



Fit for Frailty Part 2



commissioning services for frail older people

Much of the current effort in commissioning services is focused on finding ways to reduce unplanned emergency hospital admissions.

While there is little evidence for a programme which targets those at highest risk of hospital admission, systematic reviews of interventions in patients with frailty (as opposed to long term conditions generally) have demonstrated improvement in several outcomes including reducing hospital stays, maintaining independence and reducing care home admissions.

The British Geriatrics Society's recent campaigns have all centred around raising awareness of frailty as a condition which is not an inevitable part of ageing; is dynamic by nature (in a single individual with frailty, function can improve or deteriorate depending on several factors related to the frailty), and by failing to identify and manage frailty, a patient with the condition risks considerable harm and disability. We have *Frailsafe* - the protocol for identifying frailty in the patient who presents at A&E; *Fit for Frail (Part 1)* - guidance aimed at

health care professionals who do not have specialised knowledge of geriatrics but who come into contact with older people in community settings; and now, *Fit for Frailty (Part 2)* - *guidance for developing, commissioning and managing services for people living with frailty in community settings.*

The audience for the guidance includes GPs, geriatricians, Health Service managers, Social Service managers and Commissioners of Services. *Fit for Frailty Part 1* was produced in association with Age UK and the Royal College of General Practitioners (RCGP). For Part 2, the RCGP co-authored the guidance.

Despite the evidence for improved outcomes when people with frailty are correctly managed, there is no code for frailty in ICD10, hence it is not recognised as an important issue in secondary care.

The BGS *Fit for Frailty* guidance (both parts) emphasises the necessity for understanding what



Fit for Frailty Parts 1 and 2 may be downloaded from the BGS website: <http://www.bgs.org.uk/index.php/fitforfrailty-2m> (or select Resources/Campaigns)

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for better health in old age

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frailty is and the risks attendant on failing to identify the condition, Part 2’s particular focus is on the infrastructure required to manage frailty; the need to look for and identify the condition and it sets out the principles whereby services may manage the condition.

While there may be some overlap between the management approaches of people with multi-morbidity, disability and those with frailty, both the BGS’s Fit for Frailty campaigns emphasise that the differences are important and outline the reasons why frailty needs specific consideration. Some people whose only long term condition is frailty, says both documents, may not be frequent users of health services. They may not be well-known to their GP until they become bedbound, immobile or delirious as a result of an apparently minor illness. The relationship between dementia and frailty is also important. People with dementia have an increased incidence of frailty and people with frailty have an increased incidence of dementia. People with frailty may, however, have cognitive problems that fall short of the definition of dementia and which may be reversible with an appropriate treatment approach for frailty.

Managing Frailty

At the heart of confirming the presence of frailty and managing the condition is the comprehensive geriatric assessment (CGA). Frailty-sensitive services need to make interventions available which improve overall physical, mental and social functioning, using a goal-orientated rather than a disease-focused approach, taking account of individual needs and personal assets, rather than deficits. Fully integrated health and social systems are essential to address the whole pathway across primary care, community care and secondary care. This includes joint working with ambulance services, community teams, geriatricians and old age psychiatrists.

The importance of shared care and support plans which involve the older person with frailty, the family and carers through all the stages of the process is highlighted. The guidance urges a recognition that most of the long-term care and support for those with frailty is provided by family, friends and private carers. These people should be identified, supported and networked into the primary care and community teams.

While services should provide real and safe alternatives to hospital admission, when admission is clinically appropriate, health and social care need to overcome their historical ‘territory’ and develop pathways to ‘pull’

older people with frailty out of hospital and prevent unnecessary days in transfer of care.

To achieve greater integration, services need to develop local training and education packages structured around the application of CGA in frailty for multi-professional teams, working in primary, community, intermediate and secondary

care to maximise the sharing of skills.

As with Part 1, the guidance includes a number of case studies featuring aspects of integrated pathways and service models for the management of frailty.

Gill Turner

Vice President for Clinical Quality

Editorial



New year, new beginning. Although, if you were one of the twenty or so trusts that declared a major incident, or the even larger number that declared internal incidents, simply to get through the festive period, you might be forgiven for believing it was the beginning of the end.

As a community geriatrician I found myself working shifts in the Emergency Department and staying back to plug gaps in the AMU receiving rota of an evening. Colleagues found all elective and non-clinical activities cancelled just to meet the day-to-day workload. At the height of all this activity, an ED colleague stopped me to give thanks for the work that the Geriatric Medicine Department had done to find her 25 beds the day before. She said we'd responded in a way that no other specialty seemed willing, or able, to do.

It's difficult to know how to respond to this. Does one feel angry, when the hospital is overwhelmed by older frail patients, that this is seen to be an emergency predominantly for geriatricians? Surely it should be an emergency for all appropriately skilled doctors who care about patients and patient care. Or should we be flattered that we're seen as being more capable than others at providing care to the oldest and most vulnerable patients? At least it's acknowledgement that we have a particular skill-set, which needs to be

learned, and is not possessed by all colleagues however much it should be. The answer is probably a bit of both.



At a practical level we are physically unable to care for such overwhelming numbers all by ourselves. An additional consideration is that the elective clinics, outpatient, rehabilitation and community geriatrics services that we are cancelling to support the acute take are exactly the sort of things most likely to take pressure off the system. There's an element of cutting off the nose to spite the face here.

Does one feel angry, when the hospital is overwhelmed by older frail patients, that this is seen to be an emergency predominantly for geriatricians?

It's at times like this that we need to remain focused around the BGS statement on the Role of the Geriatrician, produced by Finbarr Martin at the end of his presidency (see

box below). This reminds us of the role we have to play in delivering hands-on care but also that we have an even more important role as leaders, managers, educators and researchers. We have to show the rest of the medical profession the way.

Coming into a new year, this means we need to keep focused on the work of the Future Hospitals

Commission, which aims to make General (Internal) Medicine a priority for all medical specialties. We need to continue to try to influence the broader response to the Shape of Training Review on making training about core skills in care of older people mandatory for all doctors. We need to continue our work with *Age UK* on understanding lay perceptions of frailty and frailty-specific services, so that we can harness patient-power to drive change. The BGS has strategies in place to support each of these programmes of work.

There is also the opportunity for us to harness the crisis and use it as a platform (albeit a burning one) from which to advocate for service improvement. We have to avoid the temptation to say, "I told you so," but service managers and commissioners looking for a *raison d'être* could do much worse than consult *Fit for Frailty Part 2*, the *Silver Book* and the *Commissioning Guidance for Care Homes* - we have provided weblinks to all of these at the bottom of this article.

One thing that should fill us with hope is the high calibre colleagues who are increasingly finding a home within our specialty as higher medical trainees and consultants in geriatric medicine. I felt honoured to attend the Second Annual Trainees Leadership and Management Meeting in Birmingham in December. Specialist trainees from around the country wowed us with their enthusiasm, eloquence, intelligence, accumulated experience and skills and, above all, their absolute determination to make the world a better place for older patients with frailty. The *Geriatrics 4 Juniors (G4J) Conference*, also in Birmingham, in November introduced me to a cohort of FY2s and CTs desperate to come and make a difference within the specialty. What a fantastic group of people to carry the torch forward!

The success of both these events mean that they're sure to run again towards the end of 2015. We'll announce them through these pages as they become available but please do start preparing your trainees to attend these excellent days in advance. One thing is clear from both, geriatrics

is now a specialty chosen by star doctors who want to make a difference. How's that for something to look forward to?

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Vacancy for Future Hospital Officer

To close, at the time of writing the Royal College of Physicians (London) has advertised the position of Future Hospital Officer. Hopefully this newsletter will hit doormats in time for a few geriatricians to put their applications in before the deadline of 13

February. As Tom Downes says, as three of the four Future Hospital development sites are focusing on frail older patient pathways it would be great (nay, essential!) to have a geriatrician influencing this work.

Adam Gordon

Box 1

Geriatric Medicine and Geriatricians in Medicine: Finbarr Martin (2012)
<http://tinyurl.com/ml52ahp>

The Silver Book
<http://www.bgs.org.uk/index.php/bgscampaigns-715/silverbook>

Commissioning for Excellence in Care Homes
<http://www.bgs.org.uk/index.php/resources-6/bgscampaigns/commissioning2013>

Fit for frailty - part 1: Consensus best practice guidance for the care of older people living with frailty in community and outpatient settings
<http://www.bgs.org.uk/index.php/resources-6/bgscampaigns/fit-for-frailty>

Fit for Frailty - part 2: Developing, commissioning and managing services for people living with frailty in community settings
<http://www.bgs.org.uk/index.php/fitforfrailty-2m>

President's column

It's been a busy three months since I took office as BGS president. Thanks to the efforts of the secretariat and officers already in post before the new officers stepped up, our membership has continued its upward trajectory and reached an all time high at over three thousand.

Our social media "footprint" has gone from strength to strength with an increasingly lively blog and twitter following. Indeed, the Brighton Scientific meeting attracted nearly 8 million twitter hits in total. Under the editorship of David Stott, *Age and Ageing* continues to grow its impact and a number of our Sections and Special Interest groups are very lively. We continue to respond to and influence many guideline groups, national audits and policy consultations. We have also produced our own priorities for the General Election (thanks to Patricia Conboy in particular).

I am also personally delighted that the paper I co-authored for the King's Fund, *Making health and care systems fit for an ageing population* has ended up being the Fund's most downloaded report this year¹ - showing just how much interest there now is in improving care for older people and therefore in the work of geriatricians and their colleagues delivering innovations in local services. The Health Service Journal Commission² on the care of frail older people in hospital also received a great deal of profile and the website carries links to several good service models as well as the Animation³ *Mrs Andrews revisited* in which I discuss the pathway of care for an 84 year old lady with falls and declining mobility and what could have worked better.

