British Geriatrics Society – Strategic Review – 2008 Appraisal

In addressing the Charity Commission's latest Statement of Recommended Practice on reporting requirements, Trustees approved (in May 2006) the following as the three prime activities of the Society:

- The holding of scientific meetings
- The publication of peer reviewed papers
- The active promotion of research, education and training in all aspects of geriatric medicine

---

Trustees will have the opportunity to consider the scope of our three key objectives when considering the following review.

The review is in two parts: the first part, on pages 2-5 focuses on the next two years and highlights key areas of activity for the Society to engage in. The second part, on pages 6-10, covers the period April 2006 to March 2008 and takes a retrospective look at the many areas of Society activity during this time; this section comprises the supporting objectives identified to achieve the three key objectives above

THE NEXT TWO YEARS

Opening observation:

From the BGS Newsletter – March 2008 – leader article:

"This is not about preserving our services, as they are now, as things around us change and threaten what we have built. It has to be about reshaping our services but more important than this is to export the lessons we have learnt into the wider clinical world"

Other opening comments:

The latest NHS Review (Darzi) and the RCP (London) publication "Teams Without Walls" are just two examples of the changing environment geriatricians now find themselves in. The former heralds the era of clinical leadership outside the hospital boundary – we need to engage as a matter of priority the commissioning organisations and alter our internal business model to do so.

We must instil a greater degree of assertiveness into the membership, otherwise clinical colleagues will take over; CEO's will listen to the loudest and most financially persuasive cases - they must understand that geriatricians deliver not only excellent clinical outcomes, but also cost effective ones.

The message from DH is "go out and deliver" – no point at present in lobbying them for policy drives – there will not be any. The response would be "the NHS Review was prepared with the direct involvement of clinicians (including geriatricians), read it and act on it"

How to make sure our members are prepared for this change, and keen to take it on? We must assist our members with their Service reconfiguration plans

The Society must do all it can to maintain high quality, timely hospital care

Need "sharp elbows" – (David Behan, DG of Social Care at DH). We (the Society, that means the members), MUST become more assertive in our daily dealings with colleagues

The Society has always had a strong community base – we have the opportunity to expand on this

Key areas to address

The single most important initiative for us is to break new ground, and create an imaginative plan which will see geriatric medicine reassert and enlarge its role in the community. Such a plan must be:

- Professionally deliverable
- Capable of being "sold" to commissioners
- Acceptable to the existing membership
- Capable of raising the profile of geriatrics and emphasising our central role and effectiveness

The concept is not new – can be traced back to Marjory Warren – the Society now has the opportunity to provide vision and leadership to ensure geriatricians play a key role in community geriatrics and emphasise the fundamental nature of this aspect of the specialty. There is plenty of material on the subject (our own Best Practice Guide Document 4.12 is an example – "Interface between primary and secondary medical care in the new NHS in England…."). However, we do not appear to have succeeded in pushing this all the way through to country-wide delivery.

This will require a Business Plan. Outline template below:

Objective: To establish the BGS as the leading provider of community based services for frail older people who would benefit from the clinical expertise provided by geriatricians and their interdisciplinary teams.

By 2031 it is estimated 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 naturally remain an important part of our service, bed closures will continue and our hospital base will shrink

The main challenges?

(a) Community geriatric medicine already works in many places – it is nothing new; BGS must be seen to be devising country wide cost-effective solutions which commissioners will buy into. We will have to create models that work not only in England, but Scotland, Wales and Northern Ireland (this will be a good exercise in keeping BGS "together")
(b) We must encourage more units to provide excellent community care
(c) Whilst maintaining our traditional values, we must accept that the NHS is rapidly evolving; we must do likewise
(d) To ensure that the key Standing Committees (Policy, Education & Training, Academic & Research and CPEC) work as one with as many of the Special Interest Groups and Sections as are deemed necessary. Immediately this will involve: Primary & Continuing Care, Telecare and Telehealth, Cerebral Ageing and Mental Health
(e) To ensure we adopt a multi stakeholder, multi disciplinary approach from the outset, whilst at the same time keeping BGS at the top of the pile. By multi stakeholder I mean: care home sector; social care sector; regulatory functions (the new Care Quality Commission) as well as DH and the obvious clinical partners such as: Royal College of Physicians; Royal College of General Practitioners; Royal College of Psychiatry; Royal College of Nursing;
(f) Will we benefit from outside professional expertise? NHS Institute for Innovation and Improvement?
(g) What timeframe will we set ourselves?
(h) Will we need to champion a "new" type of geriatrician?
(i) 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

Terms of Reference: will require UKMC debate and decision to pursue this objective

Working with: section covering other organisations, as well as existing internal structures.

