assurances, a balance

between trust and checking.

Regulation must have the three components of direction setting, surveillance and enforcement and it must justify its £250m costs.

“It might sound cheesy to call the QCC a ‘people’s regulator’ but its primary interest group will be the users: patients and their families and

carers. We will always take the user’s side in any conflict. Our independence is key. We’ll have big fights with government and with service providers if user interests need that.”

The new body is a merger of the Healthcare Commission, the Mental Health Act Commission and the Commission for Social Care. There had previously been a disconnection between these fields and their different approaches. It was as if healthcare was from Mars, social care from Venus. The former dealt with ill health, sick individuals, prescribing and institutions; the latter with well-being, the whole person, decisions and networks. But they needed to be part of the same continuum offering joined-up, personalised services and choice.

“This is a new way of looking at care,” added Prof. Marshall. “My mother who has had dementia for eight years has just gone into a care home so I have a close personal interest in this.”

The commission would also look at patient safety and quality of life. It would seek to involve expert groups and to carry out both formal and informal consultations with users, carers and providers. There would be emphasis on outcomes and value for money for the £250m budget. There was already a growing body of evidence that regulation did make an impact in focussed areas: the Healthcare Commission’s annual check in 2005 found that twice as many NHS trusts showed improvements as deteriorations; by 2008 the figure had increased to 20 times as many showing improvements.

The QCC would continue the trend towards self-assessment by service providers which would be checked by periodic reviews and targeted inspections. Whereas previous regulators had had few powers the new body could firstly name and shame with a public warning and follow that with financial penalties, suspension and closure. “We’ve no desire to be draconian and I suspect their use will be rare but they are there and will be used if necessary.”

could wander freely in a safe environment. Deprivation of liberty had to be authorised by a supervisory body and meet several criteria. In urgent cases, however, staff could make the decision themselves. "It's important to stress to front line staff that where something needs to be done within the hour in the patient's best interests then they must not get hung up on the issues. Authorisation can wait until the next day." She cited various cases and their solutions. One was a patient with alcohol related dementia living in a care home who wanted to go to the pub and get drunk. The staff felt that should not be allowed but his daughter felt that the refusal was depriving him of his liberty. The decision was that the care home be required to provide an escort to take him to the pub three times a week for limited quantities of alcohol. Another example was a woman who was highly mobile in her wheelchair but so confused she was a danger to herself and others. The solution was to give her the freedom of the wheelchair when it could be supervised. Similarly complex dilemmas were then the subject of stimulating and enlightening group discussions.

### **Trial by jury**

This was the other format, requiring delegate participation. It addressed the consequences of atrial fibrillation with various 'charges' being brought, including the need for significant improvement in its management and the underestimation by physicians of its impact on quality of life. Witnesses were called and cross-examined before a verdict was reached. This and the masterclass were two of several sponsored symposia at the event which also featured stands and displays from 21 pharmaceutical and other exhibitors.

Although the programme was, of course, primarily concerned with old age, it did feature one important 'new baby'. (see box on page 24).

Our second guest lecturer was Prof Allan McLean, associate dean at the University of Notre Dame in Sydney and director of clinical services at Werribee Mercy Hospital in Melbourne. Prof McLean, who is also a consultant in geriatric medicine, spoke about some aspects of Australia's policy on ageing including strategies to promote older people in the workforce, particularly women, and to target the prevention of the common diseases which prevent people working in later life.

"It's estimated that if 64 year-olds could be retained for only one more year there would be a ten per cent increase in the GDP. So we should start by being nice to them and paying them properly."

Prof McLean then devoted the second half of his lecture to discuss in detail his work on age related changes to liver mechanisms.

There are 57 different medical and surgical specialities in Britain today and as geriatricians need to 'know something about everything' the conferences can provide valuable insight into those areas where their subject overlaps with another.

In the session entitled The Older Surgical Patient – A Guide for the Referring Physician, Andrew Severn, consultant anaesthetist at the University Hospitals of Morecambe Bay, spoke of the need for geriatric input before surgery was carried out. "We can all recognise the extremes of frailty, for example. We need you to tell us the borderline cases."

He was followed by another consultant anaesthetist, Irwin Foo, of the Western General Hospital in Edinburgh, who looked at preoperative risk prediction in older patients. The mortality rate increased with the degree of invasiveness so it was vital to assess physiological ageing and see how much function was reduced. It was often necessary to follow questionnaires with 'a reality check'. "Ask a patient who says they don't have breathing difficulties to climb a flight of stairs, for example, to see if they really don't. One of mine once collapsed. Patients who've waited a long time for an operation may gloss over difficulties for fear of it being postponed." New computerised risk assessments based on 12 physiological parameters could put patients into low, medium or high risk categories and help with post-operative placement.

Jugdeep Dhesi, consultant in geriatric medicine at Guy's and St. Thomas's Hospital, gave an update on POPS: Pro-active Care of Older People undergoing Surgery. The system included comprehensive geriatric assessment and the involvement of physio- and occupational therapists, and social workers as well the surgeon and anaesthetist. Over 600 patients a year were now being seen under the scheme which had reduced deferrals and cancellations, post-operative

**“Doctors don’t like doing it but sometimes it has to be done and you need to lead by example.”**

complications and length of stay in hospital. It was hoped other centres would adopt the model.

### **Computers, everywhere computers**

Although there was no

designated session on telemedicine at this conference, the role of computers inevitably appeared elsewhere. In a clinical update on orthogeriatrics, for example, Prof Cyrus Cooper, professor of rheumatology at Southampton University, referred to the use of a computer programme to assess the probability over ten years of a patient suffering a hip or other major osteo-fracture. The programme was useful, he said, in deciding on intervention thresholds. High risk individuals would be given immediate treatment, usually with alendronate, whereas mid-range ones could then have their bone density measured and be reassessed accordingly.

There were also clinical updates on cardiology and gastroenterology. In the latter, Trevor Smith, consultant gastroenterologist at the Royal Bournemouth Hospital, covered the diagnosis and treatment of oesophageal disorders and James Barrett, consultant in geriatric and stroke medicine at Arrowe Park Hospital in The Wirral, discussed the investigation and management of constipation in the elderly.

With a touch of humour - the ideal ‘Goldilocks stool’, for instance, would be not too hard and not too soft but ‘just right’ - Prof Barrett stressed the need to investigate and deal with a problem that can adversely affect a patient’s quality of life and sometimes even be life threatening. And he was forthright about rectal manual examination. “Doctors don’t like doing it but sometimes it just has to be done and you need to lead by example.”

Constipation was in fact the subject of the first breakfast sponsored symposium when Adrian Wagg, senior lecturer and consultant in geriatric medicine at University College Hospital, London, spoke on the scale of the problem and its consequences. Its incidence was 20 per cent among the elderly in the community and 50 per cent in care homes. Causes included a wide range of medical conditions and drug side effects as well as age related changes like a loss of rectal sensation and a decline in the call to stool. “It has a very

negative impact on quality of life. The distress can be so high that I’ve known patients actually welcome diarrhoea as a side effect of radiation.” Extreme cases could lead to sepsis, breathing difficulties, even death. Yet despite its prevalence and dangers there was evidence that the problem was often poorly managed.

Andrew Davies, consultant in palliative medicine at the Royal Marsden Hospital in London, said opioid induced constipation was a major problem for his cancer patients, occurring in up to 70 per cent. It could be caused by lower level analgesics as well as morphine and complications could include haemorrhoids, anal fissures, intestinal obstructions and perforations. Everyone on opioids should be put on prophylactic laxatives, he believed.

On a more cerebral level there was a Meet the Professors session. Prof Chakravarthi Rajkumar, professor of geriatrics and stroke medicine at Brighton and Sussex Medical School, outlined his department’s work on cardiovascular disease, the effects of the Mediterranean diet – they had done a study comparing old people in Brighton and Verona – and pro-biotics. And he called for geriatricians to be active in their hunt for research funding – “there’s lots of money out there.”