For those interested in learning more about the BGS's activities, we have an updated narrative slide set outlining the range of activities, some of which may be less visible to the membership than our scientific meetings or publications but which have

equal importance. Beyond all this 'feel good' factor, one or two specific things merit a mention.



The National Audit of Intermediate Care Round 3⁶ was launched at a conference in Birmingham in November. Its findings are highly relevant to the work of geriatricians and our members Duncan Forsyth, John Gladman and John Young have been key members of the steering group from the outset. The audit is a large and incredibly detailed look at the capacity, responsiveness, cost and effectiveness of intermediate care services (median age of users 82) both bed-based and home-based, both "step-up" (pre-hospital) or "step-down" (from hospital). It's just about the most useful resource I have seen in striving to understand integrated care pathways for older people with acute and subacute illness. Please read it, please show it to your local colleagues, please subscribe to participate.

RCP London Poll on Physician Assisted Dying

The findings were published⁴ in November and I wrote a BGS blog summarising them. In essence, only 30 per cent of the 8,000 RCPL members polled favoured a change in the law and fewer still would want to play an active part in assisting - even if it were legalised. Many of those polled were geriatricians. Presently, we therefore have no mandate for changing the BGS's current position of opposition. If a law were to be passed, we would of course have to engage constructively with getting the regulations and safeguards right but we aren't there yet.

The BGS's meetings with Andrea Sutcliffe - Chief Inspector of Social Care at the CQC

Colin Nee, Eileen Burns and I have now had two very constructive meetings with Andrea - someone we respect, trust and want to work closely with.

She has set out her plans for the new care home inspection system.⁷ We in turn have highlighted the crucial importance of adequate assessment and rehabilitation before people enter care homes, and of adequate healthcare for residents – as set out in our BGS Care Home Commissioning Guidance⁸. We are now in discussions about how our members might help with the training of inspectors (volunteers please); whether we could provide some geriatricians or other BGS members to go on inspection visits and whether we could make better use of the “soft intelligence” of our membership about any local care homes which might be causing concern. We look forward to a good ongoing relationship.

BGS work with the RCP London and Future Hospitals Commission

Talking of people we can do business with, several BGS officers enjoyed a very constructive meeting with Prof Jane Dacre, the new College president. As the biggest GiM speciality within the college, this needs to be a mutually beneficial relationship. The College has just launched its Five Year Strategic Plan and a copy of this will have been mailed out to all College members and fellows by the time you read this. When we met Jane she was keen to know more about the work of the BGS, our workforce issues and our own view on the proposals in the *Shape of Training*, as well as the

drive to revive General Medicine. She was also pleased at the progress we were making as a speciality in supporting flexible training.

Professor Dacre is particularly interested in ensuring that female trainees are encouraged to stay in acute hospital specialities and also in ensuring that black and minority ethnic doctors are supported to take on more clinical leadership roles; also in ensuring that the RCPL is seen as being “out and about” and supporting physicians in the frontline. All of this is music to our ears.

Talking of the RCPL, I wrote a letter in December’s *Clinical Medicine* responding to John Firth’s article⁹ on the *Future of General Medicine*. My central point was this. When it comes to dealing with the overwhelming and increasing demand on acute hospital beds, with rising ED attendances, admission rates, delayed transfers of care and readmissions, with insufficient community alternatives and a growing focus on integration, it is Emergency Medicine, Geriatric Medicine and Acute Medicine which now constitute the engine room of adult secondary care. Services would fall over without our skills and insight which hold the key to solving many of the system’s problems. Whilst Firth talked about single organ medicine being seen as traditionally more prestigious, he also admitted that it was often intellectually less demanding than treating people with frailty or complex co-morbidities. Surely we need to go beyond getting a few extra “ology” trainees on the registrar rota and start sending out the clear message from undergraduate training onwards that there is no more important role in modern services than that of the “expert generalist”.

Allied to this, funding has now been secured from NHS England and *Monitor* for an Acute Frailty Clinical Network, with ten hospitals in England participating and geriatricians from all involved. This should prove a great vehicle for peer support, quality improvement and disseminating good practice.

Finally, I want to mention the BGS’s ongoing efforts to diversify our membership. Most of us work closely in our day jobs with nurses, GPs, mental and allied health professionals as well as doctors who have not yet chosen their higher speciality. We have been in discussion with our GP, nursing and therapies members, with the RCN and RCGP and with Health Education England.

1. www.kingsfund.org.uk/publications/making-our-health-and-care-systems-fit-ageing-population

2. www.hsj.co.uk/Journals/2014/11/18//q/r/HSJ141121_FRAILOLDERPEOPLE_LO-RES.pdf

3. www.bgs.org.uk/index.php/press/3539-mrs-andrews-part-2

4. www.rcplondon.ac.uk/press-releases/rcp-reaffirms-position-against-assisted-dying

5. <https://britishgeriatricsociety.wordpress.com/2014/12/04/physician-assisted-dying-the-bgs-the-rcp-and-the-law/>

6. www.nhsbenchmarking.nhs.uk/CubeCore/uploads/NAIC/NAICSummaryReport2014.pdf

7. www.cqc.org.uk/content/care-homes

8. www.bgs.org.uk/index.php/resources-6/bgscampaigns/commissioning2013

9. www.clinmed.rcpjournals.org/content/14/4/354

Wednesday sessions at our last three scientific meetings have all focused on interdisciplinary community care models and attracted a new audience. We had a stand at the Intermediate Care Audit Conference and the King's Fund Conference on "Empowering Allied Health Professionals". We are in discussions about offering new CPD and accreditation in geriatrics for General Practitioners with a special interest. The recent *Geriatrics for Juniors* conference was a

great success and hopefully has sparked an interest for some young doctors in becoming geriatricians. Finally, we have a joint conference with the RCN in March at which we hope to attract some more nurses to join us as well as enjoy some good joint education. We work together in multidisciplinary teams so its good sometimes, to learn together.

David Oliver

Lessons from Japan

tackling the dementia challenge by supporting carers

Writing for the *Health Service Journal*, Mayumi Hayashi discovered that in Japan, communities recognise that support and care for the families of those living with dementia is essential.

In October we went to Japan on a fact finding mission: to understand how Japanese society was responding to the challenge of 4.6 million people living with dementia (15 per cent of the over 65s).

Our first stop was the Alzheimer's Association in Kyoto, with 885 volunteers managed by a staff of mere eight paid people. Its focus is to develop "tsudoï"- open and informal meetings for people with dementia and their carers to generate information sharing, companionship and peer support. In 2013, a total of 3,517 tsudoï were held - with 44,118 people attending nationwide.

Our next stop was a "Sakura-chan", or "open house", in Kobe: a privately rented dwelling opened up to receive dementia patients and their carers for lunch, and providing a base for other social activities such as day trips and dementia awareness education.

In addition, carers were offered respite by peer carers in a planned manner. The manager, unpaid like all her assistants, had introduced a 24 hour care

helpline to support carers.

The next day we went to Tokyo's biggest borough, Setagaya-Ku, known for providing rapid response to support those recently diagnosed with dementia - and their carers.

We also noted the successful co-partnerships with community groups and voluntary organisations. Grants were available and allocated non-competitively; there was an emphasis on future self-sufficiency and co-production on an intergroup and peer group support basis. This model has successfully launched a variety of initiatives including carers' cafés and community "bars", which welcome and support carers and those in their care.

Cries for help

That night, we visited an "Arajin" bar - opened up next door to a GP's surgery. We were moved by the open-to-all "exchange notebook", which recorded simple two-line messages - or full page cries for help - written by carers in their moments of distress. The concept incorporates what is both social enterprise in principle (the café / bar makes a operational profit) and a platform for integrated support.

The next day we visited "Katarai-no-ie" - a public, specialised dementia day centre in the "friendly environment" of an ordinary house - again in the Setagaya-Ku residential area of Tokyo. This day centre offers eight hours of specific dementia related care and activities for up to 12 people. We were

offered lunch prepared by people with dementia. Our trip continued to Tama (a Tokyo suburb). Here we were shown two initiatives, which are already widespread across Japan.

First, there is the neighbourhood watch style scheme (not related to crime prevention but with similarly organised local networking) which looks out for “wanderers” - those among the 10,300 nationally recorded people with dementia who stray from home in their confusion.

Then we were shown the Tama grassroots and flourishing “dementia friends” scheme - again, part of a 5.4 million national cohort. After that, we headed for the dementia care unit at the Japanese Ministry of Health, Labour and Welfare. Here we learned that they had two guiding principles for underpinning dementia care and support nationally: the avoidance of even a “light touch” Care Quality Commission style inspection framework; and support for carers. This essentially pragmatic and humane approach ensured the proliferation of so many informal, but seemingly effective, innovations.

Peer support

Our final visit was to the “Suzu-no-ya” - another example of the “open house” based in residential suburbia. In this rented house, a charismatic

manager and her volunteer team welcome local people with dementia and their carers to lunch and companionship - within an informal environment. In addition, “Suzu-no-ya” volunteers run a 24 hour care helpline for carers together with preparation for possible bereavement and post-bereavement counselling. This support was always provided on a peer support and voluntary basis.

