Both groups promise to improve the quality and consistency of care for patients as they approach the end-of-life, including for patients with uncertain prognosis, where recovery is possible but not guaranteed. Here we present a real-life case from a recent morbidity and mortality meeting and ask the GSF/Amber Care Bundle team to consider where they might help.

It was mid-November when the patient was initially admitted. He presented with a non-specific decline in mobility but was soon identified as having bilateral leg ulceration and was treated as having cellulitis. He had a background of alcohol dependency and recurrent falls. He had previously been seen by a geriatrician for hyponatraemia and chronic anaemia and no cause for either had been found. In the year leading up to admission, he had developed gradually increasing dependency. He had declined a care package but, at the point of admission, was struggling to get out-of-doors and had become dehydrated and malnourished. His house was in an awful state and upon his admission, his GP had notified the local environmental health team of hazardous conditions in his home.

He was admitted under a general physician and treated with antibiotics. After 21 days he moved to a slow-stream rehabilitation facility where a consultant geriatrician’s review highlighted the additional issues of subclinical hypothyroidism and hypovitaminosis D. He was commenced on a programme of strength and balance training, with rehabilitation goals around safe independent transfer in and out of bed.

Twenty days later, he fell whilst transferring out of bed and developed left hip and arm pain. He moved back to the acute trust site, where the orthopaedic surgeons diagnosed fractures of his left acetabulum and humerus. After four days of conservative management, with mild opioids administered orally, he was referred back to the rehabilitation team. They, however, declined his care as he was too confused and they were worried that he had a delirium, the source of which had not been clearly identified.

Seventeen days later, after treatment for a urinary tract infection, he was transferred back to the slow-stream rehabilitation facility. This time around, the consultant geriatrician review identified issues with polypharmacy (he had accumulated a complex combination of weak and strong opioids), worsening functional dependency (he was now bedbound), and worsening cognition (his MMSE had declined from 27 to 12/30).

Eight days later he was transferred back to the
acute hospital facility, where he was again admitted under a general physician. His confusion had worsened further. He had become pyrexial. He was diagnosed as having sepsis secondary to urinary tract infection on the basis of monoclonal growth of E. coli from urine and an associated E. coli bacteraemia. He was commenced on intravenous antibiotics and fluids.

Seventeen days later, he was still bedbound and still suffering from marked cognitive impairment when he was moved to a “medical outlying” bed on an elective specialty ward, pending transfer back to slow stream rehabilitation. He remained there, without demonstrating functional or cognitive recovery, prior to transfer back to the slow stream care facility after a further 27 days.

After a further 4 days at the rehabilitation facility, he was moved, again back to the acute hospital, again under a general physician. He was once again treated for sepsis and once again showed improvement in his inflammatory markers and observations but failed to show any improvement in his cognition or functional status. His treatment was delivered on a general medicine ward. After 16 days he was deemed “medically fit for discharge”, to have “no rehabilitation potential” and was listed for transfer to a care home. The discharge coordination team, unhappy with his progress, asked for a geriatrician’s opinion.

The geriatrician opinion suggested that he had persistent delirium and identified a gradual worsening of inflammatory markers, which the base-ward team had failed to identify, since stopping antibiotics. Over a further 17 days he was recommenced on antibiotics, had an NG tube inserted, a central line inserted and underwent paracentesis for emergent ascites. On the 17th day, now in late April, he was once again reviewed by the consultant geriatrician, who identified that no progress was being made and the patient was close to death.

A meeting was convened with the patient’s next-of-kin. He, by now, had no capacity to participate in end-of-life decisions, and it was agreed that he should be commenced on the end-of-life care pathway, with plans for him to have palliative care delivered in his own home as part of a fast-track discharge scheme. The patient died, 21 days later, in hospital whilst awaiting this.

Our patient spent 173 days in hospital across 8 wards and 3 hospital campuses. He was under the care of 10 separate consultants over that period. This is far from
Gold Standards Framework (Box 1)

Before admission to hospital, the patient might have been flagged up by the GP for inclusion on their QOF/GSF/DES register, with team meeting discussions to prevent avoidable admissions. This might have led to the original admission being averted. If a person resides in a GSF trained care home, similar GSF coding and measures helps prevent admission (GSF care homes have halved admission and hospital death rates).

In the event of the patient being admitted, he would be identified, included on a register, and a needs-based coding would have been used to estimate his stage of decline. It is likely he would have been coded blue/green on admission (see box for explanation of coding system). His condition and code would have been reviewed at a MDT discussion, and a proactive GSF Core Care plan would have been developed appropriate to his stage. A key worker would be allocated.

Clinical Assessment

would proceed, including full geriatric assessment and use of other appropriate clinical tools. He would have been fully assessed for reversible conditions.

Personal assessment and Advance Care Planning (ACP)

An initial ACP discussion with the patient and his family would have explored their understanding of his condition and future wishes and preferences. It is likely a preference for home care would have been expressed and staff would have taken measures to discharge him either home or to a care home, thereby preventing further transfers.

Gold standard care. It will, sadly, be all too familiar to those of us that work in acute trusts.

There are many aspects of this case that readers will identify where things might have been done better. There were, however, many points in his stay where simple day-to-day care, including symptom control, were approached in a poorly co-ordinated way. Whichever way the case is considered, this was the patient's last year of life and his quality of care - and quality of life - were inadequate. We asked proponents of the gold-standards framework and Amber bundle how these schemes might have mitigated against this, even whilst continuing to actively pursue treatment?

Box 1:

The National Gold Standards Framework (GSF) Centre in End of Life Care runs widely-used quality improvement programmes that aim to improve the care of any person in the last year or so of life with any condition, at any time, adapted for use in any setting. GSF is a systematic evidence based approach to optimising care given by generalist frontline staff, supported by specialists and geriatricians, with practical step-by-step guidance for each stage. Extensive use of GSF by GP practices (95% practices at foundation level) and care homes (over 2,500 trained) in acute or community hospitals (over 80), domiciliary care and hospices, means that patients coming into or out of hospitals can receive excellent continuity of care through a common proactive approach, leading to better integrated cross-boundary care, reduced hospitalisation and more living well and dying where they choose.

Key features of GSF Acute Hospitals are:

- GSF relates to the whole journey of care, from early recognition of the patient considered to be in their final year of life, to care in the final days, after-death care and bereavement.
- GSF is used extensively in the community so improves cross-boundary care, in and out of hospital. It helps reduce avoidable hospitalisation by triggering better proactive care by GPs using their GSF/palliative care registers via discharge letters or locality registers/EPaCCs.
- GSF is structured around the three steps of identify, assess and plan care at each stage in response to patient needs and wishes. It helps identify the 30% hospital patients thought to be in their final year of life, assess both clinically and personally and plan care in line with their needs and preferences.
- GSF is a comprehensive ‘umbrella’ framework that includes a number of locally adapted tools, including early alerting, clinical assessment (e.g. AMBER care bundle) personal assessment (advance care planning discussions), and others.
- The GSF Prognostic Indicator Guidance (evidence based guidance helping to identify the 30% hospital patients thought to be in their final year of life) and needs-based coding system (blue-final years, green-final months, amber-final weeks, red-final days) enables earlier recognition of decline, leading to more proactive care and communication through GSF Core Care Plans.
- GSF includes all care in the final year of life as defined by GMC and therefore covers the full EOLC requirements of the CQC inspection – final year, final days and after care.
- The GSF programme include workshops, resources, personalised coaching and independent evaluation and leads to Accreditation and the Quality Hallmark Award endorsed by the British Geriatrics Society.
- The GSFH evaluation has demonstrated significant reduction in patient length of stay, improved confidence of staff and more proactive care leading to more patients being discharged home earlier to their preferred place of care.

Gold Standards Framework (Box 1)
Regular review. If he was still in hospital, on deterioration his coding would have been reviewed at board rounds or at the MDT reviews and he might have been coded green/amber, with his needs being addressed, following the core care plan. If he still wished to be discharged home, a Rapid Discharge process would have been introduced.

In the event of further decline he would have been reviewed and coded amber/red with appropriate actions taken as above. With GSF leading to a reduced length of stay, it is more likely that care would have been given in a community bed when the patient was deemed medically fit.

Care in line with preferences. The ACP would have highlighted his and his family’s preferences, and any intervention the patient did not want. There would have been a focus on comfort care and palliation rather than the aggressive treatment that resulted in his increased risk of polypharmacy and falls, confusion with multiple moves and dying on a hospital ward. If he lacked capacity a best interest discussion would have been initiated.

Care in the final days (GSF Code red) follows the Five Priorities of care including a full discussion with the family, and this might have led to rapid discharge home or to a care home.

After-death care suggested by GSF includes support for his family, pointing to bereavement support and the giving of the death certificate. For the staff his care would have been reviewed and included in the regular ward audit.

Amber Care Bundle

There were a number of opportunities both to involve the patient and/or relative in the treatment planning and to achieve greater coherence between the clinical teams during the prolonged spell in hospital. The decision to start the end-of-life pathway was taken very late and at a time when the patient was unable to participate.

We would have started the AMBER care bundle at the time the patient was transferred back to the acute site for the second time i.e. “Eight days later ...", which is about two and a half months before he died. It is possible that it should have been started earlier than this, when he became functionally dependent and developed delirium following a hospital fall.

Recognising the patient’s recovery was uncertain would have triggered a process whereby patient, family and the clinical team proactively identified the goals and appropriateness of treatments at a

Box 2:

The AMBER care bundle supports shared decision making during times of clinical change and provides a systematic approach to managing the care of hospital patients who are facing an uncertain recovery and who are at risk of dying in the next one to two months.

It is a four stage process: 1) Recognition; 2) Initial response (including agreed plan between medical and nursing staff and patient and/or carer planning meeting); 3) Daily review with the patient (ACT) and 4) Discontinuing when patient recovers or an individualised plan of care for last days of life is developed.

Implementation of the AMBER care bundle with clinical education impacts on the culture of a hospital. Recognition and response to clinical uncertainty in an acute hospital setting is challenging for health professionals where there is often a focus on acute management in isolation.

Any member of the team can raise the alert that a patient’s recovery is uncertain, which then leads to shared treatment planning between the clinical team and the patient and those important to them. Patients typically receive care supported with the AMBER care bundle for 8 days on average (median). Around 50% of patients are discharged home.
Hospital patients who are facing an uncertain recovery and who are at risk of dying in the next one to two months are helped to receive systematic care through the AMBER care bundle. The care bundle is used to support care by promoting better teamwork and involvement of patients and/or carers in decisions about their care during a period of clinical instability and uncertainty. This ensures plans are agreed and coordinated across the clinical team (Fig. 2).

The GSF is a framework that can be described as a wardrobe in which to hang other tools. It uses a four-colour needs-based coding scheme using anticipated prognosis.

The AMBER care bundle is a decision support tool that can fit within any care pathway or phase when a patient’s potential for recovery is uncertain. This period of clinical instability and uncertainty may occur in any of the GSF stages. The AMBER care bundle therefore complements existing tools identified in the Gold Standards Framework to support better patient centred planning and decision making during any phase of uncertainty in recovery.