In a talk entitled ‘Beyond the black box’ Prof John Gladman, professor of medicine of older people at Nottingham University, spoke of the benefits of backing up randomised controlled trials with qualitative research to illuminate missing areas. “So you ask not just what the outcomes were but how they were achieved. You get a richer picture.”

### **A little play ‘midst all the work**

The meeting was, of course, not all work and no play. With lovely weather and a conference centre just yards from the beach there were opportunities for delegates to enjoy being by the seaside. On the Thursday evening, the Royal Bath Hotel, once the haunt of Oscar Wilde, was the setting for the dinner. The after dinner speaker was former RAF pilot and air traffic controller David Gunson. As President Mulley reminded delegates in his introduction: “you don’t stop laughing because you grow old; you grow old because you stop laughing.”

**Liz Gill**

Freelance journalist, with a little help from **Simon Conroy**, Senior Lecturer, Leicester, **Katy Ladbrook** and **Recia Atkins**



# Raising the profile of geriatrics and the BGS

## - thinking and communicating strategically

**T**he single most important initiative in the 2008 strategic review of the British Geriatrics Society is for us to break new ground and create an imaginative plan which will see geriatric medicine re-assert and enlarge its role in the community.

The Society has the opportunity to provide leadership to ensure geriatricians play a key role in community geriatrics and to emphasise the fundamental nature of this aspect of the specialty. There is plenty of material on the subject (our own “Interface between primary and secondary medical care in the new NHS in England...” is an example). However, we do not appear to have succeeded in pushing this all the way through to country-wide delivery.

By 2031, it is estimated that there will be 4.8 million people over the age of 80 and 2.5 million over the age of 85 (Office for National Statistics, summer 2008). Whilst hospital based services will remain an important part of our service, we can expect bed closures to continue and our hospital base to shrink.

### The main challenges for the BGS

- ◆ Community geriatric medicine already works in many places – it is nothing new; but the Society must be seen to be devising country wide cost-effective solutions which commissioners will buy into. We will have to create models that work in all four nations of the United Kingdom.
- ◆ We need to ensure more cohesive action between the key standing committees as well as the special interest groups and sections.
- ◆ We have to adopt a multi stakeholder, multi disciplinary approach from the outset without losing ourselves in the pile.
- ◆ We need to re-align our Regions within England, to be in step with Strategic Health Authority boundaries and those created by the Royal College of Physicians, at the same time finding local BGS members who will champion the specialty to commissioners

Central to dealing with these challenges is the profile of the British Geriatrics Society. Put simply, our specialty is sometimes under-recognised and under-valued. We have experienced several false starts when it comes to effectiveness in the arena of Press, PR and Parliamentary Affairs, but the time was right to expand the present Secretariat by recruiting a professional PR person to direct our thinking on this very important front. To this end, we have recruited Iona-Jane (see her introduction below) whose role will include:

- ◆ Achieving coverage in various media formats, and establishing links with key journalists;
- ◆ Helping us to influence politicians before policy is decided. (This will be a long term objective and may include the creation of a cross-party lobby group);
- ◆ Ensuring that the Society has notice of key decisions and the ability to prepare advance press notices;
- ◆ Raising the profile of the Society amongst the public while ensuring that our grass roots members are assisted in the role of making their voices heard - particularly with PCT commissioners;
- ◆ Raising amongst carefully targeted local populations, particularly older people and their carers, the importance of having geriatricians
- ◆ Ensuring media training courses are sourced and completed by appropriate Society Officers
- ◆ Expanding the existing base of links with charities and voluntary organisations; possibly hosting a reception at MWH as we have for the pharma industry
- ◆ Producing executive summaries to the numerous consultation responses we produce – these to appear on the website
- ◆ Producing reports on key scientific publications and articles (Age and Ageing, conferences, others)

This is an ambitious job specification and to achieve all these objectives will take time and require a good deal of support, not only from other members of the Secretariat, but also from key officers and grass roots members. We welcome Iona-Jane to the Society and wish her fortitude (and fair wind) in her role!

**Alex Mair**  
Chief Executive Officer



# Lifting the bushel which hides our light

- the person who will help us do it...

**I**ona-Jane Harris was appointed BGS Press, PR and Parliamentary Affairs Officer in mid-April, following the BGS 2008 Strategic Review. David Oliver asked her about her background and initial impressions of her new role.



## What is your background and how/why did you first get involved in public/media relations work?

I studied Modern Languages at Oxford University, graduating in 2001. After some time spent exploring the world, Public Relations and Public Affairs appealed as a career option as it offered me the opportunity to combine my analytical and creative skills to develop strategic communications plans. It is exciting to be in a position in which you can contribute to public debate and seek to influence policy developments and legislation.

## What kind of roles have you played before joining the BGS and what kind of projects were you involved in?

I spent five years working as a consultant at Keene, an independent public relations and public affairs consultancy. I was responsible for a diverse range of clients in the public, private and charitable sectors. These included IndependentAge, a national older people's charity, which rebranded from the Royal United Kingdom Beneficent Association as part of a campaign to raise its profile and increase its influence. I worked on a variety of activities to draw greater attention to the importance of independent living for older people. These ranged from conducting surveys into attitudes towards ageing and publicising their results to arranging Parliamentary receptions to facilitate the organisation's political contact building.

I gained valuable insights into the workings of the Department of Health and the NHS through my work with Hidden Hearing, a private sector hearing

healthcare provider, during the Modernisation of Hearing Aid Services Programme and its aftermath. This included identifying and acting on opportunities to contribute to the development of audiology policy through working with MPs with an interest in audiology, or who were concerned by long waiting lists in their constituencies, and responding to a Health Select Committee Inquiry into Audiology Services. My work with Hidden Hearing also brought me into contact with the Welsh Assembly and the Scottish Parliament.

I also provided the West Midlands Fire and Rescue Service with strategic government relations advice during the modernisation of the fire service to ensure that they maintained good relationships with their constituency MPs at a time of significant restructuring and strike action.

In 2008, I had the opportunity to work on a project in Uganda, to provide NGOs with public relations training. On my return to Europe, I decided to spend some time in Paris to brush up my French. I have just returned to London after working for a small French communications agency and I am delighted to have been appointed to this newly created role at the BGS.

### What appealed to you about becoming our first ever Press/PR/Parliamentary Affairs Officer?

It is an exciting challenge! The creation of this role represents a fantastic opportunity for the BGS to raise the profile of geriatric medicine and to draw political, media and public attention to the excellent work members are doing to provide older people with the care they deserve.

I am looking forward to developing a structured communications strategy, which will raise awareness of the BGS' concerns, whilst highlighting the vital work of our members amongst our target audiences, whether these be journalists, fellow health professionals, PCT commissioners, politicians, carers, or the public at large.

**I am looking forward to developing a structured communications strategy which will raise awareness of the BGS' concerns**

### What will you be doing first?

In order to develop a successful communications plan, I need to meet and hear from as many members as possible over the coming months. The

key to any profile raising activity is to have an agreed set of communications objectives and priorities. I would like to receive members views on what you see as key messages the BGS should be communicating and who you perceive as our key target audiences.

If you have been in touch with journalists or MPs in the past, I would be grateful if you could drop me a line so that I can establish a database of the BGS' political and media contacts.

I am also on the look out for members prepared to speak to the press and media on topics they have specialist knowledge of and media training will be provided for these individuals.

So please don't hesitate to contact me either by email at [IonaJaneHarris@bgs.org.uk](mailto:IonaJaneHarris@bgs.org.uk) or give me a call on 020 7608 8573. I look forward to working with you!

**David Oliver** interviewing **Iona-Jane Harris**  
Press, PR and Parliamentary Affairs Officer  
BGS

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# Care and dignity



all the time, every time

**I** was looking forward to the Nursing and Midwifery Council (NMC) guidance for Care of Older People<sup>1</sup>, in the hope that it would further support my role as a senior practitioner in the field.

Throughout my 31 year career I have actively used my Professional Code as a tool to review my own practice and to challenge both practitioners and managers when care has been compromised, or the environment or resources has negatively impacted on the delivery of optimum care.

