Nottingham City, one of six areas in the country selected by NHS England as a ‘vanguard’ site to develop a new model of enhanced healthcare in care homes, describes its ambitious vision for an outcomes-based model which is fit for the future.

The Vanguard sites were announced following publication of the NHS Five Year Forward View (October 2014) which sets out a series of new ways of providing care. It is intended that the Vanguards act as the blueprints for the future NHS, inspiring the rest of the health and care system.

The Nottingham City approach, being developed over the next 12 months, will offer older people better, joined-up health care and rehabilitation services.

Care home residents have complex medical needs. The average resident has six diagnoses and takes eight medications.

Currently, care homes residents are 0.5 per cent of the city’s population but account for 5 per cent of all admissions to hospital. Many older people are cared for in hospital but best practice evidence indicates that care is most effective when provided at home or in the community.

Achievements
The Vanguard initiative seeks to build on progress to date. Since 2010 the local NHS and partners have been working on a whole systems approach to improving care in care homes. Activities have included:

- Enhanced primary care support to care homes service – building more constructive relationships
between care homes and GPs by contractually aligning Nottingham City residential and nursing homes with a named GP practice. There are currently 1,200 care home residents who are registered with 23 GP practices providing this service. Since the service went live, there has been a 5 per cent reduction in emergency admissions from care homes to hospitals.

- Care homes nursing team - providing a dedicated nursing service to Nottingham City registered patients in residential care homes with a view to improving relationships, communication and clinical care

- Specialist nurse practitioners to care homes – aiming to achieve individualised, assessment driven, multi-disciplinary healthcare for residents newly admitted to care homes

- Care home clinical pharmacist (pilot) – looking at the added value and efficiencies associated with having a clinical pharmacist role in the skill mix of GPs, advanced nurse practitioners, community geriatricians and other health and social care professionals involved in the care of residents

- Dementia outreach team – improving quality of care for people with dementia through specialist input, support and training in care homes

- Resident representative service – engaging with people resident in a Nottingham City residential or nursing care home to support the strategic development of proactive and preventative health-related service models to care homes

- Community geriatricians.

**Vanguard vision**

The Vanguard vision will enable residents living in a care home to be healthier, have a better quality of life and to be treated with dignity and respect, focusing on residents’ capabilities rather than their dependencies. It hopes for all residents and their families to have a positive experience of care. This will be achieved by the care home sector, commissioners and providers working together to transform the model of support provided to care homes.

The Vanguard programme in Nottingham City is set to move more older people’s care from hospital to the community, introduce greater use of healthcare assistive technology and IT in care homes (such as video consultations), improve medicines management, and
build partnerships of support across professions and organisations in improving patient/citizen care. Feedback mechanisms will be put in place so lessons can be learnt and services continually adapted and improved.

Russell Pitchford, commissioning manager for community services and integration with Nottingham City Clinical Commissioning Group (CCG), said: “We believe we have the basic building blocks in place forming a solid foundation to work from at pace. Our aim is to remove organisational barriers and ensure that care home staff have support from specialist health services to identify, understand, manage and respond to the everyday impact of providing essential care. Residents will receive co-ordinated input from generalists and specialists of multiple disciplines in partnership with social care professionals and care home staff. These partnerships are essential, built on shared goals, reliable communication and mutual trust.”

The programme will be overseen by a steering group which includes GPs, nurses, pharmacists and community geriatricians. Organisations and networks involved in the Nottingham City CCG-led programme include Nottingham City Council, Nottingham CityCare Partnership, Nottingham University Hospitals, Nottinghamshire Healthcare, Age UK, University of Nottingham and the Care Home Managers Forum.

The Vanguard work with care homes fits into the Integrated Care programme that is taking place within the city, bringing together health and social care services to provide joined-up, holistic care for citizens/patients.

**Vanguard objectives**

Over the next 12 months Nottingham City CCG will work with local partners to develop a new clinical model for care home residents based on the following objectives to:

▶ Strengthen the culture of partnership, support, and engagement with the care home sector, local community services and voluntary sector, working together to develop an outcomes framework and improve the experience of residents
▶ Review and re-design services commissioned to support care homes in order to improve outcomes for residents and deliver efficiencies through better use of resources
▶ Support the roll-out of new technologies and telemedicine to provide fast and effective access to clinical and specialist input
▶ Increase the provision of community beds to support people to return to independent living with appropriate support from community services
▶ Develop an effective hospital discharge pathway and processes that support residents to return to care homes as early as possible, seven days a week
▶ Ensure care home residents have agreed goals of care based on proactive, resident-centred multi-disciplinary review involving families
▶ Develop and implement an effective urgent care pathway for care homes
▶ Develop and implement an effective end-of-life pathway for care homes.

