A strategic review by Forster Communications of BGS member services and communication channels is now underway. In the article below, we explain what is happening and how every member can contribute.

Listening to members
A core feature of BGS’s current strategic plan is to improve support to our members. The best place to start is by finding out what our members want. With some grant support from Yakult, we have commissioned a major information gathering exercise from Forster Communications, a specialist communications agency with considerable experience of working with medical societies and health charities. Forster bring expertise on both aspects of the review, and will take a holistic approach to assessing the needs and wishes of BGS members concerning our service offering and communication channels. They will use surveys, focus groups and interviews to audit what members think of our services, assess their communication preferences, and advise on refreshing BGS’s corporate look and feel. All of this work will feed into the development of a new website planned to take place within the next two years. We have had member consultation before, but nothing on this scale. The review is a golden opportunity for our growing and increasingly diverse membership to help shape the service output of the society in the years to come.

The overall purpose of the review is to increase the effectiveness of our services and communications, as well as to build member engagement, including everything from sharing news of local developments, new clinical practice or research, to participation in elections, standing for election, attendance at meetings, responding to policy consultations, and providing service feedback. The four specific aims of the review are as follows:
To enable BGS to upgrade and improve our service offering and communication channels in order to better meet members’ and potential members’ educational, information and communication needs. As well as supporting member retention and growth, this should also drive the take up and impact of BGS services;

➢ To examine and address barriers to achieving our aim of a more diverse, multi-disciplinary membership;

➢ To explore members views about BGS ‘branding’ and our overall look and feel; and

➢ To address barriers to member engagement and participation.

**Forster’s approach**

As well as being a major success story, an ageing population brings important challenges and never before has the specialty of geriatrics been so well recognised and valued. With a growing membership of over 3,000 individuals, and the nature of care delivery evolving, the time is now right for the BGS to take stock of the needs of current and potential members, and to develop and extend services in line with these insights.

Our strategic review for the BGS will involve working closely with members to understand what communications and services are valued, how they might be improved and what more the BGS can do to support professionals working in geriatric medicine.

With NHS care becoming increasingly integrated, we also want to explore how we can make the Society relevant for all healthcare professionals (HCPs) working in the care of older people - from specialist consultants, to GPs, nurses and allied HCPs – while ensuring it still retains the heritage and benefits that the core membership values most.

As part of Forster’s consultation, later this month a survey will be circulated to all members, by which we hope to understand members’ views. Forster’s also attended the joint RCN/BGS meeting in March and will be at the BGS Spring Meeting in April/May to gather direct feedback and host a focus group. It is really important that they understand your perspective and how you want the BGS to evolve, so we hope as many of you as possible will get involved.
Through this, and wider consultation, Forster will develop a series of recommendations for the BGS to take forward. This will affect the services and benefits members receive, and the newsletters, ebulletins and other communications the BGS shares. The website will be modernised and re-launched, and the BGS logo and visual branding will be updated. Lastly, we want to ensure that everyone, whether working in geriatric medicine or not, knows what the BGS stands for and what its members care about, so our discussions with members will feed into external communications with policy makers, key stakeholders and wider society.

With so many challenges around older people’s healthcare there is a real opportunity for the BGS, with its strong heritage in research and scientific conferences, to grow its influence as the driving force for delivering better healthcare in older age.

As members, you play a key role in shaping the future direction for the society and we look forward to progressing this landmark project.

Colin Nee
BGS Chief Executive
Amanda Powell Smith
Director, Forster Communications

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**Editorial**

I tend not to worry if people don’t read this editorial. So if you are not reading it now, please don’t feel that you’ve caused offence! A greater worry is when people read it and take exception to its content.

One such incident occurred recently. I was meeting with a respiratory physician, something of a hero of mine - good all-round bloke, excellent physician, leading researcher. We were meeting to discuss data collection in care homes but his opening gambit was, ‘I read an editorial of yours recently.’

Pregnant pause whilst I tried to work out what was coming next.

‘It said that geriatricians are the ones that do all the work.’

Pregnant pause whilst I tried to work out how to respond to what was coming next.

‘So why, then,’ he went on, ‘did I spend all of yesterday seeing sixty outliers, all old, and all ostensibly medically fit for discharge?’

And then I felt quite small. His wife is a geriatrician. It hadn’t occurred to me that she, let alone he, might read my editorial. He wasn’t, suffice to say, my intended audience.

I went on a similar emotional journey when I recently went to a House of Lords meeting designed to draw together medical innovators to speak to the Minister for Life Sciences. As I read the abstracts on the train down to London, I thought I had the whole thing pegged. The cardiologists would speak about TAVIs, the maxillofacial surgeons would speak about 3D printing of personalised body parts and the transplant surgeons would talk about novel approaches to immunosuppression. Meanwhile the practical but innovative responses of geriatricians to the everyday pressures of the NHS would suddenly seem unglamorous and I would
stand unloved in a corner. But actually, it was quite different. The respiratory physicians spoke about going into the community to provide care closer-to-home for the frailest patients; the cardiologists spoke about doing simple things well to broaden access and reduce delays to PCI; the trauma surgeons spoke about how the humble tourniquet was revolutionising prehospital care. There was, of course, the humbling 3D printing of body-parts talk to sit through but, for the most part, it was about tackling the same issues that exercise us as geriatricians - minimising complexity, removing barriers to common-sense every day care and, more importantly, broadening access to care, often to encompass the very frail and dependent older patients that we seek to advocate for.

We can, as geriatricians, get a bit wrapped up in ourselves, especially when we are working flat out; especially when we are on a mission. And we all have been over these last few months as we’ve played our parts in dealing with the acute care crisis. If you work in a big centre like I do there’s something quite affirming about griping to colleagues about the fact that every other sod seems not to care about frail older people. If you work in a smaller centre, I suspect it can be tempting to feel isolated amongst a team of physicians and healthcare professionals, the majority of whom have never heard of CGA, let-alone modern conceptualisations of frailty.

But we have to ensure that we are not so wrapped up in ourselves that we fail to get the rhetoric right. The message is: we can help.

Hospitals and health systems can flow more smoothly with expert geriatricianly input in the right parts of the pathway. But we need to have the time and capacity to do this, which means we can’t only be staffing the acute take. In the same way that respiratory physicians need to be free to staff the two week wait clinics and the gastroenterologists need to keep the endoscopy lists moving to ensure the broadest possible access to their service, we need to be able to go to the community, to attend intermediate care, and to do the orthogeriatric ward rounds.

So we need all to pull together. Patients with frailty in acute hospitals are everybody’s - by which I mean all healthcare professionals’ - business. Putting geriatricians in the right place to support the assessment and management of older people with frailty in acute hospitals, and throughout the pathway, will help everybody conduct their business with maximum possible efficiency to deliver the best outcomes for patients.

These points are highlighted in our six decisions for the incoming government document, which David Oliver expands more fully upon in his column on the next page. The issue of reaching out to other specialties is touched upon through our ongoing work with the Gold Standards Framework team on page 9. The ongoing work to expand access to POPS initiatives and to develop a CGA toolkit in co-operation with Dr Angelo Grazioi also fit with this theme. Meanwhile, the careful balance to be struck between acting as custodians of the body of geriatricianly specialist expertise, whilst giving colleagues from other disciplines routes into training in the specialty, is considered by Zoe Wyrko on her position paper on alternative routes of training (page 18).

So hopefully I’ve phrased things a bit more inclusively this time around.

I look forward to the next meeting with my respiratory colleague with interest. If, in fact, he’s bothered to read this!

Adam Gordon
With England comprising 84 per cent of the UK population, it might sometimes seem that Anglo-centric concerns predominate in our newsletter, website or e-bulletin - though to be fair, the chairmen of all four national councils are BGS trustees and our secretariat, including our policy and communications team, are committed to supporting BGS members working in all four nations.

For this edition of BGS Newsletter we asked Wales, Northern Ireland and Scotland councils to pen a quick update of key developments in their own systems and services, given that the organisation of health and care services has now been substantively devolved to each nation, with no direct control from Whitehall. Their contribution, from page 14 onwards, relates largely to their aspirations for the NHS in their respective countries, post-election.

Worthy exemplars
Away from national specifics around organisation, funding and oversight of health care services, the patients we see, and the challenges we face in helping them, go beyond national boundaries or politics. And all of us can learn from innovations and models of care around the UK. One current example is the Health Improvement Scotland’s Older People in Acute Care (OPAC) programme (page 27). Another is the UK-wide drive to improve care for older people undergoing surgery - given fresh momentum by the drive from the Royal College of Anaesthetists focus on interdisciplinary perioperative care and building on the BGS POPS (Proactive care of Older People undergoing Surgery) section (page 17).

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Pre-election activities
We are now just weeks from a General Election, so a focus on the politics of English Health and Social Care is inevitable and needed. Key decisions taken will affect our members, the organisations they work for and the patients and carers they see each day.

In February, we issued a pre-election Manifesto setting out six priorities on Health and Social care for older people in England. Despite different systems and structures, the central priorities will have resonance across the UK. We secured meetings with Liberal Democrat, Green and Labour health teams to discuss them and also had a dialogue with the Cabinet Office (see more detail in Patricia’s column on page 12). We may be one of many organisations, some with bigger voices and more clout, but it’s important to keep on posing the questions, keep on raising awareness, keep on responding to policy consultations. And there are numerous examples over the past few years in which the BGS, geriatricians and other clinicians interested in older people have had a major influence over national policy, guidelines or quality initiatives and informed wider debates.

Within the English context, it will be interesting to see post-election how much traction the NHS England Five Year Forward View still has. The new models of care it sets out, the buy-in from other national system leaders, and the focus on sustainable long-term changes in services rather than constant short term “quick fixes” and “serial pilotitis” are welcome. The recent King’s Fund Paper, Implementing the NHS Five Year Forward View, sets out some of the detail needed on implementation if it is to be a meaningful document.
**Political promises versus reality**

Between them, the parties are putting out welcome headlines and sound-bites around more integrated and co-ordinated care, care more attuned to people’s needs, a greater focus on dementia and mental health, beefing up the primary and community workforce and allowing closer working, budget sharing and joint service planning between health and social care. However, none of them are promising funding remotely near the additional £4b per annum recommended by the King’s Fund in the Barker Commission on future funding, just to keep services at current levels. And the cracks are already widening – as the urgent care crisis and acute trusts’ rejection of national tariffs have shown. Hopes invested in drastic reductions in urgent activity have so far proved forlorn – perhaps unsurprising given the parallel crises in primary care workforce and social care funding. Even the Five Year Forward view has made heroic assumptions about our ability to generate £22bn in efficiencies and only asks for £8bn more over five years.