Internal: Standing Committees and SIG/Sections; Secretariat function
External: NHS Institute for Innovation and Improvement; NHS Confederation; DH; Royal College of General Practitioners; Royal College of Nursing; Federation of Royal Colleges; Care Quality Commission; Social Care Institute for Excellence; Strategic Health Authorities; Primary Care Trusts; Care Home sector (English Community Care Association)

Publicising the evidence bases we presently have:

What has been done already? Experience from overseas?
Which Standing Committees are charged with responsibility for doing this?
How long do we give them?
How do we measure the success of their work?
What happens in parallel whilst this is being done?

Creating the generic model

What can each of the four countries, with their differing models of care, learn from each other?

Marketing the completed model:

To whom? Strategic Health Authorities, Primary Care Trusts, General Practitioners and their Allied Health Professional teams. Also DH and Parliament
How? Major seminar for Strategic Health Authority and primary Care Trust Chief Executives; regional seminars/roadshows thereafter
Gathering feedback from commissioners

Finance:

What would this cost, from design through presentation to delivery and feedback?
What contributions would others make?

Review:

Need to set review periods: say after six months then again after one year

Profile of the British Geriatrics Society

We need to address our profile as this is central to success with our new objectives (as well as our existing ones)

Put simply, our specialty is sometimes under-recognised and undervalued

We have experienced a variety of false starts when it comes to effectiveness in the arena of Press, PR and Parliamentary Affairs. The time is right to expand the present Secretariat and recruit someone to undertake these tasks.

The role will have a number of objectives, both national and local:

- To achieve coverage in various media formats, establishing links with key journalists
- To influence politicians *before* policy is decided (longer term). This will include the possible creation of a cross-party lobby group
- To ensure we have advance notice of key decisions and the ability to prepare advance press notices
- To raise the Society profile amongst the public
- To ensure our grass roots members are assisted in the role of making their voices heard – particularly with PCT commissioners
- To ensure geriatricians receive a fair share in local budget negotiations

- To raise amongst carefully targeted local populations, particularly older people and their carers, the importance of having geriatricians available in both primary and secondary positions
- To raise the Society profile in a very focussed regional, national and international local fashion
- To provide assistance to any Region, National Country, SIG or Section who are looking to raise their profile
- To ensure media training courses are sourced and completed by appropriate Society Officers
- To create and maintain a list of “experts” to call on when creating/responding to news items
- To expand the existing base of links with charities and voluntary organisations; possibly hosting a reception at MWH as we have for the pharma
- To establish a range of BGS “Patient Booklets”, centred on topics important to care of the older person for which lay literature is not currently available or of a high enough standard; SIG’s and Sections would advise on patient literature currently available and provide the expert input for new publications
- To produce executive summaries to the numerous consultation responses we produce – these to appear on the website
- To produce reports on key scientific publications and articles (Age and Ageing, conferences, others)

Some of the above will take time to generate a positive profile for the Society – the role must be given a chance to develop

OTHER AREAS TO ADDRESS

Recertification – making sure our specialty is prepared

Education & Training Committee

Are we effective in training?
Are there opportunities in providing E-learning packages? Large potential audience for material (nurses, care home managers, social workers)
What courses should we put on for nurses, GP’s, AHP’s, care home staff?

Regulation and the Care Quality Commission – We should be providing models of best practice for them to use as measures.

What can we get out of the Specialty Certificate Examinations? (formerly KBA) Create e-learning package, revision materials

Continuity planning for existing activities – “Dignity Behind Closed Doors”. What are we going to do with this?

INTERNAL ASPECTS OF REVIEW

Marjory Warren House – still fit for purpose?

Staffing and infrastructure, with particular impact of new entrant

The BGS Website: one of our most valuable and most used resources. The Society might benefit from a uniform policy with regard to hosting pages for the Scottish and Welsh Councils respectively

The second part of the Review takes a look at the period April 2006 to March 2008.