We hope to carry a progress report in a future issue of the BGS newsletter.

*Russell Pitchford*
Commissioning Manager
Community Services and Integration
NHS Nottingham City Clinical Commissioning Group
Editorial

I realised one of the highlights of my clinical career to date whilst on holiday in late May. The email from my secretary commenced with the customary heart sink mid-holiday introduction.

“‘I know you’re on holiday but......’”

Dare I read on? Was it a complaint, or an adverse event? Had I somehow misread the AMU rota and failed to turn up for my on-call? What followed was, in fact, delightful:

By the time of the visit to Lourdes by “Jumbulance” (see: http://www.across-uk.org/pilgrimages/holidays/the-journey/) my patient required hoist transfer from bed to chair and had fluctuating arousal and moderate cognitive impairment related to Lewy Body Dementia. That she made it at all is a credit to all involved. That she had such an amazing time is either evidence of divine providence, or of the power of engaging in meaningful activity, depending on your world-view.

The back story to this post-card, anonymised and reproduced with kind permission of the author, involved two years of regular visits as part of my community geriatrics service. Sometimes I would provide advice on technical matters such as iron supplementation, courses of steroids and management of cardiac dysrhythmias. Sometimes I would provide thoughts on aids and adaptations. Other times I would help to consider prognosis, what acute hospital might add and whether management in the community was preferable. Sometimes I would just listen to how life was panning out for my patient, and for her devoted daughter.
contribution from the systematic and patient-centred approaches that we encourage through geriatric medicine is nothing short of humbling. I genuinely shed a tear – but don’t tell any other hardened Scotsmen that, or they’ll mock me down the pub.

So a happy patient and a happy carer experiencing a happy life event. I guess I should be happy. But as a reflective practitioner I find myself wondering whether I could have done more of the technical stuff better and earlier to slow or reverse her functional decline. As an academic with an interest in models of service delivery, I wonder whether using so much of me, for so long, is an efficient and effective way to provide care. Managerial colleagues might define this in terms of the question “did I do the right things?” and “did I do the things right?”

It’s important as geriatricians that we continually strive to improve. We know that our patients are not hopeless – as other parts of society and/or our profession might seek to have us believe – and our response to that has to be continued innovation and reflection - even when it seems things have gone well.

So it is good to see in this issue of the newsletter that the Society has contemplated both of these questions.

Under “doing the right thing”, there is the innovative work of the NHS England Vanguard sites in providing new models of care to older patients in ever more integrated and connected ways. Russell Pitchford’s front page article is an excellent case study of work in progress. Andrew Clegg (page 27) reminds us that we need ever more sophisticated and nuanced research approaches to build the evidence base for interventions in older patients with complex medical problems. The numerous policy challenges outlined in Patricia Conboy’s policy digest (page 16) reminds us of the campaigning and proselytising still to be done if we’re to ensure best-evidenced care gets into practice.

Under “doing the thing right”, the detailed report from the Society’s spring meeting is evidence of colleagues from across the geriatric subspecialties seeking to ever-refine their protocols and approaches to make sure we do the best for our patients. Amit Arora’s piece (page 18) on the Choose Wisely campaign reminds us that weighing the available evidence may often result in us working within shared decision-making frameworks to limit investigative or interventional algorithms. In her piece on benchmarking, (page 19) Leigh Jenkins reminds us of the importance of measuring what we do against acceptable and accepted quality criteria.

So it’s nice to feel, as I reflect, that colleagues around the country are doing the same and that the answers to my questions – well some of them at least - are in the BGS Newsletter!

That leaves us with the as yet unopened can of worms as to whether one should check one’s emails during annual leave. At the end of this particular editorial I’m left thinking that there’s no such thing as being too connected, when connectivity delivers news this good. I may not feel the same way, though, next time I read those heart-sink words.

Adam Gordon

Please vote for the next Honorary Deputy Secretary

At this year’s AGM in October, I shall be handing the editor’s quill to Andrew Williams who will succeed me as Honorary Secretary of the BGS. At that time, the membership will be ratifying the appointment of the new Honorary Deputy Secretary and I would urge you to vote for one of the two excellent candidates who have put themselves forward, i.e. Susannah Long and Shane O’Hanlon. Voting may be done by paper ballot (which came with this newsletter in the form of your mailing address carrier), or online via the BGS website.

Please vote for the next Honorary Deputy Secretary
It will be the BGS’s 70th birthday in 2017. As one of the biggest medical speciality societies in the country, we aren’t in danger of disappearing and our membership (3,250 at the time of writing) is at a record high.

At this rate the BGS will be old enough to be one of its members’ own patients! The Society’s foundation coincided with that of the NHS and caught the eye of ministers early on as a potential solution to pressing problems.