Geriatric Medicine is a key speciality for using the AMBER care bundle as we frequently manage patients where there is poor prognosis and uncertainty about outcome. Use of the AMBER care bundle means that decision making is patient centred, proactive and shared with all of the team treating the patient (box 3). It doesn’t, on its own, solve the problem of the patient being treated in the wrong ward, by the wrong team without clear goals of treatment but it is a useful start.

| A | Blue ‘All’ from diagnosis Stable Year plus prognosis |
| B | Green ‘Benefits’ - DS1500 Unstable/Advanced Disease Months prognosis |
| C | Yellow ‘Continuing Care’ Deteriorating Weeks prognosis |
| D | Red ‘Days’ Final days/Terminal care Days prognosis |

**Fig 2.**

**Box 3:**

“I think maybe that point when the nurses start triggering and saying “why are we doing this?” it would be nice for them to be able to. I don’t know, circumvent or put up a flag so that somebody else gets involved, or some kind of mediator. Because I get a lot of nursing staff telling me “why are we doing this? Why do you keep doing this?” And I say “why didn’t you ask yesterday when the consultant was coming round because it would be really nice for you to ask somebody more senior than myself what their intentions are in the situation.” (Geriatric specialist registrar) Quote from Gott et al, 2013 [1]

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We would like to thank the following people for contributing to the hypothetical alternative treatment paths of the patient journey described in the beginning of this article: Keri Thomas, Julie Armstrong Wilson and Chris Elger (GSF); and Susanna Shouls (AMBER Care Bundle).

References for AMBER Care Bundle:
http://www.ambercarebundle.org/homepage.aspx

**Editorial**

It’s been a busy few months in BGS-land. In August I represented the Society at a Guardian New Media event where I was asked to speak on preparing for an ageing population.

I presented on the importance of the emerging frailty narrative, with the possibility that changes in early- and mid-life behaviours might ameliorate later-life vulnerability. I considered the increasing body of evidence that early frailty states might be reversible in the face of improving exercise- and nutrition-based interventions. I outlined the role of Comprehensive Geriatric Assessment in delivering better outcomes for those patients with more advanced frailty states. The audience – comprising a mixture of colleagues from the third sector, social care, NHS management and policy bodies – was warm. They asked me, however, what I was going to do to get “the rest of the medical profession” to fall in line with geriatricians given that we, as a specialty, seem to speak such sense. The profession as a whole was viewed less charitably. I was left wondering what we, as humble geriatricians, could do to deliver such a change. An answer, of sorts, came over the next two months as I travelled around the country meeting inspirational colleagues who might have shown me “the way”.

**Frailsafe Launched**

The Health Foundation-funded Frailsafe Improvement Collaborative ([www.frailsafe.org.uk](http://www.frailsafe.org.uk)) finally got up and running in Sheffield in September. Twelve teams of clinicians and managers from around the UK came together to consider how this safety checklist might help to ensure that safe care is delivered more consistently to older patients with frailty presenting as part of the acute take. It was useful to reflect on the hazards of hospitalisation for our core constituency and consider how simple measures – removing cannulae and catheters, early mobilisation, timely assessment of falls and pressure risk, prompt medicine reconciliation – can make dramatic differences - if only we can do them all the time, or nearly all the time. It was also inspirational to learn about Quality Improvement from Tom Downes and his team at the Sheffield Microsystems Coaching Academy. I finally worked out what all those pathway exercises that I’ve been asked to participate in over the past few years, involving management consultants and Post-it notes, have been all about. If only I’d known at the time…

At our October conference in Brighton, Nigel Edwards, in a barnstorming keynote speech, revisited the old chestnut of integrated care. He eloquently highlighted the implementation challenges associated with patient-centred, multi-disciplinary working to deliver co-ordinated care across the primary, secondary, health and social care continuum. I had the impression that some colleagues left the session feeling fired-up and ready to take on the world – and well they might – but they should not underestimate the challenges posed by such a reformation in the NHS. This is an organisation which, Nigel reminded us, still prints out letters to fax them, to type them into a different computer at the other end, before printing them out again and faxing back a copy as confirmation of receipt!
Leadership in Geriatric Medicine

Also in Brighton, I found myself participating in an “all-share all-learn” session focusing on leadership in geriatric medicine. We discussed last year’s BGS leadership and management course for Specialty Trainees and what we’d learned from that as we prepare for this year’s programme in Birmingham. We learned from the scars on the back of the heroic and inspirational Sarah Brice as she leads her geriatric medicine service in a major London teaching hospital. We considered the lessons from Sarah Stonely, of Leicester teaching hospitals, as she moved from being a geriatrician within a service, to leading one. We concluded that leadership and management are separate, if complementary, skill-sets. We considered whether leadership skills were needed for effective followership. At the close of the session, we concluded that we need to recognise and foster skills in leadership and management if we’re to meet the challenges that I highlighted at the head of this editorial.

The scientific meetings remain relatively “research-lite” affairs. This is less by design than as a consequence of the fact that the meetings have to fulfill multiple remits, with a focus squarely on CPD. Gordon Wilcock and the Academic Affairs Committee, with the support of the Association of Academics in Geriatric Medicine, are working on a strategy to attract more primary research to the events. Meanwhile, though, what was on show was of a very high standard. A group of colleagues presented high-level epidemiological research considering the association between grip strength and ageing, establishing normative foundations for meaningful clinical translational research around sarcopenia. Elsewhere, more clinical research focused upon the possible association between allopurinol use and hip fracture. Another study considered overdiagnosis (and potentially, therefore, overtreatment) of pneumonia in older cohorts. What all of these studies had in common was the reminder of the important role that academic geriatricians have to play in anchoring high-level research to real-world scenarios where they can make a difference to patient-care.

What does all of this mean? Well the public, or at least the educated non-medical campaigners who attend Guardian New Media events, don’t take much persuasion to see that geriatric medicine has a lot to offer as we move to a world where much of the discourse around health and wellbeing will be dominated by discussions of healthy ageing. But if we’re to get on and deliver to our full potential, we’ll need both to recognise existing expertise within the specialty and develop further skills. We need experts in quality improvement, implementation science, research and leadership to lead the charge – all whilst continuing to deliver the best frontline care to older patients possible. These are not things we can afford to be amateurish about, such are the important opportunities at stake. We, as humble geriatricians, can achieve a lot. To do so, we’ll have to equip ourselves with the skills to deliver transformational change of the sort we want to see.

Adam Gordon

Geriatricians on the Health Service Journal’s 2014 Board of Leaders

It is gratifying to report that the following BGS members have been recognised in the Health Service Journal’s annual roll of top leaders:

Top 100 clinical leaders: David Oliver and Tony Rudd

Top 50 integrated care leaders: David Oliver

Top 100 innovators: Alison Cracknell and Jugdeep Dhesi
Paul was the society’s twentieth President and the fifth Scot. I must start by paying fulsome tribute to his contribution during four years as president-elect and then president of the Society. Before that he served in several clinical leadership roles in the BGS, Glasgow College and EUGMS, going well beyond the call of duty across two decades or more. His characteristic blend of calm commonsense and astuteness has brought considerable clarity and purpose to the structure and work of the society.

During Paul’s watch we brought the organisation of our conferences (including SIGs and Section events) in-house, thereby improving their profitability; we slimmed down and clarified the tasks of our various standing committees; we have appointed two excellent lay trustees in Jimmy Miller and Anna Dixon who have added considerable value to our decision making and strategy. We have overseen the appointment of a full time Policy Officer in Patricia Conboy, who started in October and increased the capacity in our press and public relations team. We also made real progress in getting the General Medical Council to recognise the importance of training and skills in the care of older people, and we are working more closely with Health Education England and NHS Education Scotland on skills and training in the care of older people.

New Appointments and a growing media footprint
Paul’s tenure has also led to the appointment of Vice Presidents for Academic and Research Affairs and Clinical Quality in Gordon Wilcock and Gill Turner respectively, and to a dedicated workforce lead (Zoe Wyrko). Our website and social media presence has grown considerably, as has our membership (c 3,000) twitter followership (3,000) and social media impact. Our website not features daily breaking news – thanks to Recia and our blog is very lively, receiving hits from all over the world. Crucially, we have appointed a first rate and highly experienced CEO in Colin Nee who is already helping us to become a much more professional organisation.

I am also delighted to welcome Dr Eileen Burns on board as President-Elect. Eileen is a hugely popular and respected clinician both in her local service in Leeds and in the wider BGS, and it is good to have someone so steeped in leading services and in collaborating across organisational boundaries with primary and community care and social services. For those who have not seen the King’s Fund write up of the Leeds interface model that Eileen leads, the interview with her can be viewed at www.kingsfund.org.uk/publications/specialists-out-hospital-settings/case-studies.

Continuing the push around care home medicine Eileen and I have already met with CQC chief inspector for Social Care, Andrea Sutcliffe – setting out the BGS viewpoint on meeting the health care needs of care home residents and ensuring adequate assessment and rehabilitation before they enter care homes. The BGS’s constant awareness raising around this issue is bearing fruit, with access to specialist care for carehome residents, the role of the BGS and our Care Home Commissioning Guidance, all featuring in the crucial NHS England “Five Year Forward View” about which I blogged in October.

Geriatricians in the spotlight
Despite our speciality’s long and noble tradition and our contribution to the development of services from the NHS’s inception and despite being the most numerous GiM discipline, we don't
always get the "airtime" and profile our work deserves.

So it has been heartening to see geriatricians getting long overdue recognition for service leadership. **Prof Tom Downes** of Sheffield who is incredibly self-effacing and generous and always gives credit to his local colleagues, has received considerable attention for his groundbreaking work on redesign of patient pathways in Sheffield – the service has been visited to death, so keen are people to learn the lessons. **Eileen Burns**, our president elect has featured in a high profile King's Fund report on specialists working in the community. **Professor Tony Rudd** has been named among the HSJ top 100 Clinical Leaders for his contribution to stroke services. Both Jugdeep Dhesi of Buys and St Thomas’ Hospital and Alison Cracknell from Leeds have been included in the HSJ "top 100 innovators" list for their contribution to surgical liaison and patient safety work respectively. It is gratifying to see our members getting overdue respect for their contributions to service leadership, thus challenging assumptions that geriatrics might be a "backwater" speciality. At the moment, rapid population ageing and the realisation that older people living with frailty, dementia or multiple co-morbidities are now "core business" has put geriatric medicine in the spotlight and it is fantastic to have inspirational medics such as these showing the rest of the health care community just what we can do.

**Membership Survey**
Colin and I will be overseeing a structured survey of the BGS membership in 2015, to find out how you think the Society is doing and what else you would like to see it doing. There is a great deal the BGS already does behind the scenes in terms of influencing, responding to consultations, guideline groups, advocating for older people, funding research and study, and the work of the committees that is less visible than the Scientific Meetings or Age and Ageing. These activities are summarised in our narrative slide set [www.bgs.org.uk](http://www.bgs.org.uk) [Select About Us/Work of the BGS], so the more BGS members we can get involved in helping us with this work, the better. We don't always want to rely on the “usual suspects” and would especially welcome up and coming trainees, newly appointed consultants, nurses and AHPs.