For instance, one carer we met was something of a tragic survivor. After caring for his late father, who suffered from dementia, he had to quit his employment and care for his mother who was also living with dementia. He wrote a book about his onerous experiences - the fear and the isolation - but not before actually losing self-control and harming his frail mother. Peer support and the nurturing care of “Suzu-no-ya” volunteers helped him through his personal crisis.

Our trip reinforced the fact that it is not only those living with dementia who need the care, empathy and support. Family carers also need this response - maybe more so - a challenge Japanese communities seem to be both recognising and responding to.

This article was re-published with the kind permission of the HSJ. Dr Mayumi Hayashi is Leverhulme Early Career Fellow at Institute of Gerontology, King’s College London

BGS Vice President for Education and Training

The British Geriatrics Society is pleased to announce the appointment of Professor Tahir Masud (Tash) to a newly-created position of Vice President for Education and Training.

Tash, who has been Chairman of the Education and Training Committee for some years, and who took up the role of Director of Continuing Professional Development will now take responsibility for the strategic leadership of the BGS’s work to raise standards in undergraduate and postgraduate education and training, and the BGS’s annual CPD and education events programme.



On behalf of the BGS and its officers, we wish Tash well in this new post. We know that along with our other two Vice Presidents, Gill Turner and Gordon Wilcock, that he will continue to contribute to the Society’s input into medical education and training.

British Society for Heart Failure

The British Society for Heart Failure 2014 Annual General Meeting was held at the Queen Elizabeth II Conference Centre London on 27 - 28 November 2014. Entitled 'Yesterday's problems, today's solutions', the programme was wide ranging, clinically focused, and relevant for a Geriatrician interested in keeping up to date in the management of older people with heart failure

The meeting began with a 2014 trials update. The highlight was PARADIAGM-HF which showed LCZ696, an angiotensin receptor neprilysin inhibitor (ARNi), was superior to enalapril in reducing the risks of death and of hospitalisation for heart failure. New NICE guidelines for device therapy in heart failure and the management of acute heart failure were presented.

A session on non-cardiac co-morbidities in heart failure patients was particularly relevant for Geriatricians. **Dr Callum Chapman**, Consultant Geriatrician in Twickenham, presented an elderly patient who had undergone a transcatheter aortic valve implantation presenting with anaemia. Ultimately coeliac disease was found to be responsible for her anaemia. During the audience discussion afterwards the point was made that intravenous iron is superior to oral in many ways, and probably under-utilised.

Uncertainties, myths and dogmas were addressed in the next section. **Dr Nigel Rowell**, General Practitioner in Middlesborough, began by confronting various demographic dogma. He disputed that the prevalence of heart failure is on the decline; and he disagreed with the idea that heart failure patients' outlook is poor. He endorsed ischaemic heart disease as the number one cause of heart failure, but refuted the claim that heart failure with a preserved ejection fraction (HFPEF) doesn't exist.

Dr Paul Kalra, Consultant Cardiologist Portsmouth, then shed light on the uncertainty surrounding sodium and water restriction in heart failure management. In a highly entertaining talk, **Professor Andrew Clark**, Professor of Cardiology in Hull argued that lower cholesterol and HbA1C failed to improve outcomes in CHF patients.

Other session highlights included problem drugs in CHF, frightening consultations and 'hearts and minds'.

Professor Christian Latrémouille (Paris) brought the meeting to its conclusion by describing the innovative surgical technological advancement on the horizon – 'the novel total integrated bioprosthetic heart'.



The BSH aims to provide high quality education in the management of heart failure, organising a number of training meetings which give Geriatricians an ideal opportunity to update their knowledge on all aspects of heart failure care. The BSH would welcome Geriatricians as members. For more information please visit www.bsh.org.uk.

The BSH gratefully acknowledges the support provided by the Friends of BSH: Bayer, Medtronic, Novartis, Pfizer, ResMed, Servier Laboratories.

BSH meetings

7th BSH Heart Failure Day for Revalidation and Training, 5 March 2015, Charterhouse Square, London

5th BSH Heart Failure Nurse Study Day, 6 March 2015, Charterhouse Square, London

18th BSH Annual Autumn Meeting - 26-27 November 2015, Queen Elizabeth II Conference Centre, London

BSH contact details

E-mail: info@bsh.org.uk

www.bsh.org.uk

@BSHeartFailure

John Baxter

BRITISH SOCIETY OF HEART FAILURE

Heart Failure Revalidation and Training

5 March 2015

Heart Failure Nurse Study Day

6 March 2015

Both events will be held at Charterhouse Square Campus, Queen Mary University of London

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

SCOTTISH DIZZINESS SYMPOSIUM

How to treat dizzy patients without getting dizzy

16 March 2015

Medico-Chirurgical Hall,
Aberdeen Royal Infirmary

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

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

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BREAST CANCER

Third symposium on primary breast cancer in older women

Friday, 6 March 2015

East Midlands Conference Centre, University Park,
Nottingham NG7 2RJ

Topics include biology and treatment options; the specific physical and psychosocial needs of these patients. Gain insight into the development of a holistic and multidisciplinary management approach and the importance of supporting research; and share your work and experience by submitting an abstract.

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ROYAL SOCIETY OF MEDICINE (REGIONAL)

An Update on managing the health problems of older people

13 May 2015

Weetwood Hall Conference Centre in Leeds

Currently 10 million people in the UK are aged over 65 years old and 3 million are aged over 80 years.

The objective of this meeting is to provide an update on the assessment and management of problems which affect the elderly from speakers recognised as leading experts in their field. Topics will include dementia, pulmonary fibrosis, thyroid disease and heart failure.

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BGS EVENTS REGIONS AND SIGS

BGS Wales Branch meeting
5-6 March 2015, Wrexham Medical Institute

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

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

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

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

16th Falls and Postural Stability Conference
11 September 2015, Hilton Wembley, 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

STROKE

BASP Trainees Weekend

20 - 21 March 2015

College Court, Knighton Road,
Leicester, LE2 3TQ

The programme covers a broad range of topic from acute intervention, rehabilitation to research. We have a number of internationally recognised experts including (but not limited to) Philip Bath, Gary Ford, Hugh Markus, Tom Robinson, Cathie Sudlow, and BASP President Damian Jenkinson and BASP President-Elect Helen Rodgers.

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**ROYAL COLLEGE OF ANAESTHETISTS
PERIOPERATIVE MEDICINE PROGRAMME**

The Royal College of Anaesthetists is committed to developing a collaborative programme for the delivery of perioperative care across the UK; to deliver more efficient healthcare and better outcomes for patients from contemplation of surgery until full recovery.

Following the College's stakeholder engagement event in January, it intends to work with its stakeholders to implement changes and work towards making perioperative medicine a reality for every patient considering surgery.

Read the vision document, Perioperative Medicine: The Pathway to Better Surgical Care; watch an animated film and share your comments.

<http://www.rcoa.ac.uk/perioperativemedicine>



**PUSHING THE
BOUNDARIES OF
GERIATRIC MEDICINE**

Royal College of Physicians
Edinburgh

27 March 2015

Topics include: the provision of medical and therapy input into care homes; care of the elderly outwith the geriatric ward; the growing demand of cancer care in the elderly; global trends in the ageing population and meeting future demands how to inspire the next generation of geriatricians updates on drug treatment and polypharmacy, dizziness, macular degeneration, polymyalgia rheumatic and giant cell arteritis, chronic kidney disease

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**RCN Older
People's forum
and BGS joint
conference**



Fees from just £220

This inaugural joint conference celebrates how older people's experiences of services can be improved through multi-professional, multi-agency collaboration. The programme will offer keynote speakers who are UK leaders in older people's medicine, nursing and social care alongside a wide variety of concurrent sessions which will be relevant to professionals and staff at all levels who work with older people and people who live with dementia.

30-31 March 2015

Renaissance Manchester Hotel,
Blackfriars Street, Manchester M3 2EQ

Details @ www.rcn.org.uk/olderpeople15



Scholarships, essay prizes and other funding

Please bring to the attention of your colleagues, the BGS's 2015/16 round of scholarships, essay prizes and grants including the Amulree Essay Prize (open to students of medicine and dentistry in the United Kingdom); the Movement Disorders Prize (open to students of medicine, nursing and therapy); the Undergraduate Bulpitt Cardiovascular scholarship, the Masters Scholarship and more.

The Masters Scholarship funds a taught Masters course at a UK University. Degrees in Geriatrics, Gerontology, Medical Education, Medical Ethics and Health Services Research will be supported. Candidates must hold a UK NTN in Geriatric Medicine; have written support from their training programme director and must be a member of the British Geriatrics Society.



The Award amounts to £3,000 - £7,000 spread over 1 - 3 years. More expensive courses (up to £10,000) may be considered but clear justification must be provided for the course of study chosen and the additional costs incurred.

For more information, see the BGS website (Select Resources/ Grants and Prizes from the menu). The closing date for most of the awards mentioned above is end July.

Lend me your ears

We have a new Podcasts section on the BGS website (select Resources/ Podcasts from the menu), where you can find links to a range of educational podcasts. These have been produced by BGS members on topics such as dementia, interface geriatrics and syncope. We will be adding to this throughout the year, with upcoming podcasts on clinical updates and news in geriatrics (see the planned changes for clinical quality presentations at BGS scientific meetings on page 24). They are ideal for a refresher while you commute.



If you would like to get involved in producing podcasts, please contact the Digital Media Editor, Dr Shane O'Hanlon, on sohanlon@gmail.com

Job vacancies



The BGS website (select Resources/ Vacancies from the menu) regularly lists opportunities for working overseas including posts vacant in France, Canada and the Antipodes.

We also list local vacancies. Please contact editor@bgs.org.uk to list your vacant post.

