



Editor: David Lubel

# BGS

n e w s l e t t e r

## Spring and Autumn Meetings 1999



### Spring Meeting 1999

Cork University Hospital is looking forward to welcoming members to the Spring Meeting from **8 to 10 April**, which promises to be a great success, with several keynote lectures, Special Interest Group meetings, symposia and over 200 abstracts being presented by delegates. Details regarding the scientific meetings, accommodation and travel are available on the provisional programme, sent out last November.



### Registration deadlines

Please note, however, that the last date for registration is **Friday 2 April 1999**.

To register, please contact the Registration Secretariat, Lucette Murray, at 10 Beaumont Ave, Ballintemple, Cork. Tel: 00 353 (21) 293918. Fax: 00 353 (21) 293930. Email: [lucette@iol.ie](mailto:lucette@iol.ie).

Details are also available on the BGS website on: [www.bgs.org.uk](http://www.bgs.org.uk), from which registration

forms may be downloaded.

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### Autumn Meeting 1999

The Autumn Meeting this year will take place on **16 to 17 December**, not in October, as previously advertised. A great opportunity for last-minute Christmas shopping in London!

The Meeting and Society dinner will take place at purpose-built conference facilities in the Novotel Hotel, Hammersmith, London, where accommodation and exhibition space will also be available.

The new deadline for abstracts for the Autumn Meeting has been moved to **1 September**. More details to follow in a future issue of the BGS Newsletter or on the BGS website (above).

**President:** Dr Brian O Williams, MD, FRCP (Glas, Lond, Ed) **President Elect:** Prof Cameron Swift, PhD, FRCP  
**Honorary Secretaries:** Dr David D Lubel and Dr Rebecca Dunn **Meetings Secretary:** Dr Margot A Gosney  
**Honorary Treasurers:** Dr Jonathan M Potter and Dr Robert J Shepherd **Administrative Director:** Richard Lynham **Sub Editor:** Rawia Habiby

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FOR HEALTH IN OLD AGE

# Editorial

page



**T**he recent GMC decision on revalidation will have a far-reaching impact on the medical profession.

It is responding to pressure from an increasingly questioning and cynical public, with measures that it believes will help protect the status of the profession. Whether the GMC has gone far enough with these proposals to maintain its future independence is debatable. And many will consider the absence of an examination, as part of the revalidation process, a major omission. There is clearly a balance to be struck between the comfort and security of individual doctors and the need of the profession as a whole to reassure the public.

### Benefits of examination

Examinations have the benefit of providing a simple, reliable measure of acquired knowledge, but the down-side is exposure to the risk of failure. Exams are considered useful, if not essential, throughout our education from early schooling to postgraduate training, yet once we have achieved a certain level of seniority we deem them irrelevant, even harmful. The simple truth is that no-one with the power to avoid it would allow themselves to be subjected to a system of examination. Quite naturally, therefore, the senior medical establishment, with its power of self-regulation, has till now assiduously avoided self-exposure to examinations and other such unpleasant experiences that it readily forces upon its trainees.

### Are there alternatives?

What alternatives are there to the examination? Ideally our specialist clinical practice should be judged by outcomes. However, no more so than in geriatrics, large variation in patient case-mix and co-morbidity will make meaningful inter-clinician comparison difficult for the foreseeable future. It is possible to assess a clinician's

competence at managing individual conditions by auditing case notes but this is a very time-consuming process and would be difficult to implement systematically. This really just leaves the examination, which is likely to become the initial screening tool for ensuring continuing clinical competence.

### A possible system

How could a system of examination work in practice? Imagine we are in the year 2010. You have just received from the internet your biennial CPD/clinical competence MCQ examination. You have agreed in advance, with your clinical and medical directors, the scope of your clinical practice (e.g. general geriatrics, acute general medicine) and your declared special interests (e.g. Parkinsonism and movement disorders). This information has been submitted to the examination board and dictates the content of the MCQ and ultimately the presentation of your results. You have taken four half-days' study leave to complete the 1000 question, time-controlled MCQ and immediately on completion (and submission via the internet) you receive feedback of your results. The results are broken down into distinct areas of clinical practice (including wider aspects of CPD) and for each area you are given your ranking versus your peers nationwide. In addition, for your area of special interest, you are compared with all other clinicians declaring this interest.

### Analysing the results

So how did you get on? Your results are entirely confidential but you are encouraged to use them as the basis for your local discussions about continuing professional development. Overall your score places you on the 75<sup>th</sup> centile compared with 1000 other geriatricians who have completed this exam over the past 12 months. However, you score less well in certain areas: staff management and appraisal theory (10<sup>th</sup> centile), management of acute MI (20<sup>th</sup> centile), management of urinary incontinence (25<sup>th</sup> centile), latest CPR guidelines (25<sup>th</sup> centile),

diagnosis and management of COPD (30<sup>th</sup> centile). These areas should be your first priority for CPD activity over the next year. In fact you will automatically receive notification of the most up-to-date CPD opportunities for the subjects in which you rank below the 50<sup>th</sup> centile. These will include live educational seminars, on-line tutorials, CD-ROM and written material. Overall you score well on the management of Parkinsonism (80<sup>th</sup> centile). However, comparing you with your peers who have declared a special interest, you have performed less well (40<sup>th</sup> centile) making this an area worthy of further attention.

#### Failure to improve performance

What happens if you fail to improve at the next examination in two years' time? Probably nothing, since you performed well overall. However, if you had performed badly and were showing no improvement in key areas, you

might expect to receive an official visit and a more detailed audit of your performance. Very few doctors would ultimately find their right to practice withdrawn, but there would be a constant incentive to increase one's knowledge base and to drive up 'the average'. The days of collecting CME points for the sake of it would be over.

#### The choice

We now have a choice. We can continue to eschew examinations - and wait for them to be imposed on us by others. Alternatively, we can accept the inevitable and develop our own voluntary system of examination. This will leave us more firmly in control of our own destiny and, if we act quickly, we will be seen to be leading the rest of our profession.

David Lubel  
Editor

## President's column



**G**eriatricians now comprise the single largest specialty group of physicians and more than half play a role in general internal medicine (see table below).

The Royal Colleges of Physicians have set up a working party to consider the problem of continuing to provide a high quality acute medical service to patients admitted to UK hospitals. The concept of an acute physician will be revisited and the BGS has been asked to contribute to the working party's deliberations.

#### Distribution of consultants

The trend for geriatricians to become more involved in the acute care of elderly patients or

direct general medical adult take is likely to continue in view of demographic trends and further specialisation within the medical consultant workforce. We can only be comfortable with this development if adequate consultant time is afforded to our own specialty requirements for comprehensive interdisciplinary assessment, rehabilitation and long-term care. Otherwise, we will be faced with the spectre of poorhouse medicine for older people and the need to re-invent geriatric medicine.

#### BGS membership

BGS membership continues to show a welcome increase and I was delighted to note reports of almost sixty new members when our Executive Committee met in December and January. I was particularly pleased to note the steady increase in our associate membership, which includes scientists, nurses and members of the

rehabilitation professions. Although the Society is primarily a specialist association for geriatricians, we warmly welcome nominations for associate membership for health care professionals who are dedicated to working with older patients and play an important role in interdisciplinary teamwork.

**Clinical governance**

Clinical governance currently dominates the medical scene and, after discussion with the Presidents of the Royal Colleges of Physicians,

academic and clinical professionals with special interests in ageing and older people. It is likely that we will at least have strengthened ties with the Society and BSRA in terms of our existing tri-partite liaison committee and, hopefully, we will improve lines of communication and promote interdisciplinary and international issues.

**CME/CPD**

At the December Executive Meeting, we welcomed the new Director of CME, Professor Mark Castleden, who posed the questions of what would we want geriatricians to do that would affect patient outcomes, and how would we measure this? He will take the lead in developing CME/CPD policy in the Society and

DISTRIBUTION OF CONSULTANTS			
Specialty	No.	Percentage doing general medicine	Percentage of all physicians doing general medicine
Geriatrics	761	56	19
Cardiology	522	58	14
Gastroenterology	484	85	18
Diabetes/Endoc.	440	88	17
Respiratory	437	84	16
Rheumatology	388	27	5
Others	608	39	10

*R.C.P. Census 30.9.97*

we thought it prudent to form a Clinical Governance Working Group within the BGS to advise on clinical governance and its implications for geriatric medicine and geriatricians. The group, led by the President Elect, Cameron Swift, includes Finbarr Martin (Chairman of the Policy Committee), Mark Castleden (Director of CME), David Black and Martin Severs. Clinical governance might encompass comprehensive service accreditation, enhanced CME (more properly designated as CPD (continuing professional development)), and perhaps individual specialist revalidation. The Royal Colleges will welcome our advice in this area.

**Gerontology associations**

Perhaps one of my over-ambitious ideas was to cajole our sister gerontological societies, namely the British Society of Gerontology (BSG) and the British Society for Research in Ageing (BSRA), to form the vanguard with the BGS to promote a UK umbrella “Gerontology Association”. In due course, such a group might recruit associations which represent other

keep us up-to-date with activities taking place on the national scene. He will also attend regional and national meetings of the Society to canvass office bearers’ and members’ views on the subject.

**BGS premises**

After a lively debate at the October Council Meeting, the Executive and Finance Committee were asked to explore options for purchase of property to replace our rented accommodation in the RCP precinct. We would hope to continue discussions on the subject at the April Council meeting in Cork.