I attended my first BGS Spring Meeting in 1993 as a Medical Registrar – the year I joined the Society. I worked out the other day that Nottingham in May was my 35th (no-one gets to them all!). Those early meetings made a real impression on me but “going to BGS Conference” has always been a highlight of my calendar – not least because there are so many fantastic colleagues and friends to catch up with, set the world to rights, swap information and air collective moans. I always go back to the day job with new insights into better care for older people.

A perennial feature of my time in geriatrics has been suggestions from some of our number that we have somehow lost our mission or core values, sold our soul and betrayed the Society’s principles. I strongly dispute this view and having heard several prophets of doom across three decades, I’d say our foundations are still solid and our house as strong as ever. All specialities evolve with the times. During that same 1993, Coronary Care Units were run by jobbing on call doctors, with streptokinase and TPA the mainstay of treatment and middle-aged patients frequently dying of complications. Has Cardiology somehow “sold out” because of 7/7 speciality leadership, ACS protocols and urgent revascularisation?

Over the 26 years I’ve been qualified, we’ve lost around one third of our acute beds, length of stay has shortened dramatically, urgent hospital activity has doubled and the age, frailty and complexity of hospital inpatients has altered to the point where geriatrics is now “core business”. The long-stay units I remember working on have gone, as have most old-style day hospitals. But geriatricians are embedded and prominent in acute general medicine and consistently working in “geriatric assessment units” much closer to the “front door” of the hospital. Rapid assessment clinics to provide Comprehensive Assessment for older people have grown. Integrated community rapid response and intermediate care teams provide a range of supports that no longer necessitate a trip to a building. The more things change, the more they stay the same.

At the BGS’s very first meeting of nine people, chaired by Trevor Howell, its aims were defined as “the relief of suffering and distress among the aged and infirm by the improvement of standards of medical care for such persons, the holding of meetings and the publication and distribution of the results of research”. As we approach our 70th anniversary, we may use less paternalistic language, focusing more on enabling and empowering people but we haven’t changed that much.

In 1949 Professor Norman Exton-Smith described the role of the speciality in “Medical Management,
Rehabilitation and Long-Term Care of Older People. In 1977 Dr Cross wrote a BMJ paper “Geriatric Medicine – death and rebirth”, showing there's nothing new about this soul-searching. He described the early influence of the BGS thus: ‘persuading the health minister to appoint more geriatricians as the NHS grew; an emphasis on the assessment and care of frail or disabled patients by a geriatrician and multidisciplinary team; discharge home for those who recovered; patients who were frail, disabled and previously often classified as senile were reassessed and often found to have modifiable disease; in turn more patients were able to return home enabling the use of beds for other specialties and the updating and decorating of facilities’.

I’d like to think that any of our earlier pioneers, would be pleased to see how far we’ve come and would see their values and mission were alive and well.

Can you imagine them being displeased to discover that Geriatric Medicine is now the biggest internal medicine speciality – with at least 1,500 UK Consultants - a fact that always astounds colleagues overseas where Geriatrics is often small and struggling for a foothold outside academic centres); or that we consistently attract high calibre trainees who have actively chosen the speciality yet are also trained in acute internal medicine; or that several hundred of our consultants now have community or interface roles; or that far from abandoning long-term care, the BGS has produced a suite of publications on care homes, and community assessment of people with frailty, provided clinical leadership to intermediate care; or that Dr Irvine’s pioneering work in orthopaedic-geriatrics has now mushroomed into a National Hip Fracture Database and Audit with geriatric involvement in trauma services being the norm; or there is now a growing role for geriatric medicine in peri-operative services supporting other surgery?

I feel confident that if long-departed geriatricians could have ghosted into our Nottingham Spring Meeting, they would look on with pride and approval. If they do have social media up in heaven, perhaps they could even follow the tweets on #BGSConf (now “storified” for each of the three days). They’d see that every one of Bernard Isaacs “Geriatric Giants” of Falls, Immobility, Incontinence and Confusion was discussed fulsomely - for instance in a whole day on care for people with Dementia, presentations and posters on Delirium, Falls, Rehabilitation and Intermediate Care for “discharge of patients who are frail or disabled”. “Support for the vulnerable and infirm” was to the fore throughout the three days.

Despite our ongoing BGS dialogue about the range and quality of science presented at our meetings, (notwithstanding the large amount now also showcased at well-attended Sections and Special Interest Groups) the abstract book contained around 96 posters or platform presentations. This did not include all the guest presentations by experts in their field. The founders would see that their legacy hasn’t been squandered.