“When will I have my operation?”

The BGS welcomes the publication of a booklet, ‘My Hip Fracture Care’ by the National Hip Fracture Database,

The booklet describes what a hip fracture is, why it happens and how it will be treated.

It includes a list of 12 questions patients should consider asking the team looking after them, based on the essential elements of high quality hip fracture care.

The questions cover aspects of care such as pain relief, memory problems, the seniority and kinds of doctor that should be involved in care, how soon an operation should take place, and rehabilitation following the operation or procedure. The booklet also includes the relevant results from the National Hip Fracture Database annual report for each question.

The booklet was available from the NHFD website from 30th January.

Dementia: the one-stop guide

‘...contains a wealth of information written in a way that it would be hard to put down. It is an extraordinary useful thing for anyone concerned with dementia care whether it be from personal experience (direct or indirect) professional, policy or politics..’

Professor Alastair Burns, National Clinical Director for Dementia in England.

In *Dementia: the one-stop guide*, published on 5 February, international dementia care expert Professor June Andrews sets out to empower families, people living with dementia and those closest to them. Drawing on decades of experience and the latest research into the illness she explains what really makes a difference in the life of a person with dementia. June believes that there are two very different routes following a dementia diagnosis: staying well as long as possible or going downhill faster than you need to.

The book includes chapters on:

- ▶ What dementia is – and what it isn’t
- ▶ How to cope with a dementia diagnosis – for patients and family
- ▶ What life really feels like for the person with dementia
- ▶ How to be a real ‘dementia friend’ to

someone affected by the condition

- ▶ Small changes in your home that can make a big improvement in the person with dementia
- ▶ Disturbing behaviours – from hallucinations to incontinence: what causes them, and ways to cope with them
- ▶ Sleeplessness and how to handle it
- ▶ How to find the assistive technology that works for you
- ▶ Ways around the maze of social/health care – without being labelled a ‘vexatious’ client
- ▶ How to avoid hospital admission and how best to handle one if you can’t
- ▶ What to look for when choosing a care home

Full of real-life examples from people affected by dementia, *Dementia: the one-stop guide* offers advice that isn’t always obvious but is easy to implement at home, without extra help. Written with warmth and even some wry humour, the book offers gentle encouragement combined with reassurance, without dodging the hardest issues.

Dementia: the one-stop guide was published by Profile books on 5 February 2015, price £9.99 paperback original, ISBN: 978178121713, eBook 97817847569910



BGS Policy Review

A pre-election call from the BGS to the incoming Government

Health is already a hot topic in the lead-up to the General Election on May 7th. In the early weeks of 2015, problems in hospital Accident and Emergency departments have alarmed the public and been the subject of heated political and media debate.

Healthcare and support services are struggling to cope with flat funding to the NHS, reduced social care funding and increased demand for services, much of it driven by the ageing of the population. Performance on NHS efficiency targets, including the 4 hour target for treatment in A&E departments continues to dip, often because the health and care system is not geared to meet the needs of its core user group – older people with multiple long-term conditions. This is the backdrop against which the BGS has prepared its General Election 2015 Position Statement, launched earlier this month (access at www.bgs.org.uk/index.php/2015-ne).

The BGS has issued a call to the incoming Government to take six decisions to promote excellent healthcare and support for older people. Excellent care and support is person-centred, effective, efficient, safe, equitable and timely. Older people deserve no less.

Decision 1: End the Divide between Health and Social Care

The Barker Commission has recommended that those whose needs are currently defined as ‘critical’ should receive free social care, ending the current distinction between free NHS Continuing Healthcare and means-tested social care at the highest level of need. The BGS supports this recommendation and is calling on the incoming Government to end the divide between health and social care for people with ‘critical’ care needs and to provide clarity at national level about people’s entitlements to health and social care.

Decision 2: Build capacity in Intermediate Care

Currently there is a 50 per cent deficit in the capacity of intermediate care i.e. community services forming a link between home and acute hospitals and enabling older people to receive

rehabilitation, re-ablement or sub-acute treatment in more appropriate settings. The NHS National Clinical Director for Integration and Frail Elderly has said that the annual spend on intermediate care should be doubled from £2 million to £4 million per 100,000 population. The BGS supports this recommendation and calls on the incoming Government to build the capacity of intermediate care to meet the needs of an ageing population.

Decision 3: Invest adequately in healthcare and social support

The BGS calls on the incoming Government to provide sufficient funding to the NHS to achieve the goals of the Five Year Forward View, to reverse the trend of cuts to social care funding, to reduce the imbalance in funding between NHS and social services, and to provide adequate funding to local authorities to meet their social care obligations, including those to older people.

Decision 4: Provide national strategic direction on older people living with frailty, dementia, complex needs and multiple long-term conditions

Older people living with frailty, dementia, complex needs and multiple long-term conditions need expert, multi-disciplinary and co-ordinated care. The incoming Government should provide strategic direction and highlight those needs in future Mandates to the NHS. Specifically, future Mandates should set out expectations of the NHS with regard to older people’s access to comprehensive geriatric assessment, personalised care plans for treatment and long-term follow-up.

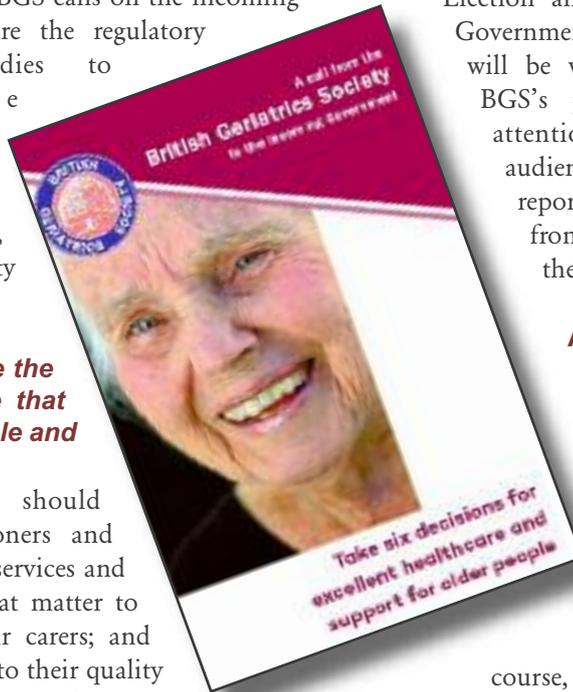
Decision 5: Support the development of staff competencies in the management of older people

One of the keys to the equitable and safe care of older people is the assurance that staff caring for them – doctors, nurses, allied health professionals, care attendants and others – have the right

knowledge, training, skills, values to deliver care to them; combined with the flexibility to do so in multiple settings. The BGS 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, professional and quality standards.

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

Outcome measures should incentivise commissioners and providers to focus on services and dimensions of care that matter to older people and their carers; and that make a difference to their quality of care and its outcomes for them, not alone the service they have used. The BGS calls on the incoming Government to ensure that future reviews of the NHS Outcomes Framework address current deficits in the measurement of older people’s experience of care pathways, their access to a continuum of care and care outcomes; and to direct that new outcome measures are developed to close existing gaps.



What happens next?

In the months leading up to the General Election and to the formation of a new Government, officers and staff of the BGS will be working together to bring the BGS’s pre-election messages to the attention of political and other audiences. Watch out for a progress report on the responses we receive from the different political parties in the next issue of the newsletter.

A call for advice

Finally, I’d like to ask for your help. As members of the BGS, through your clinical practice, you will have direct experience of the healthcare and support issues discussed in this column. Your insights and direct experiences, anonymised of course, would be an invaluable resource in our political meetings. If there are experiences you can share for this purpose, please get in touch with me. I would really like to hear from you.

Patricia Conboy
 BGS Policy Manager
 policy@bgs.org.uk
 Tel. 0203 747 6940

Urinary continence in women

In January, the National Institute for Clinical Excellence (NICE) published its quality standards on urinary incontinence in women. The contents of the standard include:

- Initial assessment*
- Bladder diaries and lifestyle changes*
- Containment products*
- Supervised pelvic floor muscle training*
- Bladder training*
- Indwelling catheters*
- Multidisciplinary team review before surgery or invasive treatment*

See <https://www.nice.org.uk/guidance/qs77>



BGS Communications update

It has been an exciting few months for media and communications activities at the BGS, both in terms of ongoing press coverage, and developing our plans for upcoming campaigns in 2015.

Fit for Frailty Part 2

Our major new guidance on commissioning services for older people with frailty in community settings, *Fit for Frailty Pt. 2*, was launched on January 14th. Even before the public launch date, we had seen several hundred downloads of the guidance from a limited pre-launch campaign and press release, and lots of positive feedback on the contents of the guidance itself.

As you'll have read on page 1 of this newsletter, *Fit for Frailty Pt. 2* provides guidance on recognising frailty as a long term condition, how to identify those who are frail and assess its severity, the kind of services we need to provide to support them and the education, the knowledge and skills staff might require, and the importance of ensuring that the patient and their family are at the heart of care planning.

Dr Gill Turner wrote a large comment piece for *Commissioning Monthly*, and a jointly-written opinion piece from **Prof David Oliver** and **Dr Eileen Burns** ran in the *HSJ*.

You can help publicise the campaign by telling your colleagues and contacts about the guidance: it's a substantial and incredibly useful piece of work, and will be invaluable to anyone involved in commissioning.

BGS Elections Manifesto

The other major communications project we worked on related to the general election, and the second BGS pre-election call to the incoming government - the first having been developed in 2010.