Whilst no party has pledged to reverse major cuts in social care funding which have made around 800,000 people with “substantial” care needs unable to access services, nor put social care on an equal footing (universal and free at the point of access) with NHS care, the 2014 Care Act came into force on April 1st and has been widely welcomed as a potential force for good.

**NHS metro-devolution**

Another development that hasn’t waited for a General Election is the sign off in March of plans to devolve an entire health and social care budget and control over services to the 2.6 million people and 10 metropolitan districts of Greater Manchester. This raises some interesting opportunities around the care of older people. However, the recent “healthier together” work there has thrown up much controversy and a lot of detail around risks of implementation is currently missing. We have asked a number of BGS members and local service colleagues to set out their views in a series of blogs. Anyone working in big conurbations around England will be following events closely.

One of these is Nottingham – the location of what should be a lively Spring Scientific Meeting spread over three full days and with a programme diverse enough to appeal to many members, some outstanding headline speakers, the possibility to book for “standalone” days and preferential rates for non-doctor members. We hope to see you there. I hope readers will make good use of the preliminary programme which has been mailed with this issue of the newsletter!

David Oliver

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**Research and academic medicine**

**Royal College of Physicians (London) survey**

The Royal College of Physicians (London) will be conducting a survey throughout April, looking into research and academic medicine activities, covering respondents’ current engagement in research, allocated and actual PAs and SPAs, level of interest in research, the barriers they feel currently limit their engagement in research, and what they perceive could be done about them. It is aimed at doctors and surgeons from all specialties and career stages, including medical students and trainees, and the findings will be publicly reported.

The British Geriatrics Society hopes to benefit from the RCPL’s findings as it could serve the organisation in establishing a baseline for certain elements of its current research strategy. We would therefore urge BGS members – of all grades - to complete the survey when the link is posted. This will be promoted on the BGS website, in the e-bulletin and in all the BGS’s social media.

Gordon Wilcock  
Vice President of Research and Academic Affairs
The debrief is on-going, but candidate theories include ‘too many old people’ (sic), lack of primary care, poor Emergency Department staffing, and reduced outflow relating to social care cuts. The truth is likely to be a combination of all of these factors, and many others. An important output from the post-mortem is to determine what we might do about it in the future.

Undoubtedly one of the drivers is the ageing demographic, which does mean that hospitals need to expect more older people coming though their doors, many of whom will be frail. Whilst there have been significant improvements over the last few years in the acute care response to older people, there is still a long way to go. There have also been some significant misunderstandings about what is required for older people accessing urgent care. It is not just geriatricians! Rather, it is the technology to which geriatricians can usefully contribute, or even coordinate - Comprehensive Geriatric Assessment (CGA). But CGA is not an exclusive club. Every physician involved in managing frail older people should be able to play a useful part in CGA. It is just that geriatricians are specifically trained to do it, although increasingly other physicians are developing their skills in this area. It is key for future-proofing urgent care. Yet we see significant variation in the interpretation of what constitutes CGA. I have taken the liberty here of illustrating some of the key concepts.

Geriatricians are specifically trained to do [CGA] although increasingly other physicians are developing their skills in this area. It is key for future-proofing urgent care.
Interdisciplinary diagnostic process – in a mature CGA service, the hierarchy should be flattened so that all staff feel empowered to constructively challenge within and outside their particular area of expertise. For example, the option to admit for rehabilitation by a therapist concerned about falls at home might be challenged by pointing out that admission often increases the risk of falls, and that home-based rehabilitation may offer substantial benefits. Equally therapists will bring useful information to the diagnostic process – for example, the patient who is ‘fit to return home’ who develops new dyspnoea on mobilisation might prompt a re-evaluation of respiratory function and identify potentially new diagnoses such as pulmonary embolus. That this assessment is a process and not a discrete event is also key; the process should continue in an iterative manner over the course of the acute stay and the diagnostic elements should be sensitive to deviations from the anticipated pathway. For example, if the initial treatment plan for an individual with a fall and hip pain but no fracture was to ‘increase analgesia, reduce anti-hypertensives and aim to return home once able to walk five metres unaided using a frame’, yet after fourteen hours, pain remains a problem, the diagnosis may need to be re-visited and further imaging considered.

Frail older people - targeting patients who will benefit most from CGA is important. CGA requires time and staffing resource, both of which may be in short supply in a hospital e.g. busy ED environment. The use of accurate and easy to use case-finding or screening tools should be a critical first step. A wide-range of screening tools are available, but none are perfect and none have an ‘Area Under the Curve’ of greater than 0.7 – so the current tools alone are insufficient to identify the population of interest, although they can be used to reliably screen out those that do not require CGA as their specificity (and hence negative predictive value) tends to be good. The most common targeting criteria are a combination of age, physical disease, geriatric syndromes, impairment of functional ability and social problems.

Coordinated and integrated plan for treatment – reinforces that the members of the team caring for an individual need to know and respect each other’s roles and know and

References
understand what each is doing, and how the medical treatment will impact upon the rehabilitation goals and vice versa. For example, whilst therapists would not need to know the detailed intricacies of managing acute heart failure, it is important that they know that intravenous diuretics might be required for the first few days resulting in polyuria, and they then should be able to incorporate continence needs into the rehabilitation plan. Equally, doctors will need to appreciate that just because a patient has grade 5 power on the MRC grading system, that does not necessarily translate into useful functional ability.

‘Follow-up’ – as many older people will have multiple long-term conditions, they will usually require some form of on-going care and support. How this is delivered will vary from country to country, but there is little point in providing excellent acute care if conditions are only going to be allowed to decline because of a lack of on-going support. For example, a two-week admission during which Parkinson’s disease medications are carefully titrated and optimised in conjunction with the multidisciplinary rehabilitation process can easily be reversed if there is no on-going titration of L-Dopa once the patient returns home.

So whilst integrating standard medical diagnostic evaluation, CGA emphasises problem solving, team working and a patient centred approach.

It is incumbent upon geriatric services, which by definition should be specialised in the care of frail older people, to ensure that they lead and evidence great clinical care and that they support other services through education and training in delivering CGA to all frail older people.

The Acute Frailty Network seeks to bring together centres from across the country to share best practice in developing urgent care solutions for frail older people. The focus is on the first 72 hours in acute hospitals, whilst maintaining strong relationships with, and awareness of, the broader system. If you want to know more see the website (www.acute frailty network.org.uk) or contact frailty@nhselect.org.uk or follow us on Twitter: @acute frailty.

Simon Conroy
Head of Geriatric Medicine
University Hospitals of Leicester

Gold Standards Framework
First awards for hospitals in Exeter and Morecombe

The CQC Inspector has praised hospitals for improving end of life care for patients using the Gold Standards Framework and Programme and presents them with the first GSF BGS Quality Hallmark Awards.

The Gold Standards Framework (GSF) Centre started in 2000 in primary care, now runs GSF programmes in end of life care in all settings. The biggest and most comprehensive of these aims to improve care at the end of life. One of its key elements is to offer everyone the chance to record

an Advance Care Planning discussion to clarify their needs and preferences. The GSF accreditation for Acute Hospitals is endorsed by the British Geriatrics Society (BGS) who also partnered in assessments.

Two wards at Royal Devon and Exeter Hospital and one at Royal Lancaster Infirmary, part of United Hospitals of Morecombe Bay, are the first to be accredited by the National Gold Standards Framework Centre (GSF).

All three wards at the two hospitals demonstrated key improvements to the quality of care for all
patients in the final year, months, weeks and days of life, the coordination of their care as well as, crucially, enabling more people to live and die at home if that is their choice.

Staff from the two hospitals were in London at the end of March to receive their awards from Professor Sir Mike Richards, Chief Inspector of Hospitals at the Care Quality Commission. Sir Mike congratulated the two hospitals for leading the way in the care of patients approaching the end of life and urged other hospitals to follow their example. He said: “End of Life Care is a central focus in our inspection process of all hospitals. We know that many hospitals struggle to identify patients in the last year of life and consequently find it difficult to coordinate their care adequately.

He said: “By delivering earlier recognition and more effective communication with the patients themselves and other professionals in the community, the Gold Standards Framework enables better care for people in the last months of their life.”

Yeo and Yarty wards at Royal Devon and Exeter, oncology and haematology wards respectively, and Ward 23 at Royal Lancaster Infirmary, a stroke ward, provided evidence of measurable change to the way they systematically organise their care, and the impact on patients and their relatives and carers and staff.

They demonstrated early recognition of decline (with more than a third all patients identified as being in the final year of life), offering advance

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Interview with Dr Pradeep Kumar on the GSF

All of the scaremongering about the Liverpool Care Pathway meant that as soon as people heard those words, they panicked. But GSF is a way of engaging patients and starting a conversation with them, where possible, and with their relatives from an early stage – looking at their preferred place of death and long term care where indicated.

Recently, we had a patient who’d had a severe stroke and had cancer. We were in little doubt that he was coming to the end and was going to die very soon. So, we immediately coded him ‘Red’ on GSF, got all the documents in place and initiated discussions with the family. The family decided that it would be best for him to be cared for at home. So we fast-tracked his discharge – coordinating with his GP and district nursing team. He went home within 24 hours and died there peacefully, two or three days later. This was the best possible outcome and we received fantastic feedback from the family. It is very unlikely this would have happened prior to us doing GSF.

The key driver has been the feedback we have received from patients and their families that their voices were not being heard. GSF has then given us the framework to engage with relatives and put things in place to ensure the outcome they want for their relative. It has also helped us form closer working relationships with GPs and district nurses.

I think the biggest change has been the culture change – knowing that it’s not about the nurses and doctors taking a paternalistic approach. Rather, it’s about getting patients and their families to take ownership of their care. GSF is the framework that allows us to make that happen.

The best bit is making sure that patients receive the care they want, where they want it, when and how they want it and the satisfaction they and we get from that.