What has been missing for some time is a clear, affirmative document as to the specialist skills and knowledge required to ensure best practice is applied wherever older people are receiving care and treatment.

There is much written about the needs of older people and the impending resource implications of the ageing population, as well as the continuous media horror stories of where care fails. But there has never, I believe, been a commitment to address the true issues behind the failures.

This latest publication of guidance for Nurses on the care of older people identifies in a 39 page

**...care of frail older people is so commonplace that it can be over-simplified in people's minds, to the fundamentals, nutrition, hygiene, respect.**

Code and the raft of documents which have been produced over the past 10 years, stemming from the work that has developed through the dignity in care campaign.

They are no different from the attitudes and behaviors I was taught and assessed on back in the late 1970's and 80's.

However, this publication misses the opportunity to emphasise that older people need from the professionals who manage their care, advanced, specialist assessment skills which go beyond those involved in

general care. There is no clear message around the competence to recognise and detect ill health in people unable to ask for help, or the need to detect underlying illness resulting from ageing systems which do not present in classic textbook fashion, but which will impact on recovery or worse still, result in premature death. There is no recognition of the skills in pharmaco-kinetics and pharmaco-dynamics needed to monitor and prescribe treatment to a group of people who have complex multi-pathology and are already suffering poly-pharmacy.

booklet the principles of care and the behaviours expected. There is nothing wrong with the fundamental principles and they are in total concordance with the NMC

Instead, the guidance promotes the focus on preventing acute hospital admission and on commissioning out health and social care services, with increasingly complex care being carried out in the community by a range of providers - the recipients of much of this care being older people. However, I suggest with the changes comes little evidence of a commensurate commitment to providing specialist nurse and geriatrician access and expertise in these settings.

Given that people "do not know what they do not know", care of frail, older people is so commonplace that it can be over-simplified in people's minds to the fundamentals, nutrition, hygiene, respect. This leads many to believe that elder care basic care, deliverable by non specialist staff.

What is not recognised by non specialists, is the impact of the ageing process on the delivery and consequences of those fundamentals, when not provided appropriately, or adapted and managed during episodes of physical or



psychological instability in a timely fashion.

My hope was that this guidance would clearly identify the skills and knowledge required to ensure the older people's safety, and I feel it is a missed opportunity to lay down some clear educational and resource standards which nurses could use, both to review their own competency, but also to challenge service commissioning and delivery.

In my cynical moments I believe that nobody is prepared to clarify the level of specialist nursing staff, the knowledge and skills they require, and skills mix of the teams they work with, to ensure excellence in older people's care, because they wish to avoid the cost implications.

**1 NMC (2009) Guidance- For the Care of Older People: London. NMC**  
<http://www.nmc-k.org/aDisplayDocument.aspx?DocumentID=5593> [accessed April 2009]

**Soline Jerram**  
 Consultant Nurse

– Older People and Intermediate Care

## Parkinson's Disease Academy Update

Thursday morning at the Spring BGS Meeting in Bournemouth saw an update from the Parkinson's disease (Pd) Academy. The Masterclasses, delivered by the Pd Academy, were described by a past BGS president as 'not just the jewel in the crown of the [then] Pd Section, but of the BGS itself.'

Now in its 8th year the Pd Academy will see 66 participants pass through 2009's three Masterclasses which will make a total of 312 over 16 Masterclasses. The first 7 comprised mixed groups but from 2006 onwards the 2 classes per year have been badged 'Classic' (for consultants and other more senior colleagues) or 'SpR' for more junior colleagues with curricula to match. During 2009 for the first time there will be 2 'SpR' classes as well as the 'Classic'. In all Masterclasses, around three quarters of participants are drawn from Geriatric Medicine with others drawn from Old Age Psychiatry, Neurology, and Rehabilitation Medicine plus colleagues from nursing and the Allied Health Professions. There have also been 2 'Advanced' Masterclasses – the latest in 2008 – for alumni.

Audit has always been part of the 2 module Masterclass (now rebadged the Classic) and has run alongside the mentoring period that characterises the 6 months between the modules. Since the publication of the NICE guidelines it has become possible for these audits to use those guidelines as the audit Gold Standard.

This in turn has prompted the construction of a website based audit tool in a project led by Dorothy Robertson (Bath) with the support of the Pd Society and colleagues from other professions. This was demonstrated. Moreover the Masterclass has proved a superb opportunity to pilot the tool – something that has been happening since Masterclass 8. The tool will be rolled out over 2009 and will be trialled once again in Masterclass 14 which begins in May.

Serendipity is a wonderful thing. No sooner had we analysed the data from Masterclass 12, than the All Party Parliamentary Group (APPG) on Parkinson's disease launched its enquiry into the inconsistency of provision of Pd services in the UK. Invited to make a submission the Section was able to draw on the results of Masterclass participants' audits to demonstrate just that.

So from humble educational beginnings have come not just opportunities for fabulous CPD and service developments based on participants' interests and involvement, but also audits that have been heard at a level from where commissioning change might, just might, result.

**Peter Fletcher - Chair**  
BGS Movement Disorders Section

## Parkinson's Disease appraising the time of treatment

The hot topic in Parkinson's disease (Pd) management currently, is not so much *what* to treat with, but *when* to treat.

With Movement Disorders Section Chair, Peter Fletcher umpiring, this issue was debated at the Teva Pharmaceuticals and Lundbeck Sponsored Symposium "Timing of treatment in Parkinson's disease" during the Spring Meeting at Bournemouth. Arguing 'for' was Richard Walker (North Tyneside) and 'against' was Chris Gordon (Winchester).

UK estimates suggest that around half of patients diagnosed with Pd are not started on medication immediately. This is often due to patient choice, but also due to the assumption that all treatments are purely symptomatic while most carry significant

risks of side effects. Hence 'against' the motion, traditional teaching has been that it is better to wait until the patient suffers significant problems before initiating treatment.

However, 'for' the early treatment of PD are a number of studies (e.g. DATATOP, PDLIFE and the recent ADAGIO delayed-start study) which demonstrate that earlier treatment initiation offers benefits to patients both in terms of clinical progression of the disease and quality of life. It was also noted that there is a need to reappraise when changes are made to the patient's medication, for example to manage wearing-off. There is a wealth of data to demonstrate the efficacy of adjunct therapy and now increasing moves to introduce adjunct therapy much earlier than before. We now have a better understanding of how to delay the use

of levodopa and/or keep the dose low if initiating.

Not at issue, is that the choice of which medication class to use should be individualised. Effects on cognition (especially with dopamine agonists) and other side effects need to be taken into account.

So what of the debate? Well, Richard had a tough job as the audience's pre-debate votes reflected the growing view that early treatment is indicated. Although Richard's eloquence ensured that the post

debate vote went his way, Chris's forensic destruction of 'the evidence' did erode Richard's margin somewhat!

My thanks go to both the speakers for their excellent contributions and to our sponsors for organising the session.

**Peter Fletcher - Chair**  
BGS Movement Disorders Section

### Third issue of Stroke Matters now available

Produced by **The Stroke Association**, **Stroke Matters** is a quarterly e-publication for professionals with an interest in stroke. The publication promises to deliver interesting and accurate news on stroke issues, carefully selected by an expert multidisciplinary editorial board comprised of leading stroke specialists. Stroke Matters covers: stroke policy and practice; the latest stroke research, upcoming conferences and news from The Stroke Association. The third issue is now available. To subscribe free, please email your contact details and profession to [strokematters@stroke.org.uk](mailto:strokematters@stroke.org.uk).

### Erratum

**In the March issue of the newsletter, we misspelt the name of Lucy Sutton, author of the article: "The National End of Life Care Strategy"**

## In memoriam

### Professor John Pathy OBE FRCP (1923 - 2009)

**It is with great sadness that we announce the passing away of Professor M S John Pathy, who died on Wednesday 8 April 2009.**

Professor Pathy became a member of the board of the Old People's Welfare Committee for Wales, an early incarnation of Age Concern Cymru, in 1961. Devoting nearly 50 years of service to the charity, Professor Pathy became the President of Age Concern Cymru in 2001. In 2005 Age Concern named their new offices as Ty John Pathy in recognition of his distinguished career in geriatric medicine and his services to older people in Wales. The administrative office of BGS Cymru is now also located in Ty John Pathy.