As you'll see from Patricia Conboy's policy update, we're urging the government to take six key decisions to improve the care of older people. In

doing so, we're not just posing a challenge and raising awareness of the issues, we're offering our expert guidance to help politicians make better care a reality.

Our outreach strategy has a number of aims. Firstly, we want to expand our profile in the political world, through direct contact with political decision-makers: we'll be meeting with politicians, think-tanks, and policy teams, building relationships with them and making them aware of the crucial work BGS members are doing.

Secondly, we'll be using those connections after the election to strengthen our influence on the political debate: we've been careful not to simply issue a list of demands, but to provide a clear roadmap for politicians to improve care for older people, informed by the experience of geriatricians around the UK.

Finally, we'll be using the election to build wider understanding of our work and the challenges facing older people amongst the public and media. In all of these areas, we are only as strong as professionals we work with: if you have insights or ideas on political issues, whether nationally or more local to you, please contact us!

Of course, amongst all this our usual media work has continued apace: **Dr Eileen Burns** featured on *BBC Breakfast* discussing older people's health, and we've been quoted in the *Guardian*, *Daily Telegraph*, *Times* and *Daily Mail* over recent weeks.

We've responded publicly to the *National Audit of Intermediate Care*, the NHS England *Five Year View*, and the *HSJ Commission on Older People*, being picked up in news coverage for each, and placed a comment piece by **Dr Viveca Kirthisingha** in the *HSJ* on the back of her presentation at the Autumn Meeting.

[The BGS] is only as strong as the professionals we work with: if you have insights or ideas on political issues, whether nationally or more local to you, please contact us!

The BGS blog continues to be widely-read, covering everything from geriatric medicine in New Zealand to empowering allied health professionals, the use of microneedles, and what geriatricians get up to in their spare time!

We're always looking for new ideas, so please feel free to email me if you'd like to blog for us: this

could be anything from a great pilot at your hospital, to a piece of research you've worked on or just a particular issue you feel strongly about.

Ed Gillett

BGS Communications Manager

communications@bgs.org.uk

Tel. 0207 608 8572

Reconfiguring clinical services: what's the evidence?

In late November, The King's Fund published a paper called 'The reconfiguration of clinical services – what is the evidence?' in which they consider the drivers and evidence base behind the constant push for change which is endemic within the NHS. The authors discuss an analysis carried out by the National Clinical Assessment Team, commissioned by the National Institute for Health Research, and its implications for the National Health Service.

The document confirms what many of us have suspected for some time: there is no evidence that reconfiguring hospital services on financial grounds alone produces a positive impact but it exposes organisations to distraction together with clinical and financial risks. There is mixed evidence as to whether reconfiguration with the aim of improving quality is beneficial, with the most positive results manifesting when the changes relate to specialised services.

In keeping with many earlier reports, the authors found evidence that senior medical input is linked with high quality performance, but correctly acknowledge that current workforce issues have an impact on successful implementation of this strategy. Interestingly, they also warn against 'designing tomorrow's services to today's workforce constraints' and state that workforce and service planners must work together in order to support development of new models of care.

The authors stress that reorganisation has an important role in delivering quality, but on its own is insufficient, and should be used alongside other measures to "improve delivery of care an organisational culture." We should welcome the recognition that there is no one-size-fits-all model to service reconfigurations, and that local context is important. Any plans for reconfiguration must be underpinned by detailed workforce and financial plans, and that following implementation of change there should be routine post-project financial and clinical evaluation.

Chapter 4 specifically considers the reconfiguration of community based services, reflecting the policy direction of delivering 'care closer to home.' In summary, the report

concludes that it can be hard for community initiatives to significantly reduce hospital admissions, particularly because success in delivering improvement requires systems change across primary and secondary care, and piecemeal initiatives are ineffective. They also warn that there is little evidence to support the perception that moving care into community based settings will produce financial savings. Future workforce issues are likely to have significant impact in this area, particularly considering the mismatch between supply and demand of nurses, who are integral to these types of model. Issues within general practice recruitment are important, with a gradual increase in the number of GPs, but a reduction in participation rates. Despite these negative findings, quality improvements in terms of patient satisfaction and quality of care delivered are emphasised.

Geriatric medicine is referred to in Chapter 6, which looks at A&E and urgent care services. The report states that "A&E services require ... Rapid access to specialist medical opinion, including geriatricians." Reasons given for this statement include: "to enable rapid diagnosis and treatment to improve outcomes" which could be interpreted as early Comprehensive Geriatric Assessment, in keeping with published literature and more recently the BGS publications '*Fit for Frailty*.' Chapter 7, on acute medical services, discusses that there is an urgent need to provide adequate specialist geriatric assessment and support to those aged over 65.

There is no mention of Geriatric support in sections on acute surgery, elective surgery or trauma care, despite these being areas with growing involvement from our specialist teams. Interestingly, the only area where reconfigurations were driven by 'Quality' was Stroke.

This publication could be useful to those who want to drive change, and also those who have reconfiguration forced upon them. The take home message seems to be that change in a specialist area, driven by experts, with improving quality as the aim can be a success. Warnings need to be heeded when there are other drivers for major change in service structure, and insufficient workforce can result in failure of even the best plans.

Zoe Wyrko

Director: Workforce

I'm still me

Frailty from the patient's perspective

I'm still me: a narrative for co-ordinated support for older people, was published in December by UCL Partners, National Voices and Age UK. The report describes what older people want from their lives and from the services that support them, and is based on the analysis of seventy-four interviews.

The main themes arising from the research were around independence, community interactions, decision making, care and support and terminology. The report asks health and social care services to reflect on whether their services support the 'I statements' outlined in the report, and calls for a national debate around how we define and manage frailty.

Over the past few years there has been an increasing focus on 'frailty' and its definition,

measurement and management. The BGS's guidance, *Fit for Frailty (2014)* recommends that "older people should be assessed for the possible presence of frailty during all encounters with health and social care professionals". It acknowledges that frailty varies in severity and is not static but promotes the concept of frailty as a long-term condition. It highlights why this is important; to "help health and social care professionals to take action...and to start a pathway of care to address the issues contributing to frailty".

However, it is interesting to view frailty from the patient's perspective. Although there were mixed views on the terms 'old' and 'elderly' there was almost universal rejection among our interviewees when it came to seeing themselves as 'frail' or being associated with 'frailty'. Whilst they recognised the constraints their health conditions sometimes

placed on their lives, they did not want to be defined by these conditions. They wanted instead, to focus on living their lives. Independence remained one of the most important things to them and was not only about

attending to basic activities of daily living but about 'doing what I want, when I want'.

The case study featured in the report illustrates this contradiction between the clinician's perspective and the patient's perspective. Ken was 100 and could have been described as frail by clinicians by virtue of his having a number of co-morbidities and because he required a walking stick. He was also close to the end of his life, passing away a few weeks after our interview. However, Ken vehemently denied that he was 'frail'. He lived alone with domestic assistance, used an iPad and went to pilates classes. He described his health as "pretty



References:

British Geriatrics Society (2014): *Fit for Frailty*. London: British Geriatrics Society, Age UK, RCP

Gawande A. (2014) *Being Mortal: illness, medicine and what matters in the end*. London: Wellcome Collection

Redding D., Gentry T., Shand J. & Stuart L (2014) *I'm Still Me: a narrative for coordinated support for older people*. London: UCLPartners, National Voices & Age UK.

Accessible at:

http://www.nationalvoices.org.uk/sites/www.nationalvoices.org.uk/files/im_still_me.pdf

www.oxforddictionaries.com Accessed on 16.01.15

good” and said that independence to him meant “doing things for others”.

In his book, *Being Mortal*, Atul Gawande (2014) asks whether through trying to medicalise old age, we have actually lost sight of the key issue of helping people to live well. There is no doubt that clinicians identify frailty with the best of intentions, and without having resort to such a label there is a risk that patients with frailty may ‘slip through the net’ and fail to receive the services that they require. Perhaps, the focus needs to be on identifying the ‘pre-frail’ to ensure that we are proactive in taking a preventative approach by helping them to maintain their independence for as long as possible.

But how do we identify people in a way that is acceptable to them? Is it the terminology, rather than the label, that is the problem? The term frailty was already in general usage before being adopted as

a ‘diagnosis’. The Oxford dictionary gives the definition of frailty as “the condition of being weak and delicate”. Indeed many of the older people we spoke to felt that being described as ‘frail’ implied weakness. Perhaps we need to have a debate with the public about our intentions in using the term ‘frail’ and what it offers to the patient – in the same way that we have done with dementia, for example.

This report aims to generate discussion and debate. We need debate within the health and social care professions but we must also ensure that we engage older people themselves, the very people we are seeking to serve.

Join in the debate at [#imstillme](#)

Laura Stuart

is the Frailty Programme Manager at UCLPartners and is an occupational therapist by background

Aberdeen geriatricians go global

First stop - the Himalayas?

Professor Phyo Myint and Professor Prasanna Gautam describe their experience of training Nepalese doctors in geriatric medicine - a country which, hitherto, has not had a single geriatrician.

Nepal is a beautiful country in the spectacular mountainous region of the middle Asia. After years of armed conflict and instability, it has now become a stable democratic republic. The civil unrest created severe social upheaval, including the in-migration and displacement of the country’s older citizens. The exponential rise of older people aged 60 years and over from 3.2 per cent in 2001 to 8.3 per cent in 2011, with rapid growth rate in the very elderly age group, has already become alarming for the fragile health services provided by the Ministry of Health and Population (MOHP) of the Government of Nepal.