I have been working on this unit for ten years and we have had a number of complaints in that time. Over the last three years we’ve had none and I anticipate that with GSF this will continue because of the improved communication.
care planning discussions to all and improved communication with GPs, with more patients discharged to live and die at home where appropriate.

The wards undertook several on-line evaluations, assembled a portfolio of evidence demonstrating the attainment of five key standards and underwent a visit from the GSF assessment team.

Dr Martin Vernon, BGS End of Life Care lead, said: "The vast majority of patients approaching the end of life are cared for by generalist doctors, nurses and other members of the multi-disciplinary care team rather than specialist palliative care professionals. Hospitals increasingly care for greater numbers of people towards the end of their life with frailty and complex health conditions.

“That’s what makes this such a milestone event, as staff on the wards that have been accredited will feel more empowered to provide the coordinated care this most vulnerable of patient groups require. GSF accreditation in the general hospital setting helps to drive up quality in the delivery of end of life care by ensuring recognised standards are maintained for providers.”

The successful hospitals are among more than 40 to have completed the GSF Acute Hospitals Training, a two year programme which aims to enable the provision of integrated tailored care, by helping generalist frontline staff better recognise decline, anticipate and meet their needs in line with patients’ preferences. In turn, this has helped them, where appropriate, to reduce the length of patients’ hospital stay and improve the discharge process, leading to better outcomes once the patients return home.

In Yeo oncology ward more than half (57 per cent) of patients are being identified as being in the last year of life, which has helped staff then initiate conversations with patients about their wishes so care can be planned and given in line with those wishes.

Em Wilkinson-Brice, Chief Nurse/Chief Operating Officer at the Royal Devon and Exeter NHS Foundation Trust, said: “We are thrilled to have received the Gold Standards Framework (GSF) Quality Hallmark Award in End of Life Care. Achieving this accreditation is a testament to the hard work and dedication of all the staff and End of Life teams on Yeo and Yarty who daily provide safe, high quality and compassionate care for our patients.”

Professor Keri Thomas, GSF National Clinical Director, said: “Caring for patients nearing the end of life is one of the biggest challenges facing the acute hospital sector. What these two hospitals have proved is that by implementing a structured systematic approach such as GSF with earlier recognition, improved communication with patients and fellow professionals, and better coordinated care, it is possible to provide a higher quality of care for people in the final year of life wherever they are. We hope others will aspire to this standard, as others have in primary care and care homes also thereby developing a national momentum of best practice for all people nearing the end of life everywhere.”

Tom Tanner
Freelance Writer
Key questions on health and social care for parliamentary candidates

Funding crisis in health and social care
As the debate about the NHS heats up in the final weeks before the General Election on 7 May, the issue of future funding has risen to the top of the agenda. The debate is focusing on both NHS and social care funding and the relationship between the two. Many commentators argue that "unless social care is fixed, the NHS will not cope and cannot improve". While NHS funding has been spared from 'real-term cuts' since 2010, local government funding has not been ring-fenced and one of the consequences has been a 17 per cent fall in spending on social care for older people. Age UK has stated that there are currently 900,000 older people aged between 65 and 89 who have unmet needs for social care. Looking to the future, The Five Year Forward View, which provides a blueprint for the development of the NHS calls for an additional £8 billion funding per annum by 2020. The funding gap in social care is estimated to reach £4.3 billion by 2020.

At the time of writing, we clearly need to hear much more detail from the political parties on how, if elected to Government, they would tackle the funding crisis in health and social care.

BGS and the General Election
This is the backdrop against which the BGS secretariat and officers have been engaging with the UK political parties since the new year. The focus has been on the Six Decisions we are asking the next Westminster Government to take to promote excellent healthcare and support for older people. The six decisions include calls for an end to the divide between health and social care and adequate investment in both: http://www.bgs.org.uk/pdfs/2015ne/2015manifesto_summary.pdf. In many respects our involvement with politicians in several of the main parties has been heartening. We have met politicians who are alert to the care needs of older people, well briefed on health and social care issues and who support the need for reform within the system.

Key questions for parliamentary candidates
Nonetheless, the reality is that parties’ plans for the future funding of the NHS and social care remain incomplete. An election campaign offers professionals who know the health and care systems intimately, a chance to make their concerns known to decision-makers. That is why I am prefacing feedback from our political meetings with a call to BGS members to take every opportunity to question parliamentary candidates in your constituencies about their parties’ future funding plans for the NHS and social care.

Now is the time to press, with utmost courtesy, for detail on how parties would close an £8 billion annual gap in NHS funding and a £4.3 billion gap in social care funding by 2020.

The Greens
That said, what have we found in our interactions with politicians? We met Natalie Bennett, Leader of the Greens, in the wake of her party’s annual conference. She had just announced a commitment to free social care for the over 65s and was keenly interested in the training and working conditions of social care staff; the relationship between staff morale and quality of care in the health and social care system; and the maintenance of the NHS as a public health service.

The Greens would earmark an NHS tax to maintain funding at European average levels.

Labour
Andy Burnham MP, Shadow Secretary of State for Health told us that the Labour Party is committed to giving people new rights to care at home, with free social care for those who are at end of life; to the development of a year-of-care tariff for those with complex needs, such as older people with frailty, which would cover all of a person’s care costs over a year; and to personalisation of care which would benefit older people living with frailty, dementia, complex care needs and multiple long-term conditions.

Labour would introduce an annual £2.5 billion
Time to Care Fund to pay for additional GPs, nurses and midwives.

**Liberal Democrats**

**Norman Lamb MP, Minister for Care and Support** (who we met at a panel discussion convened by National Voices) has called for a single government Department for Health and Social Care; for the set-up following the election of a non-partisan commission to examine all issues related to future of the NHS and to engage the public in this discussion; and that, by 2018, every locality would have a single pooled budget and single commissioning for health and social care.

Asked by BGS about the divide between NHS care free at point of access and social care means-tested at point of access as an impediment to delivery of integrated care, the Minister said that, if we were starting now, we would not design the system in the same way. However, there is also a need to be pragmatic and, uncomfortable though it sometimes is, the current arrangement is not ultimately an impediment to provision of good quality care.

The Liberal Democrats have pledged £8 billion a year to the NHS by 2020/21 and an extra £5 million a year to mental health services.

**Conservatives**

In the absence of a face-to-face meeting, the BGS wrote to the Conservative Party requesting comment on their future plans for older people’s health and social care. **The Prime Minister and Leader of the Conservative Party, David Cameron MP** responded. He thanked our membership, saying “Their work is invaluable and I am immensely grateful for all they do”. He stated that there had been a real terms increase of £6.5 billion in funding allocated to NHS between 2010/11 and 2015/16. The Prime Minister highlighted their investment in the Better Care Fund to promote integrated care; the restoration of named GPs for patients; and the Challenge on Dementia 2020 which he launched earlier this year, embodying their commitment to make England the best country in the world for dementia care and support with an increased emphasis on post diagnosis support, and on dementia-specific training for NHS staff.

The Conservatives have promised to continue to ring-fence the NHS budget and to provide real terms increases from 2015 to 2020. An allocation of £5.3 billion from current NHS funding has been promised to the Better Care Fund.

**National Health Action Party**

The National Health Action Party responded spontaneously to the BGS Call to the Incoming Government. **Dr Clive Peddell, on behalf of the Party**, fully endorsed the six decisions set out in the Society’s position paper.

**Make your voice heard between now and the General Election**

This feedback provides a flavour of how each of the political parties is thinking on healthcare and social support of older people. In an election campaign, issues become fluid and positions can shift dramatically and quickly. A good way to keep abreast of party political developments on health and social care is to follow The King’s Fund General Election tracker which is updated regularly: [http://election.kingsfund.org.uk/](http://election.kingsfund.org.uk/).

Finally, I would ask that between now and May 7th, please do take every opportunity to explore with parliamentary candidates in your constituency what their party’s thinking is on the funding gap in the NHS and in social care.

If you have any comments or questions, I would be happy to hear from you.

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**Patricia Conboy**  
BGS Policy Manager  
Tel. 0203 747 6940 and policy@bgs.org.uk
The general election is around the corner but the Wales assembly election is not until May next year. Although health is devolved to the Assembly I believe all countries will recognise the issue facing Wales.

I see considerable merit in the questions for the candidates and next government in the six decisions from excellent health care published by BGS Central. The objectives of the national BGS are reflected in the Constitution of the BGS Wales.

However these look at individual parts of a huge machine that is the NHS and that machine is in serious need of maintenance or a complete overhaul. The recent winter events have caused me to question the strategy of a reduction in hospital beds, investment in community services and a reliance on quality improvement to deal with an ageing population with increasingly complex needs.

I have worked in the NHS since qualifying in 1988 and this is the worst I have ever seen it. When I think about last winter I see hospitals declaring major incidents when dealing with the routine winter workload. I was on call over this period and it was not possible to send people home because they were simply too ill. We had so many sick people in our emergency department we ran out of non-invasive ventilation machines. Primary care was in the same boat with massive demand. In summary the ‘normal’ demand outstripped available services.

Patients sitting in the emergency department were concerned about the wait for a bed but seemed to accept that this is ‘the way it is’. The medical profession did not question the situation. I read an article in the Geriatric Medicine journal about how Accident and Emergency targets had hit the headlines. The title was ‘A&E targets: Nursing levels key to safe care?’ Why is A&E being used as a medical ward in the first place and why was the title not ‘Disgrace that hospital is too full to admit patients’?

I asked our chief executive what the plans were to deal with these pressures in future and I was told it was building community resources and working on quality and patient flows - a message I have been hearing for many years now. ‘More beds’ was not the answer and anyway there were no staff to look after the extra beds. Obviously I was less than reassured by this response and a quote by Albert Einstein came to mind, 'Insanity: doing the same thing over and over again and expecting different results.'

I have serious concerns about the role of intermediate care. And yes, this is heresy. All the patients I saw were too ill to get any benefit from intermediate care. I have sat in meetings where the aim of an intermediate care service was to stop placement in residential and nursing homes, stop admission to the hospital and to facilitate discharge from hospitals. In reality, the funding and resources were not enough to achieve one of these objectives. While patients have been managed in intermediate care environment I get the distinct feeling the needs of those left in hospital is increasing, as by definition they cannot be managed in intermediate care. If we are hoping intermediate care is going to sort out the crisis hitting our hospitals, we should think again.