**Cork**

I look forward to meeting many of you at the main BGS Spring Meeting in Cork. The provisional academic and social programmes look excellent and I have never been disappointed by the marvellous hospitality extended to us in Ireland.

**Brian Williams**

# Modernising Social Services

- promoting independence, improving protection, raising standards



The following is a summary of the White Paper, entitled ‘*Modernising Health and Social Services: National Priorities Guidance*’<sup>1</sup>, and the BGS Policy Committee’s response.

The document describes a number of proposals which will affect how Social Services are delivered and monitored and further develops the theme of joint working between local authorities and the NHS. It breaks new ground but is also complementary to other recent policy initiatives.

## Related White Papers

The Government has now produced a whole raft of related ‘White Papers’, proposals and official guidance<sup>2</sup>, which transform planning, commissioning, providing and monitoring arrangements. Together these increase opportunities for developing better integrated health and social care of older people.

How can we respond to these opportunities?

Acute adult medicine continues to demand increasing amounts of our time and energy, at the expense of the non-acute aspects of specialist geriatric practice in hospitals. Short-term funding initiatives, e.g. Winter Beds, Whole Systems, Waiting List, etc, often seem to come on timescales that require circumvention and, thus, the undermining of local planning mechanisms. In addition, there are the uncertain aspirations of primary care groups to contend with. All these factors make for difficulties in keeping up with the constant change. But, if we are to reverse the past decade’s disintegration of hospital and community care of older people and to re-establish the role of the speciality

across this divide, the next year or two look crucial. We need to be in there as leaders, both nationally and locally, while these interconnecting policy strands develop in practice.

Although ‘White Papers’ are not consultation documents, but statements of intent, there are many areas that will need further discussion before and during implementation. For this reason, the Society sent its comments to Frank Dobson, Secretary of State, Department of Health (DOH). The main points, with the BGS responses, are set out below.

## 1 Introduction

Overall the proposals are intended to:

- 1 improve protection for vulnerable children and adults;
- 2 promote and facilitate better co-ordination within and between social care and other agencies;
- 3 reduce inflexibility of provision;
- 4 clarify the roles and limits of Social Services;
- 5 produce consistency of standards, eligibility and funding arrangements;
- 7 reduce inefficiency; and
- 8 encourage local authorities to focus on priorities, which are improving, for example: protection; standards; partnerships; and efficiency.

## CHAPTER 1: INTRODUCTION

The three key themes are:

- ◆ modernisation of service provision, regulation and monitoring;
- ◆ the ‘third way’ for social care; and
- ◆ new money, i.e. the Social Services Modernisation Fund.

## BGS response

The BGS welcomed the statement that Social Services are to complement and support the efforts of individuals and other agencies and do

not exist simply as a safety net. The ‘third way’ appears to be about creating a clearer national framework of policy and standards, whilst maintaining the local, mixed economy of provision, albeit, thankfully, without the idolatry of the private sector, evident with the previous Government.

The modernisation fund will provide £1327 million over the three years from 1999. This comes under a variety of grants: the *Partnership Grant* - £647 million over three years; the *Prevention Grant* - £100 million; the *Mental Health Grant* - £185 million; the *Training Support Grant* - £20 million; and *Children’s Services* - £375 million.

The promise of new money is welcome. On the other hand, an appreciable proportion of this will go on new ‘innovative’ schemes, increased local and national monitoring, and pay increases.

## 2 Services for adults

### CHAPTER 2: SERVICES FOR ADULTS - INDEPENDENCE, CONSISTENCY, MEETING PEOPLE’S NEEDS

There is a fair amount of detail on the inadequacies of current arrangements. The inadequacy of review and follow-up of care

packages for individuals, the variation in quality and availability of services, inconsistency in funding eligibility, and the general inflexibility of provision are all criticised.

### Independence

The specific action points about independence are as follows:

- 1 better preventative services and a stronger focus on rehabilitation;
- 2 extension of direct payments schemes to people over 65 years of age;
- 3 better support for service users who are able to work;
- 4 improved review and follow up arrangements, taking account of peoples changing needs;
- 5 improved support for people with mental health problems; and
- 6 more support for carers.

The *Partnership Grant* and the *Prevention Grants*

will provide some of the necessary resources but re-direction and more efficient use of existing resources are also required. It is suggested that the Prevention Grant could be used to provide early and low levels of social care intervention to enhance independence and delay or prevent subsequent need for greater social care and other support. This might work but the BGS has pointed out that evidence to guide it is scant and inconclusive. Thus, if resources are to be diverted for this objective, there needs to be evaluation sufficient to influence decisions further afield. This could be done as part of Health Improvement Programmes, using Joint Investment Plans (*Partnership in Action*) in collaboration with primary and community healthcare providers. Perhaps the opportunity should be taken to revamp the focus of the ‘75 plus’ GP check up.

### House of Commons inquiry

The Society has agreed and welcomed the judgement that there is currently insufficient time or resources devoted to maximising recuperation and rehabilitation of elderly people after acute illness and drawn attention (again) to the perverse incentives of the current funding arrangements. (This point seems to be getting through as it was specifically mentioned in the House of Commons’ Committee Inquiry into the Relationship between the Health and Social Services, January 1999 (see this Newsletter, page 22)). The proposal is that Health and Social Services should jointly be responsible for rehabilitation. The BGS has suggested inclusion, in the Social Services’ performance assessment framework, of a performance indicator, such as local admission rates to residential or nursing homes, which would encourage integrated social and health care to promote rehabilitation.

### National Carers Strategy

Emphasis is made at several points in the White Paper of the importance of carers and the need to support them. The National Carers Strategy is due to be completed this summer. It is proposed that all local authorities will provide assessment and help for carers to support and maintain their health and provide them with the information needed on the health status and medication of the person they are caring for. As a first step, systems should be in place by April

2000 to identify primary care and social service users who are looked after by carers. We have welcomed the overall intent, but pointed out that the rights to autonomy and medical confidentiality should be a constraint to the unlimited flow of information.

The Society has welcomed the expansion of the provision for direct payments to people over 65

**(CHAPTER 3:  
CHILDREN)**

in order to increase the flexibility of social care, but have pointed out the need for more

clearly written guidance and monitoring by Social Services to protect vulnerable individuals from substandard or exploitative providers.

**Improving consistency**

The action plan to improve consistency includes:

- 1 the Government centrally taking a greater lead in setting objectives and standards for Social Services;
- 2 the introduction of a National Service Framework for Older People (and other groups later on), in partnership with the NHS;
- 3 a Fair Access to Care initiative; and
- 4 action to establish greater consistency and fairness in regard to charging for services.

**Charging for services**

With regard to the latter, they await further advice from the Royal Commission and Audit Commission.

The Society has repeated the view expressed in its contribution to the Royal Commission on Long-Term Care that there

should be nationally agreed eligibility criteria for continuing nursing home care and for determining financial responsibility for its provision. These national criteria cannot and should not be so prescriptive as to obviate the need for clinical decision-making locally. Consistency (and, therefore, equity) could be demonstrated by national comparisons of admission rates to different types of institution and of casemix. A similar benchmarking approach might be useful in other areas where consistency is a worry.

**CHAPTER 4:  
IMPROVING  
PROTECTION**

The BGS agreed that arrangements for review and follow-up of people receiving complex care at home or in residential or nursing homes is inadequate and does not meet the guidance in HSG(95)8. This indicated the need for a health component to these reviews, particularly with respect to applying eligibility criteria for continuing health and social care. Rarely has provision to meet this need been put into the contracts between providers and health authorities along with the additional resources necessary to do it. We have suggested that national guidance should be given on this. In addition, we have again suggested that national guidance is needed to sort out the varying interpretations of health and social care in so far as it affects financial charges.

**User Centred Services**

Government action to promote Convenient User Centred Services (meeting peoples' needs) will include development of a Long-Term Care Charter, to:

- 1 empower users and cares - by providing information and advice about local services, and how agencies should respond to needs; and
- 2 give authorities a tool against which they can set local standards and which can be used by those monitoring the authorities' overall performance.

As part of the monitoring arrangements, local authorities will be required to conduct opinion surveys with users and carers, and to report

findings centrally. Joint commissioning, pooled budgets and integrated provision, as described in *Partnership in Action*, is expected to create easier access to a range of services and less shunting

of individuals around the system. Some permissive legislation is required for this.

**3 Children**

This chapter deals with children (see page 994).

**4 Improving protection**

The key themes are:

- 1 the creation of a new independent system for protecting vulnerable people;
- 2 the Commissions for Care Standards (CCS);

- 3 the extension of inspection; and
- 4 stronger national standards.

The Paper describes the current fragmentary and inadequate mechanisms, e.g. the lack of suitable professional scrutiny of personal care standards in residential homes. The proposals will result in more services covered by inspection and stronger national standards. The CCSs are to be established at regional level, based on the boundaries of the NHS (see January Newsletter, page 23) and social care regions (eight in England). They will cover residential care homes, nursing homes, children's homes, domiciliary and social care providers,

**CHAPTER 5:  
IMPROVING STANDARDS  
IN THE WORK FORCE**

independent fostering agencies, residential family centres and boarding schools. With CCSs, the organisation for the inspection and

registration of nursing and residential homes will be combined. At first, there will be separate categories of registration (or combined) but the legislation will allow this to be abolished later, if thought sensible.

The BGS welcomed these changes. Although registration of domiciliary care agencies will not be required by law, local authorities will be required to use registered agencies.