Before the meeting, I started a twitter hashtag #youknowyoureageriatrician (when) – partly for fun but also to “crowdsource” my Presidential after-dinner conference speech with the most humorous or moving tweets. A US writer, Linda Abbit became interested and wrote it all up for the “Senior Planet” online magazine. If you want to feel good about who we are and what we do -and understand our collective psyche and credo then do read or contribute to the hashtag (still open for business) and Linda’s article (page 8).

You know you're a geriatrician

“Geriatricians See the Years Lived” “Geriatricians Care About the Whole Person” “Geriatricians don’t see age as a reason to give up on you” “Geriatricians are wary of too many medications” and “Geriatricians take it all in their stride”.

...as summarised by Linda Abbot in ‘Senior Planet’

So if we do start succumbing to doubt about what we stand for, the good we do or the commitment of geriatricians 68 years on from the first BGS meeting, this outsider’s view should re-affirm it. I don’t pretend there aren’t dark clouds on the horizon for health and social care. The Queen’s speech didn’t promise the scale of funding
increases that independent bodies such as the King’s Fund or Health Foundation say we need just to keep up with demand. It said still less about reversing the huge local government funding cuts which put social services for older people and their carers in grave danger. Whilst geriatric medicine can’t just “take in its stride” these challenges, we have ample evidence that our speciality and its members will endure. With one in five of the population projected to be over 65 by 2030 and with the care of older people with frailty now key to the whole health and care system, the 550 who attended the Nottingham Conference and the thousands more who followed it on social media can continue to be in the vanguard of change as much as those nine pioneers were in the first meeting that Trevor Howell convened.

David Oliver

You know you’re a geriatrician when...

Following David Oliver’s setting up of the Twitter hashtag #YouKnowYoureAGeriatrician, the thread was picked up by Linda Abbit who wrote about it in ‘Senior Planet’. Here we re-publish her article and give a flavour of the tweets.

What is a geriatrician? You could ask Wikipedia – or for a more entertaining answer, you could consult Twitter.

A month ago, the president of the British Geriatrics Society, David Oliver set up the Twitter hashtag #YouKnowYoureAGeriatrician and asked his colleagues to tweet the rest of the sentence.

So, What Exactly Is a Geriatrician? We did check in with Wikipedia – here’s a quick breakdown: A geriatrician is a doctor who develops and manages care plans tailored to the unique needs of older people, who often have multiple health problems and take several medications. In the U.S., these specialists are usually primary care physicians board-certified in either family or internal medicine, who complete three to five years of additional training to become certified in geriatric medicine.

The U.S. has a geriatrician shortage – we have one geriatrician for every 2,620 American aged 75 years or older – and it’s only expected to get worse as the senior population surges. In contrast, in the U.K. geriatricians represent the largest group of internal medicine specialists.

What’s up with that? Over the past five years, fewer U.S. medical school grads have been choosing careers in internal medicine and family medicine, the two fields that feed geriatric fellowship programs. Besides, geriatricians earn less than other specialised doctors and have unpredictable work schedules – so why go into geriatrics when you could make more and play more? Read the tweets and find out!

On the Bright Side...
The #YouKnowYoureAGeriatrician tweets show that professionals on both sides of the pond care about older patients’ welfare in unique, patient-centred ways (and can get a little sentimental!).
The CIRS app is an interactive tool designed to measure comorbidity in older patients. It was developed to provide healthcare professionals (HCPs) with information on the 'Cumulative Illness Rating Scale for Geriatrics' (commonly abbreviated to CIRS-G), and to help them calculate a patient's biological fitness based on a ratified CIRS-G scoring assessment.

The app allows the scoring of common problems of older people by measuring the chronic medical illness burden while taking into consideration the severity of chronic disease in 14 individual body systems including: haematopoietic, cardiac, respiratory, musculoskeletal and psychiatric.

HCPs will be able to assess their patients’ health status, analyse whether the score reflects a few serious problems or multiple problems and manage the treatment of patients as needed.

The app is compatible with IOS devices and is available to download at the iTunes store: http://apple.co/1Jtfqnu

Alternatively, it may be downloaded at: http://roche-cirs.herokuapp.com/

The app was developed and funded by Roche Products Limited.

Please note the app is for guidance only, does not replace expert medical opinion and is not deemed to be a medical device within the terms of the Medical Devices Directive 93/42/EEC.
So widespread is the risk – an estimated 1.3 million of people aged over 65 suffer from it – that the entire first day of the BGS’s Spring meeting was devoted to the subject.

Lesley Carter, manager of Age UK’s taskforce partnership, spelled out the scale of the crisis: 93 per cent of the malnourished lived in the community, 22 per cent of people over 60 skipped meals to cut back on food costs and a third of those aged 65 or over were at risk of malnutrition on admission to hospital. “This must be recognised as a priority across all disciplines,” she said.