The only message I heard on the media from politicians was that hospitals were full of ‘bed blockers’. This seems to refer to the people one might call ‘patients’, most of whom are old. Older people are now the NHS core business so how can they be ‘bed blockers'? Patients know hospitals are still the most efficient way to deal with their problems and that is why they are in so much
It is true medical staff are in short supply and who can blame them when faced with the above? Sadly, the enthusiastic role models that encourage juniors to move into senior positions are demoralised and talking about retirement themselves.

Cutting the number of hospital beds and staff with a view to increasing the throughput in those beds is, in my view, better suited to younger patients with a single condition. This is no longer the core business of the NHS. If the NHS hospitals were a private business and had the same demand, would it be contracting that service or expanding and delivering more of it? Why don’t we question this policy of intermediate care? Is it really wrong to admit older patients to hospital to sort out their co-existent social circumstances and medical issues?

Even recently, modernising medical careers has driven juniors to specialise earlier in their training but increasingly frail patients with multiple conditions which bridge those medical speciality silos need doctors who can treat them holistically.

Yes, we must challenge the government, but do we need to ask ourselves some basic questions before we do so? Are we going to accept mediocrity? I hear no counter arguments to the fall in the number of hospital beds. Is the government’s policy of community care and decreasing hospital beds ageist? Why are we still training any specialist who can’t deal with complex medical and social problems? Why haven’t we stood up and spoken out about the dreadful state of the NHS? What is the plan to deal with these problems?

Until we are able to do this I fear the NHS is in the hands of the dubious motor mechanic who charges too much and won’t show you the parts they have replaced. That, as we know, is the garage to avoid.

Antony James
BGS Welsh representative on BGS Policy and Communications Committee

Northern Ireland - what is the significance of the Westminster elections for health and social care of older people in Northern Ireland?

Northern Ireland’s health and social care system is subject to a high degree of political and media interest. The last five years have seen a period of unprecedented scrutiny of the system. The Northern Ireland population is highly reliant on the public sector as an employer with 10 per cent of all employees in Northern Ireland working in the health and social care system on a full or part-time basis (Northern Ireland health and social Care workforce census 2013). The responsibility for the provision of health and social care was devolved from Westminster to the Northern Ireland Assembly, which serves a population of 1.8 million, of whom approximately 250,000 are 65 years and over.

BGS Northern Ireland supports the ethos of Transforming your Care’ (2011) which was a review of the provision of health and social care in Northern Ireland, describing and building a system that placed the individual, family and community at the heart of how things are done. This unfortunately has not been effectively costed and implemented to date. Our hopes are that our politicians will implement advice given in the recent Donaldson report – The right time, the right place (2014) which reviewed the health and social care governance arrangements in Northern Ireland to ensure quality of care provision. We ask that our politicians make courageous but essential decisions regarding re-configuration of health and social care services. This should be above political self-interest and will require active ongoing public engagement and education from all parties involved. We would also ask for a re-design of the commissioning system in Northern Ireland to make it simpler and more capable of re-shaping services in the future. Our concerns are that none of these issues will be effectively addressed.

Key messages on older people’s health and social care to candidates in the elections - seven priorities for action

1. Health Promotion Activity should enable all people to remain physically active and socially engaged as they age.

2. Most health and social care provision should be available through community-based services.
3. No individual should enter long term care (residential or nursing) without being offered the opportunity of comprehensive assessment and rehabilitation by skilled professionals.

4. Individuals living in care homes must have better access to appropriate health care.

5. Palliative care services for older people should be extended equally, to cover a full range of conditions, notably dementias, and must not just be cancer focused.

6. When older people require services in hospital they must have equal and equitable access to the whole range of services they are likely to gain benefit from.

7. Dignity and respect for individual service users should be the central tenet of all Northern Ireland health and social care services.

Are you engaging with candidates
As a group, BGS Northern Ireland has not actively lobbied any of the political parties. Our recent meeting with the former health minister’s representative was unproductive. BGS members have some informal contact with politicians through their work at Trust level and we will continue to raise the issues that are important in improving the health and social care for older people and will be sending our election material to the Northern Ireland Assembly’s Committee for Health, Social Services and Public Safety and to the local political parties. We intend to follow this up with further dialogue with the parties concerned.

Patricia McCaffrey
BGS Northern Ireland representative on BGS Policy and Communications Committee

A call to action from BGS Scotland to the incoming government

Why the incoming Government must act
We know that Scotland’s population is ageing. Older people are more likely to be admitted to hospital as an emergency and to have multiple and complex health problems - unplanned hospital admissions for people aged over 75 increased by 26 per cent in the 10 years to 2013/14.

Healthcare and support services are struggling to cope because systems are not geared to meet the needs of a core user group – older people with multiple long-term conditions. BGS Scotland is therefore calling on the incoming Government to take six key decisions to promote excellent healthcare and support for older people.

Decision 1: Ensure that health and social care integration works for older people
The new integrated authorities need to develop clear plans for the care of older people, particularly those who have multiple long-term conditions. This should include the ability to respond rapidly to crisis situations to avoid unnecessary hospital admissions.

Decision 2: Ensure adequate levels investment in high quality care
The health infrastructure needs adequate investment to ensure primary, rehabilitation and re-ablement services meet the needs of older people and should be focused on maximising independence and minimising moves into care homes.

Decision 3: Develop capacity for health and social care providers to enable high quality care
Older patients are core business for the NHS in Scotland and are entitled to expect high quality care everywhere; the Older People in Acute Care programme has made considerable progress with this but continued support of this work is vital. Budgets for the new integrated authorities need to reflect the requirements for older people’s services of adequate size and quality.

Decision 4: Provide national strategic direction on older people living with frailty, dementia, complex needs and multiple long-term conditions
There should be clear planning for older people’s access to comprehensive geriatric assessment, personalised care plans for treatment and long-term follow-up.

**Decision 5: Support staff across all care sectors to develop competencies in the management of older patients**

One of the keys to the equitable and safe care of older people is the assurance that those caring for them – doctors, nurses, allied health professionals, care attendants and others – have the right knowledge, training, skills and values to deliver the right type of care for this group. The BG S calls on the incoming Government to require the regulatory and advisory bodies to incorporate competencies in the management of older people in their curricula, guidance, and professional and quality standards.

**Decision 6: Measure the dimensions of care that matter to older people and their families**

Performance assessment for service providers should include dimensions of care that matter to older people and their families and carers, and that make a difference to the quality of care provided and the outcomes of care, with evidence of feedback from service users about their experiences of the care pathway.

Jennifer Burns
Chairman: BGS Scotland

A fully referenced version of BGS Scotland’s ‘Call to Action’ is available in html format and in print-ready format, for download and distribution to your government networks. See the BGS Scotland website: www.bgs-scotland.org.uk

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**Perioperative medicine stakeholders’ event**

Royal College of Anaesthetists

On a freezing cold Friday in January the Royal College of Anaesthetists held a stakeholder event launching Perioperative Medicine. Attendance was dominated by anaesthetists but there was a wide representation including from the BGS and the Royal College of Physicians (London).

Their vision is the delivery of integrated care to those undergoing high risk surgery, provided by a perioperative team to enable better patient outcomes and experience within the context of more effective and efficient use of finite resources.

A simple but effective five minute animated film introduced the concept along with a vision document both available on the website www.rcoa.ac.uk/perioperativemedicine

The speakers used powerful statistics: £16 billion spent on surgery each year in the NHS, 20 million referrals for elective surgery which continues to increase year on year, 27,000 undergoing surgery each day of which 700 are high risk. The overall ‘on-table’ mortality lies in the region of 0.06% but with the in-patient mortality at 3.6%. There is also a significant morbidity with up to 15 per cent of those undergoing elective surgery experiencing often predictable and potentially preventable complications with prolonged post-operative morbidity.

Yet it seems that we know the answers, supported by a reasonable evidence base and shown to be cost neutral, if not cost saving, this has been demonstrated by Enhanced Recovery Programmes in a number of conditions, the successes of the hip fracture programmes with widespread implementation of orthogeriatrics and in the Proactive Care of Older People undergoing Surgery (POPS). Jugdeep Dhesi eloquently presented the work of the POPS team and represented both acute medicine and geriatric medicine on the expert panel emphasising the importance of recognising frailty and the benefits of comprehensive geriatric assessment.

It was suggested that the majority of the public would assume that joined up personalised care for those undergoing high risk surgery already exists in the NHS but sadly we know this not to be true. All agreed that it should not be left to the overburdened medical registrar to sort out in the middle of the night.

The future is likely to be Perioperative Medicine. Work on a curriculum, a training programme and workforce planning have already begun. The BGS and the RCP(L) both voiced their support. Those keen to be involved should register their interest at: perioperativemedicine@rcoa.ac.uk

Helen Wilson
Consultant Orthogeriatrician
Alternative Routes to the Specialist Register in Geriatric Medicine

BGS Position Statement

There is a perceived recruitment crisis within geriatric medicine. However, in 2013-14 more appointments to the consultant grade were made in geriatric medicine than any other Physicianly speciality. This is against the background of increasing demand for the services and skills we can offer as specialists in the field of medical care for older people, particularly given our focus on both acute illness, and rehabilitation of older people with frailty.

The British Geriatrics Society has responded to a consultation posing testing the notion of alternative routes which might facilitate non-geriatricians being recognised as, and thus being appointed as, Consultant Geriatricians. The BGS’s Policy and Communications Committee, Education and Training Committee, and the Specialist Advisory Committee (SAC) in Geriatric Medicine considered the question, resulting in the issuing of the following statements:

- It is acknowledged that the title ‘Consultant Geriatrician’ or similar is not protected in law, therefore individual Trusts may already appoint a person from any background into a post advertised as such. The BGS is not in a position to intervene in this. However, to be on the Specialist Register for geriatric medicine, a person needs to have either undertaken an approved training programme, or have achieved sufficient equivalent competencies and experience to be admitted via the CESR route.

- Geriatricians have specialist skills, knowledge and experience in looking after older people. This requires supervised training in a quality-assured and nationally recognised programme, and cannot be achieved simply by having experience of looking after older people.