Professor Pathy's medical education started at the King's College University of London where he qualified in 1948. He then held a number of posts in dermatology, general medicine, paediatrics, casualty, and infectious diseases at various London hospitals.

He moved to Wales in 1951 to become Medical Superintendent at the Llwynypia Hospital in the Rhondda and after a short return to England he returned to Wales in 1960 after turning down an opportunity to become a Consultant Physician at Rugby Hospital, to take up a similar post with the Cardiff Hospital Management Group

because he and his wife Norma both preferred to live in the Welsh capital.

During his time in Wales, Professor Pathy became the doyen of geriatric medicine inspiring and teaching many of today's practitioners. He pioneered the close collaboration of the work of health and social services. He championed the establishment of day hospitals and hospital aftercare services for older people and developed a wider role for health visitors. Respected around the world for his work in geriatric medicine, Professor Pathy was the author of numerous papers and was the editor of *Principles and Practice of Geriatric Medicine*, the essential reference book for those working in geriatric medicine.

John Pathy will be remembered by all who knew him as a kind and modest man, a real gentleman, a wonderful teacher, a man passionate about his work and a friend to so many people both young and old. He was one of those rare people who have become a legend in his own lifetime and he will be sorely missed.

**Michael Phillips**  
Media Relations Manager/Rheolwr Cysylltiadau a'r  
Cyrfryngau  
Age Concern Cymru and Help the Aged in Wales

# Payment by Results

implications for geriatric medicine

**T**his article covers an introduction to the system of Payment by Results (PbR), and is the first of a series of two articles on the subject.

The second article in the series, to be published in the July issue of the newsletter, has more of a Geriatric Medicine focus, relating PbR to clinical practice and its potential implications for the future direction of Geriatric Medicine within the NHS.

## Background to Payment by Results

Payment by Results (PbR), as a concept, was first introduced by the Department of Health in 2002, as part of wide-ranging reforms within the National Health Service (NHS)<sup>1</sup>. It is a model of how money flows around the NHS, and sets up incentives for NHS hospitals to become more financially aware, charging commissioners (usually the local Primary Care Trust (PCT)) for treatments and services provided. The effective implementation of PbR depends on constructive relationships between all parties operating within the system.

In the United Kingdom, PbR is currently being

used in England and Wales, and is based on similar models used in many countries world-wide such as Australia and Sweden<sup>1</sup>. Most patient attendances and admissions in a secondary care setting are translated into a national tariff, which is charged to commissioners. Each tariff is determined by the Health Resource Group (HRG) that is in turn dependent on complex coding of clinical information. The HRGs are assigned using a national piece of software called the HRG Grouper. Data about an individual patient encounter, such as whether they were seen as an elective or emergency, as an in-patient or out-patient, is taken into consideration, as well as their diagnoses, investigation and procedures undertaken, and their age and background co-morbidities<sup>2</sup>. The old version of HRG was 3.5 and was replaced by HRG4 in April<sup>3</sup>.

## Why the need?

PbR introduces transparency in NHS financial flows as essentially the funding follows the patient. It challenges and incentivises organisations to improve efficiency and increase productivity in a very dynamic environment. Charging for each treatment provided should drive cost efficiency, incentivise new clinical activities, and make the flow of funds to and within NHS Hospital Trusts more transparent and fair<sup>4</sup>.

## Move from HRG 3.5 to HRG4 – Concept of ‘Unbundling’

In April 2009, the previous version of HRG (v3.5) was replaced with HRG4<sup>3</sup>, which sees an increase in HRGs from over 500 to over 1400, designed to better reflect the complexities of clinical care. The concept of unbundling was to be introduced in a limited way from April 2009 and is designed to support patient choice by better aiding the process of breaking down a tariff for a patient into its constituent parts<sup>3</sup>.

As an example, the acute admission of an elderly patient because of a hip fracture secondary to a fall would be separated financially from their subsequent period of 10 days of rehabilitation prior to returning home. This gives commissioners flexibility to have different providers for discrete

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1. Department of Health. Reforming NHS Financial Flows: Introducing Payment by Results. London: Department of Health; 2002.
2. Department of Health. Delivering the NHS Plan: next steps on investment next steps on reform. London: Department of Health; 2007.
3. Department of Health. Options for the Future of Payment by Results: 2008/09 to 2010/11. London: Department of Health; 2007.
4. Department of Health. Payment by Results Guidance 2007-8. London: Department of Health; 2006.

elements of a patient's journey, to stimulate competition between providers; importantly though, the correct unbundled HRG will only be generated if the data is recorded appropriately and coded correctly.

Originally, there were nine areas due to be unbundled from April 2009, including rehabilitation. Other clinical services that were proposed to be unbundled within the same timescale included palliative care, chemotherapy and radiotherapy, and critical care services.

Unfortunately, only one part of one of the originally proposed areas was unbundled from April 2009 – outpatient diagnostic imaging. As yet, because not even non-mandatory tariffs have been released, Trusts are unclear as to when rehabilitation will be unbundled. It may therefore be prudent for Trusts to negotiate a local tariff for their rehabilitation element of care to account for this.

### The importance of clinical information and the correct coding of patient data

Accurate HRG allocation (and reimbursement) is reliant on accurate coding; however the accuracy of coding is fundamentally determined by the accuracy and timeliness of the clinical information that is documented about each patient's investigations, diagnoses, and management. This is then coded by the hospital Clinical Coding Department and these

codes produce an HRG for each patient episode.

Different tariffs are applied for investigations and procedures that the patient may have had during their in-patient episode. For example, if a patient has both a chest radiograph and an OGD (oesophago-gastro-duodenoscopy), an OGD attracts a higher tariff than a chest radiograph, and thus becomes the 'dominant

investigation'. The 'dominance' is determined by how resource-intensive the procedure is deemed to be and there is a procedure hierarchy that demonstrates this.

Similarly with outpatient clinics, attendances at different clinics are charged at different rates, depending on the specialty assigned to that clinic. For example, a patient attendance at a geriatric-neurology clinic may attract a higher tariff than a general geriatric medicine clinic.

The HRG is generated by a complex series of steps undertaken by individual Trusts' Coding Department. This includes generating a code for the dominant procedure carried out, using OPCS-4.4 (Office of Population for Census Survey Version 4.4). The principal diagnosis reached during an in-patient or outpatient episode is used to generate a separate code using ICD-10 (International Classification of Diseases Version 10). The two different codes from procedures and diagnoses are then used to generate an HRG code, which is the 'currency' of PbR. This process of HRG code generation is illustrated by an example below.

A term that is used within PbR is the 'trim point' for a particular HRG. Using the example in the box, the HRG code for thrombolysis of a TACI would assume an in-patient stay of a certain number of days – the 'trim point'. If the patient stays in hospital for fewer days than the trim point, then the tariff is not reduced (an incentive to plan for early discharge), but if the patient's in-patient spell exceeds the trim point, then each extra day can be charged at a pre-specific rate for that diagnosis, as set out in the HRG coding manual.

The source documentation used for coding is important and can vary from Trust to Trust - case notes, discharge summaries, operation sheets, and practice varies between Trusts as to the use of information technology to record this data. However, a common aim across Trusts must be to strive to record data used for generating income to be accurate, sufficiently detailed, and timely. The national move to the electronic record makes recording clinical information onto information systems even more important.