**Our strategic goals**
For the next three years, we have set out a clear strategic vision and set of priorities. The strategy document can be read at [www.bgs.org.uk/index.php/about/strategic-plan](http://www.bgs.org.uk/index.php/about/strategic-plan). Of course, with an election coming up, there will be plenty of “breaking news” for us to respond to. But our policy priorities will continue to be:
1. Improving care for frail older people in hospital
2. Integration and care closer to home for older people
3. Dissemination of good practice models
4. Workforce skills and planning.
And we have a particular focus to expand our membership by attracting more GPs, Nurses, Allied Health Professionals and Psychiatrists as
well as pre-higher speciality training doctors and medical students. As a speciality, we preach multidisciplinary team working and so, as a society, there is an urgent need to embrace and encourage multi-disciplinary membership.

**Broadening the scope of our meetings**

What might we do to improve our scientific meetings? Expanding our membership to greater numbers of ‘non-geriatricians’ will, of course entail putting on meetings and publications which have sufficient relevance to these wider professional groups. With regard to our bi-annual scientific meetings, I have heard a variety of views about what people would like to see at these and would welcome more feedback. Any views sent to me at

president@bgs.org.uk or to conferences@bgs.org.uk

would be gratefully received.

**Matters of conscience and law**

Last but by no means least, in the wake of Lord Falconer’s Bill on physician-assisted suicide, we thought long and hard about whether to poll the membership for general views on this issue. However, because the RCP London is conducting its own poll, for the time being, we would encourage geriatricians who are members of the London College to participate in that poll. The results might give us food for thought about how to proceed, not just in England but in all four nations.

David Oliver

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### A multi-disciplinary network to provide fascia iliaca block for patients with fractured neck of femur

Every year, approximately 77,000 hip fractures occur in the UK, accounting for 1.5 million bed days, at an inpatient cost of £0.785 billion. Older patients with hip fracture are at risk of significant morbidity and mortality and there is considerable variation in patient outcomes and management.

For patients with fractured neck of femur (NOF), national guidelines in the UK recommend that we consider nerve blocks for preoperative pain relief and that opioid dosage be limited. Single-shot or continuous femoral or fascia iliaca nerve blocks may be successfully administered by appropriately trained emergency department, orthopaedic, orthogeriatric and anaesthetic medical staff. These approaches reduce analgesia requirements, improve pain scores and are amenable to ultrasound-guided placement and continuous catheter infusions.

Since 2007 at East Surrey Hospital, we have been providing an anaesthetic-led fascia iliaca block (FIB) service for patients with fractured NOF. We aim to perform the block within four hours of the patient presenting to the emergency department and to insert a catheter for a continuous infusion of local anaesthetic. With this service, we have found an opioid sparing effect and importantly, protection against cognitive dysfunction, with greater retention of Abbreviated Mental Test Scores. We have also found the service to be improved when run in conjunction with our orthogeriatrician team.

Could this procedure benefit patients in your Trust?

We would like to share our experiences of setting up and running this service and intend to hold a Fascia Iliaca Block Service Network Day on the 24th April 2015 at East Surrey Hospital (fibnetwork.eventbrite.co.uk). We look forward to seeing you there!

Victoria Ferrier

Regional Anaesthesia Fellow

East Surrey Hospital

### References


Changes to Deprivation of Liberty Safeguards and what they mean for clinical practice

Health care professionals in England and Wales, have been slightly Janus-faced about Deprivation of Liberty Safeguards (DoLS) since the roll-out in response to the Bournewood judgement in 2008. On one hand they have been seen as an important adjunct to the 2005 Mental Capacity Act, protecting vulnerable patients from the worst vagaries of best interest assessments. On the other hand, they are considered logistically burdensome, generating both additional paperwork and workload for hard-pressed health and social care professionals.

These rulings have effectively extended DoLS in England and Wales to the domestic setting (when the Court of Protection must provide authorisation) to any patient who would be refused the right to move freely, even if they had not asked to do so, or were incapable of doing so. The ethics of the situation are complex and difficult. One must reconcile the individual right to autonomy against the potential harms sustained if social services are overstretched by processing an unseemly burden of applications. These issues are being reviewed on behalf of the BGS by Dr Prem Fade and Dawne Garrett, who presented an excellent session on DoLS at the Brighton spring conference (page 15). In the interim we have summarised the key issues in an Age and Ageing editorial (available online through the journal’s advance access portal).

DoLS require that, where an individual who lacks capacity is deprived of their liberty, an application should be made to a ‘supervisory body’ – the local authority in England and either the local authority or relevant health board in Wales – for authorisation to accommodate the individual. The supervisory body assesses the person’s capacity and best interests, reviews the planned care and determines if detention is appropriate.

The Code of Practice for DoLS published in 2008 was vague. ‘Restriction’ of liberty was permitted under the Mental Capacity Act 2005, if necessary to preserve life or health, and proportionate to the threat. ‘Deprivation’ of liberty was deemed to occur if the extent and duration of restriction ‘amounted to’ deprivation, ‘taking into account’: the use of sedation or physical restraint; refusal to release a person to the care of others; restricting visiting rights; or loss of autonomy due to constant supervision and control. Given such lack of clarity, physicians have often tended to avoid applying for DoLS, arguing that they were not depriving, but merely restricting, liberty.

Case law, however, has supervened, following a ruling from the Supreme Court in April 2014 regarding the cases of P, MIG and MEG. P was a man with learning disabilities who had one-to-one care in a supported bungalow, enabling him to undertake outings and activities. However, he wore a restrictive body suit to prevent self-harming. MIG and MEG were sisters with profound learning disabilities. MIG lived with a foster family, to whom she was devoted. MEG lived in a care home, but went on outings and to college. Their cases were reviewed in April 2014 by the UK Supreme Court. In that judgement, Lady Hale stated that “what it means to be deprived of liberty must be the same for everyone, whether or not they have physical or mental disabilities. If it would be a deprivation of my liberty to be obliged to live in a particular place…and unable to move away without permission even if such an opportunity became available, then it must also be a deprivation of the liberty of a disabled person”. She added: “a gilded cage is still a cage”. People may be justifiably deprived of their liberty if it is in their best interests, and they may be happier and better cared for if they are. But it remains a DoL, and must be subject to safeguards.

Adam Gordon
Sarah Goldberg
Rowan Harwood
Drawing an analogy between improving health care and the old television programme *Scrapheap Challenge* where contestants had to build a machine from what they could scavenge from a junkyard, **Nigel Edwards** added: “That’s your job. You have to build an effective geriatric machine out of suitable components left by the old systems. You have the opportunity to bend things to your shape and it’s time to get on with it.”

In a lecture entitled ‘Redesigning Care’, the head of the research and policy analysis institution said that the system in many hospitals was constructed around the disciplines of medicine rather than the problems of the patient. “It’s about individual events not patient journeys. The sickest patients usually see the most junior doctors because of the batch and queue system. If you arrived from Mars what would you think an outpatients’ department was for? You’d think it was for storage.”

New design principles would be to standardise where possible, centralise where necessary and decentralise where possible and to match needs to services. “How many people here are confident that patients could navigate the systems in which they work? Patients are often in the wrong place.”

An estimated 20 to 25 per cent of admissions, he noted, could be cared for at a lower level of care; 45 to 55 percent of bed days could be in other settings such as intermediate care. It was important to do the jobs necessary to keep someone at home: managing complexity meant that multi-skilled staff needed to be able to turn their hands to all kinds of tasks in order to meet patient requirements. “So, sometimes a highly skilled nurse might have to wash up and sort out the fridge.”

Flow was a key factor with decision making needed at the front of a process. “A senior who delegates is better than a junior who escalates.”

Systems should be standardised to ensure coordination, continuity and the anticipation of needs. Networks should enable professionals to share information, work across organisational boundaries and understand the different attitudes and cultures of each discipline. There should also be more discretion over consultant to consultant referral. “We don’t want systems though, that are so big we lose the human perspective. If you can’t get all the people you need to talk to about something in a reasonably sized room, you’ve generally got a problem.”

Rethinking the outpatient model could mean more advice being given via the web and by phone. Although it was not appropriate for those with language, hearing or cognitive problems, it was still estimated that a large number of issues could be sorted by telephone. “You should also use your assets. Find out what voluntary groups are around, what neighbours will do someone’s shopping.”

Above all, patient care should be goal orientated with decision making shared. “And it should not be just a narrow bio-medical model but one with emotional and life based objectives.”

**The healing power of being ‘home’**

The need to redesign the system to cope with a changing demographic was one of the first themes to be highlighted when the opening session of the conference heard from **Maj Pushpangaden** that without effective redesign the country would need to build another 22 800-bed hospitals.

Dr Pushpangaden, clinical lead in elderly care in Bradford Teaching Hospitals, was describing the virtual wards system set up in her area to care for patients post discharge. Since its inception in 2012 it has seen 1500 patients. One example was of an 88 year-old woman with osteoporosis who had fallen and broken her arm. She was desperately keen to
return home as she helped care for her daughter and her partner, both of whom had learning difficulties. “In the old days she would have gone to an intermediate centre but we elected to let her go home and worked out a care programme which could be handed on to the home team.”

In another case, a 98 year-old woman with soft tissue injury following a fall, instituting a home care plan was quite dramatic. She had been delirious on the ward but after being settled back at home and checked on during the night she opened the door to the health worker the next morning wearing lipstick and smiling warmly.

The Community Geriatrics session had opened with an account by Daniel Lasserson, senior clinical researcher at the Nuffield Department of Primary Care Health at Oxford University, of the work of the Emergency Multidisciplinary Unit, launched as an alternative to acute admission to hospital for frail elderly people. Its aim was to provide a rapidly responsive assessment, aided where possible by modern technology diagnostics: there were now, for example, hand held devices which could give blood test results.

Early diagnosis meant treatment could be started and sometimes continued and monitored at home. Where admission was required it was into a special local unit instead of a main hospital site. “Our approaches tend to be polarised between in patient bed-based hospital care and primary care but we need more in-between systems like this.”

The patient’s perspective
Insights into patients’ viewpoints are always valuable as was proved by a talk on physiotherapy after hip fracture by practitioners Victoria Goodwin of Exeter University Medical School and Louise Briggs from St. George’s NHS Trust in London, who see patients from two days after surgery through into the community. “They’re often very frightened and may refuse help. They might feel it’s too early to get up and fear falling again and harming themselves,” she said.

“It’s important to take time to show them it’s the right thing to do and you can use a hoist on day one if they are very nervous about getting out of bed. It’s also important to put them in control, to choose the right equipment and adapt it to their cognitive abilities. We love gadgets but patients who’ve never seen them before might view them as cages or instruments of torture.”

Patients with dementia needed special consideration. Those who refuse therapy may be distracted by pain and fear, hunger, thirst or a need for the toilet. Those with short term memory problems may need a lot of repetition or may find it easier to copy movement than be told what to do.

“We need to keep to the same equipment as it may be difficult for them to learn if we keep swopping. And we should always try and train them in an environment which closely resembles the place where the skills will actually have to be used. A gym setting, for instance, might not transfer to a home setting.”

Falls and Fractures
Earlier in the orthogeriatrics session Roger Francis, emeritus professor of geriatric medicine at the Institute for Ageing and Health at Newcastle University, had spoken of the effectiveness of his local osteoporosis and fracture liaison services where a specialist nurse gives advice on treatment for the condition and further falls prevention.

Such prevention was vital with 16 per cent of the population suffering 50 per cent of all hip fractures. The cost to the country of excess mortality – between 17 and 20 per cent – and excess morbidity - up to 50 per cent, leading to loss of independence –
The study showed, were the ability (at 93 years) to get out of a chair unaided and to have a score of more than 23 on the mental state exam: statistically a third of those who could do that would live to be 100.