**Inspection work force**

The eight CCSs will have boards nominated by central government and will include representation from a variety of agencies, including local authorities and health authorities. They will be accountable to the Department of Health. The inspection workforce will consist mainly of professionals and managers on short-term placements, including secondments, etc. The Society welcomes this move, which will bring some of the advantages of peer review. From a practical standpoint, however, we are concerned about sustaining developments in both services and regulation. If senior experienced practitioners are increasingly involved in regulation, they must be replaced by adequately trained, experienced staff on the ground. At present, there are not enough people around with the skills and commitment

to provide good quality care for disabled older people and, therefore, the introduction of additional responsibilities must be phased with the completion of training and development programmes.

Three levels of standards are proposed. Some will be set in legislation, some specified nationally and others defined by CCSs. At national level, there may be a possible role for HAS 2000 (see January Newsletter, page 1).

**5 Standards in the work force**

The main proposal here is the introduction of the General Social Care Council, which is intended to enhance the status of social work and others involved in social care. It will have some similarities with the GMC except that it appears to be more directly accountable to government. Increasingly, professional and other workers in social care will be required to be registered with this Council. In the first instance it will probably only apply to qualified social workers and those working with children in particular circumstances. The White Paper also proposes a new training strategy centred around a National Training Organisation. The two organisations together will oversee education and training, whilst the Central Council for Education and Training of Social Workers will be abolished.

The Paper discusses the responsibilities of employers to continued education and training as part of the national training strategy. As the mixed economy of provision develops, it will be vital, however, to ensure that there are no competitive disadvantages to those employers, statutory or otherwise, who devote resources to this end. Thus, participation in education and training would seem a suitable quality marker for regulation and inspection of providers.

**6 Improving partnerships - better joint working for more effective services**

The key themes in 'Improving Partnerships - better joint working for more effective services' are as follows:

- 1 better joint working to help people get services they need;
- 2 integrated health and social care; and
- 3 better co-ordination of children's services.

Again, attention is drawn to the potential

improvements to flow from the proposals in *Partnership in Action*. Pooled budgets would be created by Health and Social Services putting a proportion of their funds into a mutually accessible joint budget (e.g. to provide aids and

**CHAPTER 6:  
IMPROVING  
PARTNERSHIPS - BETTER  
JOINT WORKING FOR  
MORE EFFECTIVE  
SERVICES**

appliances in the community). Lead commissioning will allow either the local authority or health service to delegate their functions and budget to the other to allow development of a

better integrated provision (e.g. for mental health day care). Integrated provision would allow local providers (e.g. community trusts and Social Services) to provide services on behalf of them both (e.g. domiciliary personal care). These proposals could spell the end of the problem of the social bath! The BGS response has been supportive but suggests (again) that there should be a detailed consideration of the advantages and disadvantages of amalgamating local authorities and health authorities. We are mindful of the successful integration such arrangements have made possible in Northern Ireland and are likely to be developed in Wales.

The Paper cites examples of what they regard as good practice in joint working. I am familiar with the examples they give which are local, e.g. the introduction of hospital discharge co-ordinators.

Whilst they might be well regarded locally, in the main they have not been evaluated adequately to justify this description. This use of enthusiastic anecdote, rather than evidence, is a common theme in this and other recent White Papers.

**7 Improving delivery and efficiency**

This chapter covers the setting of standards for services, in accordance with the national priorities for health and social care set for the period of 1999/2002. The Paper describes a Best Value Performance Management Framework and includes various requirements

for local authorities to set up objectives for improving performance. The improvements will involve quality, efficiency and other objectives such as fair access.

Examples of possible performance indicators include the rate of emergency admissions of older people to hospital, delayed discharges from hospitals, and amounts of day care provision, etc. One specific national target proposed is to reduce the annual growth rate of emergency hospital admissions of people over 75 to 3% by 2002 (against an average of 3.5% growth in recent years). The Society has cautioned that there is no evidence for the proposition that a rise in emergency admission rates is due to a rise in unnecessary admissions or that interventions of a social care nature would be adequate alternatives. Evidence regarding healthcare alternatives to hospital admission, such as hospital at home schemes, are also unclear about cost effectiveness. We have emphasised that, although it is important to avoid unnecessary admissions to hospitals, older people should not be denied appropriate admission on the mistaken, ageist belief that their problems are not legitimate reasons for acute hospital care. (Indeed evidence presented at the BGS Spring Meeting in 1998 (Reid et al) showed that inappropriate admissions were not

**CHAPTER 7:  
IMPROVING DELIVERY  
AND EFFICIENCY**

a preserve of older patients). In order to avoid ageism, it is vital that performance standards relating to age are well supported by evidence. Thankfully, the Government plans further consultation on the

content of the National Performance Framework.

**Finbarr C Martin**

\*Chairman of BGS Policy Committee

\*(with acknowledgements to fellow members)

- 1 The White Paper was submitted to Parliament in November 1998 is available on: <http://www.official-documents.co.uk/document/cm41/4169/4169.htm>
- 2 *Better Services for Vulnerable People* (1997), *The New NHS: modern, dependable* (1997), *Partnership in Action* (1998), *Modernising Health and Social Services: National Priorities Guidance 1999/00-2001/02*(1998).

# Care-Home Medicine

## Special Interest Group



**A**n assessment workshop was convened in November 1998 by the Society's Care-Home Medicine Special Interest Group (SIG).

Participants included consultant geriatricians, representatives from Help the Aged, The Relatives' Association, Health Authorities, General Practices, the long-term care insurance industry, nursing, the PAMS (Professions Allied to Medicine) and social service departments.

This report not only summarises the proceedings of the workshop but also puts the concepts of assessment and review into the context of the Government White Paper on *Modernising Social Services*<sup>1</sup> and of *Partnership in Action*<sup>2</sup>. It should help aid the implementation of the Royal Commission on Long-Term Care.

### Introduction

The 1993 Community Care Act<sup>3</sup> laid the responsibility for the co-ordination of comprehensive assessment for placement in residential or nursing home care and the arrangement of complex domiciliary packages of care with Social Services departments. This has led to a concentration on prosthetic rather than therapeutic care for frail older people, who may

thus bypass opportunities for treatment and rehabilitation. The Clinical Standards Advisory Group, in a recent report, described Community Care as 'fragmented with unacceptable variations in standards and quality'<sup>4</sup>.

At present, local authorities have independently developed individual assessment procedures, with no standardised structure or format. There has been a resultant inability to benchmark assessment, service, or indeed even the eligibility for service. The relative disengagement of health services from much assessment has isolated individuals from effective remedial treatment and led to care that cannot adapt to medically predictable evolving needs, and often to inappropriate hospitalisation and institutionalisation.

### Integrated care

Both the Papers on *Social Services* and *Partnership in Action* emphasise the need for health and social services to work together to provide integrated care services and to promote independence through rehabilitation. As well as the importance of integrated health and social care, with joint working and pooled budgets, they also stress throughout the importance of consistency in assessment, clear objectives to promote independence, and risk assessment with regular reviews. Primary care groups, through health improvement plans and joint investment plans, should be looking at schemes which promote independence. The Paper on Social Services, with its subheading of *Promoting Independence, Improving Protection, Raising Standards*<sup>1</sup> (see page 6), outlines a programme of action for older people which will include better preventive services and a stronger focus on rehabilitation. Authorities are being encouraged to draw up an action plan during 1999/2000 to develop support systems for people most at risk of losing their independence.

### Inadequate care plans

The workshop heard that GPs newly responsible for residents admitted to care



Inaugural meeting of the Care-Home Medicine SIG

homes often experienced a two to six-month delay for the transfer of medical records, with an inevitable lack of care continuity and limitation of medical input to a comprehensive care plan. Furthermore, general practitioners and specialists in hospitals have become preoccupied with crisis intervention, with less time to evaluate and monitor chronic health problems. The elderly are often repeatedly assessed but inadequate care plans are provided and not reviewed.

### Developing systems of care

Despite this depressing litany, interested GPs and geriatricians have developed systems and pathways of care which are based on effective

assessment and identification of problems, with regular reviews and monitoring of patients' problems. Systems such as the Elderly Persons' Integrated Care System in Amersham and the over-75 assessment in West Byfleet in Surrey have pioneered integrated care systems, allowing patients' health and social needs to be dealt with together rather than separately. Historically, assessment

systems have been driven by the need to determine care. The workshop considered that more progressive approaches to care would start earlier on in a patient's life course, allowing the need for increased care to be anticipated and planned for, with services and surveillance tailored to individual needs.

### Need for standardised national approach

The workshop, as if pre-empting the Social Services White Paper, agreed that a standardised

national approach to assessment, diagnosis, prognosis, progress review, service standard review and inspection is a prerequisite for services to dependent and vulnerable older people. Multidisciplinary team work across health and social care will only work if such procedures are accompanied by good communication and shared documentation developed by primary care groups. IT systems that allow appropriate health and care personnel immediate access to information about identified frail older people would ensure appropriate service provision, for example, care homes could be connected to the NHS network, allowing them to access and, therefore, edit centrally held records. If the technology allows it, these could be supplemented by patient passports or smart cards. Some standardised assessments do exist: following a not dissimilar set of circumstances, the Americans developed a mandatory minimum data set - resident assessment instrument (MDSRAI).

