

**BRITISH GERIATRICS SOCIETY
POLICY COMMITTEE**

Minutes of the meeting held on Thursday 8th March 2007 in the Amulree Room, Marjory
Warren House, London EC1M 4DN

Present: Dr D Beaumont, Dr P Belfield, Dr B Chapman, Professor P Crome, Dr I Donald, Dr K Kelleher, Dr J Morris (chair), Professor G Mulley, Dr D Oliver, Dr L Patterson, Dr J Starr, Dr F Tracey and Dr C Vellodi.

In attendance: Mrs S Allport, Mr A Mair and Dr Adrian Wagg.

PC07/01 Reconfiguration of Acute Services

Action

Professor Mulley's paper had been circulated in advance of the meeting. He explained that he had been asked to write a paper for the Academy of Royal Colleges on reconfiguration from a geriatrician's perspective and that it was part of a series of papers the Academy had commissioned on reconfiguration. In summary he explained that:

- Bed numbers are decreasing without their being alternative sources.
- The present system of hospitals is not well designed.
- Changes are occurring without an evidence base.
- There is a belief that a large number of patients being admitted acutely need not be and that they would prefer to be cared for closer to home.
- There is an assumption that geriatric care is easy and can be undertaken by anyone with a minimum of training.
- In the future there will be a small number of highly specialised short stay hospitals.
- Doctors in general are perceived as inhibitors to change – we need to show that we are for change where it benefits our patients.
- We need to show our skills and keep hold of what is best done by us.
- An important future role for geriatricians could include acting as signposts/ indicators for appropriate care.
- This should be seen as an opportunity rather than a threat for our speciality.

The Committee responded with the following comments:

- We have an opportunity to intervene before the crisis.
- We are also working in the community more.
- Have we considered the training requirements – Does the new curriculum cover this?
- We still need to champion improved standards in our hospitals.
- Is there a question of who will pay for geriatrician's to work in the community if other professionals are seen to be able to do it more cheaply?
- Reduction of Acute Beds in the secondary and tertiary sector serving older patients may not be wise until it is proven that community management of exacerbations of Chronic disease has been shown to reduce hospital attendance-role here for Academic Health Services research.
- Practice based commissioning may/will allow more involvement of the private sector for provision of services serving older folk e.g. CGA related to movement disorders, Heart Failure, COPD, Rehab in the Care Home environments etc. How would the Geriatric profession engage here?

- Does the curriculum, newly agreed by PMETB reflect the production of Trainees who will serve re-engagement of geriatricians in the community especially if you look at the new Primary Care curriculum?
- Does the curriculum covering Acute medicine deliver Trainees with competences to deal with the older sick patient in the first 72 hours or illness?-probably and so the “need” for Geriatricians to engage in Acute Care may go down.
- How do we retrieve the notion of a therapeutic environment for older patients who are slower to recover in the Acute Sector? Do we a) Give up altogether as the Hospitals are no longer designed for this or b) support Intermediate Care environments serving Orthopedic recovery, Stroke, “off legs” episodes etc. Does the delivery of care in b) need direct input of geriatricians in the view of commissioners?
- There is a huge need for Academic Geriatrics to re-establish prominence in these areas of Health Services research.
- Many can do community work but many colleagues do not have the confidence to work in a patient’s home. This has training implications.
- We need to work more closely with the RCGP.
- We also need to tackle the language that is used e.g. bed blockers which put the problem back onto the patients not on the system.
- We need to be clear about the services that we must carry forward such as clinics.
- Rehabilitation starts for older people at the moment of presentation.
- Older people do not present with single specialty issues.
- Many geriatricians are propping up the acute rota, if they are moved to the community who will fill this role.
- In Scotland the politics differ but the direction of travel is the same. Scotland is probably not under as much pressure as England but they are concerned about what facilities are available in the new community hospitals.
- Once acute physician numbers increase geriatricians will no longer be required on the acute rota.
- There is a threat that PCT’s think that they can do everything.
- We should be looking at the patients needs and realigning ourselves with those.
- The future is what the patient needs and as a specialty we must be able to do both acute and community geriatrics.
- We have a great opportunity to work with other groups.
- We must make sure our gains are not lost and that we are flexible.
- There will need to be a range of care not just acute or community.
- We must run community training as part of the curriculum.
- The Gold standard Framework is being run by the Palliative Care Physicians and we should be working with them.