**Do you like old ladies?**

A major attraction of BGS meetings is the opportunity to hear from world experts in the field of geriatrics and Brighton was no exception with the Trevor Howell guest lecture being given this year by **Kaare Christensen**, the distinguished epidemiologist at the Institute of Public Health in the University of Southern Denmark. Prof Christensen who has been conducting a long series of studies of the oldest old took as his theme, the key question of whether we could live better as well as longer.

“There’s no doubt that we are doing very well at surviving. In the last century most countries have increased life expectancy by 25 to 30 years. Every year mortality has been beaten by three months. Up to World War II the decline in mortality was among the young; since then it has been among the old.

“The first question I ask medical students is – ‘do you like old ladies? I then show them the age distribution of people who go to medical doctors. They can then see that most of their professional lives will be spent dealing with old ladies.’ To laughter, he added “I never check the drop-out rate afterwards.”

The question he and his team had been trying to address, however, was whether, by improving longevity, we were we simply adding a fourth age which had no pleasure for anyone, not for the people in it, nor for society – did extreme longevity lead to extreme levels of disability or was there a positive side?

His department had studied two large cohorts. The first were those born in 1905 who were measured at the age of 92 for physical and cognitive abilities. They were assessed as being independent if they could, unaided, get out of bed, out of a chair, walk around the house and use the toilet. A reasonable level of cognition was set at a score of 23 or more out of the 30 questions on the mini mental state examination. The cohort was then re-examined at the age of a hundred. “In one sense, at 92 you are only halfway to being a 100 because it is as hard to get from 92 to a 100 as it is to get from 0 to 92.”

Although half the cohort had died in those eight years, those who had survived to reach their century showed a stable level of independence. “Strength, cognitive functioning and happiness scores were very encouraging. They were not more disabled or unhappy at 100.”

The study then looked at a 1915 cohort. “For every decade another 30 per cent make it into their 90s but would this cohort be frailer?” said Prof Christensen. “In fact they had become cognitively significantly better over those ten years. In the 30 question chart they had increased their score by 1.5 marks and in the activity of daily living they were doing better.” Doctors faced with treating a very old person had to weigh up potential life extending benefits against possible side effects. Two of the main predictors of being in good shape later, the study showed, were the ability to get out of a chair unaided and to have a score of more than 23 on the mental state exam: statistically a third of those who could do that would live to be 100.

Further optimism could be gained from the fact that each successive generation is cleverer than the previous one and that new technological developments could compensate for, say, a lack of mobility or other functions. “I’m not diminishing the extent of depression or suicide but I think we can be positive. If you can keep your cognitive functioning and master some IT, that sounds like a good combination for the future.”

**It’s not fluffy stuff**

The meeting featured three workshops giving attendees a chance to input their own ideas. In one intriguingly entitled, ‘It’s not fluffy stuff : using the medical humanities to understand the practice of geriatric medicine’, participants were asked to spend as few minutes drawing a cartoon strip of themselves behaving as geriatricians and then to share how that might have illuminated the discipline’s underlying values.

The issues prompted by the exercise included...
the need to see the whole person, the importance of listening carefully and not making assumptions; and the need to work with other specialists even when they did not understand our speciality.

**Muna Al-Jawad**, consultant in elderly medicine at the Royal Sussex County Hospital, launched the workshop with examples of her own amusing and cleverly drawn cartoons, including those with the super hero character, Old Person’s Whisperer, which she uses both as teaching aids and to illustrate her own research.

The other half of the workshop led by **Kate Wardle**, consultant geriatrician at the Salford Royal Foundation Trust, focused on how film could illuminate the experience of ageing with clips from *Up*, *Iris* and *Amour*. Audience members were then asked how they would deal with some of the issues raised. Film, she said, could cut across time and across social and cultural settings and be a powerful tool for unlocking and managing emotions.

**Deprivation of liberty**

A second workshop dealt with palliative care and a third with mental capacity. In the latter **Premila Fade**, consultant in geriatric medicine at Poole Hospital and **Dawne Garrett**, professional lead in the care of older people at the Royal College of Nursing, looked at the implications of a Supreme Court ruling earlier this year in three test cases on the question of deprivation of liberty.

The decision that Article 5 of the European Court of Human Rights must be judged objectively, i.e. in comparison to a person with capacity and without disability, and not subjectively, meant there was a whole new cohort of people who fell outside Deprivation of Liberty regulations and therefore needed authorisation by the Court of Protection.

These included minors aged 16 to 18 and incapacitated people living in their own homes or assisted living who require continuous supervision and control where care is provided by the state. This was going to mean a huge rise in applications going up from the current 13,719 to an anticipated 176,000 in the next couple of years, swamping social services and the Court of Protection (see page 11).

**Early dementia diagnosis**

Another approach to exploring current issues at Brighton was a debate on the timely topic of dementia diagnosis. The motion “This house believes that earlier diagnosis of dementia is good for patients and their families” was proposed by **Jill Rasmussen**, clinical champion of dementia for the Royal College of General Practitioners, who argued that research suggested most people would want to know provided it opened the door to evidence based treatment and support. Although the initial feelings on hearing the news included shock, anger and grief these could be balanced by a sense of reassurance and empowerment.

“Early diagnosis allows people to plan ahead while they still have the capacity to make important decisions” she told the meeting. “It allows them to get timely practical information, to consider drugs and non drug treatments and to participate in research.”

It would also, she argued, reduce stigma which often contributed to people’s reluctance to discuss symptoms and raise awareness generally. “People often think cognitive decline is just normal ageing so patients and relatives don’t seek medical advice. They often wait until the illness is so advanced it cannot be ignored.”

There was also an economic cost of delaying diagnosis. “We need cost effective packages of medical and social care for people with dementia and their carers across the course of the illness. We need multi targeted interventions, pharmac and non pharmac, plus support and training and respite care.”

Opposing the motion **Surrey GP Martin Brunet** maintained that it was screening by the back door, that memory clinics could be swamped by the worried well and that giving doctors financial incentives to make diagnoses was ethically unsound.

“It’s good that the government initiative Dementia Challenge is putting it on the map but there are a lot of people benefiting from it including politicians and pharma: there are lots of vested interests here.”

Evidence about effective ways of preventing the progress of the disease following early diagnosis was
still thin and money spent on finding cases might be better spent on research and support for patients in hospital or at home. There was also the danger of false positives and the over-enthusiastic use of drug treatments. “A dementia friendly society is basically just a caring society. I want to see nurses and doctors showing interest in and respect for patients irrespective of their cognition.”

An electronic vote before the debate showed 62.5 per cent of the audience in favour of the motion, 22.7 per cent against and 14.8 per cent abstaining or undecided. Afterwards it was 59 per cent for, 36 against and 5 abstentions or undecided.

ICU’s and the older patient

Technological advances have led to dramatic changes in intensive care units over the past ten to 15 years but there are still big questions over their suitability for older patients, as a session devoted to the subject heard on the second day of the meeting.

Andrew Bentley, consultant in intensive care medicine at the University of South Manchester, told his audience that there was a significant mortality rate among such cohorts but that age was only one factor. Others included co-morbidities, frailty, severity of organ dysfunction, infection and inflammation and timing of discharge. There was, however, no difference in the pattern of the use of resources. “We are treating them the same as younger groups.”

The eventual outcome – only 40 per cent were able to return home, the others having to have residential care - was determined more by functional reserve and by what happened during the whole stay in hospital.

One of the big problems in ICUs is delirium defined as disturbances in attention, awareness and cognition not explained by pre-existing states or conditions. The condition could be hypo- as well as hyper-active, which made it difficult to diagnose in patients who were in a stupor, according to Valerie Page, consultant in intensive care at Watford General Hospital.

Evidence suggested that both mortality and functional outcome including memory impairment and poor concentration, were both affected by delirium, the risks increasing with the longer a patient suffered, but it was still severely underestimated. “If in doubt, assume everyone has it”, was her message.

What happens post-ITU is vitally important according to Carl Waldman, consultant in intensive care medicine and anaesthesia at the Royal Berkshire Hospital in Reading where he also runs a follow-up clinic. Problems could include nightmares, hallucinations, loss of taste, poor memory and sexual dysfunction. “It can be similar to post trauma stress disorder,” he said.

Adverse effects could be mitigated by keeping patients as awake and interactive as possible, preferably in natural light, and talking to them while they were actually in intensive care as well as appropriate referrals and rehab later. “You need intensive after care after intensive care.”

ICU’s and the older patient

At the opposite end of the spectrum of care are conditions which do not involve highly sophisticated equipment but mastery of more basic techniques. This was the theme of the talk given by Alison Hopkins, chief executive of Accelerate CIC which provides complex wound management services to the NHS.

The extent of venous ulcers among older patients was shown by the number of audience members who raised their hands in response to her question of whether this was a problem they had to deal with.

“These patients have a terrible quality of life and have had for years,” she said. “They have often not had their pain managed properly but their coping mechanisms like sleeping in a chair have made matters worse.”

There was hope though, as she explained with photos showing extreme examples of ulcers which had subsequently been cured or greatly improved by the right amount of compression and skilled bandaging “We ask patients to rate bandagers. It’s a way of empowering them and it ups the game of the nurses.”

It must be a UTI

If ulcers have been widely under-managed then, conversely, urinary tract infections have perhaps been over-managed according to Sean Ninan, ST6 in geriatric medicine at Hull Royal Infirmary. “Many doctors feel that all acutely ill old people must have a UTI,” he said, citing cases where a stroke and an epileptic fit were misdiagnosed as UTIs. Over-prescribing of antibiotics was contributing to the possibility of an antibiotic apocalypse as well as putting patients at risk of possible side effects.

He was followed by Keith Hawkins, consultant
A geriatrician at the University Hospital of South Manchester, who outlined various treatments for UTIs and the prevention of their recurrence.

Other sessions at the meeting included ones on respiratory medicine, neurology, management and leadership and peri-operative care. There were platform presentations of papers on rheumatology, anti-coagulation and pain management. The subjects covered by more than 60 posters included research into clinical effectiveness, diabetes, epidemiology gastroenterology and Parkinson’s Disease.

On the social side there was a drinks reception in the Skyline bar at the conference centre and a dinner and dance at the Brighton Hilton.

Abuse and neglect

The last afternoon in Brighton looked at the abuse and neglect of older people when Jackie Morris reminded the audience of the Society’s long involvement with the problem: the first professional conference on the subject was organised by the BGS in 1988.

The definition of abuse was the violation of an individual’s human and civil rights by any person or persons. As well as physical, it may be verbal, psychological, emotional, financial and sexual. It could be an act of neglect or a failure to act. It could be committed by a friend, a family member or a stranger; it could happen at home or in an institution. “It happens when we forget to be humane, when we stop seeing patients as people and start seeing them as numbers.”

Dr Morris then provided examples of case histories and asked attendees to confer with a partner to see what each illustrated. Themes which emerged included recommendations to embed geriatricians in the system, the importance of dispassionate whistleblowers, the importance of knowing the Mental Capacity Act and the need for procedures to protect staff against malicious allegations. Supporting staff generally was fundamental. “Unless they’re treated with dignity and respect, it’s very hard for them to treat their patients with dignity and respect.”