Strategies included increasing awareness in education and training, developing personalised care and support, finding solutions to social isolation and creating opportunities for self care through information. “By the age of 75, calorific value is more important than five a day for example.”

Hospitalisation brought its own hazards, Andrew Rochford, consultant gastroenterologist at Barts, told his audience. Patients often had lower reserves at the outset. “They then might come in for a relatively minor procedure but they’re put on nil by mouth for a gastroscopy and then again for radiology and before you know it they’ve gone five or six days without eating anything.”

Patients needed to be risk assessed and managed accordingly. He recommended the MUST, the Malnutrition Universal Screening Tool as consistent, reliable and quick and easy to use. If the score was low the patient simply needed routine care, if medium, observation and if high, referral to a dietician.

A striking illustration on his powerpoint presentation highlighted how the most basic needs could be overlooked. The question asked had been ‘what can I as a doctor do for you the patient right now to improve your stay here in hospital?’ and the size of the letters giving the answers was in direct proportion to their frequency. The largest lettering by far was the answer ‘a glass of water’. “Maybe on ward rounds we should routinely pour one for everyone,” he added.

With nurses under ever increasing workloads it was not always possible for them to assist patients at mealtimes and he envisaged a time when families might be needed to plug that gap.

A way of plugging that gap which has already been tried in Southampton is the Mealtime Assistance Study, a two year project where 29 volunteers, trained by a dietician and a speech therapist, helped with a variety of tasks for over 3900 patients with a mean age of 87. These included cleaning patients’ hands and their tables, preparing food trays and opening packaging, encouraging eating, cutting up food, guiding food from plate to mouth where necessary and completing food and fluid intake charts.

Nursing staff who had been initially hesitant, fearing an increased risk of choking or aspiration came to welcome the volunteers’ input, said Fiona Rossiter, clinical research fellow at University Hospitals in the city. Although food intake did not increase, the quality of patients’ mealtime experience improved and they valued the regular presence of someone with whom they could build a relationship.

Up to 75 per cent of patients lose weight in hospital with a significant association between malnutrition and increased length of stay, slower rehabilitation and increased rates of infection, ulcers, re-admissions and death. Malnutrition was estimated to cost the NHS £8bn a year.

Volunteers can similarly work with geriatricians in other ways to prevent malnutrition according to Karl Demian, director of strategy and development at the Royal Voluntary Service. “When you’re commissioning services you can recognise the value of what the sector can offer and you can expand the concept of social prescribing, like suggesting someone joins a lunch club for example.”
Throughout the day the meeting heard of the various barriers to good nutrition including acute illness, low mood, poor appetite and a decline in or loss of taste and smell. Problems with mobility or weakness made shopping and cooking difficult and eating often became a lonely consumption of calories rather than a social event or shared experience. Cognitive impairment was a major factor as Margot Gosney, professor of elderly care medicine at Reading University, explained. “There are very few fat elderly patients with dementia. They get thinner and thinner and fade away in front of your eyes. This is very distressing for families though patients themselves may be unaware of it.”

Older people generally, but especially those with dementia, got less pleasure from food and there were fewer triggers to eat. Nutritional supplements could bring their own problems: patients often complained of a metallic taste or a drying mouth.

Strategies could include getting patients to eat little and often – five small meals a day rather than three big ones; offering snack rounds or afternoon tea; getting families to bring in a delicious dessert as a reward for eating a main course; prescribing a small sherry as an appetite booster; not leaving too long a gap between meals so that patients did not get past hunger; being prepared to swap foods in the middle of a meal. “If someone eats half a plate of fish and chips and you take the rest away and give them a roast dinner they’ll eat half of that. It’s something to do with boredom”, added Prof Gosney. “And never use sandwiches. No-one likes them. Not even junior doctors will eat them.”

Prof Gosney and her team had been working with chef Heston Blumenthal to enhance the ‘umami’ or meaty fifth taste content of dishes like shepherd’s pie by adding flavourings like soy or miso sauces. Such dishes were proving more popular with older patients. “Use familiar terms. A lamb tagine means nothing to an older person, a lamb stew does. Basically do anything you can to increase calorie intake. Give them a Mars bar if they want that.”

“We have got to get through to people that food is probably the most important medicine in hospital. A patient might leave 95 per cent of what they’re given. We wouldn’t find that level of waste acceptable with medication but we do it all the time with food.”

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Cognitive difficulties

The parallel sessions on Wednesday were similarly devoted to another widespread geriatric concern, dementia: with older people occupying two thirds of NHS beds and 60 per cent having a mental disorder - depression 29 per cent, dementia 31 per cent and delirium 20 per cent, there is a pressing need for progress in the field. Sessions included ones on hospital screening for cognitive impairment, the role of education and training in changing practice and models of care in the community.