Following a three day high profile conference in Kathmandu in 2009 on Healthy Ageing, organised by Nepalese Doctors Association, (UK) and Connect for Change, supported in part by DFID, the Government had formulated a national health policy for its older population resulting in a 50 per

cent reduction in the hospital costs and free supply of 24 commonly prescribed medicines. Other facilities on offer are separate and fast track consultation in the outpatients and designation of some beds as 'geriatric beds' in the government hospitals. However, to date there has been a dearth of training in care of the elderly. There is not a single geriatrician in Nepal to provide specialist services. The country’s two dozen medical colleges do not include Geriatric Medicine in their curriculum and age related changes are only generally taught in their basic science courses. The concept of Occupational Therapy is practically unknown in Nepal. There is only one School of Physiotherapy in the country which will produce the first cohort of graduates next year. The ethos of the physicians working within a multidisciplinary team does not exist.

A call for help

It was in this context that Dr Prasanna Gautam, former Medical Lead of the Department of Medicine for the Elderly and Senior Lecturer in Medicine, Aberdeen University was approached early in 2014 by Manmohan Memorial Teaching Hospital (MMTH) in Kathmandu, to lead care of the elderly services. This new hospital was being established in the memory of the visionary late Prime Minister Mr Manmohan Adhikari whose government had initiated a state old age pension for Nepalese elders in 1991- the first by any government in this region of South East Asia. MMTH was also planning to develop a medical college and had adopted "the elderly friendly hospital" as its mission statement.

Prasanna Gautam provided a six week on site intensive training to Dr Shah, a general physician and rheumatologist, two staff nurses and one physiotherapist prior to establishing an Outpatient service and a Day Unit as the Department of Gerontology in MMTH which opened in March 2014. Dr Shah gained further experience at Woodend Hospital and Aberdeen Royal Infirmary, Aberdeen, for a month in September.

A strong collaboration was being forged between the Department of Medicine for the Elderly and the Medical school in Aberdeen and MMTH. A further collaboration was proposed with the School of Health Sciences, Robert Gordon University (RGU) in Aberdeen which is the main producer of highly skilled professionals allied to Medicine. The Ministry of Health and Population and WHO in Nepal were then approached by us to secure support for holding an intensive national course in Geriatric medicine for Nepalese doctors representing as many regional hospitals in the



Professor Gautam, Professor and Head of Gerontology Department MMTH, Kathmandu acting as the Master of Ceremony at the opening ceremony of the Training Course

country as possible. The funding was obtained from the WHO and MMTH.

Two principle objectives of the course were (1) to provide an introduction to the principles and practice of Geriatric Medicine and Gerontology, and (2) to promote the concept of holistic medical care for the older people in the hospitals in Nepal. Emphasis was given to quality of life issues, multidisciplinary team working and principles of rehabilitation both in the hospital and in the community settings. The course was a successful and high profile event opened officially by the Minister of Health and Population, the Honourable Mr Khagaraj Adhikari, MP. He said: "The government is very happy to support this kind of training because although at the policy level we have made several provisions nationally for the proper healthcare of the elderly people in Nepal we have no trained manpower to deliver the service. I am thankful to organisers for bringing this collaboration".

The Minister of Health & Population lighting the Paanas, a traditional Nepali lamp used for auspicious occasions, to open the event



Forty two participants, many of them senior doctors from the thirty-two Government hospitals scattered throughout the twenty

districts in the country took part in this course. It comprised seven plenary sessions, three key note speeches and a state of the art lecture from the visiting faculty. There were two half-day workshops on Comprehensive Geriatric Assessment and on establishing a Care Home for the Elderly. The topics included the spectrum of geriatric medicine, establishing geriatric services, manpower development and research, stroke, osteoporosis, elder abuse, surgical aspects, palliative and end of life care. There were sessions on stroke rehabilitation, case studies in multidisciplinary team working and community geriatrics. Two elderly women, one blind since childhood and other a frail widow, who had been subject to horrible abuse themselves, participated in the elder abuse workshop co-ordinated by Mr Prakash Khanal. They provided harrowing tales of their personal experience of physical and psychological abuse and the insults which had forced them to seek refuge in the house of a kind lady. The relevant issues on social gerontology were also highlighted. The fifth afternoon session chaired jointly by us provided an overall review which brought out lively discussions and was highly useful in reinforcing the key messages of the course.

The pre- and post-course questionnaires showed that participants scored 4 or 5 out of maximum 5 points regarding the usefulness of the course and whether it would change their practice. They were given a

In addition to the authors of this article, the visiting faculty consisted of:

Professor David Reid, the Head of the School of Medicine & Dentistry, University of Aberdeen; Ms. Thérèse Jackson, Consultant Occupational Therapist for NHS Grampian Stroke Services, the Subject Lead in Physiotherapy, Mrs Ann Wallace and the Subject Lead in Occupational therapy, Mrs Dawn Mitchell from RGU and Mr Prakash Khanal, a science journalist who is researching on "Skills Transfer by the Diaspora" as a PhD fellow with the University of Reading. The local Faculty consisted of Mrs Durga Mishra, Associate Professor of Public Health Nursing, Mr Chhatra Pradhan, the Secretary General of Nepali Senior Citizens Federation, Dr Deepa Shah, Lecturer in Medicine with special interest in Care of the Elderly, Dr Ashish Dutta, a Lecturer in Psychiatry with special interest in dementia syndromes, Professor B D Jha, Professor of Anaesthesia, Dr Raj Kumar Chhetri, Associate Professor of Surgery and Consultant Urologist, Dr Ram Prasad Shrestha, a senior Consultant Surgeon and former Director of Teaching Hospital of National Academy of Medical Sciences, Kathmandu and Dr Gongal, Consultant Hepatobiliary Surgeon with special interest in Palliative Care.

certificate at the end of the course by Dr Guna Raj Lohani, the Chief of the Curative Division of the MOHP.

An ancillary half day seminar, "Improving the quality of life", was also held at the Nurses School in the Campus at Banasthali, near MMTH. Approximately 40 participants, including Nurses, Physiotherapists, Pharmacists and Lab technicians participated. The seminar was on rehabilitation and professional development options of therapists. The objective of the seminar was to disseminate the concept of holistic medicine, comprehensive geriatric assessment and multidisciplinary team working to help develop health care workforce that fits for the purpose in Nepal.

The dinner reception for the faculty, hosted by the MMTH Chairman Mr Pandey, an MP and the Chief Whip of the ruling Coalition party in the Government, was entertaining and useful to get to know one another. This was also attended by the Health Minister and the Education Minister, former Finance Minister and four members of parliament, and several other local dignitaries. The proceedings of the whole course are being compiled to be published in an abstract book form. It is likely that there will be further development and mutually beneficial collaboration between the Department of Medicine for the Elderly (DOME), NHS Grampian, the School of Medicine of Dentistry, University of Aberdeen and Robert Gordon University from Aberdeen, and MMTH in Nepal. The overall experience was overwhelmingly encouraging for the visiting faculty.

The local sight-seeing opportunities provided visits to a few of the fascinating World Heritage Centres of ancient architecture and temples. The faculty members were able to see the Himalayan range of mountains early in the morning in a Mountain Flight in a small plane of Simrik airline! The views of Mt. Everest and other six highest mountains of this world from the cockpit gleaming different shades of pink and white in the early morning sun was the most spectacular panorama that we shall ever see.

Prasanna Gautam

Former Lead Clinician
NHS Grampian and Honorary Professor of
Gerontology, Manmohan Memorial Teaching
Hospital, Kathmandu, Nepal
(gautam5@hotmail.co.uk)

International medical trainee in elderly care medicine a personal experience

Adeniji Leye describes his experience of the NHS as an international student on the Royal College of Physicians (London) training programme.

The international medical training initiative is a programme of the Royal College of Physicians (London in my case) in collaboration with other postgraduate medical colleges around the world. It seeks to develop skills and competencies in middle-level specialist trainees, which would be transferable to participating countries at the end of the training period while also offering a good exposure to the workings of the National Health Service in the United Kingdom.

Having the opportunity to work in a geriatric unit within the UK offers

good exposure to the model of elderly care being practised here. In Nigeria, where I come from, and in much of Africa, the qualitative experience of elderly care is based on a communal model whereby every member of the family is involved in caring for the elderly and old age is venerated. This appeared to work pretty well until a few decades ago when the realities of urbanisation and travel reduced the effectiveness of this practice, as young people left the homestead and their elders were left to fend for themselves. So, as in many other industrialised countries, elderly care is a growing problem. There are no geriatricians and no specialised post graduate training for elderly care medicine in Nigeria - this despite the fact that about 5 per cent of the current population in Nigeria (which stands at about 170 million) is aged 60 years and above (so around 8.5 million people) .

Doing the rounds

Coming from a background in Neurology, there is significant overlap between neurology and geriatrics and this was something I was keen to explore while



In contemplating the mass of resources and personnel to keep this model going, one begins to realise that elderly care is not cheap.

taking up the MTI fellowship. I started with a six week induction programme. This was designed by my educational and clinical supervisors with the aim of getting acquainted with the workings of the hospital and to rehearse for the roles I shall be undertaking. During this period I spent time in the cardiac, chest, radiology and stroke wards as well as the elderly care wards and the emergency unit. I was present at ward rounds and clinic sessions run by these specialties and also attended

the medical ambulatory care unit and the elderly care assessment unit. In addition, I attended falls and TIA clinics. I observed and participated in the initial assessment of emergencies/triage, acute stroke assessment, thrombolysis, endoscopic sessions as well as thoracoscopy. I spent time in the Movement disorders clinic and had the opportunity to observe the inter-individual heterogeneity of Parkinson disease presentation and the differences in the response to treatment. I did some time with the on-call medical team. I was also able to attend regional seminars organised by the British Geriatrics Society and interact with trainees as well as practising geriatricians.