### Conclusions

PbR has been a huge change in the way acute hospital trusts are funded. Service line management and reporting will make services and

#### Example:

##### Clinical Data:

- ◆ Intervention – Thrombolysis for acute Stroke
- ◆ Diagnosis – Total Anterior Circulation Cerebral Infarct (TACI)

##### Coded Clinical Data:

- ◆ Intervention - X29.2
- ◆ Diagnosis – I63.9

HRG code generated - A23  
Cost – £2680

In the example above, if the patient also had a diagnosis of Alzheimer's Disease, but underwent exactly the same treatment pathway, this 'relevant co-morbidity' would attract an additional ICD-10 code, and would lead to a higher HRG tariff of £4102 being generated instead. This illustrates the importance of accurate documentation of the primary diagnoses, and well as relevant other information.

consultants accountable for the contribution they make to the Trust's income and so clinicians need to understand how the processes that generate income work

Clinicians are not often business-minded, but may have to start to justify individual activity figures and patient data (including lengths of stay, need for rehabilitation etc.) more robustly, now that new financial importance has been placed upon these.

What is absolutely critical to PbR's success is:

- ◆ clinical engagement to ensure that clinicians are aware and involved in the processes needed to ensure accurate reimbursement, not forgetting the impact that finance and good data quality can have on patient care.
- ◆ clinical validation to ensure that the activity data used to generate income and measure performance actually reflects the patient care.
- ◆ improved clinical information that accurately

reflects patient care that is documented in real-time.

An important note to re-emphasise is that the principles of PbR lie not solely within finance but also on using it as a tool to impact on performance, service delivery and most importantly, improved patient care.

**Sally Chambers**

Specialist Registrar in Geriatrics and General Medicine, University Hospital of North Staffordshire, Stoke on Trent

**R Kirkham**

Data Quality and Clinical Coding Manager, University Hospital of North Staffordshire, Stoke on Trent

**Amit Arora**

Consultant Physician and Geriatrician, University Hospital of North Staffordshire, Stoke on Trent

## Letters to the editor

Dear Editor

### **How to prevent inappropriate admissions to hospital**

A patient can only be deemed to be an inappropriate admission after admission to hospital. A patient at home or in the Health Centre may appear to be most appropriate for admission but it is only after admission that they can become inappropriate. To avoid such inappropriate admissions, General Practitioners should be persuaded to stop sending patients for admission to hospital and Receiving Doctors should be trained in how to refuse any who are referred, tactfully. This will save the Country even more money than encouraging assisted suicide and we may never see a credit crunch ever again.

**Dr C Cohen**  
Aberlemno

Dear Editor

### **Reference: Addenbrookes exercise video publicised in the March issue**

What a fantastic idea – all we need to do at our Trust now, is persuade *Patientline* to replace the bedside televisions on our elderly medicine wards (removed as not making enough money!!)

**Bridget Leach**  
Falls Educator  
Birmingham

Dear Editor

### End of Life Care Report (March 2009)

I was alarmed to read the following statement in the précis of the NAO End of Life Care report. 'The report suggests also, that DNR orders are not being communicated to all the multiple agencies involved in care, leading to inappropriate hospital admissions.'

The purpose of a DNR order is simply to indicate either that a clinician believes that cardiopulmonary resuscitation would not restart the heart or breathing and therefore should not be undertaken when the heart or breathing stop, or that the patient has decided, with or without detailed consultation with the clinician, that they would not wish the procedure to be undertaken when their heart or breathing do stop. It applies to that decision, and that decision alone.

In my current hospital practice I sense increasing unease amongst many colleagues that a DNR order is taken as shorthand for "do nothing except keep the patient comfortable" - doing nothing often meaning not even assessing to see what may have gone wrong, when something suddenly does go wrong. As such, an increasing number of patients are left as "for resuscitation" to ensure they still have the chance of active management when the Hospital At Night team is suddenly called. I have little doubt - and the NAO statement would seem to support the view - that the presence of a DNR form in a patient's house will often be interpreted - by those called to make rapid judgements about what is best - in much the same way. "Not for resuscitation" quickly becomes "not for hospitalisation".

Perhaps the article simplified what the report said? And that review of the individual patient, their problems, the potential treatments, and the detail of any anticipatory care plan that exists, followed by a discussion with the patient to see if they have changed their mind about previously expressed "preferences", might better inform whether or not hospital admission would be appropriate? In fact not, the report itself says exactly the same.

There is a very fine line to tread between minimising the inappropriate admission of clearly terminal care home residents to acute hospitals for a final 24 hours of life before death - a desirable aim to my mind - and creating an obstacle to access to acute care for older people or those with chronic disease. A single form, designed to cover a single decision, cannot substitute for individual patient assessment. But it may well do so - people like shorthand.

**Andrew Elder**  
Edinburgh

*Editor's reply:*

*Thanks for your letter. In short, I couldn't agree more. As Rowan Harwood wrote in the Daily Mail after sensationalist reporting stirred up on the back of the BMJ article by Conroy et al 2007, "DNAR is not about denying older people treatment. It's about what happens when your heart stops." When asked to make these decisions in my own practice, I am keen to emphasise for certain individuals that DNAR does not debar a patient from all manner of other interventions e.g. for sepsis, shock, dehydration, syncope, hypoglycaemia, arrhythmia etc. - and that's for patients on hospital wards. If they are in long-term care or in their own homes, it would be a big mistake to assume that DNAR equates to "don't call the GP" or "don't convey to hospital". Of course, older people deserve access to high quality end of life care and should not be subjected to burdensome or futile treatments or treatments which they have explicitly refused as part of care planning. But if we want palliative care or we want to proscribe certain interventions, then we should be explicit about this and not use DNAR as a catch-all term. It is a shame that many journalists and members of the public already conflate "DNAR" with "do not attempt treatment of any kind - the patient is too old to bother with" and we need to combat this misconception. In the BMJ 1 May 2009, Daniel Sokol wrote a piece about the use of AND ("allow natural death") as an alternative to "DNAR" but to my mind that is more fraught and open to misinterpretation as it is not sufficiently specific. I mean, technically, I could get pneumonia or maybe swine flu tomorrow and it would be the "natural" course of the illness for me to remain untreated. I think when we write DNAR or make any other advance decisions we need to be very specific about what level we want to treat the person to.*

*David*

Dear Editor,

### **A question of gender**

The BGS newsletter of March 2009 devoted 9 pages to a debate on the state and future of academic geriatric medicine. The 8 contributing authors shared more than knowledge and achievement – they were all men. In fact, the only allusion to women at all was a discussion of the inconvenience caused by the “reproductive track record” of registrars in the north of England (1).

For the past 20 years, women have represented over 40% of medical students yet relatively few occupy senior academic positions (2). Greater visibility of female role models and increased recognition of the achievements of women are important incitements to career progression (3). Currently, about 50% of trainees in geriatric medicine are women. Including the voices of female academics in future BGS discussions would more effectively convey the message that research and academia are options available to all geriatricians.

Ruth E. Hubbard, Fountain Innovation Fund Research Fellow, Geriatric Medicine Research Unit, Dalhousie University, Halifax, Nova Scotia B3H 2E1. (Ruth.Hubbard@cdha.nshealth.ca )

Zoe Wyrko, SpR Geriatric Medicine, Heart of England NHS Foundation Trust; Chair BGS Trainees Committee. (zoewyrko@tiscali.co.uk)

Emma Vardy, Walport Clinical Lecturer in Elderly Medicine, Manchester (emmavardy@lineone.net)

Claire Steves, Wellcome Fellow in Geriatric Medicine, Guy's and St Thomas' NHS Foundation Trust, London  
Claire.Steves@gstt.nhs.uk

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1. Jay R. The view from the “coalface”. BGS newsletter March 2009; 20: 19.
2. Sandhu B. Margerison C. Holdcroft A. Women in the UK academic medicine workforce. Med Educ 2007;41:909-14.
3. Andrews NC. Climbing through medicine's glass ceiling. N Engl J Med 2007; 357:1887-9.

### ***Editor's reply:***

You are of course quite right. The founder of our society and speciality was female. There are currently a number of very eminent female professors of geriatric medicine within the British Isles and a greater number of female senior lecturers and lecturers many of whom continue to make a major contribution to the field. If we look to North America for instance, many of the leading researchers in our speciality are female. And the majority of trainees coming into the speciality are now also female - reflecting the fact that over 60% of UK medical graduates are women. You may also have noted Julia Newton's excellent piece in the newsletter last year about the thriving academic set up in Newcastle - in no small part a result not only of Julia's work but of that of Rose Anne Kenny before she moved to Dublin.