Demystifying confusion and delirium

Dr Claire Copeland, consultant physician in care of the elderly at University Hospital Crosshouse and Ayr, devoted her address to demystifying the confusion about delirium - an acute medical disorder manifesting itself behaviourally as a psychiatric illness. Symptoms included disturbance of consciousness and a reduced clarity of awareness of the environment, a reduced ability to focus, sustain or shift attention, changes to cognition or the development of perceptual disturbance, not better accounted for by pre-existing or evolving dementia.

It developed over a short period of time usually hours to days and tended to fluctuate over the course of the day. It was common for it to be superimposed on dementia but the latter was gradual and irreversible. Delirium could occur as a direct physiological consequence of a general medical condition, an intoxicating substance, medication or other causes.

The pathogenesis was probably neuro-inflammatory causing an acute brain dysfunction, a direct insult to the brain by something like a stroke or infection or an overreaction or exaggerated response to a mild insult. “There is the notion of the ‘vulnerable brain’ which is tipped over the edge by something - age, frailty, severe illness sensory impairment, polypharmacy, infection, even constipation. I’ve cleared out patients’ bowels and they’ve woken up brand new. Sometimes there doesn’t seem to be any obvious cause. I had one lady who had terrible delirium for weeks after a flu jab. It probably wasn’t that but we couldn’t see anything else.”

Delirium was bad, Dr Copeland added, because it had an impact on cognitive status, could worsen or even lead to the development of dementia and was associated with increased length of stay, a higher rate of institutionalisation and increased mortality. It could also lead to post traumatic stress type symptoms. “Hallucinations are incredibly distressing and patients are terrified of them happening again.”

The condition could be hyper or hypo active or a mixture of both. The hypoactive type was often worse - patients were ‘no bother’ so they were left alone. It was vital for nursing staff to know what was normal for an individual so they could recognise change and that they listen to what families and carers said about someone not being their usual self.

Drug treatments could be divided into the ‘do something now’ type or those which ‘take the edge off’. There was also a ‘delirium toolkit’ showing how to help patients by playing music, talking to them, offering drinks and helping to orientate them.

Understanding aggression to defuse aggression

Dementia was also a theme in the following morning’s sessions on aggression which began with Dr Liz Sampson, clinical senior lecturer at University College London, looking at its causes as the key to managing it. Firstly though, she said, one had to differentiate between aggression proper – anger or antipathy resulting in violent behaviour and a readiness to attack or confront – and other actions. “Arguing, shouting, rattling the ward door or shaking a fist when someone approaches you with a catheter might just be ways of trying to make yourself understood or asking for help.”

Causes could be biological, psychological or environmental or a ‘collision of all three, an unholy trinity’. Biological causes could be the loss of brain cells or neurochemical changes. Alzheimers tended to affect the fronto-temporal part of the brain which controlled higher function behaviour. Neurochemical changes might lead to a decrease in serotonergic activity and from that a rise in anger and depression, deficits in cholinergic transmission could make a patient disinhibited.

“It helps to take a step back and understand that this person is brain damaged,” she said.

Other possible factors were delirium, constipation, misperceptions due to visual problems such as cataracts and pain which was often underdiagnosed in those with dementia who could no longer express their pain. Similarly, discomfort could be a reason: someone sitting
awkwardly or being too hot or too cold.

Psychological causes included depression, fear, boredom and embarrassment – “shame is one of the deepest human fears and we do anything to save face.” Toxic environments would be too much noise and light, sleep deprivation, disorientation and lack of exercise. “These are actually the ‘enhanced interrogation techniques’ used in Guantanamo Bay but they could apply to many hospital settings.”

Behaviours were driven by unmet needs so it was important to ask what the patient was trying to communicate. Early intervention was a great help. “My plea is for you to ask us to see people early. Too often we’re only called when something has got really bad.”

The last speaker, Prof Graeme Yorston of the Centre for Ageing and Mental Health at Staffordshire University, spoke about violence in old age. “There is a continuum of seriousness but violence is different from aggression which is mainly reactive. Violence implies a more severe result, it’s a physical act with the intention to harm or kill and it may include sexual violence.

Although the number of older homicide offenders was relatively small – between ten and 20 a year – the methods could be as savage as anything perpetrated by younger adults. “You are never too old to be dangerous.” Weapons he had encountered included a mallet, a flat iron, garden shears and a saw. Methods included punching, strangling, suffocating, drowning and using a blunt instrument.