Please note that the individual items which appear under the "Progress" headings are *not* intended to be an exhaustive list of Society activities, they demonstrate that the Society is active on a great many fronts

1. The BGS is recognised as the representative body for the specialist professional practice of geriatric medicine, establishing and maintaining an authoritative voice on health care and ageing with both public and politicians

Activities:

(i) Formal responses to inquiries from government and other professional groups

Progress:
The Society has responded to the following:

- The Department of Constitutional Affairs on:
  - *Lasting Powers of Attorney*
  - *Mental Capacity Act Code of Practice*
- The European Commission on:
  - *Improving the Mental Health of the population: Towards a strategy on Mental Health for the EU*
- The Department of Health on:
  - *Mental Capacity Act 2005: Consultation on Draft Research Regulations*
  - *National Strategy for End of Life Care*
  - *National Framework for NHS continuing healthcare and NHS funded nursing care in England*
  - *"Good Doctors, Safe Patients": proposals to strengthen the system to assure and improve the performance of doctors and protect the safety of patients*
  - *Direction of Travel for Urgent Care*
  - *Options for the future of Payment by Results*
  - *Guidance on Nominating a Consultee for Research Involving Adults who Lack Capacity to Consent*
  - *A New Ambition for Stroke – a National Strategy*
  - *Essence of Care – a Consultation on Patient Involvement*
  - *Mental Capacity Act 2005: Deprivation of Liberty Safeguards*
  - *Draft Revised Mental Health Act 1983 Code of Practice*
  - *Healthcare and Associated Professions Order 2008; and No 2 Order, 2008*
  - *Pandemic Influenza*
- The House of Lords (call for evidence) on:
  - *The EU: Improving the Mental Health of the Population*

- The Healthcare Commission on:
  - *Quality of Care Provided by Wave 1 Independent Sector Treatment Centres for NHS Patients*
  - *Developing the Annual Health Check in 2008/09*
- The Royal College of Psychiatrists on:
  - *Scope for a National Audit of Dementia Services*
- The UK Parliamentary Joint Committee on Human Rights call for evidence on:
  - *The Human Rights of Older Persons in Healthcare*
- The National Audit Office on:
  - *Improving Services and Support for Older People with Dementia*
- The General Medical Council on:
  - *Consent: Patients and Doctors Making Decisions Together*
- The Tooke Inquiry into:

    - *Modernising Medical Careers*
- The Workforce Review Team on:
    - *Workforce Risk Assessment 2008/9*
- The Joint BMA, Resuscitation Council (UK) and RCN consultation on:
    - *Decisions Relating to Cardio-Respiratory Resuscitation*
- The House of Commons Health Select Committee inquiry into:
    - *Modernising Medical Careers*
- The British Thoracic Society guideline on:
    - *Emergency Oxygen Therapy*
- The All Party Parliamentary Group (Dementia) inquiry into:
    - *Prescription of Antipsychotic Drugs to People with Dementia Living in Care Homes*
- The Department of Health, Department for Children, Schools and Families and the Home Office consultation into:
    - *Safeguarding Vulnerable Groups (Northern Ireland)*

(ii) Working with medical colleagues in other disciplines

Progress:
The Society has:

- Been active in working with the British Orthopaedic Association to ensure the work of the National Hip Fracture Database has enjoyed a successful first full year in operation. We have a Memorandum of Understanding in place with the BOA, which will lead to more collaborative working in the future
- Worked with the Royal College of General Practitioners (Scotland) in their work on long-term conditions
- Entered into a Memorandum of Understanding with the Age Anaesthesia Association, to foster closer collaborative working in the future
- Provided input into the Royal College of Physicians (London) working group on Payment by Results
- Held a joint workshop with the Royal College of General Practitioners and the Royal College of Physicians and Surgeons (Glasgow) to examine how care home medicine could be improved. Hosted by BGS Scotland
- BGS Wales has established the Welsh Stroke Alliance, a multi-disciplinary clinical collaborative

(iii) Working with non-medical groups with age related objectives

Progress:
The Society has:

- Successfully established a partnership with the Dunhill Medical Trust, providing research Fellowships for allied health professionals
- Entered into a Memorandum of Understanding with Help the Aged, which will provide the vehicle for the Society to become more effective both as a lobbying entity and in terms of profile raising
- Completed the first stage of the work on the campaign “Dignity behind Closed Doors”, working with Age Concern, Help the Aged, The Continence Foundation and others.
- Taken a leading role as a member of the “Older Peoples Specialist Forum”, originally established under the umbrella of the DH

(iv) Working with the media

Progress:
The Society has:

- Established an agreement with the Royal College of Physicians (London) through which the Society can disseminate information to the media

- Through the Memorandum of Understanding with Help the Aged, gained access to sophisticated and professional media expertise

(v) Maintaining and expanding on existing international links

Progress:

- The Falls and Bones Section has completed work with the American Geriatrics Society on an update on to Anglo-American Falls Guidelines
- The Society maintains links with: The American Geriatrics Society, The Canadian Geriatrics Society; the European Union Geriatric Medicine Society; the Union of European Medicine Society and the International Association of Gerontology and Geriatrics
- The Society continues to provide the secretariat to the European Union Geriatric Medicine Society
- The development and delivery of a training programme in geriatric medicine in Taiwan has continued, with members from many sub-specialties playing a key part in helping overseas doctors provide a better service for their patients

2. The BGS remains an independent charity, promoting knowledge through research, education and training, providing the necessary funding to achieve this

Activities:

(i) Providing financial support for available grants

Progress:

- There are grants available in the following categories: Medical Students Elective & Vacation Projects; Nurses Study Grants; Therapists Study Grants; Young Doctors Educational Grants and Specialist Registrar Start-up Grants.
- Grant limits raised again for certain categories (for members)

(ii) Providing financial support for research Fellowships

Progress:

- There are now two jointly funded research fellowships in conjunction with Research into Ageing: the Dhole Fellowship and the Marjory Warren Clinical Research Fellowship
- Funding was provided centrally to boost a legacy left to the Society to create a full research fellowship in the name of Dr M A Kuck, a former member
- The Society has introduced a new fully self-funded clinical research fellowship in honour of Bernard Isaacs

(iii) Providing access to externally run courses

Progress:

- The Society has collaborated with the University of Salamanca to provide opportunities for up to ten UK junior doctors to an annual educational conference for aspiring geriatricians. The Society has provided programme direction and tutors

3. The BGS maintains a compendium of best practice statements and guidelines, together with information on training and education

Activities:

(i) Web-based compendium

Progress:

- The Policy Committee keeps all compendium documents under regular review and has introduced several new titles
- The Education and Training Committee keeps all educational material under review, and has developed an information booklet for medical students/junior doctors considering a career in geriatric medicine

(ii) Section on clinical guidelines being expanded

Progress:

- The Clinical Practice and Effectiveness Committee is expanding its breadth of coverage, introducing for the first time Society funded guidelines

4. The BGS promotes scientific meetings and the publication of peer reviewed papers

Activities:

(i) Spring and Autumn scientific conferences

Progress:

- The Academic and Research Committee, working closely with the Meetings Secretaries has ensured that the programme of twice yearly scientific meetings has continued. Supported by the pharmaceutical industry, this still remains the key Society activity which enables the charitable objectives to be carried out.
- Experiment with delegate voting key-pads at Harrogate 2007

(ii) Publication of "Age and Ageing" and themed supplements

Progress:

- Increase in submissions in both 06 and 07
- Turnround times decreased in both 06 and 07
- Successful move of administrative function to new location
- Working towards consistent and timely publication of accepted abstracts online

5. The BGS will actively engage in academic interfaces with Royal Colleges etc., at the same time promoting a rigorous and systematic approach to CPD

Activities:

(i) Update rolling programme of Continuing Professional Development

Progress:

- Trial period for CME Journal – Geriatric Medicine continuing; questionnaire to be launched seeking members feedback
- Academic and Research Committee controlling the rolling programme and working with the Director of CPD and the Meetings Secretaries to ensure that future scientific meetings address the fundamental topics for key presentations and parallel sessions; includes the rolling cycle of Special Interest Group and Section contributions

(ii) Joint Speciality Committee for Geriatrics with the Royal College of Physicians (London)

Progress:

- The Committee, which consists of senior officers from the Society and the Royal College, meets three times each year to:
    - Ensure that the Society is supporting the Royal College on policy matters relating to geriatric medicine, with particular reference to responses to government. This is increasingly important, given the number of changes taking place within the delivery of healthcare and the forthcoming changes to the re-validation of doctors

6. The BGS will encourage multidisciplinary involvement in SIG's and Sections, at the same time promoting appropriate multidisciplinary membership, by fostering closer relationships with other specialist groups

Activity:

(i) Special Interest Groups and Sections working with professional colleagues

Progress:

- Cardiovascular Section joint meeting with the British Society for Heart Failure
- Medical Ethics SIG continues membership of the UK Clinical Ethics Network
- Primary & Continuing Care SIG collaboration with the RCGP on the interface between primary and secondary care
- Falls and Bones Section instrumental in creating alliance with British Orthopaedic Association; also work continued with the American Geriatrics Society on falls guidelines. Members active in work with the RCP CEEU on national audits of falls and bone health
- The Movement Disorders Section have established links with neurology and PD nurse specialists under the umbrella of the British Movement Disorders Group

7. The BGS will adopt a policy of forward looking, flexible management structures, monitored by regular reviews, to ensure maximum effectiveness

Activities:

(i) Two yearly Strategic Review

Progress:

- Complete

(ii) Effectiveness monitoring of United Kingdom Management Committee and other committees

Progress:

- Each Standing Committee has its own business plan, which is a standing item on every agenda. Committees are carrying out critical review each time they meet.