### Clinical specialist nurses

The identification of those who might benefit from assessments, both of health and social needs, could be triggered by a number of factors that are associated with complex medical and social situations (see Figure 1), as well as by general concern or self-referral. Accredited clinical specialist nurses, operating across health and social care boundaries and contracted by primary-care groups, social service departments and hospitals, could undertake individual and standardised needs assessments wherever an older person was in need. These nurses should work closely with departments of geriatric medicine to ensure that the frail elderly identified as at risk receive a fuller assessment.

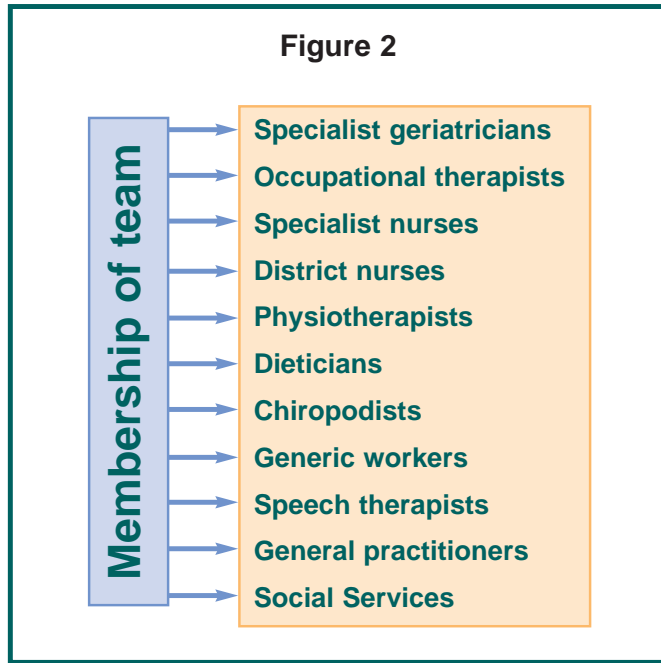
A structured assessment of local health and social care needs could be developed by population analysis of this data. This would inform strategic development and also allow service appraisal through national benchmarking.

### Community rehabilitation systems

Multidisciplinary community rehabilitation teams supported by geriatricians linked with primary care groups should work in partnership with these specialist nurses, GPs and social services. Standardised national assessments will

#### Figure 1 Indicators for Assessment (Casefinding by Identifying)

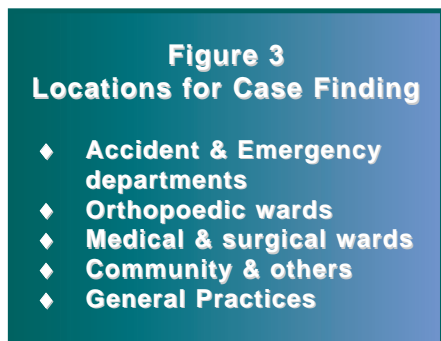
- ◆ recently bereaved
- ◆ aged over 85
- ◆ recently discharged from hospital
- ◆ house-bound patients
- ◆ patients with chronic disease, e.g. Parkinson's, dementia, osteoarthritis of knees or hips, respiratory and cardiac disease
- ◆ patients with strokes
- ◆ fractures, especially neck of femur
- ◆ triggered by over-75 assessment
- ◆ patients prescribed more than four drugs
- ◆ frequent fallers



give teams the opportunity to make a prognosis and provide a treatment plan, and allow patients to receive rehabilitation in their own homes or wherever appropriate, with provision for their needs to be reviewed. Appropriate equipment should be provided in order to promote their independence, without the previous boundary disputes that have existed so often.

Following assessment and the demonstration that individuals would benefit from rehabilitation, it is important that rehabilitation goals are set with the patient by the team, and that these goals are reviewed and treatment stopped or reinstated when appropriate.

Community rehabilitation systems or



social workers have tended to work in isolation in the community. Community rehabilitation cannot replace inpatient rehabilitation, it should

intermediate care systems will need support and encouragement when being developed. For so long, multi-agency work has existed in name only, and doctors, therapists and

complement hospital services and should be evaluated. Complex assessment and rehabilitation can also be done in the day hospital, but ongoing rehabilitation needs may have to be provided in the patient's own home. It is essential that there is consultant medical involvement in assessment and in community rehabilitation, otherwise treatable conditions may not be identified and the team may fail.

**Culture of dependency in old age**

A transformation in the culture of dependency in old age and a reduction in the inappropriate placement of older people in the care-home sector can only be achieved through the following.

- 1 Early identification through national standardised assessment of at-risk older people by specialist nurses.
- 2 Access to expert assessment with timely information exchange and collection of data aided by good IT systems. This will enable hospital, community and social service personnel, and care-home staff to contribute to the assessment, which can be recorded in a standardised way.
- 3 The establishment of well coordinated community-based multidisciplinary rehabilitation teams working in partnership with specialist nurses, social service departments, geriatric medicine departments and GPs, allowing older people an opportunity to enjoy timely diagnostic intervention, treatment and rehabilitation.
- 4 Assessment of local population needs, which could be done on the basis of standardised assessment and would inform strategic planning of health and social services.

**Dr Jackie Morris**

**Dr Clive Bowman**

**Dr Bev Castleton**

- 1 *Modernising Social Services: Promoting independence, Improving protection, Raising standards.* Cm 4169. London: The Stationery Office. November 1998.
- 2 *Partnership in Action (New Opportunities for Joint Working between Health and Social Services). A Discussion Document.* CCC9, 1998–99. London: Department of Health, September 1998.
- 3 *Community Care Act 1993.* London: HMSO, 1993.
- 4 *Community Health Care for Older People: A Report of a CSAG Committee.* Ed. June Clark. London: The Stationery Office, 1998

# HAS 2000 report

- a cause for concern



**H**AS 2000 Report, '*Not because they are old*', is chosen by the Deans and Canons of Windsor as a 'Cause for Concern'

Demand for the Report (summarised in the BGS January Newsletter) has been great and caught the attention of Anne Noble, Visiting Fellow for Community Care and Health Studies at St George's Chapel, Windsor. She runs annual 'Consultations' which address issues of public concern. To these two-day meetings are invited the 'great and the good'. The motive is to raise public awareness and, by attempting to influence key policy makers, ensure that the issue for debate is turned into positive action. In this spirit, the authors of the Report were invited to shape and address the event which was held from the 3 to 5 February in the majestic setting of Cumberland Lodge, Windsor Great Park.

## Participation in the Consultation

Over 70 delegates were invited to participate in the Consultation, chaired by Dr Alistair Main (co-author of the Report). Delegates included senior officials from the Department of Health (DOH), the Royal College of Nursing, representatives of the Social Care sector and many organisations concerned with the care and welfare of older people, including Age Concern, Help the Aged, the BGS, the Relatives Association, Action on Elder Abuse, representatives of the Hospice Movement and individuals who brought the Report's findings to life by describing their direct experiences (good and bad) of the care of older people in our hospitals. The meeting was made possible by generous support of The Gerontius Group, whose founder, Mary Heaward, participated in the proceedings.

Sir Alan Langlands, NHS Chief Executive, launched the meeting, and welcomed the Report, acknowledging the impact it had already

had within the DOH, most notably in assuring the early launch of the NHS Framework for Older People by Frank Dobson.

## The Consultation

The Consultation consisted of two components, as follows.

- 1 Formal presentations:
  - ◆ background, methods and findings of the report, supplemented by the positive actions which had already occurred in the participating hospitals; and
  - ◆ passionate addresses from nurses, the Hospice Movement, representatives of service users and Age Concern, Help the Aged and Action on Elder Abuse.
- 2 Six workshops on:
  - ◆ putting quality not just quantity into our acute hospitals;
  - ◆ effective inter-agency working;
  - ◆ training and work practices in the care of older people;
  - ◆ improving the ward environment;
  - ◆ recruitment and retention of staff; and
  - ◆ informing the NHS Framework for Older People.

## What next?

A report of the proceedings will focus on further action required to ensure that '*Not because they are old*' does not gather dust on Trust Chief Executives' shelves. It will emphasise:

- 1 what would make a difference;
- 2 what is 'doable' without a lot of money being spent; and
- 3 the role HAS 2000 could play implementing the recommendations, bearing in mind the experience gained and methodology developed during the enquiry.

The Report will be targetted at influential people in Health and Social Services, and in a year's time it is planned to convene an half-day meeting to gauge progress.

**Alistair Main**  
Specialist Advisor to HAS 2000

# RCP Geriatrics Committee

## Annual Report, January 1999



**T**he Royal College of Physicians (RCP) Geriatrics Committee recently produced its Annual Report, covering meetings held in 1998.

These included the Spring Meeting held on 21 May, chaired by Professor Ken Woodhouse, the Extraordinary Meeting of the Committee held on Wednesday 30 September, and the Autumn Meeting held on the 15 December. Issues discussed this year include the following.

### 1 Clinical Governance

The Committee accepts the proposed College structure for clinical governance involving appraisal, enhanced CME and service accreditation.

It strongly supports a joint BGS/RCP approach to encourage Ministers to make the new Health Advisory Service (HAS 2000) the organisation effecting systematic accreditation of all geriatric services. The main arguments in favour of this are that: it is now revitalised using a systematic evidenced based approach; the Government has already invested over a million pounds in its development; and it has the support of the BGS, as well as credibility with geriatricians.

The Committee requests that the Society's new Director of CME, Professor Mark Castleden, attend future meetings to ensure a convergence of approach to CME between the College and the BGS.

The issue of audit and outcome measures for each individual clinician continues to cause concern. The Society has recently set up a working party on clinical governance, under the chairmanship of Professor Cameron Swift (President Elect). Dr Black, for the RCP Committee, accepted an invitation to join this working party with the intention of eventually producing a joint document.