Lessons learnt

I found intriguing, the complex social and psychological problems of older people. In general they were less direct in articulating their problems and often cognitive impairments make them unaware of these deficits. I noticed that treatment aims were realistically modest and I was also able to appreciate the continuum of care available to older people from hospital to care settings such as nursing homes, and assisted living. One immediately discerns the outlines of a logistic ultra

Working within the NHS has meant working within a well organised environment with emphasis on adherence to best evidence and protocols. This can appear a bit overwhelming at times due to the range of protocols and pro-formas on almost every aspect of patient care.

structure supporting such a model (institutional linkages, communications and a carefully supervised regulatory framework) congruent with the social and ethical context of the community in which it is situated. In contemplating, the mass of resources and personnel to keep this model going, one begins to

realise that elderly care is not cheap.

While a single-pathology approach worked well in other medical specialties, I found this not to be the case in elderly care. Often, itemising the problems of the patient one by one and solving them or attempting to solve them usually proves mutually rewarding for patient and doctor alike. I have also been able to appreciate the unique insights that an interdisciplinary approach can contribute to the management of older people with multiple co-morbidities with diverse inputs from every sector of care. There is a strong emphasis on palliation and end of life issues with advance considerations of the wishes of the patient documented and discussed well with the family. I found the do not resuscitate (DNAR's) documentation process very revealing coming from a background where, discussing in advance about a patient's death, may not be culturally appropriate and usually elicits a range of dramatic emotions from denial to anger. Also, I found the trainees friendlier, less competitive and patient.

Working within the NHS has meant working within

a well organised environment with emphasis on adherence to best evidence and protocols. This can appear a bit overwhelming at times due to the range of protocols and pro-formas on almost every aspect of patient care. However, these are quite helpful in challenging situations and are a good way to refresh one's knowledge. Also, trainees are allowed to try things out for themselves in a learning environment which I find pretty much experiential rather than didactic.

Benefits and recommendations

Practising within a UK hospital for a young doctor coming from overseas can at first be a daunting task. There is a sense in which the doctor struggles to cope with a completely different way of practising medicine. Fortunately for most, this phase is short. What I found most helpful in adjusting were the initial induction programme I had, the opportunity to 'work backwards' with the foundation doctors and junior trainees (some of whom, I found out, during our coffee time discussions, also struggled to cope initially) and the excellent mentoring I enjoyed from my supervisors during this period. It also helped that I met a few Nigerian doctors and nurses already within the system who helped me settle in.

An appreciation of the problems of ageing both in health and in disease states will add an edge to the quality of care I can provide to many of our underserved seniors back home. I now apply many of the principles learned during my rotations to clinical problem solving on my own. I would recommend that this program be extended to trainees from those areas of Africa where geriatric needs, are as yet unmet both to increase physician awareness about geriatric issues and to promote the

The BGS Retired Members' Group

For the information of newly retired or about-to-retire geriatricians, I would like to bring your attention to the BGS Retired Geriatricians group which was formed in 2000 following a survey carried out to assess interest in a group of retired geriatricians. Those who expressed interest meet annually for a few days for good dining, conversation, relaxation, visits and a few 'light' lectures from volunteers. Wives are included. A short business meeting is held during each visit, when a volunteer is sort for organising and taking responsibility for the next year's event.

The group have met each year at places such as Bath, Lichfield (twice), Windsor, Beverley, Stratford, Norwich, Kings Lynn, Beaulieu, Newquay, St Albans, Southwold, Stamford, and the Lake District. The 2015 meeting in the Lake District is, I understand, fully booked.

Those who wish to be on the mailing list and/or to know about future events should email the current organiser, Dr. John Knox: johnknox@doctors.org.uk

I am grateful to Dr. Peter Horrocks for much of the above information.

Clinical Quality Presentations

at BGS scientific meetings

In the run up to the BGS spring meeting, we would like to remind presenters of clinical quality work, of a number of changes to the way CQ posters will be treated from the Spring BGS meeting in Nottingham in April. This article aims to highlight these. In summary

- Successful abstracts will be displayed online after the conference.
- Abstracts will no longer be automatically eligible for publication in the *Age & Ageing* supplement.
- There will be a platform presentation session for the best abstracts.
- Poster presenters may be asked to take part in an interview about their project for the website.
- The categories and headings for abstracts have been updated (see the November issue of the newsletter).
- The Clinical Quality section replaces what was previously known as Clinical Effectiveness.

There have been a number of changes as part of a long-term strategy to improve the value of abstracts beyond the posters and stimulate lively discussion both at the meetings and after; leading to wide reaching improvements in care through collaboration and building on each others successes.

Successful abstracts will be displayed online after the conference

The BGS is developing an online space for accepted abstracts to be shared; where as many relevant people can view your work as possible. **As part of this development, you may also be asked to provide a pdf copy of your poster.** Ultimately, we aim for this to become a valuable resource that members will be able to navigate by topic to find relevant projects to their needs more easily than currently.

Abstracts will no longer be automatically eligible for publication in the *Age & Ageing* supplement

Clinical Quality abstracts will no longer automatically be eligible for publication in the *Age & Ageing* supplement. This is for two reasons. Firstly, the above changes to presentation will provide a more meaningful way of sharing good practice with a larger audience.

Secondly, it was felt that journal publication of abstracts should be reserved for the most methodologically robust



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

There will be a platform presentation session for the best abstracts.

The best clinical quality abstracts will be invited to present their work as a platform presentation at each meeting from now on, in the same way that scientific abstracts have done for some time. These may be recorded and included in the online space too.

Poster presenters may be asked to take part in an interview about their project for the website

Some poster presenters may be approached to participate in a recorded interview to discuss your project in more detail. This would be an audio recording, to add to the website as a podcast so that your work can be more widely shared beyond the meeting.

The categories and headings for abstracts have been updated to reflect the goals of the section. (See the November issue of the newsletter)

The shift in focus towards development of new or existing services and their evaluation and away from simple audits is reflected in changes to categories under which abstracts are submitted and in the headings for writing the abstract.

Jo Preston

on behalf of the BGS Clinical Quality Group

In memoriam

Dr James (Jimmy) Andrews (1924-2014)

Dr James David Bruyn Andrews MD, DPH, was born on 10th February 1924.

His father was an author, his mother a schoolteacher, while two great uncles were doctors. He was educated at Westminster School and St. Bartholomew's Hospital. He qualified in 1949, passed the MD examination in 1952 and later the DPH. He was Senior Hospital Medical Officer in Coventry in 1957, where he described the local current geriatric service for the Hospital Board. Although he had eliminated the waiting list, some hospital beds were still occupied by inpatients who did not require a hospital bed. He pressed for better accommodation for the paramedical staff, a laundry service for the incontinent and increased Part III housing. The following year he was appointed consultant geriatrician at St. Tydfil's Hospital in Merthyr Tydfil. In 1960, he succeeded Marjory Warren at the West Middlesex Hospital following her accidental death.

He continued the development of the West Middlesex Hospital geriatric unit. The outpatient department thrived, the day hospital flourished and the number of his junior medical staff increased. In 1966, he admitted 749 patients, mostly from general practitioners. The majority were discharged and only 9 per cent became long-stay. He was well aware of the problems posed by mentally disturbed patients on wards or in the community and was a member of the Regional group, which studied that challenge. No doubt he was involved when Bruce Archer's research team, which included the celebrated Doreen Norton in a major advisory role, was assessing beds and ward equipment at the West Middlesex hospital. The work of this team culminated in the design of the renowned King's Fund hospital bed in 1967. In 1969, he invited those attending the BGS Autumn meeting in London to visit the day hospital before the conference, to see the newly designed beds and other equipment. Following the demonstration, there was discussion on haematological problems and lunch at the

nearby 'London Apprentice'!

Dr Andrews wrote papers relating to general and specific aspects of elderly patient care, in particular ward equipment, pressure mattresses and beds including a rather critical account of the recently launched King's Fund bed. He co-authored an erudite, extensively researched article on hereditary coproporphyrinuria, which affected his family. He followed Norman Exton-Smith as clinical editor of *Gerontologia Clinica*, which published an article by the controversial Professor Ana Aslan about the use of procaine (Gerovital, GH3) in delaying the onset of old age. When the journal ceased publication, he became editor of *Gerontology*. He was meticulous in checking authors' references and could be seen, dressed in colourful clothing, prowling the journal/book shelves in the Royal Society of Medicine.

He lived for many years in a Thames side bungalow built on piles, which prevented it being flooded during recent deluges up river. He recalled that he had bought the building in 1960 for £3,000! Ill health clouded his later years, which required hospital visits and the support of a home help. He was married but later divorced: there were no children. In 1997, the BGS awarded him its Jubilee medal. He died at home on 2nd November 2014.

Michael Denham

Past BGS President and currently BGS archivist and historian

It is with regret that the BGS reports the passing of another early member, **Dr Rita Walker FRCP**, former consultant physician in geriatric medicine at St George's Hospital Hornchurch. She passed away on 17th December 2014 in the presence of her family following a short illness.

As we were

Care of the elderly in hospital/community: the Hospital/Health Advisory Services

In his continuing series charting a course to, for all its faults, the kinder world we live in today, Mike Denham, past President of the BGS and currently our archivist, features the precursors to the present-day Clinical Quality Commission

"There is no doubt that the occasional scandal does an enormous amount for a social service."