- The current Certificate of Completion of Training (CCT) and Certificate of Eligibility for Specialist Registration (CESR) routes provide robust, quality assured methods of demonstrating sufficient training and skills to work as a consultant geriatrician. Introduction of a further simplified route onto the Specialist Register for geriatric medicine carries a significant risk of devaluing the specialty. An accelerated CCT is available at the discretion of the regional training committee, which can reduce training duration by one year, if felt to be appropriate.

- Geriatric Medicine is a broad speciality, which welcomes multidisciplinary working amongst differently skilled doctors, as well as allied health professionals. General Practitioner with Special Interest (GPwSI) roles are an existing method for interested doctors, who are not on the specialist register for geriatric medicine, to do more work with older people and have this formally recognised.

As part of its ongoing workforce strategy, the BGS will continue to address recruitment issues within Geriatric Medicine.
In January Thomas Jackson attended a course of the European Academy for Medicine of Ageing. Here he shares his experience and reflections on a stimulating week.

The European Academy for Medicine of Ageing was set up in 1995 as a 2 year course of 4 intensive one week sessions. It aims to bring together mid-career geriatricians from all over Europe and beyond to improve knowledge and to develop “future teachers and leaders in geriatrics”.

With some trepidation I flew into a snowy Munich airport, met with colleagues from across Europe and up the hills we went; the roads getting narrower and the snow deeper. However, any concerns I had were put to rest pretty much immediately. After introductions of new students we were treated to our first Teachers state of the Art Lecture, a tour de force by Professor Jeune from Denmark, about the longevity dividend from which I also learnt a lot of Greek mythology (the Tithinos error anyone? [http://en.wikipedia.org/wiki/Tithonus]). The key to these lectures lay in the 30 minutes of questions and discussion afterwards – something I was initially wary of but found very informative – good quality questions answered by the top people. Following coffee and cake, it was our turn, with four shorter Student State of the art lectures. I had been assigned a talk on Nursing home beds across different European countries, and although nervous I had the consolation that at least English is my mother tongue! These lectures turned out again, to be consistently high quality and we all received very detailed feedback on our performance, as well as feedback on how we responded to questions or indeed, asked them. This was followed by another impressive Teachers State of the Art lecture on studies of longevity. The evening started with a tutorial on beer tasting, and OSCE stations students had developed to introduce us to their countries. Thus, the pattern of the week was set as we rolled on through biology of ageing, geriatric assessment, frailty, sarcopenia, nutrition. The lecture from Professor Olde-Rikkert from Nijmegen using complex systems biology and the concept of tipping points ([www.nature.com/nature/journal/v467/n7314/abs/467411a.html](http://www.nature.com/nature/journal/v467/n7314/abs/467411a.html)) as new concepts in geriatric syndromes was especially good, as was Professor McMurdo’s powerful yet witty descriptions of multimorbidity. Small group sessions included a revealing session on how to peer review as well as a session on different approaches to delivering CGA.

In between all this formal learning was the informal learning. Mealtimes consisted of discussions about everything from geriatrics to the Scottish referendum via variations in child care provision across Europe (we don’t come out well!) Well organised social events mostly included good food and Bayerish beer. A walk through the snowy forest resulted in me wondering what the collective noun for snowball throwing geriatrician was? Reflecting on a high quality week, I think what was most revealing was how other countries ‘do’ geriatric medicine. The general feeling seems to be that in the UK we must be doing it well, but I think we have a tendency to look at ourselves and believe this without really looking elsewhere. Most European countries have been able to design systems around high quality geriatric care, as opposed to trying to fit high quality care into an existing system. There appears to be a much higher emphasis placed on pure comprehensive geriatric assessment (CGA), including assessment scales forming the basis of this – “If you are not delivering the CGA described in the research how do you know it is any good?”. I am certainly envious of having a full 2 hours to deliver CGA in a clinic, or 4 consultants and 11 junior grade doctors managing a 40 bedded acute geriatric unit. Perhaps we need to be more open to how our European colleagues have embraced geriatric medicine in the wake of the pioneering work here in the UK.

EAMA is a true community of practice and one I would strongly encourage people to attend.
The GMC expects doctors to develop and improve their practice by maintaining up to date knowledge and skills through continuing professional development (CPD). It aims to enhance the safety and quality of the care provided across all work areas of a physician’s professional practice. For geriatricians that includes keeping up proficiency in general medicine and pertinent geriatric sub specialities. The BGS has a role in supporting CPD and all meetings organised under the BGS umbrella are authorised for CPD accreditation by the RCP (Royal College of Physicians London).

Of the 86 responders to the BGS’s survey to evaluate how the organisation fares in meeting its members’ CPD needs, 73 per cent were consultants, 16 per cent STRs, 5 per cent career grades, 5 per cent nurses or AHPs, and there was one research fellow. The results will be used to try to improve CPD availability and quality for the BGS members. Furthermore since the survey was undertaken there have been further developments to help CPD on the BGS website, blog, e-bulletins and twitter.

**Bi-annual scientific meetings:** 80 per cent of respondents were satisfied these usefully contributed to their CPD needs

Suggestions for improvement of these meetings from respondents include incorporating more original science material as they are “science-lite”. Additionally some consultants would welcome new sessions covering service provisions, controversies in geriatric medicine and the changing directions in which we need to work. However the programme content of the BGS scientific meetings is obliged to concentrate on topics for CPD through a 5 year cycle as all physicians need to demonstrate 250 hours of CPD over a 5 year period, averaging 50 hours per year. General medical topics with a frailty perspective are deliberately included in the programme to ensure the BGS fulfils its responsibility in maintaining knowledge across all clinical areas of a geriatrician’s work including general medicine.

For the NMC (Nursing and Midwifery Council) the requirement is to attain 35 hours of CPD in 3 years.

Other feedback from the survey included proposals to incorporate more interactive sessions and video enabled presentations as they are well received learning tools.

**Location is the main obstacle given by all grades for not attending more than 2 BGS Scientific Meetings in the past two years**

The BGS tries to address this by rotating the venues across the UK, but inevitably some regions are less accessible than others. The second reason given by consultants was limited staff cover during conferences with all colleagues wanting to attend the same conferences.

The other concern from non-consultant grades was the expense attached to attending these meetings, especially as study budgets for STRs do not cover more than one conference a year. Allied Health Professionals (AHP) felt it necessitated too much time and money for the educational return. Suggestions of an annual conference were proposed by a few but this would be at a variance with the concerns on limited staff cover that
prevented some from attending more frequently.

Special interest group (SIG) meetings: over 55% of respondents were satisfied these usefully contributed to their CPD needs

Typically each SIG either holds its own 6-monthly or annual scientific meeting or provides parallel sessions at the Society’s UK meetings. The feedback varied with some SIGs gaining excellent feedback compared to others. The most popular SIGs attended by those questioned were movement disorders, falls and cardiovascular. However a few respondents felt elite participation, heavy industry sponsorship and poor advertising provided negative experiences of these meetings. Some consultants were disappointed in the coverage of the same topics repeatedly overlooking new advances. AHPs found travel and cost a stumbling block to attending and felt that the meetings were too focused on medical staff, needing more multidisciplinary emphasis to be worthwhile.

Regional meetings: over two thirds of consultants were satisfied these usefully contributed to their CPD needs

The regional meetings are organised locally and the BGS provide support including publicising the events, online registration and co-ordination of abstracts. Several comments emphasised that the success of these meetings depended on the enthusiasm and commitment of the organisers. Several consultants in this survey experienced discontent that the BGS assistance is not being fully utilised and felt that this may contribute to the reduced quality of the teaching. One AHP proposed an Internet based regional meeting to attain CPD points and to limit travel and costs.

Positive suggestions for improvement included more regular regional meetings that concentrate on a dedicated CPD programme which, if set nationally, could free up the Society’s scientific meetings to incorporate more science.

Age and Ageing: 92 per cent of consultants and 92 per cent of STRs were satisfied the journal usefully contributed to their CPD needs

Age and Ageing is primarily an international scientific journal published by the BGS comprised of original articles and commissioned reviews on geriatric medicine and gerontology. Its range includes research on ageing and clinical, epidemiological and psychological aspects of later life. The clinical reviews are favourably welcomed by both consultants and STRs and some of those surveyed suggested there could be a greater clinical emphasis within the journal, especially in relation to best practice. Some responders wanted more articles on service improvement to provide added value of the journal to everyday practice. In this regard the editor of Age and Ageing Professor David Stott is keen to encourage submission of high quality health service improvement evaluations. Intending authors should look at extensive guidance for different study types on the EQUATOR network (Enhancing the QUAlity and Transparency Of health Research; www.equator-network.org).

CME journal: over 80 per cent of respondents were satisfied with the journal contributing to their CPD needs

Sadly the next edition of CME in Geriatrics Journal will be the last one. Many respondents considered the journal useful for teaching and valued the review articles in particular. The STRs surveyed felt it to be of high quality and very relevant to practice development. The MCQs were valuable to consolidate learning but many needed more “evidence” of CPD attainment for their portfolios such as printable certificates. One AHP felt the journal was not suitable as it is too targeted towards medical staff. The BGS would like to thank Professor Duncan Forsyth, the last editor of the CME in Geriatrics and the previous editors (Professor Steve Allen and Professor Mike Vassallo) for their hard work over the years.

Other sources of CPD accreditation are available

There are many other methods of attaining CPD accreditation outside the BGS and feedback from the survey implied most respondents chose resources based on location and cost. Thirty-three out of 47 consultants who replied to this question used the RCP (London), RCP (Edinburgh) or its published journal: Clinical medicine. The RCP organises local events, has a dedicated CME section in the journal and the RCPE provides educational online modules. The BMJ (British Medical Journal) group is the next favourite with consultants; it provides journals, BMJ learning online and BMJ masterclasses. Both organisations provide good coverage of acute general medicine, are easy to use and provide flexible education through online learning. The UK Stroke forum
and specialist stroke meetings are popular for those specialising in this field. Other organisations specialising in geriatrics also provide CPD accreditation such as the EUGMS (European Union Geriatrics Medicine Society) and IAGG (International Association of Geriatrics and Gerontology).

For STRs regional training days in GIM, the British Association of Stroke Physicians and online general medical modules again especially from RCPE provide additional resources.