Geriatricians are concerned that appropriate expert advice to improve geriatric medical services is not always sought. A short document (see page 16) on *Improving Geriatrics Services*, which is hoped can be jointly supported by the BGS and RCP, will go to the RCP Council in January. It will be particularly aimed at the new Primary Care Groups and Primary Care Trusts.

### 2 Relationship between GIM/GER

The issues around the interface between general internal medicine (GIM) and geriatric medicine (GER), and the related complex issues of manpower, have surfaced in various guises. Two College documents published earlier in the year, entitled *Provision of Acute General Hospital Services* and *Consultant Physicians Working for Patients*, both caused concern among many geriatricians and led to an extraordinary meeting of the RCP Geriatrics Committee. Whilst that meeting raised concerns about the lack of consultation, a very positive document entitled *'GIM/GER Statement of Principles'* (see November 1998 Newsletter) was produced, which has subsequently been endorsed with minimal changes by the RCP Council and the Policy Committee of the BGS.

This document has now been submitted to the GIM/GER Working Party, chaired by Dr Carr, which is continuing its enquiry and hopes to have a draft document in the late summer 1999.

### 3 Interface between rehabilitative medicine and geriatric medicine.

The final paper drafted by the joint working group has now been accepted by both committees and will be appearing as an appendix in the Rehabilitation Committee's document on disability.

### 4 Training

The Geriatrics Committee is pleased that special advisory committees have been able to work on improving assessment within the training process. It believes that the penultimate year assessment (PYA) 'with teeth', which genuinely has a set of

**Continued on page 17**

## IMPROVING GERIATRIC SERVICES - SOURCES OF HELP

This document provides a brief overview of the pathways available for getting expert advice on improving geriatric medical services.

### In summary

- 1 Local geriatricians.
- 2 BGS/RCP Specialist College Advisers.
- 3 British Geriatrics Society (BGS).
- 4 Royal College of Physicians (RCP).
- 5 Health Advisory Service (HAS 2000).

### Local geriatrics departments

Trained to take a whole systems approach, not just a clinical approach, the local geriatrics department should always be the first source of advice for improvements or problems with local service delivery of elderly care.

### BGS/RCP Specialist College Advisers

This is a national system of advisers set up administratively along the lines of the old Regional Health Authorities. Where parts of the country have kept specialist subcommittees, the Specialist College Adviser will usually be the same person as the Chairman of the Specialty Sub Committee. Many Specialty College Advisers will work with the Dean's Adviser in Geriatric Medicine, as well as with the regional BGS Committee Members to act as a local 'executive' for advice on geriatric care.

The Specialty College Adviser has a crucially important role in providing a source of advice on both developing services and helping solve local service/delivery problems. The BGS Administration (Richard Lynham, Tel: 0171 935 4004) can advise on current names and addresses of each region's

Specialty College Adviser (see table on page 17).

### British Geriatrics Society

The BGS can give a national perspective on patterns of service delivery, best practice, and national guidelines. These are available in the BGS Compendium of policy statements and statements of good practice. This is available over the Internet (<http://www.bgs.org.uk/>) or by personal correspondence to the British Geriatrics Society at 1 St Andrew's Place, Regent's Park, London NW1 4LB.

### National experts in clinical practice

The Society can also give names of national experts in various areas of clinical practice who may be available to offer advice on specific clinical issues.

### The Royal College of Physicians

The RCP role has been to uphold and improve standards of medical practice in hospitals in England and Wales. It has a direct influence on the quality, training and appointments of all consultants in all medical specialties, as well as encouraging educational and research activities in medicine. The RCP runs the programme of continual medical education for all physicians.

The college has been increasingly asked to advise on adequacy of standards, and is willing to respond to such requests. Recently, this has included advising on the structure of specialist services, the suitability for view consultant appointments or in-depth service reviews where general practitioners had made complaint about clinical standards.

The regional college network is

available as a first resort and includes: a District Tutor in each DGH; a Specialist Adviser (see b); and a 'Regional Adviser' in each Postgraduate Deanery.

Beyond this network, contact: The Registrar at The Royal College of Physicians, 11 St Andrew's Place, Regent's Park, London NW1 4LE. Tel: 0171 935 1174.

### Health Advisory Service (HAS 2000)

The HAS was first established in 1969 by the then Secretary of State and originally run as an independent arm of the Department of Health looking at the quality of care of mental health services and health services for older people - across organisation and professional boundaries. Following a review in 1995/1996, service was put out to tender and is currently run by a consortium of four national organisations with managerial responsibility. This new charitable organisation is called the HAS 2000. The four consortium members are: The Royal College of Psychiatrists; The BGS; The Royal College of Nursing; and The Office for Public Management.

HAS 2000 provides service reviews to facilitate service improvement and as a step towards organisational development. These reviews use systematic methods and evidence based standards as the foundation.

Further information about the reviews or services of the Health Advisory Service can be obtained from the joint Chief Executive, Dr Paul Lelliott, and Prof Geoff Shepperd at HAS 2000, 46-48 Grosvenor Crescent, London SW1W 0EB. Tel: 0171 881 9255. Fax: 0171 881 9260.

Continued from page 15

objectives that measure competence and skills, is a very positive approach. It is also pleased at the clarification of consultant locums versus 'acting up', and wishes to endorse any encouragement for trainees to gain experience abroad.

Commission had not yet reported. It is possible that it may contain recommendations that would significantly influence the way geriatricians work and have manpower implications. The Geriatrics Committee will convene an extraordinary meeting when it is published.

**5 Royal Commission on Long-Term Care**

At the time of writing this report, the Royal

**David Black**

Chairman RCP Geriatrics Committee

BGS REGIONAL SPECIALTY ADVISERS*			
Speciality College Advisers	Region	Specialty Training Adviser or Dean's Adviser	Academic
Dr D E A Luxton	East Anglia	Dr D Maisley	Prof Kay-Tee Khaw
J J Turner	Mersey	Prof M Lye	
Dr R Francis	Northern Ireland	Dr R Francis Prof D Coakley	Prof R A Kenny
Dr Ken Fullerton	Northern Ireland	Dr Ken Fullerton	Prof R W Stout
Dr A K Banerjee	North Western	Dr A K Banerjee	Prof R C Tallis
Dr C Gent	North East Thames	Dr G S Rai	
Dr C Vellodi	North West Thames	Dr La Brooy	Dr D Levy
Dr D A Black	South East Thames	Prof C Swift	
Dr N Gunther	South West Thames	Dr I Hastie	Prof P Millard
Dr C Foote	Oxford	Dr D S Fairweather	Prof J Grimley Evans
Dr V Pearce	South Western	Dr V Pearce	Prof G K Wilcock
Dr C A Austin	Trent - North	Dr C A Austin	
Dr J Marrant	Trent - Mid	Dr J Marrant	
Dr D Ives	Trent - South	Dr D Ives	
Prof K Woodhouse	South Wales	Prof K Woodhouse	
Dr B K Bhowmick	North Wales	Dr B K Bhowmick	
Dr S C Allen	Wessex	Dr S C Allen	Prof R Briggs
Dr P Overstall	West Midlands	Prof A J Sinclair	
Dr Ann McEvoy	Yorkshire	Dr O J Corrado	Prof G P Mulley
	West Scotland	Dr Margaret Roberts	
	East Scotland	Prof M E T McMurdo	
	South East Scotland	Dr Colledge	
	North East Scotland	Dr McArthur	

**\*BGS Health Warning!**

The above list is based on a survey effected in January 1999. It is believed to be correct for most regions; however, some regions did not reply and others sent conflicting data!

Outlaw

# age discrimination

in the Health Service



**L**ady Sally Greengross, Age Concern England, campaigns against discrimination and 'being thrown on the scrap heap at 70'.

*"...I was discharged from hospital after a heart attack. I was invited to a kind of get together of patients who had recently been in the coronary care unit, to watch videos relating to their recuperation and have talks by a dietician and a chemist. About six people with their wives attended. During the meeting it transpired that all the ex-patients except myself had been to a hospital to be tested on a 'treadmill'. All had seen the physio-therapist. All had had access to the gymnasium and relaxation tapes. I was told by the person in charge that the cut off age for the treatment was 70...I was very hurt, as was my wife, to feel that I had been thrown on a human scrap heap."*

## Review of age discrimination

Age Concern has campaigned for many years for decisions about healthcare treatment to be made on the basis of an individual's need. If rationing has to happen, there must be an honest and open approach, informed by public, professional and parliamentary debate. In opposition, Labour promised a thorough review of age discrimination in the Health Service. An audit of this kind would be a valuable first step towards evaluating the criteria already used by some health authorities to determine who has access to which service and towards adopting a fair and transparent way of allocating NHS resources. Doctors and other healthcare professionals are in a unique position to contribute to this audit. If we are going to beat ageism we need to work together and ensure that good practice becomes the norm.

One year on from the launch of Age Concern's age discrimination campaign, awareness of the harm this prejudice causes workers and

companies has grown inside and outside parliament. However, ageism in healthcare is still to be addressed. A Gallup survey conducted at the time of the campaign (February 1998) showed that more than one million people over 65 believed they had experienced age discrimination in health care. Older people interviewed for Age Concern's report *'Time for a check up: older people and the NHS (3.7.98)'* felt that lack of resources has led to age discrimination and inadequate quality of care and that the NHS was straining to cope with the growing number of people in their age group.