We have had one female president (indeed, only one female candidate for the presidency), and no female candidate standing for the Secretary's posts has ever lost out to a male candidate, so I don't believe anybody can insinuate that the BGS has a “jobs for boys” mentality. It is a fact that when advertising posts on BGS committees, it is mostly men who put themselves forward.

There is no bar on female doctors volunteering for various committee or external roles within the BGS, nor submitting articles to the newsletter. If you would like to write a piece on females in academic geriatrics and problems they might face we would be delighted to publish it.

David

# Ethics

- and why medicine needs it

**E**thics, I have been told, is a side show to the main event - the science and the practice of medicine.

The argument goes that medical science is based on rational theory and experimental proof. It poses questions but has no “right” answers. But the art of medicine is all about doing the right thing for our patients and the study of ethics is primarily concerned with the nature of right and wrong. It is not true that ethics is all relative, there is a great deal of agreement about what is right (e.g. freedom, equality, privacy) and wrong (e.g. murder, theft, rape) and there are methods for resolving ethical conflict by the application of principles and reason.

**Integral to our practice is the idea that we should consider the whole person as more than the sum of their pathologies**

It is true that we do not always resolve conflict but then scientists do not always get it right the first time either.

### A grey world

Geriatricians see things differently; we spend our

time in the grey area of difficult decisions. Black and white decision making according to protocol and guideline is not for us because we understand that for every individual the application of evidence is different. Integral to our practice is the idea that we should consider the whole person as more than the sum of their pathologies. Ethical reasoning must be part of this decision making process. If we cannot explore the ethics of the problem how can we justify our decision?

### Should we? Shouldn't we?

Mr B is 70 years old, he has had a severe stroke, he has a dense right hemiplegia and he is aphasic. He is not imminently dying. If we put in a PEG (percutaneous endoscopic gastrostomy) feeding tube his life may be prolonged, if we do not provide ANH (artificial hydration and nutrition) he will die. Therefore, the moral question is: should we attempt to prolong Mr B's life?

We start by specifying the ethical principles relevant to our decision. A number of different approaches may be applied; the four principles of Beauchamp and Childress provide one such structure.

**Autonomy** – the patient has a right to decide for himself what treatment to accept or decline.

However this patient is unable to communicate verbally. So we need help to gauge his understanding and interpret his non verbal communication. His family may be able to give us information on previously expressed wishes and values.

**Beneficence** – we start with the *prima facie* premise that human life is worth preserving, unless doing so would involve unbearable suffering to the individual. Generally the individual should decide but if they are unable to do so we must avoid making judgements on social utility or from our own perspective. Family members and friends also make an important contribution here.

**Nonmaleficence** - All medical care has side effects or burdens which must be taken into account when deciding if the treatment is worthwhile. There is a risk of complications with PEG placement. After the procedure the PEG may cause physical or psychological discomfort.

**Justice** – medical professionals should act within the law, respect human rights and take account of distributive justice. A treatment which is very expensive and only prolongs life for a short time may not be affordable. A publicly funded healthcare system has to ration healthcare resources and doctors have a professional duty to consider the wider implications of their decisions.

1. 'Introduction in Ethical Theory' ed James Rachels Oxford University Press 1998
2. 'Principles of Biomedical Ethics' fifth edition Tom L Beauchamp and James F Childress Oxford University Press 2001

**Conclusion** - The procedure has relatively few complications and is not prohibitively expensive therefore the decision depends on whether prolonging life is of benefit to the patient. This will depend on the individual circumstances of the case.

### Consistency and balance

What is important is that ethical decisions are made in a consistent way – using ethical principles justified, specified and balanced in the light of the individual facts of the case. This is not a care pathway or protocol; it is a method of ethical reasoning to ensure that decisions are reached in a logical and consistent manner.

I am excited to be taking over as Chair of the Medical Ethics SIG from Dr Martin Vernon who did an excellent job and will be a hard act to follow.

Highlights of the past 3 years include:

- ◆ A debate on physician assisted suicide at the BGS in Harrogate October 2006.
- ◆ A conference on 'Ethical issues in the management of older people' in Nottingham June 2007 organised by SIG secretary Professor Tahir Masud.
- ◆ A joint conference with the Royal College of Physicians in London September 2008 organised by

Dr Martin Vernon.

- ◆ Publication of the RCP/ BGS guideline on Advance Care Planning 2009
- ◆ A debate on restraint at the BGS spring meeting in Bournemouth April 2009.

The SIG has a role in several areas:

1. **Theory:** To contribute to theory and debate in medical ethics e.g. the role of ethics in medical training, the application of normative theory to medical dilemmas.
2. **Policy:** To inform BGS policy on matters which have an ethical dimension e.g. consultation on privately funded drugs and NHS care.
3. **Practice:** To engage all geriatricians in the relevance of applied ethics to their clinical practice e.g. recent debate on restraint and workshop on the Mental Capacity Act 2005.

I hope over the coming two years to expand membership and set up a regular discussion forum for the SIG. If you are interested in joining the SIG (no fee) then please contact either [prem.fade@poole.nhs.uk](mailto:prem.fade@poole.nhs.uk) or [Tahir.Masud@nuh.nhs.uk](mailto:Tahir.Masud@nuh.nhs.uk).

**Premila Fade**

Chair, BGS Medical Ethics SIG

Consultant Physician

Pool Hospital NHS Foundation Trust

## Ethical Dilemmas in Older Patients

### Survey to test clinicians' awareness

Ray Hyatt, Consultant Physician and Geriatrician of the East Lancashire Hospitals NHS Trust, and Chairman of the BGS North West Branch, is in the process of doing a study designed to test clinicians' awareness of legislation affecting the management of common ethical dilemmas in older patients, with particular reference to the Mental Capacity Act.

To this end, there is a short (10 - 15 minute) on line questionnaire listing a series of scenarios. The questionnaire has been piloted at a recent north west BGS meeting and was adjudged to be both educational and fun!

The scenarios listed are faced frequently by clinicians in the course of their work in our speciality.

The questionnaire is being undertaken under the joint auspices of the North West BGS and the department of Bioethics, Cardiff Law School.

When the results of the study have been analysed, a copy of the results will be sent to all participating clinicians.

The survey may be found at: [https://www.surveymonkey.com/s.aspx?sm=dEZ6BER3sQDvmYulo5e7zA\\_3d\\_3d](https://www.surveymonkey.com/s.aspx?sm=dEZ6BER3sQDvmYulo5e7zA_3d_3d)

Readers' input would be greatly appreciated.

Ray Hyatt

**VACANCY**

**Faculty of Medicine & Health  
Leeds Institute of Health  
Sciences**

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with Honorary Consultant Status**

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Informal enquiries to Professor John Young, Head of the Academic Unit of Elderly Care and Rehabilitation, tel. (+44) (0) 1274 383400, e-mail [john.young@bradfordhospitals.nhs.uk](mailto:john.young@bradfordhospitals.nhs.uk)

To apply on line please visit <http://www.leeds.ac.uk> and click on 'jobs'. Alternatively further information can be obtained from Susan Alexander, Recruitment and Administrative Co-ordinator, email [s.alexander@adm.leeds.ac.uk](mailto:s.alexander@adm.leeds.ac.uk), tel +44 (0)113 343 3949.

**COMMISSIONING**

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Thousands of people with Rheumatoid arthritis (RA) are set to benefit from a new guideline published recently. NICE and the National Collaborating Centre for Chronic Conditions based at the Royal College of Physicians have issued a guideline to improve the management of RA in adults. It sets out how best to identify RA, which treatments and therapies are effective, and when surgery should be considered.