Examples of institutional abuse could include ignoring requests for assistance to go to the toilet, scolding or humiliating incontinent patients, not helping with eating or drinking, not offering hand washing facilities, no privacy, no access to personal possessions, infantilisation, dehumanising language, restraints and abuse of medication.

Signs of physical abuse included cuts, scratches, bite marks, fractures, sprains, bruises and poor hygiene. Psychological abuse could be indicated by anger, excessive fear, passivity, confusion, by changes in mood, attitude and behaviour, by changes in sleep patterns and by a hesitation to talk openly.

Combating abuse involved raising awareness, ensuring people felt able to complain without fear of retribution, nurturing both the receivers and givers of care and assisting older people to maintain confidence and self esteem.

The event concluded with an address by Stephen Bowen, director of the British Institute of Human Rights who spoke about the interface between health care and human rights. “The idea that every member of the human family is equal in dignity and worth even if they’re old or their behaviour is difficult underpins everything.”

The NHS was in fact founded in the same year as the Universal Declaration of Human Rights was made and there was a natural linkage between the two. The principle of autonomy, for example, and informed consent were key principles of both. The second great UDHR principle was about the right to regulate the relationship between those with power and those over whom they have power which had relevance to the doctor/patient relationship.

Human rights provided the lens through which to view the world. “People say it’s utopian but in fact it is very much an attempt to find a balance between idealism and realism.”

Liz Gill
Freelance Journalist

Future BGS Scientific Meetings

**2015 Spring**
29 April - 1 May 2015
Nottingham
Abstracts invited from 1 Nov - 1 Dec 2014
Registration is now open

**2015 Autumn**
14 - 16 October 2015
Brighton
Abstracts invited from 1 April - 1 June 2015
Registration is now open
Living well in older age: the health care professional contribution

Viv Bennett, Director of Nursing at the Department of Health and Public Health England, argues that the increasing focus on prevention of disabling conditions through healthy lifestyle is no longer the remit of public health specialists only.

Improvements in public health, health care and medical advances have ensured that people are now living longer. This is indeed a cause for celebration but not all people in our society have the same chance to live longer in good health. Health inequalities persist and the gap between living longer in good health and living longer in poor health can be 20 years between rich and poor areas. Whilst many older people remain in good health, are economically active or contribute hugely through caring and volunteering, for others the picture is one of increasing ill health and frailty.

We know that wider determinants of health, such as poor housing, pollution and fuel poverty, impact both directly and influence lifestyle choices. Taken together, this has contributed to the rising numbers of long-term health conditions (LTCs), with many older people living with two or more LTCs. Social isolation, depression and dementia also impact significantly in older age.

It is clear that if health outcomes in older age are to be improved and inequalities are to be addressed, we need a new public health model that focuses on prevention and health and care services based on supporting independence. This approach requires the engagement of all healthcare practitioners, not just public health specialists.

Nurses and Allied Health Professionals (AHPs) have vital roles in health and care for older people and can make a real difference in the move from episodic reactive models, to preventative, integrated services promoting health and wellbeing. Despite understandable concerns about pressures and capacity, many practitioners are embracing more prevention and health promotion as part of clinical practice.

Professionals have been clear about the need for information, evidence and capacity to demonstrate outcomes of their work. Working with the professions, Public Health England and the Department of Health have developed a Framework for Personalised Care and Population Health, which provides a national menu for health promoting practice.

Practice at individual, family, community and population levels

The Framework sets out six activities for population health which are based on the domains of the Public Health Outcomes Framework. It is a resource to support healthcare practitioners, managers, educators, commissioners, researchers and national professional leaders to access evidence-based research, guidance, standards, good practice interventions and outcome measures.

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<th>National models covered in first release</th>
<th>National models covered in development for future release</th>
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<td>Use of the Framework is demonstrated in worked examples in the following high priority areas:</td>
<td>Healthy ageing</td>
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<td>• Healthy 2 year olds</td>
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<td>• Tuberculosis</td>
<td>• Transitions 10-14 years</td>
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<td>• Antimicrobial Resistance</td>
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The Framework was published in July 2014 and has been well received. Front line practitioners have stated that it will assist them in undertaking the population health aspects of their role and that such a tool is “long overdue”. Educators have embraced the Framework with enthusiasm and have started using it to teach student nurses about the principles and mechanisms of population health. This is important, as some nurses are under the
m isconception that prevention and health promotion is the remit of public health specialists only. The Framework has been developed to de-mystify public health and provide all nurses, midwives and AHPs with ready access to information that will support them in this role.

The Framework also supports Making Every Contact Count (MECC), in which every contact between a professional and a member of the public is seen as an opportunity for providing basic health promotion advice and sign-posting to local support services if needed. Relevant NICE Guidance, including Behaviour Change Guidance, is accessible via the Framework.

Public Health England is discussing with British Geriatrics Society how we can work together, with other stakeholders, to develop the Framework to cover more areas of older age health and encourage a lifecourse approach to, for example, frailty in older age.

Nurses and AHPs play key roles in changing attitudes on the value placed on health. The Framework for Personalised Care and Population Health has been designed to underpin practice for delivery of new approaches to health which support living well for longer and to contribute to a culture of health in our society.

Topics covered in detail in the Framework are shown below. The Framework can be accessed from:  


Comments are welcome and can be sent to: PHPFramework@dh.gsi.gov.uk or left at  


Viv Bennett  
Director of Nursing at the Department of Health and Public Health England

Developing Enhanced Primary Care Services for residents of nursing homes

Dawn Moody and Jo Williams describe a project arising out of the need to address poor access to specialist services by care home residents. The project has been shortlisted as a finalist in two categories (Innovators of the Year and Commissioners of the Year) at the General Practice Awards 2014.

A strong theme of the British Geriatrics Society reports, 'Quest for Quality' (2011) and 'Failing the Frail’ (2012) identified the need for improvement in the care given by the NHS to people who live in nursing homes. In response to these two key reports, back in the spring of 2012, we launched a project aimed at improving the quality and experience of care for residents of nursing homes in North Staffordshire.

The guiding principles were that all older people must have access to NHS care that is patient centred, needs based, equitable and free at the point of delivery. Our objective was to design, deliver and evaluate an enhanced primary care service for nursing home residents. The model of care was intended to:

► be proactive whenever possible
► be promptly reactive whenever necessary
► maximise continuity of care
► minimise unplanned transitions of care
► be as we would accept for ourselves or our loved ones.

We took a strongly evidence-based approach to service design, drawing upon published evidence, carrying out local clinical audits and analysing local acute admission data. An audit of the clinical notes of all nursing home residents admitted to the Frail Elderly Assessment Unit at the University Hospital of North Staffordshire during one month was conducted jointly by a team of GPs and Consultant Geriatricians and suggested that 32 per cent of the acute unscheduled secondary care activity for this population could have been
avoided if appropriate services had been in place in primary care. Our analysis of coded unscheduled acute admission data for nursing home residents in North Staffordshire for the whole of 2011 gave similar results. Based on this evidence, primary care interventions with the potential to improve clinical outcomes were identified and collated to form the new service model. The key elements of the service were:

- Comprehensive Geriatric Assessment and care planning upon admission to nursing home
- Enhanced routine care
- Enhanced urgent care response
- Enhanced review following hospital admission.

We turned to the BGS to discuss our initial ideas and to seek expert advice regarding how best to proceed with our project. As a result, we found ourselves invited to present our plans at a joint BGS and ADASS conference ‘Commissioning Health and Social Care Services for Older People’ in July 2012. This proved to be a valuable opportunity to discuss our ideas with a wide range of colleagues and the advice and support that we received was very encouraging. We went on to hold an engagement event across our health and care economy in September 2012, designed to raise awareness of the project and to establish shared objectives. This was enthusiastically supported by 75 attendees from 10 organisations. The event included workshops examining systems of care and identifying and prioritising GP training needs.

**Pilot**

The new enhanced primary care service for residents of nursing homes was first launched as a pilot for 171 residents in a single nursing home. Eight months after its introduction, the pilot service was associated with decreases of 25 per cent in A&E attendance rate and 29 per cent in unscheduled admission rate, compared to increased rates for a population of 386 nursing home residents who did not receive the enhanced primary care service. The pilot service improved individual pathways of care, increased patient, carer and professional satisfaction, co-ordinated the professionals engaged in the home through multi-disciplinary meetings and resulted in net financial savings and quality improvements.

In the light of these results, and after extensive discussion with the CCG Board and Area Team, the service was commissioned as a GP Locally Enhanced Service (LES) across the whole of North Staffordshire CCG from April 2013. A detailed service specification and performance framework was written, including a clear set of patient-centred outcome measures. Participation in the scheme was voluntary, supported by a training scheme based on educational needs identified at GP workshops, and offered to all GPs in North Staffordshire. We organised a series of engagement and training events involving all partners, including care homes, primary, community, acute and palliative care, mental health and social services and independent sector. We also established a dedicated resource area on the North Staffordshire CCG intranet containing all the resources associated with the service, including service specification, data codes to support monitoring, good practice toolkit, clinical guidelines, advanced care planning documentation and all the training materials used at GP training events.

Following the expansion of the service over the period April 2013 - March 2014, 60 per cent (664) of nursing home residents in North Staffordshire received the enhanced primary care service and 40 per cent (449) did not. Outcomes for both groups in 2013-2014 were compared to each other and to outcomes for the same period 2012-2013. Residents receiving the service showed a decrease of 20 per cent in unscheduled admission rate, compared to the population not receiving the service who showed an increase of 9 per cent in unscheduled admission rate. There was no significant difference in rates of admission per bed per year between the two groups of nursing homes in the year before the implementation of the new service, with rates of unscheduled admissions per bed per year of 0.73 and 0.78 respectively. However, the following year there was a significant difference between the two groups, with rates having fallen to 0.52 per bed per year in the group receiving the service and

**The pilot service was associated with decreases of 25 per cent in A&E attendance rate and 29 per cent in unscheduled admission rate.**
increased to 0.85 per bed per year in the others. The growth in the number of unscheduled admissions for residents in nursing homes not receiving the enhanced service in 2013/14 was consistent with the growth in this activity for this population across all nursing homes in North Staffordshire in the previous two years.

The cumulative admissions by month for the year to that month were calculated for each group and standardised as total rates per bed, to allow direct comparison of admissions rates between the two groups. This graph illustrates the cumulative rate of unscheduled admissions per bed by month for the year to that date (y axis), for nursing homes receiving and not receiving the Enhanced Service, before and after implementation of the Enhanced Service:

These results demonstrate that the benefits of the original pilot project have been replicated at scale across the CCG and that the provision of enhanced primary care services for residents of nursing home, supported by suitable training and investment, can help to minimise acute unscheduled transitions of care for this population. Importantly, we have demonstrated that the skills to improve care for people with frailty and complex needs can be identified and developed within primary care.

How we achieved the expansion

Initially we demonstrated the impact of the service through a pilot (innovators) and then developed it further with a group of interested Practices (early adopters). As the evidence for the improvements grew, the service gradually became widely adopted and therefore self-sustaining.

