



BRITISH GERIATRICS SOCIETY  
SPECIALIST MEDICAL SOCIETY FOR HEALTH IN OLD AGE

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Submission by the British Geriatrics Society to the Workforce Review Team on:

**ASSESSMENT OF WORKFORCE PRIORITIES 2009**

The Society is delighted to be given the opportunity to contribute to this debate and we would like to endorse the NHS Workforce Review team's analysis of the forecasts from The Office for National Statistics that the fast growing UK population group will be over-75s (some of the heaviest users of health and social services) reaching 6.8 million by 2031 (equates to growth of 75% over 25 years), the rise in chronic illness and the importance of continual monitoring as well as the provision of therapy and support to patients followed their discharges from hospital as a consequence of our current community care strategy.

Of all the priorities discussed in the document, we would like to offer our comments just on those relevant to care for older people and they are as follows:-

1. **Nursing** - we support the suggestion for PCTs and employers to increase availability of community placements, including nursing home placements. But, we would welcome the development of more defined training pathways for nurses on competencies in knowledge, skills and attitudes required as well as more unified channels of communication with the aim of facilitating multi-disciplinary co-operation among community nurses, GPs, Geriatricians, social services and other therapists etc.
2. **Stay healthy** – we welcome the proposal for SHAs, PCTs and deaneries to develop plans to expand the specialist and practitioner-level dental public health workforce with the aim that access to dental services is available for frail older people both in care homes and NHS hospitals.
3. **Diagnostics** – we agree it is essential that appropriate diagnostic facilities should be available in the community as a consequence to the planned shift of provision of care to a community setting. But, this development should be funded separately and must not be achieved at the expense of reduction in inpatient diagnostic services within NHS hospitals.
4. **Dementia** – with the current UK Government (and EU) priority on dementia, we consider that it is very appropriate that a specific section is dedicated to this topic. But, we do have concern about the statements “There could be a case for the development of new specialist services to facilitate earlier diagnosis and intervention although the impact of changing the service model in this direction would require careful exploration” and “Such a service might be delivered by any of a number of types of specialists with diagnostic skills in dementia” It is because the “tenet” of these statements might be taken to suggest that dementia is somewhat “easy” to deal with and that just “some” training might be sufficient for its early diagnosis and subsequent management. Instead, the National Dementia Strategy and the National Audit Office reports have made it very clear that the main problem in the delivery of dementia care is the lack of knowledge and training on dementia among care givers in both Primary and Secondary care. Hence, it is pertinent that the wording in the document should be modified to make sure that it is communicated properly with emphasis on the essential requirement of extensive training including robust advance care planning training and adequate clinical experience.
5. **Mid-grade doctors** – we welcome the proposal to reduce the reliance on rotas staffed by mid-grade doctors for service delivery but the change should be properly funded and staffed. In particular, the burden of service delivery should not just be switched to existing Staff Grade or Associate Specialist doctors who may already be providing a large proportion of this cover. SAS doctors already struggle to meet the CPD requirements for revalidation due to the reliance of departments on their participation in rotas. Recognition of their development needs has been made in Modernising Medical Careers and monies have been allocated by the DOH. It is therefore vital that Trusts do not resort to increased use of existing SAS doctors to meet gaps in rotas, which may develop as a result of this policy. This action

would deprive SAS doctors of the opportunity to engage in the personal development training that is now on offer.

Professor Graham Mulley  
President  
For and on behalf of British Geriatrics Society  
3rd July 2009

Prepared for the BGS by Dr N Lo, Workforce Lead, Prof. P Passmore, Chair Cerebral Ageing and Mental Health SIG and Dr S Morgan, Chair Staff and Associate Specialists Group

### **The British Geriatrics Society**

The British Geriatrics Society (BGS) is the only professional association, in the United Kingdom, for doctors practising geriatric medicine. The 2,500 members worldwide are consultants in geriatric medicine, the psychiatry of old age, public health medicine, general practitioners, nurses, allied health professionals, and scientists engaged in the research of age-related disease. The Society offers specialist medical expertise in the whole range of health care needs of older people, from acute hospital care to high quality long-term care in the community.

### **Geriatric Medicine**

Geriatric Medicine (Geriatrics) is that branch of general medicine concerned with the clinical, preventive, remedial and social aspects of illness of older people. Their high morbidity rates, different patterns of disease presentation, slower response to treatment and requirements for social support, call for special medical skills. The purpose is to restore an ill and disabled person to a level of maximum ability and, wherever possible, return the person to an independent life at home.