



BRITISH GERIATRICS SOCIETY
SPECIALIST MEDICAL SOCIETY FOR HEALTH IN OLD AGE

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Response by the British Geriatrics Society to the Department of Health on:

NHS Next Stage Review: Our vision for primary and community care

The British Geriatrics Society

The British Geriatrics Society (BGS) is the only professional association, in the United Kingdom, for doctors practising geriatric medicine. The 2,200 members worldwide are consultants in geriatric medicine, the psychiatry of old age, public health medicine, general practitioners, 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.

The Society is delighted to be given the opportunity to respond to this report.

Our comments are mainly related to community care rather than Primary Care.

1. The most welcome emphasis, found throughout the document, is the importance of services fitting together. This receives frequent reference in chapters 3, 4 and 7. This is variously referred to as "joined up services" or "integrated services". One example is quoted from Leicester where services fit together by being housed together. Other examples are united through strong working relationships and sometimes by IT systems. This is a very important message for services designed for older people who have multiple problems and conditions. They require a local and integrated service. Section 4.11 comments that there is no need for them to be housed together or within the same organisation – but surely this helps! It was disappointing that reference was not made to some of the excellent examples of integrated working in Scotland and Northern Ireland, achieved through a different organisational system. There is reference in 7.15 to "Integrated care organisations" which is surely a move in the same direction. While integration is not impossible with the current agenda of choice and multiplicity of providers, it surely is made much harder. Integration was far easier in the past when there was less diversity of providers. In rural settings, one general practice, an attached nurse and social worker, a local pharmacy, and a local intermediate care service provide the basis of an excellent integrated model. Nursing Home care is also enhanced where one general practice takes the lead in supporting their residents.

2. It was disappointing that the document made no reference to Care Homes, which is a very important arena for community care, and where new models of care need to emerge.

3. It was interesting to find very little reference to Community Matrons, but this enables localities to develop their own model for delivery of community nursing care. Given the uncertain evidence around the role of community matrons, this is probably correct at the present time. There is a somewhat misleading statement "Rates of emergency hospital admissions for conditions that can be avoided (by effective primary and community care) vary more than twofold across the country" – as this fails to describe which conditions can be avoided, nor relates this to the "usual" variation in admission rates observed for most diseases across the country. The ability of case management to alter hospital admission rates remains contentious, and unsupported by the published literature.

4. We are dubious about the concept described in 4.14 about enabling the public to telephone a 3 digit number to “help people find the right local service to meet their urgent need”; especially as the increasing number of older people will mean increasing numbers of dementia sufferers. We are convinced that older people, and especially those with any degree of confusion, need to phone their GP for initial assessment and direction.
5. We are uncertain about the benefit of direct payments for health care in long-term conditions, while recognising the benefits within social care. There is insufficient detail described in 4.30 to come to a judgement.
6. The quality improvement framework for community services and hospitals would be welcome, and hopefully assist local services in their clinical governance of these, which is not always rigorously observed. We would recommend that clear linkages are provided into the accreditation processes being introduced, and the revitalised GPwSI documents.
7. As older people are already the major consumers of primary and community care and hence to be fit for purpose these services must be older person friendly. It is essential that staff have expertise in diagnosing complex problems in frail older people. Chronic disease management in older age is often about managing multiple chronic diseases in a single individual.

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President
For and on behalf of British Geriatrics Society
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