There are a number of factors that have contributed to the success of the project. Firstly, it was evidence based and a clear plan for evaluation was in place from the outset. Secondly, attention was given to communication with all interested stakeholders, and governance arrangements and areas of responsibility were clearly stated at every stage. This was particularly important with respect to declarations of interest by primary care clinicians linked to a project involving additional investment in primary care. Thirdly, the project has been characterised by clinical leadership and a sense of shared clinical purpose. In addition to delivering a new service, effective partnership working has helped add value to existing nursing home services, through a proactive and multidisciplinary team approach to care. Finally, the project included a bespoke needs-based training programme for GPs, supported by online resources.

General Practice Awards

We are delighted that this project has been shortlisted as a finalist in two categories (Innovators of the Year and Commissioners of the Year) at the General Practice Awards 2014, the results of which will be announced at the end of November. However, at the same time we recognise that there is still much work to do to. Firstly, a way must be found to give all residents of our local nursing homes access to the same level of service as soon as possible. This requires an alternative commissioning approach for those residents whose current GPs have chosen not to deliver the service personally. Secondly, the enhanced primary care for nursing home residents service model will require continued review and development if it is to remain appropriate to meet the ever-changing acuity and complexity of needs found in this population. Finally, lessons from this project should be used to help realise the full potential of primary care to offer comprehensive, holistic and timely care to all people living with frailty and complex needs, regardless of their place of residence.

Dawn Moody
GP with Special Interest in Geriatric Medicine
Jo Williams
Senior Commissioning Manager
The Guardian ran a full-page interview with Prof David Oliver to mark his assumption of office as BGS President on October 15th; this was followed up with a lively online discussion, focusing on the issue of caring for an ageing population. Dr Adam Gordon also spoke at a Guardian symposium on the same subject in September, and was quoted extensively in online coverage of that event.

An article from Age & Ageing on the benefits of mild alcohol consumption was covered by Saga Magazine and the Daily Mail, and our press release sent out as part of the ProFounD network on falls prevention was picked up by the Daily Telegraph, including a quote from Dr Tahir Masud.

David Oliver was also the subject of the “BMJ Confidential” careers column this month, becoming (we believe) the very first geriatrician to be featured there. Our press release commenting on the launch of NHS England’s Five-Year Forward View was also picked up by Health Service Journal (HSJ) in their coverage of reaction to the announcement.

In addition to direct media coverage, we’ve also raised the profile of the BGS through our partnerships with other organisations. We’ve undertaken media work on behalf of ProFounD, as mentioned above, as well as leading press campaigns for the National Hip Fracture Database and the National Audit on Intermediate Care.

We’ve worked on a number of projects with the Royal College of Physicians London in particular: Adam Gordon gave a comment to help promote the next stage of their Future Hospital project, and we were involved closely with their “Specialty of the Month” feature, which included links to BGS materials and guidance, a video interview with David Oliver, and a Twitter Q&A with Dr Shane O’Hanlon.

BGS Projects and Social Media
Other BGS projects continue to garner attention: we’re in the process of evaluating our Care Homes Commissioning Guidance, developing and disseminating new marketing brochures aimed at increasing BGS membership amongst nurses and GPs, and preparing a media strategy for the launch of Fit for Frailty part 2 in December.

Of course, the biggest item in the BGS calendar over the last three months has been the Autumn Meeting; this was not only a great success (as I’m sure anyone who was in Brighton would agree), but also resulted in some substantial social media impact.

The #bgsconf hashtag was used by more than 500 people from all over the world: at one point, a group of geriatricians in Spain picked up the online conversation (in Spanish, no less), discussing how the findings of presentations in Brighton could influence their clinical practice - a neat encapsulation, if one was needed, of the interesting ways in which social media can reach new audiences!

Just under 5,000 tweets were sent from the conference, averaging a tweet every thirty seconds while the conference was running. A combination of energetic conversations and retweeting, plus the involvement of some Twitterers with high numbers of followers, meant that #bgsconf earned a staggering 8.3 million impressions (an impression is any occasion when the hashtag shows up on someone’s timeline). This is more than 4 times as many as the Spring 2014 meeting, and 10 times more than Autumn 2013: the BGS’s social media profile is in rude health.

Likewise, the BGS Blog goes from strength to strength. We’ve featured topics as diverse as Chinese geriatric
Patricia Conboy, our new Policy Manager, joined the staff of the British Geriatrics Society at the end of September. She introduces herself and outlines her perspective on the Society’s policy priorities.

It is an exciting time to take up a new post as Policy Manager with the British Geriatrics Society. The outcome of current policy debates about choices facing health and social care systems across the UK will have a direct bearing on the quality of health care available to older people now and in the future. The BGS has a clear set of policy priorities on which it is already advocating strongly with policy-makers and decision-makers to influence these debates.

My role is to lead on raising BGS’s profile and influence among decision-makers and opinion-formers across England, Scotland, Wales and Northern Ireland, to co-ordinate BGS’s policy function and to ensure that we are well positioned in relevant policy streams. It is a challenging role but one that I am already enjoying, buoyed by the support and help I’ve received from the Chief Executive and colleagues on the BGS team since starting the job. I have come to the BGS from Ireland. My specialism is age policy and I have previously worked in age policy research, analysis, advocacy, campaigning and leadership roles with the National Council on Ageing and Older People, a statutory organisation, and Older & Bolder, an alliance of NGOs campaigning for the rights of older people. The timing of the recent Autumn Meeting in Brighton was fortunate since it gave me both an introduction to the wealth and quality of professional experience of the BGS membership, and insight into some of the issues arising in geriatric medicine in different parts of the UK.

My immediate priorities as Policy Manager include the development of BGS’s action plan for the forthcoming General Election. Watch out for a progress update in the next issue of the newsletter.

I am particularly looking forward to working closely with the four BGS Councils and I will be meeting with members in Northern Ireland, Scotland and Wales early in 2015. During these early months, I am also doing the groundwork for the preparation of BGS’s policy strategy and plan of action, based on the Society’s four policy priorities. These are: (1) the provision of high quality care for older people in hospital; (2) the integration of care across primary and secondary, health and social care systems; (3) workforce, skills and training to ensure that all those providing care to older people with frailty, dementia, or complex co-morbidities are suitably trained; and (4) showcasing, spreading and implementing evidence-based best practice in the clinical care of frail older people, and in effective service delivery.

In the short time I’ve been with BGS, I’ve seen that the expertise, involvement, and support of officers and members is, and will continue to be, core to the effectiveness of any policy advocacy that we undertake. I look forward to our collaboration and to working with you in the months to come.
Abstracts submitted for BGS Scientific Meetings
Clinical Quality Abstracts

The British Geriatrics Society welcomes papers on research and clinical effectiveness for presentation at its biannual conferences. It encourages the submission of abstracts under the categories of scientific research and clinical effectiveness (quality). Here, Jo Preston describes changes to this latter category in the hope that we can enhance the quality or presentations at our meetings.

Focus on Improving Quality of Care
The name of the section has changed from ‘Clinical Effectiveness’ to ‘Clinical Quality’. This is in recognition that clinical effectiveness is only one domain of clinical quality. Accordingly, the subcategories for clinical quality abstracts have changed too (see table 1).

<table>
<thead>
<tr>
<th>Categories for Clinical Quality abstracts from Spring 2015 Meeting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effectiveness</td>
</tr>
<tr>
<td>• Service changes increasing effectiveness</td>
</tr>
<tr>
<td>• Barriers to moving research into practice</td>
</tr>
<tr>
<td>• Improving learning for staff</td>
</tr>
<tr>
<td>• Guideline development</td>
</tr>
<tr>
<td>Efficiency &amp; Value for Money</td>
</tr>
<tr>
<td>• Measures which improve throughput, value or other performance measures</td>
</tr>
<tr>
<td>Patient Centredness</td>
</tr>
<tr>
<td>• Improving the patient experience</td>
</tr>
<tr>
<td>• Improving personalisation of care</td>
</tr>
<tr>
<td>• Empowerment</td>
</tr>
<tr>
<td>Safety</td>
</tr>
<tr>
<td>• Reducing harms</td>
</tr>
<tr>
<td>• Improving safety culture</td>
</tr>
<tr>
<td>Access</td>
</tr>
<tr>
<td>• Increasing equity of access, and timeliness of healthcare</td>
</tr>
</tbody>
</table>

It is worth reminding members that research studies i.e. those that generate new knowledge, as opposed to evaluating practical implementation, even in the above domains, must be submitted to the scientific section of the meeting.

Presentation
The BGS is developing an online space for accepted abstracts to be shared, where your work can be viewed and navigated easily. As part of this initiative, you may also be asked to provide a copy of your poster (in A4 pdf format), or participate in a recorded interview to discuss your project in more detail.

In addition to abstracts being presented in poster format, future meetings will have a platform presentation session for the best Clinical Quality abstracts. This session will have a strong emphasis on sharing initiatives that have the potential to be adopted elsewhere, and discussion centred around implementation.

Publication in Age & Ageing, no longer automatic
From the Spring 2015 meeting, Clinical Quality abstracts will no longer be automatically eligible for publication in the Age & Ageing abstracts supplement. Firstly, the changes outlined above will provide a more meaningful way of sharing good practice with a larger audience. Secondly, it was felt that journal publication of abstracts should be reserved for the most methodologically robust and, or innovative work.

The decision regarding suitability for publication in the Age & Ageing abstracts supplement will, from now on, take place at the poster assessment after judges have had a chance to review the work in more detail. It is anticipated that the number of abstracts being put forward for publication will be small.

Word Count and Headings
Abstracts should now be presented using new headings to shift focus towards discussing practical implementation:

<table>
<thead>
<tr>
<th>Topic</th>
<th>What have you decided to address and why?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention</td>
<td>What change did you make?</td>
</tr>
<tr>
<td>Improvement</td>
<td>How was it implemented?</td>
</tr>
<tr>
<td>Discussion</td>
<td>Was it challenging to implement?</td>
</tr>
<tr>
<td></td>
<td>What might others find difficult if they did the same?</td>
</tr>
<tr>
<td></td>
<td>Are there any population or service features that might limit replication elsewhere?</td>
</tr>
<tr>
<td></td>
<td>What would you do differently if you started again?</td>
</tr>
</tbody>
</table>

Abstracts submitted to the scientific section will not be affected by these changes.

The Future
It is hoped that these changes will improve the value of abstracts beyond the posters and stimulate lively discussion both at the meetings and after, leading to wide reaching improvements in care through collaboration and building on each other’s successes.

Jo Preston
ST6 KSS Deanery
Trainee Representative on the BGS Clinical Quality Group
A large number of abstracts are submitted to the clinical effectiveness (now Clinical Quality) section of the national BGS meetings. The BGS, in its endeavours to assure the good quality of the work presented at its conferences, has a relatively stringent adjudication process for abstracts submitted for its bi-annual meetings, resulting in a 40 - 50 per cent rejection rate. Owing to the volume of abstracts submitted, it is not possible to provide individual feedback to those authors whose abstracts have been rejected. It is also an unfortunate truth that a good clinical quality project may be rejected simply because the abstract was badly flawed.

This article explores common pitfalls which result in an abstract being rejected. It is intended to guide authors in the hope of improving the quality of work presented and increasing the chances of having their abstract accepted. Key changes to abstract categories and headings are also introduced (see previous article).

Pick your topic wisely
One of the main reasons for abstracts being rejected is the ‘so what?’ factor. To avoid your project falling foul of an adjudicator thinking, ‘so what?’, when reading your abstract, ask yourself:

• Why would others be interested in this topic?
• Does it have a useful message which may be applied to practitioners outside your unit?
• Is it a previously under-evaluated topic?
• Does it use a new approach to tackle known problem?