He recalled one tragic case of a middle class family man who’d been a WWII pilot and ‘something of a hero’. “He’d been a pleasant, warm, hard working man with no criminal record or any hint of what could happen but he was suffering from vascular dementia. He’d shown minor aggression and sexually inappropriate behaviour in hospital and then in the nursing home. He did some kicking of shins and raising his walking stick and he tried to push someone downstairs.

“These incidents were not dealt with and he then came to believe that one of the other residents was a German spy and when one night she walked into his room he bludgeoned her to death with his walking stick.”

It was important to watch for the danger signs caused by fronto-temporal degeneration in the brain: changes in personality such as someone becoming an extrovert after being an introvert, the loss of the ability to empathise with others, aggression, disinhibition, joking at the wrong moments, sexual inappropriateness. “Behaviour may arise out of desperation or it may be manipulative or attention seeking. You need to try and get a decent history of someone’s functioning before the offence.”

Risk assessment was always difficult because it was hard to know whether someone would get more or less violent. You must though, assess the risk to age matched peers. Violence which wouldn’t be effective against someone younger can have catastrophic results in an older frail person.”

Older people behind bars
Offenders unfit to plead would be contained in a secure hospital but others might go to prison, a subject addressed on Friday morning in the Hard to Reach Communities session. The number of older prisoners is increasing: in 2002 for example the over 60s accounted for two per cent of the population, today it is four. The rise was due to more incarcerations, longer sentences and convictions for historic sex abuse, Dr Anne-Marie Stewart, a Nottingham GP who also works in HMP Whatton, told her audience.

The prison houses 860 male sex offenders and has one of the oldest populations in the country. Prisoners were in effect, she said, ten years older than their community contemporaries. They may have previously chaotic lifestyles – addictions, homelessness and poor diet - and the stress of prison life accelerated the ageing process.

The group were often seen as giving no problems because they were old and quiet but 35 per cent had cardiovascular illness, 24 per cent musculoskeletal conditions and 15 per cent respiratory ones. Half smoked, a third were obese and there were much higher rates of diabetes and hypertension than in her local practice. Eight out of ten older prisoners had anything between one and seven co-morbidities. There was also a high incidence of mental illness: 42 per cent of those over 60 would have at least one psychiatric problem. Prisoners often refused further tests or
Because they knew they would have to be shackled for any hospital visits.

Improvements had already been made at Whatton with the provision of a dementia suite and an end-of-life palliative care suite where families could also stay. There was also a system of ‘wing buddies’ to assist and report health problems. In the future she would like to see special disability units with inhouse specialists plus an increased use of telemedicine to avoid hospital appointments and help with confidentiality.

Legal intervention

The first guest speaker at the conference was David Lock, a barrister with Landmark Chambers in London, who looked at when the state could or should intervene to protect the health and interests of a vulnerable older person who had capacity.

The concepts of capacity and vulnerability raised some fascinating questions such as the right to self neglect, to have poor personal hygiene, to hoard or to live in unhealthy surroundings. “When did the state acquire the legal right to require anyone with capacity to wash at regular intervals or not collect old newspapers?”

Should everyone with capacity be treated equally, he asked, or was there a halfway house for those who had capacity but were vulnerable. “There is a grey area between capacity and incapacity. It is a spectrum. People should be able to take an unwise decision but what about those who are too easily open to exploitation as lots of geriatric patients are.”

Geriatricians, he suggested, might sometimes see circumstances where they thought improper pressure or coercion was being applied or where someone had acquired a measure of influence or ascendency over an old person and was taking unfair advantage. “Adults have complex relationships. It’s a delicate balance between protection of the vulnerable and their autonomy.”

Cases where undue influence had been used to obtain property, possessions or money from older people might be settled in the Chancery Division, originally set up to express the monarch’s concern for the vulnerable through judges but now essentially a court of fairness. The law set limits on the extent to which one person could persuade another to act to their benefit. “If the transaction is secured by unacceptable means, the law does not permit the transaction to stand.”

Although Chancery was traditionally a private court in that only the wronged individual could seek redress, access to it had recently been extended. Local authorities also now had a statutory duty to make inquiries if they had reasonable cause to suspect an adult needs care and support and is at risk of or experiencing abuse, including financial abuse, or neglect and, as a result of their needs, are unable to protect themselves. Local authorities must make whatever enquiries it thinks necessary to decide if any action should be taken and if so by whom.

Mr Lock’s lecture followed the ethics and law session which opened with a talk on responsibility and liability by Ben Troke, a lawyer with Browne Jacobson in Nottingham, which acts for 50 NHS bodies. Ever increasing expectations bred a sense of entitlement and though this was far more progressive than the old paternalism it did have ramifications in the context of an ageing population. There were more ambitious interventions available now but in complex situations more things could go wrong.

Although people believed we lived in a compensation culture, the reality was that there were between 12,000 and 14,000 clinical compensation claims a year while the actual number of adverse incidents was 850,000, of which half were avoidable and a third were serious.