## Simply because you are old

For the hundreds of thousands of older people who are turned down or left waiting for treatment, age discrimination in healthcare is not about policy; it is about pain, anxiety, the loss of independence, dignity and hope. It is about being refused an operation, enduring chronic pain, being left on a hospital trolley, or turned down for a rehabilitation programme simply because you are old. The only way to ensure that all older people get the treatment is to outlaw discrimination in the health service.

Ageing has become an important issue because of dramatic changes in life expectancy. Only one in six Britons born 150 years ago reached 75, whereas two thirds of those born today will. People over 60 currently constitute a fifth of the British population but will be a third by 2030. Those aged over 80 are the fastest growing section of the population. In 1951, Britain had 300 people aged over 100; by 2031 it will have 34,000. We are moving towards a world where older people will outnumber children - and we are not well prepared. We do not want children competing with older people for limited resources; our society needs to change as birth rates fall and life expectancy rises.

Currently, older people constitute 16% of the population and yet budget figures show that

they account for 42% of NHS expenditure. This figure is set to rise. As people live longer they will demand more from the NHS. Because of this, there are calls for age to be used as criterion for rationing. But rationing decisions within the NHS should not be made on an *ad hoc* basis or behind closed doors. There is a growing body of evidence that some older people are being pushed to the end of the queue simply because of their age.

### Hip replacement delays

A recent survey in rationing commissioned by *Doctor Journal* reported hundreds of incidences of elderly patients who deteriorated greatly while waiting for hip replacement surgery, becoming unfit to be operated on.

### Breast cancer

Women over 65 are not invited to breast screening for breast cancer; this is despite conclusive evidence that women over 65 are at much greater risk of developing the disease. There is also concern that older women are not offered the same advice and treatment once the cancer has been diagnosed.

### Strokes

The numbers of patients with strokes needing longer-term support are increasing. People who have strokes accounted for £2.3 billion, 5.8% of NHS and Social Services expenditure in 1995/96. This estimate takes into account not only the immediate costs of stroke, but the costs of

support also. The cost of stroke care is set to increase by 30% in real terms by 2023. We need to start investing in a rehabilitation programme for all stroke patients; and yet we are not. Instead, stroke patients are receiving a lot of support from carers. Caring for people with severe disability would cost at least £672 million if it had to be replaced by paid work.

### Cardiac rehabilitation

There are very few cardiac rehabilitation units in this country and those that do exist are largely under-resourced. A recent survey by Age Concern England discovered that between a third and a

half of cardiac rehabilitation programmes have upper age limits on access to their services.

### Alzheimer's disease

It is anticipated that around half of all Alzheimer's sufferers could benefit from the drug Aricept; yet only about 40 to 130 health authorities and health boards currently fund or assess its need. Some authorities cite lack of efficacy, others admit they fear being swamped by demand, at a potential cost of £1,000 a year per patient they fear they cannot afford the drug. By far the great majority of people with Alzheimer's are older people. The reluctance of authorities to fund the treatment calls into question the value a society puts upon old people with an illness that can be helped, but not cured. And yet a recent study has shown that the cost of drug therapy may be offset completely in many situations if only a few weeks of institutional care can be avoided through its use.

### Attitudes

Older people who visit their GP suffering from arthritis are very often told that their symptoms are simply a part of growing old and therefore denied treatment. Age Concern hears time and again of instances where older people are told that they are suffering certain conditions 'because they are old', and that they ought to accept deteriorating conditions. They are often too frightened to complain.

Last year *The Observer* newspaper ran a campaign highlighting the appalling treatment of many older people on NHS wards. Age Concern has heard extreme examples of ageism on hospital wards. In November last year, an independent inquiry into the standards of NHS Hospital Care for Older People launched a report *'Not because they are old'* (see January 1999 BGS Newsletter). The Government sent copies of the report to all health authorities, calling for remedial action 'where the essentials of care are not being provided'. In *'An Early Day Motion'* (November 98), Age Concern welcomed the Government's response, but called for measures to be taken to preserve the dignity of older patients, including better training of healthcare professionals to include specific training for dealing with older patients. This document gained 93 signatures from Members of Parliament representing all parties.

BY THE YEAR 2031, IT IS ESTIMATED THAT THERE WILL BE AROUND 34,000 PEOPLE OVER THE AGE OF 100 IN THE UK ALONE

Neither the NHS Acts of 1946 and 1977 contain clauses which would prevent health professionals from refusing patients treatment on the basis of their age. The General Medical Council's Code of Good Medical Practice does state that 'you must not allow your views about a patient's lifestyle, culture, belief, race, colour, gender, sexuality, age, social status, or perceived economic worth to prejudice the treatment you provide or arrange.' The government maintains that the NHS provides treatment on the basis of need, and need alone. However, it is becoming increasingly clear that very often patients are discriminated against because they are old.

**New NHS bill**

Age Concern is asking the Government to introduce legislation against age discrimination in the health service. We believe that the new NHS bill should include a clause ensuring equal treatment for older people. An audit of age discrimination within the NHS would provide valuable evidence for an open and honest debate about the criteria used for rationing.

Healthcare professionals are best placed to inform this debate. Of course, resources are not infinite. Currently, doctors are being forced to make rationing decisions on behalf of the Government, sometimes against the best interests of their patients. But many of the current rationing decisions, although arguably saving money in the short-term, have a greater cost in the longer term.

**Challenging presumptions**

Age should not be the only factor to be considered in rationing. Organisations and professionals working with and on behalf of older people need to challenge the presumptions now before a view gains political, clinical, economic currency and acceptance. Caroline Gilchrist, 0181 765 7200, would like to hear from healthcare professionals who would like to get involved in Age Concern's campaign.

**Sally Greengross**  
 Director General  
 Age Concern England

**REQUEST FOR MRCP PART II QUESTIONS**

Although the format of the MRCP examination will be changing in the next few years, there is still a great need for the existing types of questions - data interpretation, photographic material (including x-rays) and clinical histories. We all know that increasing numbers of elderly patients are being admitted to hospital. Therefore, there is a continuing need for MRCP questions to reflect this change and for the Examination Board, to contain more questions relating to older people.

Potential questions for use in the examination are therefore being sought from those interested in submitting to the MRCP Question Group. Very few questions are actually rejected but the history and questions often need to be put in the accepted format. Potential answers and their value then need to be considered.

Once the questions have been through the Question Group, they are passed on to the Examination Board for possible inclusion in the examination itself. It can take well over a year, from the time that a question is submitted to the time when it actually appears in the exam. It is often said that the originator of the question will not recognise it by the time it has actually come out of the end of the re-writing process. The Examination Board assesses the performance of questions which it uses and lets the originator of the question know how it has performed. A number of questions I myself have submitted have turned to be good discriminators. Geriatricians know the situation well but clearly there are conditions with which MRCP candidates are not familiar.

If you are interested, therefore, in submitting potential questions for use in the MRCP Examination, please

send them to me, as Secretary of the MRCP Question Group, at the Royal College of Physicians\*. Don't be put off if you have not done this kind of thing before and don't worry about the style of the history or the questions. This will be resolved by the Questions Group itself, which consists of general physicians, gastroenterologists, endocrinologists, respiratory physicians, cardiologists and neurologists, amongst others. If you have potentially useful x-rays or photographic material, please submit them also.

All submissions are welcomed. I look forward to receiving a glut of material in the near future.

**M J Denham**  
 Secretary of the Part II  
 Questions Group

\*RCP, 11 St Andrew's Place, Regent's Park, London NW1 4LE.

# Feeding stroke patients

## - The FOOD Trial

**S**troke is amongst the most common conditions managed by geriatricians in the UK today.

Indeed, many geriatricians are responsible for running their hospitals' stroke service or unit. Around 45% of patients admitted to hospital with a stroke have problems swallowing and are therefore at risk of dehydration and malnutrition if we do not intervene. The remainder who can swallow may also be at risk because of existing malnutrition or difficulties due to ill fitting or lost dentures, poor arm function, loss of appetite and unappetising meals.

### Variations in feeding policies

The recent emphasis placed on these difficulties will have led many of us to introduce policies for dealing with nutritional issues in stroke patients. However, we have to be aware that, although these policies may be based on commonsense and experience, they are not based on robust evidence. This is simply because there are very few studies examining how best to feed stroke patients. It is, therefore, not surprising that there are marked variations in feeding policies between individual hospitals and clinicians. For example, in dysphagic stroke patients, some clinicians introduce feeding via an NG tube immediately, whereas others delay for a variable period to see if the swallow will improve, whilst maintaining hydration with parenteral fluids. Some clinicians never use NG tubes, preferring to insert a PEG if tube feeding is required. The timing of PEG insertion also varies hugely, often seeming to depend on the ease with which they can be arranged.

If feeding policy influences the long-term outcome of the patients, the variation in policy means that many of our patients are receiving sub-optimal care. The problem is that it is not

known which policy is best. This must be unacceptable.

### The FOOD Trial

The Feed Or Ordinary Diet (FOOD) Trial is a multicentre international trial which has been set up to address these important issues. It actually comprises a "family" of three trials which aim to answer the following three questions.

#### Trial 1

*In patients who can take adequate oral fluids, does routine oral nutritional supplementation (with sip feeds) increase the proportion of patients with stroke surviving without disability?*

Patients in whom the responsible clinician is uncertain about the benefits of supplements are randomised to receive either oral supplements (360ml of 1.5kCal/ml supplement per day prescribed on the drug chart) or normal hospital diet (albeit of modified consistency if necessary) until discharge. The aim is to randomise 6000 patients in Trial 1.