If you have three ‘yeses’, you are in a good position to proceed!

The sub-categories of Clinical Quality (CQ) can then be used to decide whether the topic is relevant to the CQ section. The new categories, as of the Spring 2015 meeting are: effectiveness; efficiency and value for money; patient centredness; safety; improved access.

Choose the right method and evaluation
Audit is a valid tool for evaluating certain interventions. However, audit standards must be clearly stated and the audit cycle must be completed at least once, following the implementation of a defined, relevant change. Remember, it is the intervention that is of interest, not your ability to perform an audit.

Evaluations of new service development, are encouraged. Avoid simply describing how the service operates; explain what you did and the improvements you saw, the challenges you faced. What would you do differently if you started again? What local population, or service factors might have influenced the outcome, or affect the ability for others to implement it?

Often abstracts are rejected because they did not undergo adequate evaluation. Ensure end points directly relate to the intervention. Interpretation of results should give attention to confounders. Colleagues need to be able to trust that they could implement your work in their own units and be reasonably confident of the outcome. Consequently, recommendations and conclusions mus be supported by the results.

It is accepted that some exceptional innovations may take time to demonstrate a desired end point. This is particularly the case in community interventions, for example, introduced with the intention of reducing emergency admissions. Additional interim proxy end points might need to be evaluated so that the innovation can be shared at an early stage before a significant effect is demonstrated. If this is the case it will need to be explained as part of the abstract.

Increasingly the term ‘qualitative’ is being used to describe informal discussions or questionnaires followed by broad qualitative statements to describe the success or otherwise of the initiative. However, whether using qualitative or quantitative evaluation, the methodology must be appropriately chosen, clearly explained and results demonstrated.

Check that you abstract doesn’t belong in the scientific research section!
While both qualitative and quantitative methods might be used to evaluate an outcome, be sure that your project is not a research study. Regardless of the relevance to clinical quality outcomes, research studies must be submitted to the scientific section of the meeting.

If your project is a research study, check whether you need ethics approval. If you are unsure, your local research and development team will be able to advise. If there is any concern whether ethical approval was required, the abstract will be rejected. For example, if your intervention is not considered part of routine clinical care at your institution, advice should be sought. Projects requiring ethics approval to proceed, tend to be categorised as ‘research’.

Jo Preston
Jonathan Tremil
Gill Turner
On behalf of the abstracts assessors from the Clinical Quality Group
DEMENTIA UPDATE

RCP Northern Region Centre for Life, Newcastle upon Tyne
3 February 2015

This one day conference will provide attendees with a comprehensive update on dementia and related issues such as delirium. Many of the speakers have reputations in the field of dementia nationally and internationally.

Fee: £50

For: Consultants trainees and SAS doctors, GPs, nurses and other healthcare professionals.

www.bgs.org.uk [Select Conferences and Events/External Meetings]

BRITISH SOCIETY OF HEART FAILURE

17th Annual Autumn Meeting
27 - 29 November 2014
Yesterday’s problems, today’s solutions

Includes sessions on new trials and guideline updates; NICE guidance on acute heart failure and NICE guidance on CRG and ICDs, as well as dealing with common non-cardiac co-morbidities such as anaemia, sepsis, renal impairment and more.

www.bgs.org.uk [Select Conferences and Events/External Meetings]

CONTINENCE IN GERIATRIC MEDICINE

Dunblane Hydro Hotel, Dunblane
28 November 2014

Incontinence was recognised as one of the Geriatric Giants by Bernard Isaacs; one of the “most wretched symptoms” the elderly could suffer from. We now know how it often represents the tipping point for patients and relatives to consider alternative care. Its effective management promotes quality of life, benefits rehabilitation and increases the ability of older people to remain in their own homes. The Geriatric Medicine curriculum has specific competencies that will be covered in the following lectures, as well as ideas and answers to the everyday challenges posed by this problem.

www.bgs.org.uk [Select Conferences and Events/External Meetings]

DELIIVERING BETTER DELIRIUM CARE

4 December 2014
RCPS Glasgow

This meeting provides practical information on better delirium care for practitioners working in acute hospitals and care homes. The lectures and workshops will provide teaching on:

- the assessment, clinical care and prevention of delirium (including the treatment of agitation)
- the delirium care bundle (developed by Healthcare Improvement Scotland and the Scottish Delirium Association, and now implemented in multiple Scottish hospitals)
- the patient experience of delirium
- practical methods of implementing delirium education

www.bgs.org.uk [Select Conferences and Events/External Meetings]

BGS EVENTS REGIONS AND SIGS

BGS North West
26 November, Oldham

BGS North East Thames
27 November, Royal London Hosp

Bladder and Bowel problems in Older people
5 December, Bristol

BGS Leadership and Management Course, 6-7 Dec, Birmingham

BGS Movement Disorders Section
22 - 23 January 2015, Birmingham

BGS Trainees’ Weekend
7 - 8 February 2015, Nottingham Conference Centre

Preoperative Assessment and Optimisation of the Older Surgical Patient
5 - 6 March 2015, London

BGS/RCN Older People’s Forum
30-31 March 2015, Manchester

9th Training Meeting of the BGS Cardiovascular Section
Date TBC, London

2015 BGS Spring Scientific Meeting
29 April - 1 May 2015
Nottingham East Midlands

2015 BGS Autumn Scientific Meeting
14-16 October 2015, Brighton

More details on:
www.bgs.org.uk (Select BGS Events)
Regional Officers, please contact conferences@bgs.org.uk to publicise your region’s meetings

The BGS regrets that owing to restrictions on space, we are not always able to publish all events we have been asked to publicise. Please visit the BGS Events section of www.bgs.org.uk for details of more events and the Resources section for courses related to geriatric medicine and for downloadable programmes and registration material.
DISCHARGE TO ASSESS – THE SHEFFIELD EXPERIENCE

20 January 2015, 10,00 - 16.00
Sheffield

Sheffield Teaching Hospitals with support from The Health Foundation will be presenting a learning event comprising:

- The journey so far: a description of story and the methodologies (improvement science, social movement theory, etc)
- Sharing Sheffield’s data to objectively demonstrate the outcome of improvements in our city’s health and social care services
- Breakout sessions to meet front line health and social care staff whom have designed the new processes and deliver them today

The event will cater for around 120 people and there will be no charge. To register interest please email Jessica.Huntington@sth.nhs.uk

SCOTTISH DIZZINESS SYMPOSIUM

How to treat dizzy patients without getting dizzy

16 March 2015

Medico-Chirurgical Hall, Aberdeen Royal Infirmary

This comprehensive one day course delivered by a multi-disciplinary faculty covers the practical management of the dizzy patient for the busy practitioner. Lectures and practical workshops will cover vestibular anatomy and physiology, history and examination, vestibular function tests and management of common conditions. Case-based discussions covering challenging cases will help participants to consolidate their knowledge.

This course will be of interest to clinicians of any grade and in any specialty managing patients with dizziness including General Practice, General Medicine, A&E and Geriatrics,

www.bgs.org.uk [Select Conferences and Events/External Meetings]

HEART FAILURE

Revalidation and Training

5 March
London

Feedback from 2014 meeting

"Great short, sharp bite size sessions which inform but don't overwhelm."

"A good mix of speakers with some interesting topics."

"There's a good few tips. Main impact is awareness of upcoming developments."

Heart Failure Nurse Study Day

6 March 2015
London

Feedback from 2014 meeting

"I found it interesting and motivational - lots of good learning points."

"Greatly improved my knowledge and confidence in caring for heart failure patients."

http://www.bsh.org.uk/meetings

EXAM QUESTION WRITERS - SCE

The British Geriatrics Society and the Federation of the Royal Colleges of Physicians of the UK are seeking to appoint four consultants and two specialist trainees to write questions for the Geriatric Medicine SCE.

The successful applicants will generate questions for the Geriatric Medicine Specialty Certificate Examinations as directed by the Examining Board; ensure that the academic objectives in terms of question writing and producing assessment materials for the Examination are met; advise the Chair on the content and development of the Examination; assist in any review of the question writing process to ensure that sufficient questions of quality are produced for the examination.

Applicants should meet the following criteria to be eligible to apply:

- hold the MRCP(UK) or an equivalent postgraduate diploma
- be practicing as a specialist in Geriatric Medicine or a higher specialty trainee in Geriatric Medicine who has passed the SCE, and a member or fellow of one of the three Colleges
- be registered with a licence to practise and in good standing on the GMC specialist register
- for consultants-be actively engaged in the training of junior doctors in the UK (or within the last two years)
- be up-to-date as appropriate with relevant national guidelines, CPD requirements, employer’s equality and diversity training and appraisal process

This is a non-salaried position though all reasonable expenses and travel costs will be met by MRCP(UK) Central Office in line with the Federation expenses policy.

The tenure of appointments is five years.

More detail here:
IDEAL is a major, five-year longitudinal cohort study of 1,500 people with dementia and their family carers throughout the UK using mixed methods to examine how social and psychological capitals, assets and resources influence the possibility of living well with dementia and to identify changes that could result in improved well-being, life satisfaction and quality of life.

The project draws together expertise from psychology, sociology, medicine, public health, economics, social policy, physiology and statistics to examine in detail what can be done to ensure that as many people as possible are enabled to live well with dementia.

The project is led by Bangor University in collaboration with Cardiff University, Brunel University, the London School of Economics, King's College London, Sussex University, the Research Institute for the Care of Older People (RICE) in Bath, the Alzheimer's Society and Innovations in Dementia CIC. The chief investigator is Professor Linda Clare, the project manager is Dr Sharon Nelis with Dr John Hindle as a Geriatrician co-investigator.

Living well with dementia, whether as a person with dementia or primary (usually family) carer, means experiencing optimal well-being and the best possible quality of life, and feeling satisfied with life. Enabling people with dementia and primary carers to live well with dementia is a key UK policy objective, but we need to know more about what can help people to live well with this type of long-term, chronic disability. In this project the researchers will find out how social and psychological assets and resources, and the extent to which people are able to engage in activities and participate in the community, affect the way in which people adapt to the effects of the condition and the challenges it presents, and how this changes over time as dementia progresses.

Over a two-year period the research team will recruit 1,500 people with early-stage dementia of all types, and at least 1,000 primary carers, through NHS memory services and other relevant services such as movement disorder clinics. All participants will be visited on three occasions over three years, and will be asked to respond to questions about things that influence their well-being, quality of life and satisfaction with life. Participants for whom well-being improves or declines markedly over the first year of the study will be interviewed in more depth to help explain why these changes have occurred. The findings from the study will help to identify what can be done by individuals, communities, health and social care practitioners, care providers and policy-makers to improve the likelihood of living well with dementia.

IDEAL is funded by The Economic and Social Research Council and National Institute for Health Research, and will be carried out in conjunction with NIHR CRN DeNDRoN in England, NISCHR CRC in Wales, and SDCRN in Scotland. The study will be the first large-scale study of its kind, and the results will provide a unique resource and focus for social science research on dementia.

John Hindle
http://idealproject.org.uk
The NHS Five Year Forward View was published on 23 October 2014 and sets out a vision for the future of the NHS.