Price: UK £32.00; Overseas £35.00. ISBN 978 1 86016 359 3

[www.rcplondon.ac.uk/pubs/brochure.aspx?e=271](http://www.rcplondon.ac.uk/pubs/brochure.aspx?e=271)

**CARE OF THE ELDERLY**

**Care of the Elderly: "Old  
Problems...New Ideas"**

**4 June  
Edinburgh**

The College symposium on Medicine for the Elderly has become an annual event in recent years, with high quality speakers covering a wide range of topics, reflecting the breadth of the speciality and the range of illnesses seen in older people. This year's symposium is no exception and will be of interest to geriatricians, general physicians, general practitioners, and medical trainees at all stages of their post-graduate education.

[www.rcpe.ac.uk/education/event/s/geriatrics-june-09.php](http://www.rcpe.ac.uk/education/event/s/geriatrics-june-09.php)

**CARE OF THE ELDERLY**

**Fifteenth Conference in Medicine  
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**10 June 2009**

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- ◆ Diabetes
- ◆ PD and other movement disorders
- ◆ Developments in dementia
- ◆ Mental Capacity Act
- ◆ Management of Chronic Leg Ulceration
- ◆ NICE Guidelines for the management of osteo-arthritis
- ◆ Maximising ITU and HDU Outcomes
- ◆ Urogynaecology in the elderly

See **BGS website** (Notices / Non BGS Meetings) for more details

**GASTRO-INTESTINAL HEALTH**

**Food and Function  
12 June 2009  
Zilinia, Slovakia**

The symposium will focus on the role of probiotics in the maintenance of intestinal health and prevention of intestinal diseases. Further to its scientific content, the symposium is a networking event; a unique opportunity to meet all those who influenced the past, influence the present and most importantly will enable the future of probiotics in gastro-intestinal health management. Initiation of cross-boarder co-operations between scientists and institutions will be also facilitated during the symposium.

[www.foodandfunction.com/](http://www.foodandfunction.com/)

## RHEUMATOID ARTHRITIS

**How does rheumatoid arthritis need to be managed?**

**18 June  
RCP (London)**

Rheumatoid arthritis is the commonest inflammatory polyarthritis, affecting over 400,000 people in the UK. If not recognised early, uncontrolled inflammation can lead to irreversible joint damage, with pain and disability.

In recent years the value of early intervention, close monitoring of disease activity, and aggressive use of conventional and biological drugs has led to a revolution taking place in the management of RA.

Contact: Conference coordinator  
Tel: 020 7935 1174 ext. 252

Email:  
conferences@rcplondon.ac.uk

[www.rcplondon.ac.uk/event/details.aspx?e=1389](http://www.rcplondon.ac.uk/event/details.aspx?e=1389)

## STROKE

**8th Welsh Stroke Conference**

**19 June 2009**

**Riverfront Centre, Newport, Gwent**

Programme includes: Stem Cell Transplantation: Sci Fi or Clinical Reality?; Treating Acute Strokes: the state of the art; Translation of stroke rehabilitation evidence into practice – experiences of the Canadian Stroke Network

See BGS website for more details: ([www.bgs.org.uk](http://www.bgs.org.uk) Select Notices and Non-BGS meetings or email: [lizzie\\_williams21@hotmail.com](mailto:lizzie_williams21@hotmail.com))

## NEUROLOGY

**Association of British Neurologists Annual Meeting**

**22 - 26 June 2009  
Liverpool, UK**

The ABN wishes to announce its inaugural annual conference at the newly constructed Arena and Convention Centre in Liverpool which will be held jointly with the Spanish Society of Neurology. The programme will include scientific symposia, teaching courses, communications and poster sessions.

[www.abn.org.uk/](http://www.abn.org.uk/)

## HIP FRACTURE

**8th Peterborough Hip Fracture Conference**

**26 June 2009  
Stamford, Lincolnshire**

Hip fractures: optimum management strategies, covering all aspects of hip fracture care from admission, surgery, medical and nursing care, and rehabilitation. For full programme and reservation details (£80 for the day) contact [dandmparker@tiscali.co.uk](mailto:dandmparker@tiscali.co.uk)

## CARE HOME MEDICINE

**30 June 2009  
RCP (London)**

The role of care homes has changed and will continue to develop. Intermediate care, rehabilitation and palliative care services have been developed alongside more traditional roles. New ways of working are required to ensure that residents in care homes all receive excellent care from health and social care workers and that their place of residence or age is no barrier to service access.

[www.rcplondon.ac.uk/event/details.aspx?e=1390](http://www.rcplondon.ac.uk/event/details.aspx?e=1390)

## AUSTRALIA CONFERENCES

**Inaugural Advance Care Planning Symposium (in partnership with Austin Health, VIC** (call for abstracts open), 13-15 August 2009, Melbourne, VIC

**Managing Challenging Behaviours In Older People With Cognitive Impairment** (call for abstracts open), 6-7 August 2009, Melbourne, VIC

**Outpatients – Beating the Waiting Game** (call for abstracts open), 17-18 September 2009, Cairns, Far North Queensland

**4th Healthcare Without Walls: Hospital Avoidance**, 28-29 October 2009, Sydney, NSW

**Investing in the Healthcare Team: Aligning Strategy, Leadership and the Team to Deliver Better Outcomes for Patients**, 6-7 November 2009, Sydney, NSW

[www.changechampions.com.au/](http://www.changechampions.com.au/)

## SENSORY IMPAIRMENT

**Acquired Sensory Impairment Confronting the challenges faced by older people**

**30 June 2009  
Birmingham**

The research found of most concern to older people with acquired hearing and sight loss was lack of awareness and understanding among services that could (and should) support them.

[www.bgs.org.uk/Notices/non\\_bgs\\_meetings.htm](http://www.bgs.org.uk/Notices/non_bgs_meetings.htm)

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

**CARDIFF 48TH DIPLOMA IN GERIATRIC MEDICINE**

10 - 12 June (written examination); 17 October (mock clinical exam)

This intensive course will be of interest to Doctors involved in the care of the Elderly Person (a wide range of topics are covered by experts). It will be of particular interest to candidates preparing for the Royal College Diploma of Geriatric Medicine Examination.

FEES - Whole course including Mock Clinical Examination 10th to 12th June 2009 - £500.00 (this includes lunch and refreshments on all 3 days, Course Dinner on Wednesday evening and handouts wherever appropriate).

First 3 days (Wednesday, Thursday and Friday 10-12th June 2009) £400.00 (this includes lunch and refreshments on all 3 days, Course Dinner on Wednesday evening and handouts wherever appropriate).

**CLOSING DATE FOR REGISTRATION 22 MAY 2009.**

Application forms available from Mrs Margaret Webb, Course Secretary, Tel: 02920743646. Email: [ElizabethM.Webb@cardiffandvale.wales.nhs.uk](mailto:ElizabethM.Webb@cardiffandvale.wales.nhs.uk).

**OSTEOPOROSIS**

**Osteoporosis Conference 2009  
organised by the National  
Osteoporosis Society**

**28 June - 1 July**

**Manchester**

Educational Update: Key advances  
Plenary Invited Lectures - Vitamin D, Osteoporosis in Children, Male Osteoporosis, and Hormonal treatment of Osteoporosis

Abstracts to be submitted by 16 Jan 2009

See **BGS website** (Notices / Non BGS Meetings) for more details

**IAGG**

**Longevity, Health and Wealth  
19th IAGG World Congress of  
Gerontology and Geriatrics**

**5 - 9 July 2009**

**Paris**

Held only every 4 years, the IAGG World Congress of Gerontology & Geriatrics brings together experts from around the world to discuss the latest findings in the field of ageing.

<http://www.gerontologyparis2009.com/site/view8.php>

**END OF LIFE CARE**

**Ask me what I want  
Transforming End of Life Care in  
partnership with patients and  
carers**

**14 July 2009  
London**

The views of patients, their carers and others must be taken into account when designing, planning, delivering and improving health and social care services. How can we do this in End of Life Care and how will it help us to provide better services? This one day conference will showcase examples of how involvement has helped transform end of life care services.