#### Trial 2

*In patients who are unable to take an adequate diet orally, does early initiation of tube feeding (NG or PEG) increase the proportion of patients with stroke surviving without severe disability?*

Patients may be randomised in the first week of admission to receive either early tube feeding (via an NG or PEG, depending on the clinician's preference) or to delay tube feeding for at least a week whilst hydrating with parenteral fluids. We plan to randomise 2000 patients in Trial 2.

#### Trial 3

*In patients who need tube feeding, is a PEG tube, as opposed to the traditional NG tube, associated with improved outcomes after stroke?*

Patients may be randomised between tube feeding via an NG or PEG at anytime in the

first month of admission, if the responsible clinician is uncertain about which is best. We hope to randomise 1000 patients in Trial 3.

### Co-enrolment

A patient can be randomised into one, two or all three trials depending on their condition and the clinician's uncertainty. For example, a patient with dysphagia may be randomised into Trial 2 (early vs delayed tube feeding) to receive delayed tube feeding but, after a week, if still dysphagic, could be randomised in Trial 3 (NG vs. PEG). Alternatively, if the dysphagia is resolved, they could be randomised into Trial 1 (oral supplements vs. normal diet). This so-called co-enrolment reflects clinical practice and allows FOOD to investigate interactions between treatments.

### Outcomes

Patients' outcomes are assessed at six months and are based on survival and functional status, measured by the Modified Rankin Scale. We also record their quality of life and length of hospital stay, the latter giving an indication of the costs involved.

### Funding

FOOD is funded by grants from the NHS R&D Health Technology Assessment (HTA) Programme, The Scottish Office, The Stroke Association and Chest Heart & Stroke Scotland.



### Progress

We have successfully completed the pilot phase over the past two years. The main phase started in October 1998.

We plan to recruit

a total of 9000 patients by 2002. We need this number of patients in order to confirm or exclude clinically significant differences in outcomes of patients fed in different ways. Although ambitious, our targets are realistic. We now have 86 participating hospitals in 18 countries. The majority of hospitals are in the UK, but clinicians in Eire, Italy, Belgium, Portugal, Poland, Turkey, Czech Rep, New Zealand, Australia, Canada, Singapore, Hong Kong, India and Brazil are

also participating. This is an international effort and emphasises that the questions being addressed are relevant to patients around the world. With the help of our existing collaborators we have randomised over 1000 patients so that FOOD is already the largest ever trial evaluating feeding policy in stroke patients.

### How can BGS members help?

Those looking after stroke patients, who are uncertain about how best to feed them, could participate in The FOOD Trial. Many more centres are needed to ensure that targets are reached and to answer reliably the questions about how best to feed patients. Collaboration in FOOD is simple.

- ◆ FOOD has Multicentre Research Ethical Approval (MREC) which simplifies the process of gaining local ethical approval. Help can be given for filling in the application forms.
- ◆ Once the patient's consent has been obtained, simply give a few clinical details (a single side of A4 paper) over the phone and receive the treatment allocation.
- ◆ A 24-hour freephone randomisation service is provided, as well as a 24-hour helpline to answer any queries.
- ◆ At discharge, the hospital co-ordinator completes a simple two-page form outlining how the patient was actually fed and any complications which may have occurred in hospital.
- ◆ The patients' are followed up centrally after six months to establish their survival, functional status and quality of life.
- ◆ There is some modest support available to centres to facilitate recruitment.

### Contact address

Those interested are welcome to join. Contact: The FOOD Trial Co-ordinating Centre, Neurosciences Trials Unit, Dept. of Clinical Neurosciences, Western General Hospital, Edinburgh EH4 2XU. Tel: 0131 537 3126. Fax:: 0131 332 5150. Email: [FOOD@skull.dcn.ed.ac.uk](mailto:FOOD@skull.dcn.ed.ac.uk)

**Dr Martin Dennis**

University of Edinburgh  
and

**Gina Cranswick**

FOOD Trial Co-ordinator

*N.B. A list of UK participating centres to date is available from FOOD at the above address.*

# Health and Social Services

- summary of report



**T**he relationship between Health and Social Services is discussed in the 1998/99 House of Commons Health Committee report.

In its report, the Health Committee considered the impact on patients and their carers of the division between the NHS and Social Services. It considered, in particular, the problems caused for users and carers by this separation, and the best ways to make the two services work together.

### Main conclusions

The current system for continuing health and social care is considered very confused. Responsibilities are blurred, professionals face unnecessary problems, and users and carers suffer because of barriers based on an “ill-defined and arguably non-existent boundary”. There also appears to be a lack of vision by professional bodies in evidence given. Organisations did not seem to consider the issue from a wider perspective, and especially

not from the users’ and carer’s points of view.

### Need for integrated care system

The Department of Health (DOH) proposes, in the Government’s consultation paper on ways to facilitate joint working (*Partnership in Action*, September 1998), to allow a lead commissioner and integrated provision. However, it is felt that the problems of collaboration between Health and Social Services will not be properly resolved until there is an integrated care system, either within the NHS, in local government or in some new, separate organisation. The Committee recommends that pilot schemes be established to test ways in which integration could happen, based on the lead commissioner model proposed by the DOH.

In the meantime, it feels that much can be done to improve services for both users and carers, including minimising the problems arising from the separation of the two services. These are set out in full in the report.

**Continued on page 24**

## URGENT NOTICE TO ALL POSTER PRESENTERS OF ABSTRACTS AT THE SPRING MEETING 1999

### SIZE OF POSTER BOARDS

Due to the popularity of the Meeting, and the large amount of poster presentations accepted, as well as stringent fire and safety regulations in University College Cork, we have been obliged to reduce slightly the size of the poster boards.

They will measure 4 ft wide by 3 ft high, landscape.

- ◆ They will take 2 size A1 sheets, portrait-style, side by side.

- ◆ If you intend to use A4 sheets, they will take 15 (i.e. 3 down and 5 across, portrait), or 16 (i.e. 4 down and 4 across, landscape).

We regret if this inconveniences you, but the change is unavoidable.

Contact the Registration Secretariat for further details, (see front page article).

**Dr C Twomey**  
Cork University Hospital

Continued from page 23

### Recommendations

The Committee recommends the DOH should:

- ◆ examine the effectiveness of current needs assessment methods;
- ◆ review and clarify respective roles and responsibilities;
- ◆ establish incentives and remove barriers and

perverse incentives, encouraging joint working;

- ◆ ensure effectiveness of joint working through performance monitoring; and
- ◆ take steps to ensure best practice is shared.

The report is available from Stationery Office outlets and the Vote Office, House of Commons, as *House of Commons Paper 74-I*. Telephone enquiries to: Frank McShane on 0171 219 5466.

## In Memoriam



### RONALD VERDUN DENT MARCH 1916 - DECEMBER 1998

Ronald Verdun Dent was born on 29 March 1916, the son of a Norfolk farmer. He was educated at Norwich School, Christ's College, Cambridge, and Charing Cross Hospital. He qualified in 1940. Within two years he had passed his MRCP and became Medical Registrar at Charing Cross.

After war service as a Surgeon Lieutenant RNVR, he became Medical Registrar at Chase Farm Hospital and Senior Registrar at Rochford Hospital, Southend. At Enfield, he saw the plight of the elderly chronic sick and at Southend he observed what could be done for them. Inspired by the example of Dr Sam Cieman, the Medical Superintendent of Rochford and a very early member of the BGS, he decided to make a career in geriatric medicine, a courageous decision for a well-qualified physician who might well have followed a conventional career in general medicine.

In 1951, he was appointed physician with special interest in

the elderly at North Manchester General Hospital. He discovered that he had taken over 365 beds (with patients in them) and four chairs. When he first requested new equipment, he was fobbed off with the cast-offs from other wards. His inheritance was as backward as any in the country. However, he gradually transformed it and, because of the excellence of his work, attracted good staff. One of his elderly Senior Registrars was Dr J M Leeming, who later became Secretary of the BGS. He eventually had the satisfaction of seeing his unit accepted as a teaching department in the Manchester Medical School.

Dr Dent was a natural leader and was widely respected for his achievements. He served as a member of the Manchester Regional Hospital Board from 1968 to 1973 and helped to promote the Manchester Chair of Geriatric Medicine, the first in England, established there in 1970.

In the last part of his career, he

became increasingly concerned with the care of the dying. He was Chairman of the group which established St Anne's Hospice, Manchester, the first hospice to be established outside London. In retirement, he continued to work in hospice medicine.

Dr Dent was a member of the BGS Council from 1957 to 1960. He passed away in December 1998.



**AGENDA OF THE BGS COUNCIL MEETING, 7 APRIL 1999**

**For the benefit of members, the agenda of the forthcoming Council meeting, to be held in Cork, is announced below.**

- 1 Apologies for absence.
- 2 Minutes of the meeting held 8 October 1998.
- 3 Matters arising.
- 4 Executive Committee and Standing Committee minutes.
- 5 To receive and, if necessary, discuss the following minutes:
  - Executive Committee: 10 December 98; 28 January 99; and 18 March 99;

- Policy Committee: 22 October 98; 14 January 99; and 25 March 99;
- Finance Committee: 21 January 99; and
- Training Committee: 26 November 98; and 9 February 99; and
- Scientific Committee: 12 January 99.