It was developed by the partner organisations that deliver and oversee health and care services including NHS England, Public Health England, Monitor, Health Education England, the Care Quality Commission and the NHS Trust Development Authority. Patient groups, clinicians and independent experts have also contributed to a collective view of how the health service needs to change over the next five years if it is to close the widening gaps in the health of the population, quality of care and the funding of services.

The report outlines why change is needed, what that change might look like and how we can achieve it. It describes various models of care which could serve in the future, defining the actions required at local and national level to support delivery. It requires active participation from system leaders, NHS staff, patients and the public. It covers areas such as disease prevention; new, flexible models of service delivery tailored to local populations and needs; integration between services; and consistent leadership across the health and care system.

The Five Year Forward View is the first in a series of iterative steps towards a more efficient NHS, recognising the challenges and outlining potential solutions to the big questions facing health and care services in England. It defines the framework for further detailed planning required in the evolution of the NHS over the next five years.

For a comprehensive critique of the review, read David Oliver’s two-part blog.
http://britishgeriatricssociety.wordpress.com
(Search ‘five year forward view’).

Amit Arora
Chair, BGS England Council

Contract worth £800m finalised by Cambs & Peterborough Care Commissioning Group

Cambridgeshire and Peterborough clinical commissioning group (CCG) has chosen UnitingCare Partnership to take on a £800 million community and older people’s services contract.

UnitingCare Partnership is a consortium made up of Cambridgeshire and Peterborough foundation trust (FT) with Cambridge University Hospitals FT.

The organisation was selected after a 15-month service redesign and procurement process to find a Lead Provider for older people’s healthcare and adult community services.

The CCG was aiming to find an organisation that will be able to integrate services, providing more joined-up care for patients.

UnitingCare Partnership will directly provide adult community health services and hold the budget for the following services:

► Urgent care for adults aged over 65 including inpatients as well as A&E services.
► Mental Health Services for people aged over 65.
► Adult (all people over 18) community health services for example, district nursing, rehabilitation and therapy after injury or illness, speech and language therapy, care for patients with complex wounds, support for people with respiratory disease or diabetes.
► Other health services which support the care of people aged over 65.

Amit Arora
Chair, BGS England Council
NHS England Chief Executive committed to improving dementia diagnosis

NHS England is committed to pushing up dementia diagnosis rates. Chief Executive, Simon Stevens’ pledge comes as NHS England published a Dementia Toolkit to help GPs make more timely diagnosis of the crippling condition and, importantly, what they can do in terms of vital post-diagnostic support.

The support covers many areas and is mainly directed at the person with the diagnosis or their carer. It relates to both emotional support and practical task-based help including specific interventions such as cognitive stimulation therapy.

Mr Stevens said: “The biggest test of the NHS is going to be how it treats older citizens and, in particular, how we treat people with dementia. If we get it right for people with dementia, we will get it right for everybody.

“This challenge is going to increase and it is a challenge in economic terms as well.”

Current rates of diagnosis, which show how many people have been diagnosed with dementia across the country, are relatively low, at just over 50 per cent, suggesting there may be around 400,000 people living with dementia without the benefits of a formal diagnosis. NHS England’s aim is that by next year two-thirds of the estimated number of people with dementia should have a diagnosis and post diagnostic support.

The government’s drive for early diagnosis is backed by the initiative to pay GPs £55 per early diagnosis. This has raised a furore amongst specialists and some GPs who question the ethics of ‘bribing’ GPs to diagnose dementia. They point to the risk of misdiagnoses and the fact that simply diagnosing dementia is not enough.

Professor Alistair Burns, National Clinical Director for Dementia for NHS England, said: “Being diagnosed with dementia is the start of a life changing journey, and that’s why it’s so important that we reach our ambition of increasing correctly diagnosing dementia in more people, and putting in place the support they need and deserve.

“We firmly believe every person with dementia, who wishes it, deserves a timely diagnosis to allow them to access post diagnostic support with all the benefits that can bring for them, their families and carers.

“We are working hard to support CCGs in providing services to make high quality diagnoses. We know there is significant variation across the country and we are encouraging those with the higher rates to support those with lower rates.”

The Dementia Guide has recently been published by the Alzheimer’s Society with support from the Department of Health and the Royal Colleges of Psychiatrists and General Practitioners along with the Association of Directors of Adult Social Services. The aspiration is that every person diagnosed as having dementia should be provided with the information contained in it.

Its main message is – you can live well with dementia after a diagnosis. It combines a wealth of information about dementia including the signs and symptoms and what help.

My NHS - online comparison tool

A new comparison website tool has been published that allows health and social care organisations to see how their services compare with those of others.

MyNHS is a transparency web tool that compares outcomes at both national and regional level.

It was developed by NHS England, together with the Department of Health, the Health and Social Care Information Service, the Care Quality Commission and Public Health England. It gives commissioners, providers and professionals a snapshot of published data, in the hope of driving improvements in the quality of care.

The information currently covers hospitals, providers of social care and public health, and supports the wider commitment on ensuring more transparent health and care services.

The data is now available on NHS Choices website and will be developed further in the coming months to include more areas and reflect feedback from users.

This policy digest has been provided as a service to BGS members based in England by the BGS England Council under the chairmanship of Dr Amit Arora.
Joseph Sheldon was a general physician based in Wolverhampton. He qualified in 1918 and joined the Royal Navy as a Surgeon Lieutenant on a minesweeper for the sake of the salary and danger money. In 1920 he obtained both MD and MRCP and a year later was appointed consultant to the Royal Hospital, Wolverhampton. He developed a deep affection for Wolverhampton and its people, and held his outpatient sessions on market days so that patients could visit him more easily.

Sheldon’s 1948 Wolverhampton community survey of elderly people, the first of its kind after the war, was carried out at the behest of the Nuffield Foundation, chaired by Seebohm Rowntree. The ration card register was used to locate the random 1-in-30 sample of 583 old people (186 men over 65 and 397 women over 60 years). The survey was carried out between January and April 1945. Five hundred and fifty two people agreed to take part.

He used a questionnaire to assess physical and mental health, the domestic situation and how illnesses were managed at home. General practitioners were currently treating nearly a third, while nearly a half had had treatment in the past 3 years, the remainder had never received medical treatment or not for many years. The vast majority were considered well-nourished and only 3 per cent to be undernourished. Two thirds of the participants were mobile, one third had some limitation of movement either inside or outside the home while only 2.5 per cent were bed ridden. Some had difficulty climbing/descending stairs or standing in queues due to arthritis or pain in the feet due to corns or bunions. The majority ate an ordinary diet and nearly two thirds had adequate dentures. Many needed spectacles to read, some inappropriately used glasses obtained from parents or friends. Nearly two thirds of those over 80 years had high levels of impaired hearing. Just over one third of respondents suffered from falls with the incidence increasing with age. Faecal or complete urinary incontinence was rare and only a few men and women had dribbling urinary incontinence.

Assessment of the respondents’ mental state showed that the great majority were in full possession of their faculties and most of the remainder were only slightly mentally impaired. Sheldon admired their mental vigour and ‘guts’ but noted that one in five people were lonely to some degree.

The survey studied the respondents’ domestic structure. All but 2 per cent lived at home with the minority in hostels or public institutions. Nearly half were married and a similar proportion was widowed. One third lived alone and the remainder lived with children. Widows tended to continue to live in their home but widowers tended to sell up and move in with married children. Those living alone usually maintained strong contact with their children who often lived close by. The majority of those living at home tried to maintain their independence for as long as possible. Up to the age of 75 years the women contributed more to the community than they received.

The survey explored how early illnesses were managed within the family. Usually they were handled within its own resources - spouse, children or neighbours - which could be a very heavy burden on younger members of the family. When the husband was in bed the wife did the nursing but when she was ill in bed she was generally looked after by the daughter. Community domestic help would be greatly valued in these situations.

Sheldon emphasised the positive contribution made by older people and that it was sensible to maintain their independence for as long as possible. Many would benefit from aids such as spectacles, hearing aids, dentures and access to physiotherapy and chiropody. Carers would also value relief provided for invalids by short stay hostels or permanent residential homes.

In his report Sheldon discussed: ‘What is ‘normal’ ageing’, to which he had no clear answer but emphasised the need for research, and ‘The
determination to live’, which was the result of mental attitudes and the sense of purpose. Importantly he distinguished between ‘chronological’ age and ‘biological’ age.

Sheldon’s second survey in 1961, of the Birmingham Regional Chronic Sick Hospitals was carried out at the behest of the Birmingham Regional Health Authority who were concerned about the adequacy of their services for the aged and infirm. He was commissioned to survey all regional chronic sick hospitals but not those caring for the ‘psychogeriatric’ patients. The Regional Board expected these surveys to assist planning future hospital requirements, facilitate the discharge of the ‘bed blocker’, assist admission of elderly patients to vacated beds in the chronic sick hospitals and generally improve hospital services for the elderly.

The report revealed a highly unsatisfactory state of affairs, which echoed comments made some 15 years earlier in the 1945 government commissioned Hospital Survey Reports. Sheldon found both over and under bedded areas. Thus, for example, only one seventh of the chronic beds were provided for an area containing a one quarter of the population. Some hospital buildings were not fit for purpose, having been designed as ‘human warehouses’ and were not intended for their present use. Some were over 200 years old and one was nearly 800 years old. The quality of some buildings was so poor that he recommended six should be either partially or totally demolished.

Many hospitals had no lifts to the upper floors and could only be reached by narrow external stairs, and therefore constituted a fire hazard. Patients and bodies had to be carried up and down these stairs, as did all food (either hot or cold), linen and perhaps coal. Rehabilitation facilities were often very cramped. He found it quite an experience to see bedpans stored for the night in the bath, to find the same room being used for washing bedpans and domestic crockery and being told of nurses having to queue up for the same toilet as the male patients. He commended the work of the nursing staff. He found 300 patients in Summerfield Hospital only required supervision and did not require hospital accommodation.

Sheldon thought three types of accommodation were required for the chronic sick: acute assessment units with rehabilitation; long-stay units, and small chronic sick facilities associated with the local cottage hospital. He recommended the appointment of more geriatric physicians in the region, the need for postgraduate medical education in the modern treatment of the chronic sick and adequate staffing of all sections of the rehabilitation team.

**First geriatric physician in Birmingham**

Sheldon’s representations for specialist physicians for the elderly doubtless led to Dr Lawrence Nagley’s appointment as the first Birmingham consultant geriatrician on 5th July 1948. He had a massive workload of 1,200 chronic sick inpatients, 300 able-bodied destitute people, 50-60 vagrants, 30-40 young chronic sick and 39-40 venereal and skin patients. None had written medical records. His junior staff consisted of one full time and two part time medical officers.

He found grossly overcrowded wards and congested day rooms so packed with beds there was nowhere to sit down. The floors were highly polished resulting in at least one case of a fractured neck of femur. There was a system of giving numbers to mixtures of stock medicines. Nagley postulated this arrangement was because the pauper nurses could not read. Nagley had, on several occasions, to cope with large numbers of people made homeless by air raids. They stayed for one night for shelter and sorting out before they were moved on. He was to claim later that he had spent more years looking after more sick old people in a greater concentration than any other physician.

In 1974 the Regional Board created in the Charles Hayward Chair of Geriatric Medicine in Birmingham and appointed Dr Bernard Isaacs.