For further reading Professor Mulley suggested the Kings Fund paper on reconfiguration which the office agreed to circulate. Professor Mulley also agreed to rework the document so that it could be made available via the web site.

**Office
GM**

Continence Services

Below is a summary of Dr Wagg’s talk:

- Very few geriatricians are involved in continence.
- The Continence Service links with many of the NSF themes and in particular dignity in the “New Ambition for Old Age”.
- Should have integrated services but only 20% are and of those only

- 10% have a named geriatrician.
- The RCP audit showed that assessment was poor across the board and that patients have no management plans.
- The RCOG do have a section in their guidelines on older people.
- There is not sufficient interest from our members for slots at our conferences.
- It is no longer focused on in training – perhaps because it is shared with nurses.

The committee suggested the following:

- Dementia was in a similar position until the pure science behind it was investigated perhaps we should encourage our trainees to undertake research into continence.
- We need to find out the language that the PCT's will understand which is what falls and stroke did.
- We should pursue this more via the dignity campaign and generate interest that way.,
- Our curriculum and CME is lacking in continence areas.

Actions

The following was agreed:

1. A paper in the compendium is required (See below)
2. We need to encourage trainees.
3. We should consider having a champion in each region.
4. We should contact the STC's as there is concern that RITA's and PYA's are being passed without training. The office will refer this to the E&T Committee.

Office

Continence Compendium paper

Dr Wagg had also been asked to consider writing a paper for the compendium. He presented an outline of what he felt the paper should cover:

- The role of a geriatrician – passive to active.
- A care document with hyperlinks and cross references i.e. SIGN.
- Links to JCHMT
- The NICE Faecal Incontinence Guidelines
- A section on useful further reading and web sites.

The Committee thought this was an excellent idea and looked forward to receiving the first draft.

AW

PC07/02 Welcomes and Apologies

Apologies were received from: Dr S Ahmad, Dr J Hindle and Dr M Rea.

It was also noted that Dr Hindle has had to tender his resignation from the Committee due to other commitments. The Committee in his absence thanked him for all he has done.

PC07/03 The minutes of the meeting held on 22nd November 2006.

The minutes were signed as an accurate record subject to an amendment to page 1.

PC07/04 **Matters Arising**

- (a) *Dignity Campaign Update*
The launch at the House of Lords on 18 April has been confirmed. At present there are 43 attendees. Baroness Greengross will be our host and Ivan Lewis and Baroness Hale are also speaking.
- (b) *RCP working party*
We are still waiting to hear on our revised application but they may have met on Monday.
- (c) *Lay involvement*
We have had 6 applicants from the RCP and Drs Morris and Belfield will be considering them and making a decision.

JM & PB

- (d) *The Future Hospital and the Future of Acute Care*
These papers were circulated in advance of the meeting. It was felt that the Society should be replying or at least debating these issues and we should ask the A&R Committee and Meeting Secretaries to consider having them as speakers at a future conference.

Office

- (e) *Meeting with Baroness Greengross*
Dr Morris reported that she and the President and President Elect had recently met with Lady Greengross who has agreed to ask questions in the house on our behalf. The questions can be oral or written. One example is "What kind of services are you going to offer a frail older person once they have recovered from their initial treatments?"

The Committee was asked to consider this and let the office have any questions. It was also decided that this would become a standing item on the agenda.

Committee

The Baroness has also suggested that we should have a Public affairs Officer and she has identified someone that she thinks might be able to work with us.

- (f) *BMA Central Consultants and Specialists Committee Medical Specialties Sub-Committee*
Dr Morris explained that she is the BGS representative and that in future she will be passing on information she received. Dr Patterson explained that she had signed up to the King's Fund alert e-mail and that it was very useful. Details will be circulated.

Office

- (g) *Primary Care*
Dr Donald explained that Professor Gladman is working on the final comments from the RCGP and that he is seeking their approval of the document.

PC07/05 **UKMC Update**

Professor Crome explained the purpose of UKMC is to ensure that the spending is in line with the charitable aims and to approve consultations and external appointments. Recently the format of trustee meetings had been changed and that instead of receiving a series of reports we now have a decision session, a discussion session and then reports which are for note. At our last meeting we took decisions on applications for membership, representatives on external bodies, the new workforce representative, the appointment of the Marjory Warren lecturer for 2008, the CME Journal and lay involvement. Discussions covered the strategic review, endorsement guidelines, the

relationship between elderly medicine and stroke medicine, what can we learn from other specialist societies, the BCA bid for the 2011 IAGG European meeting, statements in response to external queries, control procedures for new business and Knowledge Based Assessments

PC07/06 **BGS Business Plan**

Agenda

Mr Mair explained that he was at present working on the PR aspects and that we should be able to move this to amber shortly.