See **BGS website** (Notices / Non BGS Meetings)

**BGS REGIONAL AND SIG MEETINGS**

**BGS Cardiovascular Section and  
10th Annual General Meeting in  
association with the British  
Association of Stroke  
Physicians**

2 - 3 July 2009, Birmingham  
For further details about this meeting and a registration form please contact Tamara Lloyd at the BGS CV Section Secretariat either by email: [tamara.lloyd@lamedica.com](mailto:tamara.lloyd@lamedica.com) or telephone: 01249 700 065

**East Midlands & Trent Falls  
Symposium**

13 July 2009, Nottingham  
Joint organisers: Professor Tahir Masud and Dr Rob Morris  
A multidisciplinary day aiming to learn more about evidence-based intervention with regard to falls prevention and to understand more about the aetiology of falls.  
Contact: [sue.pinkett@nuh.nhs.uk](mailto:sue.pinkett@nuh.nhs.uk) or [jane.turner@nuh.nhs.uk](mailto:jane.turner@nuh.nhs.uk)

More details on:  
[www.bgs.org.uk/Notices/regional\\_sig\\_meetings.htm](http://www.bgs.org.uk/Notices/regional_sig_meetings.htm)

**Regional Officers, please contact  
editor@bgsnet.org.uk to publicise  
your region's meetings.**

**EUGMS**

**Glasgow Congress  
Palliative Care Medicine and  
End of Life Issues in Older  
Adults**

**17 - 18 Sept 2009**

**Glasgow, Scotland**

Download brochure from BGS website (Notices / Non BGS Meetings)

**DIZZINESS**

**7 - 8 Sept 2009  
Newcastle**

This course will be of interest to all working in Falls Services, Syncope Units, TIA Clinics, and General Medicine, though all with an interest in this area are also welcome.

See **BGS website** (Notices / Non BGS Meetings)

**CLINICAL EXCELLENCE AWARDS  
2010 ROUND**

**The British Geriatrics Society process for the 2010 round of the Clinical Excellence Awards is now open.**

In order to comply with the requirements of ACCEA the Society must seek its candidates through self nomination. All eligible Consultants are encouraged to apply for a BGS nomination and we will only consider applicants who send us completed Curriculum Vitae Questionnaires (Form A). This year the deadline for the receipt of nominations is 28 August 2009.

All intended applicants should read the latest information on the ACCEA website [www.advisorybodies.doh.gov.uk/accea](http://www.advisorybodies.doh.gov.uk/accea) and consult the web site on a regular basis for updates.

The Society has its own form for short listing members and this can be obtained from the BGS web site [www.bgs.org.uk](http://www.bgs.org.uk). Supplementary forms for Research, Teaching and Training and Leadership and Management are also available.

In the autumn those who have been successfully chosen by the BGS for nomination will be invited to apply via the ACCEA web site for the 2010 round. Applicants are asked to note that nomination by the BGS in one year does not automatically guaranteed nomination in the next year.

Please use your Regional Clinical Excellence Award Advisor for advice. Members in Scotland and Northern Ireland will need to follow their local processes.

Applications need to reach Sarah Allport at the BGS Office by 28 August.

**Sarah Allport**  
Committee Secretary

**VACANCIES  
BGS OFFICERS**

Expressions of interest are invited for the following senior posts within the BGS:

**Honorary Deputy Secretary** and (current incumbent is Dr Simon Conroy who will succeed Dr David Oliver as Hon Secretary in October 2009)

Expressions of interest to be sent to Alex Mair ([alex.mair@bgs.org.uk](mailto:alex.mair@bgs.org.uk)) by **30 May**. The candidate requires support from two members of the BGS. Please note that if there is more than one candidate standing for the post, there will be a ballot of the membership and the candidates will be required to produce a short statement of their intent for the ballot paper.

**BGS Director of Continuing Professional Development** (current incumbent is Professor Alan Sinclair). The successful candidate will understudy Prof Sinclair for a year.

Expressions of interest to be sent to Alex Mair ([alex.mair@bgs.org.uk](mailto:alex.mair@bgs.org.uk)) by **30 July**.

For more detailed job descriptions for both these posts, please visit the BGS website: [www.bgs.org.uk](http://www.bgs.org.uk) (select Notices/Vacant Posts)

**VACANCIES**

**Norfolk and Norwich Hospital  
Consultant Physician in Geriatric  
Medicine**

The successful applicant will join 13 enthusiastic consultant colleagues including a Professor and Senior Lecturer in the academic department of Medicine for the Elderly who have a wide range of research interests, 2 academic fellows, 4 SpRs and 2 associate specialists. We would be willing to consider a dynamic person with any subspecialty /research interests who has a commitment to working in large Multi-Disciplinary MFE Team and take these services forward in our newly appointed Foundation Trust.

**Hawke's Bay, New Zealand  
Consultant Geriatrician -  
Community Focus**

There is an exciting new opportunity for a Consultant Geriatrician with Community Focus to join the Health of Older People Service (HOPS) of the Hawke's Bay District Health Board in a part time or full time capacity.

**Bay of Plenty, New Zealand  
Consultant Geriatrician -  
Community Focus**

We seek to recruit a community geriatrician to join the Health in Ageing team at the Bay of Plenty District Health Board. This is a new post created to meet future challenges in the provision of service in this district.

**Singapore - Geriatricians**

The Changi General Hospital (CGH) of Singapore is a Joint Commission International (JCI) accredited multidisciplinary hospital situated in the residential area, east of Singapore. We are seeking caring and highly competent professionals to join our existing dynamic team of Physicians.

Job descriptions and contact details for these and other vacancies can be found on the BGS website: [www.bgs.org.uk](http://www.bgs.org.uk) (select Notices/Vacant Posts)



# GP's with special interest in older people

## new guidance

In February 2009, the Department of Health published revised frameworks for practitioners with a special interest (PwSI), replacing the frameworks for GP's with special interests (GPwSI) published more than 5 years ago.

The name "practitioners" has been used as the documents include pharmacists, but not nurses who are covered by separate frameworks for advanced nurse practitioners. The BGS and the RCGP assisted with the creation of this latest guidance on PwSI for Older People.

There are relatively few GPwSI for Older People in the UK at present, although far more GP's are actively involved in the delivery of specialist services such as Intermediate Care, Community Hospitals, specialist clinics and Day Hospitals. The framework describes potential competences for PwSI's, and the expectations for establishing and maintaining competence. Commissioners are also advised to commission services where the facilities are accredited. "The guidance relates to the specific training and accreditation needs of general

practitioners seeking accreditation as PwSIs in Older People. The competency framework is designed to help practitioners understand and develop the extended knowledge and skills they will require to provide services beyond the scope of their generalist roles." It is intended that a specific service should identify the competencies appropriate to the delivery of that service, rather than expecting a PwSI to have the full range of competencies listed.

Considerable emphasis is placed throughout the document on the importance of direct access to supervision from specialists, usually consultants, for their clinical work and also for their clinical governance and continuing education. It is easy to take for granted the contribution made by GP's to our services, and this framework emphasises the responsibilities on both the PwSI and the supervising consultants. It is therefore important that consultants should read this document, and use it as a stimulus to establishing, or re-invigorating, effective clinical governance structures within their services such as Day Hospitals or Community Hospitals.

Separate sections of the document deal with the infrastructure required for the service, the competency framework, teaching and learning, assessment to prove competency, accreditation and re-accreditation. While this may appear overwhelming or bureaucratic to some, it provides a roadmap for developing the skills of GP's already involved with our services, and a curriculum for those expressing an interest in our specialty.

I hope that this document will encourage more GP's to consider becoming a PwSI for Older People, and that the clinical governance structure of our services will be stimulated to respond to the standards described in the framework.

The guidance can be accessed from:

[www.pcc.nhs.uk/uploads/pwsis/january\\_09/updated\\_older\\_people.pdf](http://www.pcc.nhs.uk/uploads/pwsis/january_09/updated_older_people.pdf)

**Ian P Donald**

Chair of working party "Practitioners with Special Interest for Older People", on behalf of the Royal College of General Practitioners and Department of Health

### PUBLICATIONS INFORMATION

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