Eleanor Lunt
Specialist Registrar, Nottingham

Tahir Masud
BGS Vice President in Education and Training

There are an estimated 400,000 older people resident in care homes across the UK, many of whom experience a high level of unmet need and unacceptable levels of variation in the quality of care they receive. Residents of care homes have complex healthcare needs, reflecting multiple long-term conditions, significant disability and advanced frailty. Care provided to this complex cohort of people is often fragmented. Day to day care services are delivered to a variable standard, often with high staff turnover and limited support from the wider health system.

NHS England Guidance: Safe compassionate care for frail older people using an integrated care pathway states that, 'Healthcare for care home residents should be an actively commissioned service, with clear specifications linked to quality outcomes and contractual obligations'.

The British Geriatrics Society recommends a multi-disciplinary approach to such commissioned services, including consistent access to specialist community nursing and a range of allied health professionals.

The report Quality Watch (a major research programme providing independent scrutiny) published a document, Focus on: Hospital admissions from care homes in January 2015. This report, which routinely collected information on hospitalisations from care homes, could be used to enhance the understanding of hospital use by care home residents and thus target areas for shared learning and improvements.

The report used Hospital Episode Statistics (HES) covering the period April 2011 to March 2012, looking at hospital admission rates from 17,459 care homes compared with the over 75s in the general population.
The health problems recorded on admission to hospital were different for patients who were living in a care home, pneumonia, dementia and epilepsy being 3 times more common compared to the general population aged 75 or over. Other more common reasons for admission from care home residents include sepsis, head injuries and hip fracture.

In areas incorporating care homes where hospital admissions were high, there was a greater proportion of instances where patients had 3 or more admissions in a year (as opposed to the higher rates being because more patients had single admissions). There was also significant variation in admission rates between areas containing care homes, with an average of 0.45 admissions per bed for care homes offering nursing services and 0.59 admissions per bed for residential homes.

Successful models
Ashford and St. Peter’s NHS Trust started a care home project in April 2010 with three nursing homes that had the highest number of multiple admissions. This was expanded to twelve nursing homes from April 2011 – Oct 2012 using four interventions which led to a 35 per cent reduction in hospital admissions. The interventions included geriatrician review and telephone advice, end of life care and intravenous therapy. This incorporates some of the findings noted in the Quality Watch report.

The report mentioned a great proportion of instances where patients had multiple admissions (a patient was admitted 31 times in a year). A Sussex model identified high risk groups and with community matrons using telehealth, they reduced admissions by 75 per cent.

Another successful model is the Airdale project whereby the hospital used experienced nurses to provide a 24 hour teleconsultation for residents in care homes, using shared electronic health records. This led to a 45 per cent reduction in hospital admissions.

It is widely accepted that good quality preventive care in the general population can reduce the frequency of health crises that require hospital admission. There is no reason why that idea does not apply to people in care homes. Innovative care home models should look at community based chronic disease management, especially for the small number of individuals having multiple admissions (using telehealth where applicable). End of life care, provision of comprehensive geriatric assessment on admission with personalised care plans, regular medication review, falls risk assessment and regular access to geriatricians should also be considered.

Radeliffe Lisk

References
1. British Geriatrics Society (2011) Quest for Quality
5. R. Lisk, R. Nari, K. Yeong, (2014) Geriatrician input into 12 care homes reduced emergency hospital admissions which was maintained with education & training of GPs and care home staff. Age Ageing 43 (suppl 1):

*Caveat: The findings are based on non-controlled studies.
**BGS SENIOR OFFICER VACANCIES**

**Deputy Honorary Secretary of the British Geriatrics Society**

Expressions of interest are invited for the post of Deputy Honorary Secretary to take office from October 2015. **Nominations must reach the BGS by midnight on 15 May 2015.** As the Deputy Honorary Secretary automatically succeeds the Honorary Secretary, the Deputy Honorary Secretary may be called upon to undertake some or all of the Honorary Secretary’s duties should the Honorary Secretary be absent.

Subject to endorsement by the membership at the AGM in October 2015, the term of office for the Deputy Honorary Secretary is 2 years, followed by a further two years at Honorary Secretary.

**Duties include:** acting as editor of the BGS Newsletter (with significant support from the Sub-Editor who is a member of the BGS Secretariat); liaising with external organisations (Department of Health etc.); assisting BGS secretariat with enquiries from the press and public; playing a key role in strategic planning and projects; responding to consultations on behalf of the Society.

Expressions of interest should be accompanied by a short career summary and a brief indication of how the candidate would approach the requirements of the role. Submissions via email are acceptable.

For more details, see the BGS Website [Select About Us/BGS vacancies] http://www.bgs.org.uk/index.php/about/bgs-vacancies/2538-hon-secretary-jd

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**Deputy Honorary Meetings Secretary of the British Geriatrics Society**

Expressions of interest are invited for the post of Honorary Deputy Meetings Secretary of the British Geriatrics Society, to take office from October 2015.

**Nominations to reach the incumbent Meetings Secretary (Email: conferences@bgs.org.uk) by 30th September 2015.** As the Deputy Meetings Secretary automatically succeeds the Meetings Secretary, the attributes for the Meetings Secretary apply to the Deputy who may need to act for the Meetings Secretary in their absence. The term of office is 3 years followed by a further 3 years as Deputy Meetings Secretary.

**Nominations Procedure:** Nominations should consist of a brief CV, together with a statement from the nominee supporting their application, not to exceed one A4 page in length. In addition, there must be a supporting citation from the relevant region or national council.

Whilst this is a demanding role within the Society, it is also tremendously rewarding, as it entails working with enthusiastic clinicians and representatives from related organisations. The role is strongly supported and assisted by the Conference and Events Team plus other BGS staff and past office holders.

For more details, see the BGS Website [Select About Us/BGS vacancies] http://www.bgs.org.uk/index.php/about/bgs-vacancies/2539-jobmeetingssec

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**BGS EVENTS REGIONS AND SIGS**

**BGS North East Thames**
22 April 2015, North Middlesex University Hospital Academic Centre, London

**BGS North West Branch**
27 April 2015, Education Centre at the Royal Oldham Hospital

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

**BGS Scotland Spring Meeting**
14 - 15 May 2015, Peebles

**BGS Northern Ireland**
21 May 2015, Ramada Plaza, Shaw’s Bridge, Belfast

**BGS North West Thames and North East Thames Regional Meeting**
17 June 2015, Royal Free Hospital, London

**BGS Trent**
8 July 2015, East Midlands Airport, Derby

**Joint meeting of the European Delirium Association and BGS Special Interest Group on Dementia and Related Disorders**
3 - 4 September 2015, Waterloo Campus, King's College, London

**BGS Falls and Postural Stability Conference**
11 September 2015, Hilton, London Wembley

**BGS Oncogeriatrics Special Interest Group**
18 September 2015, London

**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 posts of Vice President for Academic Affairs and Vice President of Clinical Quality will fall vacant in October 2015. Expressions of interest are now being invited for these positions. We would like to recruit early in order to allow for a full handover with the current post holders.

**The Vice President for Academic Affairs** is responsible for leading the BGS’s work in scientific and clinical research, and for developing the Society’s scientific and education event programme. The Vice President for Academic Affairs also needs to work closely with the Vice President for Education and Training.

**The Vice President for Clinical Quality** is responsible for leading the Clinical Quality agenda for the BGS. This involves work aimed at raising standards of health care for older people through standard setting, development of quality assurance tools and quality improvement activities.

These are voluntary, unpaid roles, though travel costs and other expenses will be covered.

The anticipated time commitment is up to one day a week, but this may vary according to the demands of the role. **The Vice President for Academic Affairs** is Chair of the Academic and Research Development Committee. The **Vice President of Clinical Quality** is Chair of the Clinical Quality Steering Group (which is the main decision making and executive group for clinical quality). Both post holders will also be expected to attend meetings of the BGS Trustee Board. Administrative support will be provided by the BGS secretariat. The BGS will facilitate teleconferencing where possible to reduce travel time in attending meetings.

Those interested in discussing the purpose and activities of these posts in more detail are invited to contact the BGS President, Professor David Oliver

Those interested in applying for the posts are asked to contact Mark Stewart, Committees and Membership Manager on 0207 608 8575 (email: committees@bgs.org.uk). The closing date for the receipt of applications in the form of a short expression of interest and covering CV is midnight on the 15 May 2015.

Full job descriptions are available on the BGS website [Select About Us/BGS vacancies]


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](http://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.

**Ageing and Degeneration: A Physiological Perspective organised by the Physiological Society**

**10 April 2015 - 11 April 2015**

**Royal College of Physicians, Edinburgh**

The Society’s Theme for 2015 is ‘Understanding Ageing’. To complement this, the scientific organisers, detailed below, have brought together leading researchers to discuss the mechanisms behind ageing and its impact on our body and brain. Topic Meetings offer an opportunity for you to meet investigators working directly in the topic to forge new collaborations, and exchange scientific ideas.

See [www.bgs.org.uk](http://www.bgs.org.uk) [Select Events/External Events]

**EDINBURGH COURSE IN GERIATRIC MEDICINE**

**25-29 May 2015**

**Royal College of Physicians of Edinburgh**

This five-day course is aimed at physicians from around the world who specialise or have a major interest in the care of older people. Targeting doctors at consultant or senior trainee level, the course includes update lectures by expert speakers on topics of current and practical relevance, with frequent opportunities for interactive case-based learning. Places are limited, thus maximising opportunities for interaction.

[www.bgs.org.uk](http://www.bgs.org.uk) [Select Conferences and Events/External Meetings]

**COMORBIDITIES OF HEARING LOSS**

**A British Society of Audiology Twilight Series Meeting**

**23 April 2015, Wrexham Wales**

See [www.bgs.org.uk](http://www.bgs.org.uk) [Select Events/External Events]

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The headline item for us has been the lead-up to the General Election. We’ve produced a pre-election BGS position paper, now available on our website in both long and short versions, which asks the incoming Government to take six key decisions relating to older people’s care.

This document is geared towards the healthcare systems in England and Wales, but it also covers a number of UK-wide issues; we’re also working on tailored versions of the document for Northern Ireland and Scotland.