(iii) Strategic decision making function of Trustees under active scrutiny

- United Kingdom Management Committee to critically review its own discussion and decision making effectiveness. New meeting structure introduced to facilitate decision making and optimising use of time

Comments on the British Geriatrics Society Strategic Review 2008

My comments are restricted to the first half of the strategic review dealing with thoughts about the next two years.

I agree that it is important to draw attention to the policy context which we will be working in the next two years and, of course, this will include significant changes to the training and medical work force, the increasing need for multidisciplinary leadership in older people, the personalisation agenda in social care and the ideas included in the Department of Health document "Strategy Towards Early Intervention and Prevention". The emphasis of the latter document is towards shaping social care but this cannot be done effectively without health care alliances for reasons that we are familiar with.

Overall I was struck by how much of the document focuses on promotion of high quality care of older people whereas the three prime objectives listed at the top do not specifically mention this at all. Certainly research, education and training will contribute to better quality of care but the thrust of the subsequent ideas is that development of service models and alliances between the right sets of professionals will be key.

I think it is important to energise and equip our membership to play a leading role in the design and development of services and to acknowledge the element of competition that exists within PCTs and the NHS generally to engage attention and commitment. Whilst the way this is expressed currently in the document may be good for internal readership it might need amendment if it was to survive into any strategic statement to be shared with potential external partners such as at the RCP etc.

As for the way we shape central messages about developing effective service models, I would suggest that we do so along the lines promoted in Lord Darzi's "Next Stage Review". All strategic health authorities were asked to make strategic plans under the following headings: Acute (or urgent) Care, Long Term Conditions, Mental Health, Planned Care (including elective surgery), End of Life, Staying Healthy (prevention etc), *plus* Child and Family, and Maternity. What we need to do is to assist our members in the development of business cases which have resonance with the vocabulary being used in PCTs (and SHAs) as these strategic plans begin to materialise.

I think it is important that we emphasise the role of our speciality within urgent care in a way that is much broader than simply having specialised inpatient facilities ourselves, ie. in surgical care which must include proactive liaison not simply being referred to the ones that have gone wrong, and that we develop strategies for long term conditions in collaboration with Primary Care and others.

In order to do this it may be that the BGS will prepare strategic statements which could be distributed as position statements to assist SHAs. In addition and in support of this we could develop model business cases which could be used by clinical leaders within Trusts and in discussion with PCTs. To do that, of course, we will have to invest over the next two years in the development of clinical leadership of our membership. I would suggest that we might need to set up some sort of organisation – possibly virtual – of clinical directors or medical directors in our speciality. I think there are very many and their influence upon the Society's work up to now has not been as great as it might be.

In the section headed "Objectives" - it states "the BGS is the leading provider of" – I am not quite sure what this means but perhaps it suggests a) that we can in collaboration with other relevant professions provide examples of service models which we think would work for older people and b) that we will focus our efforts and training on other methods to try and ensure that we have adequate clinical leaders to carry these service models into practice, and c) that we use our power, CME, CPD and other activities to support these endeavours.

We have made considerable progress recently in the care homes and I know another conference is planned for 2009. Once again, I think we will need to create strategic alliances with the relevant external organisations to begin to identify and then campaign nationally for support of certain improved models of care. It would be impossible to make much headway without Primary Care on board and this might prove difficult.

The list of challenges is formidable. Whether the existing membership is somewhat inert or simply not certain what they can initially do remains to be seen. Certainly I agree that the work of the standing committees must be reviewed and properly monitored to ensure that they deliver the strategy although there will of course always be room and need to respond to the enthusiasm of individual committee members and of new initiatives that come along.

I think that we could perhaps promote the OPSF a little more in the document as a potential route to developing and implementing our strategy.

With regard to dissemination, and particularly to the public, I think we need to discuss whether we do want to work perhaps with Help the Aged in developing a website for patient use. Stephen Webster, in Cambridge had this idea many years ago and produced a number of leaflets for public consumption but it was never really enthusiastically taken up by the membership and this may have been for good reasons, I am not sure. In any case, we would need to ensure that we have the capacity to do this not inconsiderable task and it might be better to do it as part of an explicit collaboration with others.

Finbarr C MARTIN
BGS President Elect