- 6 Honorary Secretary's Report to include:
  - update on exchange of information with the RCP London et al on specialties interface and consultant workloads;
  - the Dignity on the Ward Campaign; and
  - the Royal Commission on Long-Term Care report.
- 7 Honorary Treasurer's Report.

- 8 Referrals from the Regions.

**Main Items for Discussion**

- 9 To consider a draft proposal that the Society plan to acquire its own premises.
- 10 To receive a report on responses for the regions on changes to the method of electing officers.
- 11 To receive recommendations on changes in format for BGS Scientific Meetings.
- 12 Reports from representatives on outside bodies.
- 13 Special Interest Group business.
- 14 Trainee Group referrals.
- 15 Any other business.
- 16 Date of the next meeting and study day 1 July 1999.

**CLINICAL POST IN UNIVERSITY OF DUNDEE**

**Ninewells Hospital and Medical School, Section of Ageing and Health/Dept of Medicine**

**Clinical Senior Lecturer in Ageing and Health**

**Closing date: 2 April 1999**

Applications are invited for this new post funded to expand further the activities of the Section of Ageing and Health, led by Prof Marion McMurdo. The successful candidate will join a dynamic and productive academic Section with excellent research opportunities, and will be expected to contribute to teaching and to develop a research programme to complement existing strengths, e.g. exercise, falls and osteoporosis.

The position carries an associated appointment as Honorary Consultant in the Department of Medicine for the Elderly with clinical duties in Ninewells and Royal Victoria Hospitals. Contact Prof McMurdo, (Tel:

*Continued from previous column*

01382 632436, email: m.e.t.mcmurdo@dundee.ac.uk) for informal enquiries and a copy of the job description.

The starting salary will be on the Clinical Senior Lecturer and Honorary Consultant scale, according to experience. The University is an Equal Opportunities Employer.

**JOB SHARE PARTNER WANTED!**

**Job Share Partner for Consultant Post in Care of the Elderly/ General Medicine**

**Bristol**

Dr Kyra Neubauer is looking for a job share partner to apply for above post in Bristol.

For further details contact Dr Neubauer at: Dept of Medicine, Elgar Hosue, Southmead Hospital, Bristol BS10 5NB. Tel: 0117 959 5369. Fax: 0117 959 5376.

**MEDICAL POSTING IN THE UK WANTED!**

Dr Walter Lam, currently working as a medical officer in the Department of Medicine, Geriatrics and Rehabilitation Division, Yan Chai Hospital, Hong Kong, is now looking for a placement for six months within the UK as a clinical visitor in geriatrics.

He would prefer the post to start sometime in late 1999 or early 2000.

Dr Lam obtained his UK MRCP in 1996, his MHKCP in 1997, and started his higher physician training in 1997, specialising in advanced internal medicine and geriatrics.

If readers of the Newsletter are able to help with this enquiry, please contact Dr Lam either by email: lms@medi.net.hk, or by mail at the following address: Dr Walter Muk Sum Lam, Dept of Medicine, Yan Chai Hospital, 7-11 Yan Chai St, Tsuen Wan, N.T., Hong Kong.

**ASSESSMENT OF OLDER PEOPLE**

Assessment of Older People in the Community

23 March 1999

The Royal Society of Medicine, London

Topics include: general practice, social work and nursing, concluding with the Alex Comfort Lecture

Fee: Fellows/students £40.00  
Non Fellows £60.00

CME: accredited with 5 points

Registration: Debbie Smith, Academic Dept, Royal Society of Medicine, 1 Wimpole Street, London W1M 8AE. Tel: 0171 290 2984, fax: 0171 290 2989, email: debbie.smith@roysocmed.ac.uk.

**PULMONARY DISEASE**

West Cumbria Health Care NHS Trust  
"Chronic Obstructive Pulmonary Disease"

27 April 1999

West Cumberland Hospital, Whitehaven

PGEA and CME approved

Topics include: epidemiology and risk factors for COPD; COPD vs asthma; new BTS guidelines; pulmonary rehabilitation; and overview of new developments and therapeutic opportunities.

Registration: Miss Lesley Ann McGuirk, West Cumberland Hospital, Whitehaven, Cumbria CA28 8JG. Tel: 01946 693181, ext: 4117. Fax: 01946 523520.

**INSTITUTE OF AGEING AND HEALTH**

"The Management of Stroke: How to choose surgery or the alternative?"

30 April 1999

Queen Elizabeth Hospital, Birmingham

Fees: non-members £30, members £20, half-day rate £20.

Registration: Rae Williams, IAH, Moseley Hall Hospital, Alcester Road, Moseley, Birmingham B13 8JL. Tel/Fax: 0121 449 8360.

**EFIM - 2**

2<sup>nd</sup> Congress of the European Federation of Internal Medicine

12 to 15 May 1999

Florence, Italy

Registration: Contress Secretariat, AISC, Via A Ristori, 38, 00197 Rome, Italy. Tel: +39 06809681. Fax: +39 068088491. Email: efim@aisc.it. Website: www.aisc.it/efim.

**CME**

4<sup>th</sup> National CME Conference "Eyes to See, Ears to Hear" Special Senses in the Older Adult

20 May 1999

Keele University, Staffordshire

Registration: Mrs Olwyn Mander, Dept of Geriatric Medicine, School of Postgrad Medicine, Thornburrow Drive, Hartshill, Stoke on Trent ST4 7Q. Tel: 01782 554995, fax: 01782 747319, email: mea07@keele.ac.uk.

**ELI LILLY TRAVEL AWARD**

Travel award: £300

Closing date: 31 May 1999

Eli Lilly International has provided support for a £300 bursary for financial assistance to SpRs and Registrars training in geriatric medicine who are presenting research papers at international meetings.

Candidates should submit an application to the BGS Administrative Director (address on page 27). This should consist of an abstract not longer than one A4 sheet of paper, accompanied by a copy of the acceptance of the oral or poster presentation by the meeting in question. Applications may be considered in retrospect of a meeting.

Where none of the applications are deemed suitable, the Society reserves the right to hold on to the award until the following year.

**STROKE**

Institute for the Health of the Elderly - "Stroke in the Millennium"

30 June 1999

Sunderland University

Fee: £25

Topics include: multidisciplinary management of stroke patients; and future of acute stroke care.

CME: accredited with 5 points

Registration: Julie Smiles, Dept of Medicine for the Elderly, Sunderland Royal Hospital, Kayll Road, Sunderland SR4 7TP. Tel: 0191 565 6256, x: 42109.

**PSYCHOTHERAPY**

2<sup>nd</sup> European Conference  
 "Europe, the XXI Century:  
 Psychotherapy Hand in Hand  
 with Pharmacotherapy"

13 to 16 September 1999

Princesa Sofia Hotel, Barcelona

Topics include: psychiatry and psychotherapy; combination treatment; psychotherapy research; ethics and laws; and quality assurance.

**Registration:** The Organising Secretariat, Grupo Geyseco, Marina, 27, 08005 Barcelona, Spain. Tel: 34 93 221 22 42, Fax: 34 93 221 70 05, Website: <http://www.geyseco.com>, email: [geybcn@adv.es](mailto:geybcn@adv.es).

**AGM AND COUNCIL - OCTOBER MEETINGS**

BGS Annual General Meeting and Council meeting

Thursday 7 October 1999

Please note that, although the Autumn Scientific Meeting has been rescheduled for 16 and 17 December 1999, the Society's AGM and the Council meeting will still take place in October. Due notice of the meetings will be sent to all members with the annual accounts and other statutory notices.

It is hoped to arrange a Study Day to follow the AGM.

**GERIATRICS SOCIETY OF INDIA**

International Conference

12 to 13 November 1999

**Contact:** Dr O P Sharma, General Secretary, Geriatric Society of India, K-49 Green Park Main, New Delhi, 110016, India. Email: [drmoht@del3.vsnl.net.in](mailto:drmoht@del3.vsnl.net.in).

**GMC ELECTIONS**

We are pleased to advised that **Dr Linda Patterson**, Medical Director of Burnley Health Care NHS Trust is standing again for re-election of the GMC, following her initial five years of service.

**EPILEPSY**

International League against Epilepsy - 7<sup>th</sup> SpR teaching weekend in epilepsy

1 to 3 October 1999

St Anne's College, Oxford

The course covers modern clinical epilepsy, including investigations and treatment strategies. It is free but limited to 140 delegates.

**Registration:** Tracy Dance, adOration Ltd, Century House, 100 Station Rd, Horsham, West Sussex RH13 5UZ. Tel: 01403 212100, fax: 01403 242493.

**CLINICAL EXCELLENCE**

The National Centre for Clinical Audit Conference & Exhibition

8 to 9 December 1999

**Closing date for abstracts:**  
 15 April 1999

Harrogate

Physicians are invited to share experience and expertise by submitting abstracts on quality improvement projects.

For details contact the Centre on: tel 0171 383 6451; fax 0171 383 6373; and email [NCCA@ncca.org.uk](mailto:NCCA@ncca.org.uk).

**KOREA**

Research Institute of Geriatrics

The Institute has recently opened its website on <http://kitel.co.kr/~krig/index.htm>. It is seeking to cooperate on geriatric research and to increase productivity through partnership with overseas scholars.

**Contact:** Cheol-Wan Lee, President, The Korea Research Institute of Geriatrics, Woojin B/D #301 37-20, Samsungdong, Kangnamgu, Seoul, Korea. Tel: (02)547 0166/7. Fax: (02)547 0570.

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