As she’s explained in her newsletter column, Patricia Conboy and other colleagues have been busy meeting MPs and Government ministers, highlighting the key problems facing older people and offering expert guidance from the BGS on how to improve standards of care. This has been supported by broader media outreach: we’ve publicised the campaign’s launch in the media, David Oliver has appeared next to Norman Lamb MP on LBC Radio, focusing on questions around health and social care, and we’re working on a series of BGS blogs covering each of the 6 decisions in our policy paper.

We’d be thrilled for BGS members to get involved by contacting their local MPs and prospective parliamentary candidates, asking them to focus on high-quality care for older people and work with the BGS to deliver this.

One of the easiest ways to help, if you’re active on social media, is to tweet your local MP and political parties with the hashtag #6decisions, linking to the election paper on the BGS website, and letting them know that the BGS is keen to work with them! This doesn’t have to happen via Twitter, of course: you could send them a Facebook message or email them too.

If communicating digitally isn’t your thing, then writing to your local MP as a constituent would be fantastic, as would asking a question if you’re attending a hustings or debate, or mentioning the BGS if a candidate is canvassing in your neighbourhood! If you’d like some glossy printed copies of the policy paper to help you do this, please contact communications@bgs.org.uk and I’ll be happy to post some out to you.

BGS and the media
Beyond the launch of our general election materials, Dr Eileen Burns appeared on BBC Breakfast to discuss meeting the challenges of an ageing population; Dr James Woodward provided a geriatrician’s perspective on questions from GPs in a recent issue of Pulse; we’ve put out press releases on the latest Age & Ageing research covering the assessment of depression and new patient-report experience measures in Intermediate Care. We also ran a day of media training for members willing to be put on the spot when the Society gets media enquiries.

New partners
We have been working hard to build new alliances including signing up as partner with two relatively new campaigns. The first, John’s Campaign, is led by journalist and author Nicci Gerrard: it looks to improve hospital visitation rights for the family and carers of people with dementia, to ensure that patients have the emotional support they need throughout their stay. The second, the Coalition for Collaborative Care, seeks to draw together expertise from organisations across the health, social care and voluntary sectors to improve care for older people.

Finally, we’ve been busy on social media: the BGS blog has featured pieces recently on deprescribing (from a new Age & Ageing paper), perspectives on the BGS leadership conference from a geriatrician based in Canada, a film review of Still Alice and a particularly striking piece by Adam Gordon on the thorny issue of challenging poor care at the same time as celebrating excellence.

As always, if you’re interested in blogging for the BGS we’d love to hear from you: please get in touch if there’s a subject close to your heart, and we’ll help you tell the world about it!

Ed Gillett
BGS Communications Manager
Older people in acute care
Scotland’s programme of improvement

‘Improve care for older people in acute care by March 2014.’ This was the request made to Healthcare Improvement Scotland (HIS) in April 2012. From an improvement perspective this felt like an ‘end world hunger’ type of target! Given that the vast majority of patients in hospital are over the age of 65 and these numbers are predicted to increase by 50 per cent over the next 20 years we needed to focus this work by identifying where there were shared priorities and opportunities for improvement.

Focus on delirium
Health Service Researchers supported us with scoping the initial parameters for this work through a review of the evidence, including published evidence and looking at the themes emerging from inspection reports as well as consulting with a wide range of stakeholders. What quickly became apparent was that the care of frail older people coming into hospital was a growing area of concern across NHS Scotland. Opportunities for improvement emerged in relation to the identification of frail older people in order for their care to be planned and managed appropriately. Colleagues in the Scottish Delirium Association (www.scottishdeliriumassociation.com/) were developing a delirium pathway at the time that we were scoping this work and were keen to work with us. Consequently we concentrated on identifying and responding to the needs of frail older people with a specific focus on how we identify and manage delirium.

Evidence tells us that making sure frail older people get the right care in the right place at the right time can have significant benefits in terms of things like length of stay and admissions to long term care. There are also cost benefits, not just monetary costs but critically human costs around the individuals’ experience of care. While delirium is often linked to frailty that’s not always the case and we know that delirium often goes undetected and that failure to detect it is again associated with worse outcomes such as increased risk of dementia, increased length of stay in hospital, increased risk of new admission to long-term care and even death.

The identification and management of frail individuals and/or those with a delirium is complex and the initial focus of this work has been on ensuring reliable processes are in place to support improved outcomes. A number of resources have been developed and tested in collaboration with clinicians across Scotland to support both the identification and management of frailty and delirium.

Including patient and carer experience of delirium was key in shaping the ‘TIME’ to think delirium bundle. TIME refers to triggers, investigations, management and critically engagement of family and carers. How often do we hear phrases like “This isn’t my Mum” or “I don’t recognise my Dad”. The value of listening to family members can’t be underestimated. Our recent ‘Focus on Frailty’ report (http://nhsscotlandevent.com/sites/default/files/EF25.pdf) highlights a number of case studies focused on improving care of frail older people.

A collaborative approach has been adopted to bring together healthcare teams from across Scotland to test out changes, share and spread good practice and provide improvement support. There are 14 territorial health boards in Scotland with test site teams in each board working with us. Capturing and sharing existing good practice has been hugely valuable. Although teams are at different stages in their improvement journey what is very evident is the shared commitment to improving older people’s acute care and to learning from each other. A number of national events have brought teams together from across Scotland to facilitate that sharing of ideas, experience and expertise. Feedback from these events has shown that they are a real catalyst for teams to take learning back to their own areas of work and test out improvement ideas. Individual teams are gathering data and showing real progress in terms of building reliable processes and these are being reported through local flash reports.

Tools, resources and further information including the frailty report and delirium study highlighted above are all available on our community web-site (www.knowledge.scot.nhs.uk/improvingcareforoldepeople.aspx).

Penny Bond
Improvement Support Team Leader
Healthcare Improvement Scotland
Writing for the Observer, Nicci Gerard, journalist, writer and originator of John’s campaign says: For a long time there was a stigma about cancer. There is still a stigma about dementia. People hide it from their friends and from themselves, because it is frightening and it feels in some way shameful: the diminution of control over one’s life, the self’s loss of the self, the mind’s disintegration and the solid ground breaking up. It is what we most fear for those we love and for ourselves, and so we often try to hide from it.

The introduction to Nicci’s John’s Campaign website reminds us that the battle to enable a parent to stay with a sick child in hospital was won over fifty years ago by the campaign group Mother Care for Sick Children, and current NHS advice to parents is now clear: “Stay with your child as much as you can.”

People with dementia are not children, Nicci goes on to say. They are adults with a lifetime’s experience. Their needs are more complex, yet they are not entirely dissimilar. They are vulnerable and they can be as distressed and disoriented as a child. Their ability to understand and communicate with strangers may be reduced by factors such as deafness or poor eyesight as well as by mental impairment. They may have mobility and continence problems in addition to whatever medical condition has made hospitalisation necessary. The effect of a hospital stay can be catastrophic for a person with dementia — as it was for the man whose experience prompted this campaign, Nicci’s father.

[His condition followed] a slow decline with accelerations when he was ill or upset. At the beginning of February 2014, aged 86, he went into hospital because he had infected leg ulcers which weren’t responding to antibiotics. He was there for five weeks during which time he deteriorated drastically. He went into hospital strong, mobile, smiling, able to tell stories about his past, to work in his garden and help with things round the house. He was able to feed himself, to go the lavatory, to keep clean, to have a good kind of daily life in spite of his Alzheimer’s. He came out skeletal, incontinent, immobile, incoherent. He required 24-hour care and barely knew those around him. He wore a nappy, could not stand up or walk, could not lift a mug to his mouth or put words into a sentence.

His family feel certain that if he had not lain for five weeks in hospital without people he knew to tend and comfort him, he would not have descended into such a state of incapacity. The individual nurses and doctors were kind, conscientious, respectful, but they had other patients so of course they couldn’t sit and talk to him, read to him, make sure he ate, hold his hand, keep him attached to the world.

Writing about her father’s experience - Nicci refers to it as trying to rescue her father who is now beyond rescue - she and Julia Jones, her co-campaigner, announced John’s campaign which lobbies to give carers of demented people the right to accompany them in hospital in the same way that parents of ill children may do. These carers could feed their loved ones, keep them mobile and ‘be their voice and memory bank, anchoring them to the world’.

The response to the campaign was, says Nicci, ‘inspiring
and heartbreaking in equal measure.

‘The 84-year-old wife who had to travel by taxi to visit her husband for the two-hour slot and who wasn’t allowed to stay for Christmas dinner; the son battling to keep his frail mother out of hospital after his demented father died there; the patient who lost 66lbs in six weeks; the daughter whose father was in hospital for 14 weeks (“four bare walls and a sink”), where “the plug was pulled” on his life. Stories poured in, full of anger, guilt, powerlessness and loss, ones of encouragement, optimism and advice, and they are still coming. It seems that everyone we meet has a tale to tell and that we have reached a point in our ageing society where no one is untouched by the blight of dementia.’

Nicci emphasises that the people contacting her do not attach blame to staff in the hospitals. It is recognised that they are coping as best they can in ‘an unsustainable situation.’

The campaign is ongoing. Nicci had argued, “there is a door that has to be opened – pulled by hospital staff, pushed by the public”. She and Julia have visited NHS trusts and dementia organisations up and down the country, lobbying and persuading. What they have discovered is that in many hospitals the door is more than ajar, and in a few it is already wide open. We hope that by making her campaign known amongst our membership, it will become general policy within hospitals that carers of people with dementia can make their sojourn in hospital considerably less destructive than it might otherwise be.

Recia Atkins
Newsletter Sub-Editor

The Bobby Irvine Memorial Library

Bobby Irvine (1920-2002) was a popular and widely respected President of the BGS. The Society’s newsletter of March 2003 contained extensive appreciations of his achievements. Among his many qualities was his interest in the Society, recording its history and documenting the lives of past members. It was therefore very right that the BGS library should be named after him.

The library is located in the basement of the offices of the British Geriatrics Society at Marjory Warren House in London’s St John’s Square. Advice on its maintenance and upkeep was obtained following a visit from a representative of the National Archives in 2010. The contents have since been reorganised to concentrate on UK developments in the care of older people. When finances allow, it is hoped that some material will be moved to the ground floor where it will be displayed in appropriate shelving and the current card index of books will be made available on the web.