Sir Keith Joseph in the House of Commons 12/7/1971

Infamous scandals in Victorian workhouses surfaced in 1840s. At Andover, the inmates of the town's workhouse were starving and, perforce, had to eat the marrow from horse, dog and cattle bones, which it was their job to crush to produce bone meal fertiliser. The Huddersfield situation was far worse. The official report stated that the sick poor 'had been most shamefully neglected'. They lacked necessary clothing and bedding. Beds, in which patients suffering from typhus had died, were repeatedly used for new patients without any attempt at 'purification'. The beds themselves were little more than bags of straw and shavings, and swarmed with lice. Two patients with 'infectious fever' were placed together in one bed. A living patient had occupied, for a considerable period, the same bed with a corpse!

In response to public concerns, the Lancet set up its own investigation, The Sanitary Commission, which reported in 1866. It stated that 'State hospitals are in workhouse wards. They are closed against observation. They contravene the rules of hygiene'. 'The fate of the 'infirm' inmates of crowded workhouses is lamentable in the extreme; they lead a life which would be like that of a vegetable, were it not that it preserves the doubtful privilege of sensibility to pain and mental misery'. 'If all the infirm were medically treated there would be a very large percentage of recovery'. The Editor of the Lancet called workhouses 'The Ante-chambers of the Grave'.

At the turn of the century, the government set up a review of the Poor Law. The 1909 Royal Commission's Minority Report advocated a need 'to break up the present unscientific category of the aged and infirm' and 'to deal separately with distinct classes according to the age and mental and physical characteristics of the individuals

concerned'.

Between 1941 and 1945 government commissioned teams surveyed hospitals in England and Wales. Many, in varying degrees, made devastating observations about the care of the chronic sick: they had some of the worst accommodation, their medical care was frequently condemned and staffing levels were often inadequate. Interestingly, both Lionel Cosin, who became director of the Oxford geriatric unit, and George Godber, who became one of the greatest Chief Medical Officers we ever had, were members of the visiting teams. The Nuffield Provincial Hospital Trust summed up the reports saying that the surveyors reserved their bitterest criticism for the provision of care for the chronic sick.

In 1967 Barbara Robb published, *Sans Everything: a Case to Answer*. The book quoted examples of inappropriate hospital care with authoritarian and depersonalised systems used on wards of unnamed mental and geriatric hospitals in England and Wales, and suggested solutions. The publication received wide publicity and prompted enquiries at the hospitals, whose identity were later revealed: four were mental hospitals and two were geriatric: Cowley Road Hospital, Oxford and the North Wing of St. James Hospital, Leeds. A Queen's Counsel chaired each investigating committee together with a doctor, a nurse, and one or more lay members from outside the region concerned. Lord Amulree was a member of the team which visited Banstead Hospital, Surrey while Norman Exton-Smith went to Cowley Road. The results were published as a White Paper in 1968. It concluded that the majority of allegations of cruelty were unfounded or based on unreliable evidence and that the complaints were inaccurate, vague, lacking in substance, misinterpretations or over emotional. The unnamed director of Cowley

Road Hospital, presumably Lionel Cosin, was singled out for praise for his achievements in changing a custodial regime into an active geriatric unit, with 100 acute beds out of 212 beds. The reports were considered a whitewash. Robb remained unsatisfied and complained to the Council of Tribunals, which rebuked the Minister.

The Hospital Advisory Service

Another scandal occurred in 1967 at the Ely Hospital in Cardiff in a unit for the mentally subnormal. A nursing assistant made specific allegations of cruelty to patients, coupled with pilfering of their food and property. Geoffrey Howe, Q.C., chaired the Inquiry in 1969, which confirmed the allegations and reported that the whistle blower had been victimised. When the scandal broke, the Secretary of State, Richard Crossman, considered he had been caught out because no one had warned him and therefore he was politically 'at risk'. He was exasperated to discover that his Department knew about the problem, had done nothing and had not informed him. Crossman reacted by creating the Hospital Advisory Service (HAS) in 1969, which was to act as his 'eyes and ears', would be responsible to him alone and be independent of the Department.

How did the HAS function?

Its headquarters were in south London with a staff consisting only of the director, his deputy, 6.5 whole time staff equivalents, together with a small number of specialists who formed the visiting teams, and a shoestring budget, in 1988, of about £1 million. Its visits to local hospitals, a form of 'peer review', began in 1970 under its first director, Dr. A. A. Baker. They assessed existing services mainly for elderly people and those with mental illness and, where necessary, advised on changes in management and patient care. Good practice was identified but the HAS did not investigate individual complaints.

Hospitals were notified of an impending visit. Prior to the team's arrival informal discussions took place between the Director and hospital management. Recently discharged patients were asked about their experiences. This information was supplied to the visiting team, which comprised 'in post' professionals: consultant geriatrician or psychiatrist, senior nurse, a member of the paramedical staff, an administrator and a social service practitioner nominated by the Social Service Inspectorate. Visits lasted one to three

weeks, followed by report writing for a week. The reports' specific headings ensured all subjects were mentioned. They remained confidential to the unit but became public in 1985.

At the beginning of each visit, the team met members of the Health Authority, key senior staff, local GPs, representatives of the Community Health Councils and voluntary organisations. GP opinions were sought but were not always forthcoming. Later team members met medical, nursing, paramedical, and social work staff on an individual basis, and then visited hospitals, residential and care homes. The HAS requested a response to the report after six months and two years later carried out a follow up visit. By 1976 a total of 1,410 hospital units, involving just over a quarter of million beds, had been visited at least once. The Service issued annual reports but this lapsed in the mid-1970s but reappeared in 1983.

What did the reports find?

Two studies reviewed 65 individual HAS reports between 1985 and 1989. The most common complaints were poor sanitary conditions, overcrowding on the wards, use of restraints, inadequate personal clothing, and neglect of privacy especially in toileting. Reports mention patients being put on commodes in full view of others and toilets without doors or curtains. Poor communication occurred among and within professions. In the worst case, health authorities and social service departments did not meet together to discuss or plan services for elderly patients. Many recommendations required no extra funds but did require improved management and attitudes! The first director maintained that the problem with care of the elderly with mental illness was not so much that of facilities but of attitudes.

A review of three annual reports, 1983-1986, pointed to a continued lack of financial investment in community support services, delayed admission of elderly people to hospital, lack of dedicated beds, inadequate treatment, with long-term care often provided in ancient buildings operating an institutional regime. Treatment of long stay patients was not unkind but was of devastatingly low quality. A recurrent finding was that older people could experience two very different standards of care depending on whether they were in a geriatric and non-geriatric ward. In the former, the general overall package of care was much superior to the latter. The design of new

geriatric wards emphasised improving clinical and nursing efficiency rather than the personal needs of the patients. Unhappily, too many health authorities remained pessimistic and uncommitted towards specialist services for older people. It was HAS experience that levels of 'input' measured by resources and staffing, were not always a reliable measure of quality or success. On the positive side, the reports included extensive lists of examples of good practice and indeed, the 1987 report placed particular emphasis on the dissemination of this information. Furthermore, visits brought together people of the same hospital group who did not seem to know each other.

Criticisms of the HAS

Although the HAS was seen to perform a useful function by highlighting problems and identifying good practice, it attracted multiple criticisms. Detractors pointed to a lack of standards against which a service could be assessed and that spending was not compared with areas with similar social, economic and demographic profiles. Too much reliance was placed on professional opinion. It could not enforce change, and was not as influential as the Audit Commission or the Social Service Inspectorate. The Service's original role as the 'eyes and ears' of the Secretary of State had disappeared. It was also criticised for being prejudiced towards the long stay services. But, as the first Director pointed out, it was the task of the HAS to help under-privileged services catch up with those better endowed. However, some censures were ill founded. It was accused, for

example, of failing to diagnose the problems at Normansfield Hospital, Teddington, in 1976 but it had identified them, had given appropriate advice, which had been mostly ignored. The case illustrated how difficult it could be for the NHS, with its multiple levels of authority, to deal with cases where there were personality clashes.

Change was definitely on the horizon and monitoring systems underwent considerable transmogrification. In 1995, the HAS became the Health and Social Care Advisory Service, which was followed by the creation of the Commission for Health Improvement in 2001. The Healthcare Commission replaced it in 2004, followed by the Care Quality Commission (CQC) in 2009.

Where are we now?

The CQC dwarfs the original HAS. Its budget in 2009 was £164 million. It has major offices in London and Newcastle, more layers of administration, much enlarged staffing and glossy publications. Teams number some 30 persons who measure eight core services using five key questions. Its remit is larger, covering care provided by hospitals, general practices, dentists, ambulances, care homes, and home care agencies. However, its 2013-4 annual report is so wide ranging that it is difficult to identify specific care concerns about the older people, although dementia does receive specific attention.

Shortly after its appearance the CQC went through a turbulent time when it lied to Parliament in 2010/2011 saying it had carried out 15,220 inspections and reviews when had only completed 7,368. It was then severely criticised for the Ash Court and Winterbourne affairs and for gagging its own staff. A major clear out of higher managers followed. The new chairman considered that the CQC's previous management was totally dysfunctional and was not fit for purpose but even in 2014 new members of staff were still being appointed with inadequate qualifications.

The CQC's focus now concentrates on the quality and co-ordination of patient care. Will it succeed? The recent debacle over general practice assessments does not augur too well but time will tell. Was Sir Keith Joseph still correct in saying that occasional scandals improve Social Services?

Michael Denham

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