PC07/07 **Reports from National Councils**

(a) *England*

Dr Morris reported that Professor John Young was appointed as the new Deputy Chair.

(b) *Northern Ireland*

Dr Tracey reported that Northern Ireland continues to monitor the fast moving Agenda for Change and Modernising Medical Services across Northern Ireland.

One of the main agendas locally remains the reduction of hospital waiting lists, (some of the longest in the UK) and reduction of trolley waits in Hospitals (presently around 200 daily in Northern Ireland). From the 1st of April a 72 hour discharge policy will be implemented, which means that any patient declared medically fit for discharge, will require to leave hospital within this time frame. This has serious implications for the elderly frail person for whom services to provide home care and rehabilitation are still not adequately resourced, either with personnel or funding.

The second main area of change is the Reform of Public Administration within Northern Ireland which aims to reduce administration costs by 20% and has collapsed down previous Health Boards into 5 Trusts to become 'live' on April 1 2007. Various structures are emerging for the care of Older People within the 5 Trusts. Local geriatricians in each 'shadow' Trust, have been meeting regularly in order to influence policy locally, though few Trusts have yet made appointments with responsibility for Older Peoples' Services. The newly emerging Belfast Trust is one of the largest Health Care Groupings in Europe, which creates its own issues.

BGS Northern Ireland has formulated an overarching strategy for Older People and their Care in the Community. In order to inform best practice and consolidate ideas and strategy, we are organising a Workshop/Talk Shop about Service Development for Older People, in early March. We have had a useful Joint Meeting with Psychogeriatrician colleagues in January 2007, when models of liaison community care for patients with Dementia in Northern Ireland were outlined and plans for the New Patient-led Dementia Centre, in collaboration with Stirling University, were tabled. Members have also been lobbying locally for use of anti-cholinesterase drugs for dementia sufferers.

(c) *Scotland*

At the last meeting they discussed the workforce survey and although it appears that there are more consultant posts than previously thought there are not enough trainees at present to fill them.

(d) *Wales* - No one was available from Wales.

PC07/08 **Clinical Governance**

Dr Belfield noted that he had hoped to have his paper available for this meeting, but he had been waiting for the white paper and he had also contacted the Dermatologists to see what they were planning. He has just heard that they are going to modify their year 5 assessments. He hopes therefore to have his paper for the next meeting.

PC07/09 **CPEC**

There was no-one available to attend this meeting but they are keen to work more with us as some of their work is very relevant to the work that we do.

PC07/10 **Consultation documents and correspondence received**

The Consultation response on Human Rights was circulated. We have now been asked to give evidence which Professor Crome will do probably in May.

PC07/11 **BGS Compendium**

Agenda

(a) *Standards of Service Plan*

This requires more work as it should be shorter. Ideally an introductory paragraph and then the link. Drs Morris and Beaumont will revise it further.

JM & DB

(b) *CPR Decisions (2.3)*

See above.

(c) *Interface between primary and secondary medical care in the new NHS: the care of frail older people by GP's and consultants.(4.12)*

See above.

(d) *Parkinson's Disease (6.1)*

A draft was tabled. The committee were asked to take this away and send any comments to the office.

Committee

(e) *Falls*

The paper has not yet been received. The office will follow it up.

Office

(f) *Continence Services*

See above.

(g) *Stroke*

The introduction has not yet been received. The office will follow it up.

Office

PC07/12 **Any other business.**

(a) *Deputy Chair*

The post of Deputy Chair will become available in October. Anyone interested in standing will need to have a proposer and seconder and submit a 1 page resume. This should be sent to Sarah Allport ideally in advance of the next meeting.

(b) *Composition of Committee*

The Committee were asked to give some thought to the present composition of the committee and whether it is balanced.

(c) *Discussion Topic for next meeting*

Dr Patterson agreed to speak on "Linkages"

LP

PC07/13 **Future meetings: (Please note earlier start time of 13.00)**

Agenda

Thursday 10 May 2007
Thursday 11 October 2007

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Signed by Dr Morris
10th May 2007