What is available in the library?
• BGS records from the beginning. These include minutes of council, executive and treasurer’s meetings, membership lists, newsletters and accounts of regional meetings. BGS Scotland seems particularly active in this respect.
• BGS members. There is wealth of material about early members in the ‘Hall of Fame’, including Trevor Howell’s unpublished autobiography. Unfortunately, we lack input from current members who only need to complete a form. This information makes life much easier if and when we have to write about you!
• Donated papers and publications of past/current members, including amongst others, Lord Amulree, George Adams, John Brocklehurst, Trevor Howell and Booby Irvine. We now have many textbooks on geriatric medicine!
• Official papers and documents from the Department of Health and others.
• Back copies of Gerontologia Clinica and Age and Ageing
• A large range of books either written by members or donated by them from their own collection
• An excellent selection of photographs: mainly of members rather than events
• And, of course, there is much material on the Society’s archive website.

Members of the Society who wish to visit the library are welcome to do so. Please contact Mark Stewart, BGS Committee and Membership manager, on 020 7608 8575 or by email: committees@bgs.org.uk.
Charting the course of philanthropy in the care of older people (and why it is important)

For some years, the BGS has benefitted from the research of Michael Denham, past President of the British Geriatrics Society. We asked him to tell us why he became interested in history in general and in the history of philanthropy in the British Isles in general.

I was attracted to history at school when I was taught about the Peninsular War. I ‘devoured’ the books of C. S. Forester and the stories of Hornblower. I thoroughly enjoyed reading Lord Macaulay’s History of England. Clinical activities dominated later years but my interest reigneited when I researched the death of my grandfather who was killed in the last days of the Passchendaele campaign. Now his memorial is one of almost 35,000 names of officers and men on the wall at Tyne Cot ‘to whom the fortune of war has denied a known and honoured burial’. This fired a desire to visit other battlefields mainly of the First and Second World Wars.

I let my ‘imaginary forces’ work, for example, when with eyes half closed I stood on the walls of Troy and visualised the forces of the Greeks and Trojans. Similarly, when standing on the Lion’s Mount at Waterloo it was possible to ‘visualise’ the fighting, the noise, the smell of gunpowder and the carnage. I experienced other emotions when standing on the Dunkirk beaches and ‘saw’ the lines of men standing patiently in the sea awaiting pick up. Quite different sensations occurred when sitting in the corner of the front row of the prisoners’ pew in the main court in Nuremberg, which was where Herman Goering had sat. It is difficult to express my feeling when I stood exactly where Hitler stood on the saluting dais in Nuremberg and visualised those massive disciplined ranks of Nazi troops, so well seen in Leni Riefenstahl’s 1935 film ‘Triumph of the Will’. Then there was Churchill’s funeral procession. As it passed me in the Strand on that very cold day of January 30th 1965, I was aware that history was passing by.

How did I acquire my interest in the history of the care of older people? It began for two reasons. The first resulted from visits I made as a seconded member of Health Advisory Service teams. At Joyce Green hospital in Dartford, Kent, you could see the remains of the wartime emergency wards, the tramway for horse drawn ambulances used to transfer patients from the riverside Long Reach hospital to Joyce Green, and the stalls for the horses. At Dorchester, I was shown the gateway of the workhouse through which Tess of the d’Urbervilles would have passed. The rear of the Old Windsor hospital was the site of the work area of the workhouse. Along one side was a wall with holes for a grill. It was here that men had to break up large stones to a size to pass through the grill to earn their hammock and food for the night. On the other side of the area were the outhouses where the hammocks were slung...
from hooks in the rafters, which were still visible. In East Anglia, old workhouses still exist and in one case were used for young chronic sick patients. The old workhouse at Gressenhall, near East Dereham, is now a museum and gives an idea of the life inmates experienced in Victorian times. My second reason for interest resulted from my work for a PhD on The history of geriatric medicine in England. I enjoy researching and reading while attempting to write concise clear English and avoiding ‘management speak’: if only I could emulate the prose of Lord Macaulay!

**Philanthropy and the care of older people**

Disquiet about inadequate care of older people goes back many years and early legislation is probably well known. Suffice to say that in the very early times people had to work until no longer able to do so and, if ill, would use home remedies, visit the local herbalist or seek assistance from the local monasteries. The latter ceased in the 1530s when Henry VIII experienced his dynastic problems. Pressure to resolve the situation led to the passage of the Poor Law Act in 1601. Outdoor help and indoor relief, via almshouses and/or workhouses, were provided. In 1834 the Poor Law Act was amended, outdoor relief was curtailed and smaller parish workhouses were amalgamated into larger unions.

**The workhouse system**

The general approach in the Victorian era was to discourage admission by making the buildings and regime very grim. Indeed some workhouses looked like prisons, although eminent architects, such as Sir George Gilbert Scott, did design more attractive accommodation. Once admitted, the new inmates found that sexes and families were separated. Their clothing was removed and disinfected. All had to wear the workhouse uniform, which had a red or blue cloth badge with the letter P together with the initial letter of the parish. The daily routine meant getting up at 6 a.m. in summer and going to bed at 8 p.m. The meals consisted mainly of gruel, bread and cheese with meat only provided twice a week. Discipline could be quite severe for those who broke the rules. The stigma of admission was emphasised when, following the birth of a child, the registration address was given as the workhouse. This requirement ceased in 1904, when an innocuous street address was substituted. If a resident died and there were no next of kin to organise a funeral, the authorities arranged a pauper’s funeral. The body would be wrapped in a cheap sheet and placed in an unmarked grave, sometimes in non-consecrated ground. It was no surprise that Beatrice Webb, the great social reformer, declared that few objects attracted such universal hatred and hostility as the old workhouse. Admission was the solution of last resort.

**Workhouse scandals**

In the mid-1840s, scandals were reported in workhouses of which those at Andover and Huddersfield were the most infamous. Little good seems to have resulted from published accounts, because in 1866 the *Lancet* launched its own Sanitary Commission. This stated that state hospitals in workhouses were closed to observation and contravened the rules of hygiene. The fate of the ‘infirm’ inmates of crowded workhouses was lamentable in the extreme because they led a life, which was like that of a vegetable, were it not that it preserved the doubtful privilege of sensibility to pain and mental misery. Further, if all the infirm were medically treated, many would recover.

**The dawning role of philanthropy and the emergence of radical ideas**

The government set up a Royal Commission on the Poor Laws and the Relief of Distress in 1905. The Minority report, largely written by Sidney and Beatrice Webb, assisted by a certain William Beveridge, envisaged the creation of a welfare state. Although largely ignored by the then Liberal government, it proved influential in the long term with the founding of the Labour party, the launch of the Beveridge report and foundation of the NHS. George Lansbury, a member of the Minority Report, became a Labour politician, wanted to see the end of the workhouse with more generous poor relief and later edited the *Daily Herald*.

The chorus for change intensified. Edwin Chadwick, a lawyer, contributed to the 1834 Poor Law Amendment Act and published *The Sanitary Conditions of the Labouring Population* in 1842. He demonstrated a direct link between poor living conditions with disease and life expectancy, which led to the 1848 Public Health Act. This established the general Board of Health with Chadwick as the first director. Local Boards of Health were encouraged to appoint a Medical Officer, to provide sewers, inspect lodging houses and check food offered for sale.

Others took up the cudgel. Charles Booth...
described working class life in London at the end of the 19th century. He was a cousin of Beatrice Webb and worked with Seebom Rowntree helping to improve conditions for his employees, establish old age pensions and free school meals for the poorest children. Lord Shaftesbury found that the condition of inmates in some lunatic asylums was worse than the vilest workhouses and targeted reform of the Lunacy laws. He also campaigned to improve the life of poor children by reducing their working hours, preventing them climbing chimneys and improving their education. Jeremy Bentham believed in relief for the poor and that everyone should be free from starvation. Working should be more attractive than not to work. Dr Joseph Rogers crusaded to improve medical care in workhouses. At that time, medical officers working in workhouses had to pay out of their own salary for the medicines they prescribed to patients. Florence Nightingale advocated improvements in the care of the sick poor.

Conditions in lodging houses around the 1900s concerned Lord Rowton, a lawyer and Benjamin Disraeli’s long serving private secretary. The unhealthy and squalid character of the common lodging-houses gave him the idea of a new form of a poor man’s hotel, where accommodation, tiled washrooms with hot and cold water, footbaths, washing troughs, drying facilities, large dining room, a library and clean sheets on the beds would be offered at the lowest price. He used £30,000 (equivalent to over £3 million in present day money) of his own resources to create this new accommodation. George Orwell, who stayed in a Rowton house in 1933, gave them his seal of approval.

Religious organisations added their energies. The Society of Friends or Quakers set up workhouses to provide accommodation for aged friends, employment for wearers and education for children. The Salvation Army, founded by Catherine and William Booth, set up short term accommodation for the homeless, which provided food and shelter including ‘penny sit up’, ‘two penny hang up’ and the intriguing ‘four penny coffin’. Their present day philosophy states that the older generation ‘deserve to be treated with dignity, have a say in what they want, to receive care when they require it and to have the opportunity to retain as much independence as possible’. What more needs to be said!

Reformers with literary/artistic talents used them to good effect. For example, Charles Dickens wrote Oliver Twist. Anthony Trollope published Jesse Phillips: a tale of the present day, which described scenes in the workhouse. George Sims composed Christmas Day in the workhouse in 1879. It proved popular, although vigorously attacked, as ‘a mischievous attempt to set the paupers against their betters!’ Much later George Orwell published his essay The Spike in 1931. Sir Hubert von Herkomer painted several canvases portraying life in the workhouse particularly Eventide: A Scene in the Westminster Union a (workhouse) in 1878 and Hard Times in 1885.

This slow inexorable march of democratic forces, which targeted the abolition of the workhouse and the institution of a welfare state, almost achieved success with the 1929 Local Government Act, which was introduced to Parliament by Neville Chamberlain. It abolished the Board of Guardians, who administered workhouses, and transferred their responsibilities to local authorities, who were expected to develop a hospital service as part of an integrated public health service. Furthermore, they were encouraged to take over Public Assistance Institutions (the old workhouses), which is how Marjory Warren came to start her life’s work.

Perhaps it is fair to say that this was ‘the end of the beginning’. Full abolition of the workhouse had to wait until after the Second World War when philanthropy would play a powerful but different role.

Michael Denham