The civil court is restitutionary and compensatory not punitive. Awards were about restoring to claimants what they would have been entitled to if things had not gone wrong. An old person with no earnings potential and no long life ahead would probably not be entitled to very much whereas a brain damaged baby who needed round-the-clock care would get millions. “The law is not just a stick to beat you with, it’s also a shield for doctors,” he added. “You have no liability if you reasonably think the patient lacks capacity and you do something you believe is in their best interests. Risk aversion means people often play safe but positive risk taking can be the right thing to do. The courts could be a place to share responsibility. Don’t be paralysed by liticaphobia.”
The forgotten giant

The other guest speaker dealt not with the theoretical but with one of the very practical needs of our speciality - incontinence. Giving the Majory Warren lecture Prof Adrian Wagg, director of geriatric medicine at the University of Alberta in Canada, spelled out the extent of the problem. “It leads to physical limitations, to the cessation of activities, the loss of sexual interaction, the avoidance of intimacy. It can mean a reduction in social interaction or travel or everything having to be planned around toilet accessibility.

“It means absence from work and decreased productivity, leads to depression, a loss of self esteem, the fear of being a burden, a sense of lacking control, of smelling of urine, to sleep disturbance and anxiety. It contributes to ulcers, falls and fractures, and infection. It puts demand on carers, it increases the likelihood of admission to a home with all the associated costs.”

It was not an inevitable condition of old age and it did bother people. There were also implications for the coming time when society wanted people to keep on working. There was, he stressed, no place for therapeutic nihilism.

“Geriatricians are ideally placed to manage urinary incontinence and its associated conditions in older people. There is accumulating data favouring active management.”

There was a range of treatments and approaches including prompted voiding, exercise, weight reduction, the appropriate use of catheters, minimally invasive surgery for some cases and a range of pharmaceutical options. He listed the pros and cons of different drugs but in each case the mantra would always be ‘start low, go slow’. Sometimes the aim had to be modest - “good enough for bingo or good enough to get out to the shops.”

Simple interventions and big gains

Although geriatrics deals with complex problems sometimes a simple intervention can have a significant effect as the session on pain heard from Dr Andrew Severn, a consultant anaesthetist at Lancaster University who recalled the case of an 82 year-old snooker player who was no longer able to play because of neck pain. A single needle intervention into his cervical spine enabled him to win a trophy which he presented to Dr Severn as a gesture of thanks.

“It wasn’t just being able to play, it was about socialising again, about walking three miles a day. Pain management can be about transforming lives and enhancing the quality of those last years. We should share ideas and insights so please talk to your pain management team.”

Early palliative intervention

There was also a plea from Prof Miriam Johnson, professor of palliative Medicine at Hull University for geriatricians to consider her speciality at an early stage for patients with heart failure. The old model of treating until you could treat no more and then handing a patient over to palliative care had long gone for cancer patients. Heart failure patients, however, still often had difficulties accessing palliative care despite the fact that they also suffered pain as well as fatigue, breathlessness, insomnia, anxiety and depression. “The time to involve us is when there are persistent complex symptoms and other support is needed both for the patient and their families. The care should be pro-active, specific and problem not prognosis based. The aim is to help people live as actively as possible until their death.”

The 550 attendees, including visitors from Australia, New Zealand, Canada, South Korea, Hong Kong and the United Arab Emirates could also choose from sessions on education and training, management, interface geriatrics and meet the professors as well as an early morning update on the Care Quality Commission’s review of integrated care for older people.

The meeting which was held in the conference centre on Nottingham University’s cherry blossom filled campus also had nine platform presentations of research papers plus nearly 90 poster presentations and two sponsored symposia: one by Astellas Pharma on incontinence and the other by Vifor Pharma on anaemia. For those who wanted to socialise there was a drinks reception on the first evening and a dinner and dance in the Arkwright Rooms at Nottingham Trent University.

Liz Gill
Freelance Journalist
Now that the dust has settled following the election of a new UK parliament and the formation of the Conservative Government, it is time to take stock of the policy landscape and the prospects for some of the policy priorities identified by the BGS prior to the General Election. The focus in this article is on England. Policy issues in Scotland, Wales and Northern Ireland will be considered in future articles in the context of devolved Assembly and Parliament elections taking place in May 2016.

The BGS had called on the incoming Government to end the divide between free health care and means-tested social care. Though the divide remains, the number of stakeholders calling for free social care at end of life is growing and that pressure point is a potential source of change in the future.

Regarding broader aspects of integrated care, all eyes are now on the NHS Five Year Forward View which the Government has endorsed in the Queen’s Speech. There are already 29 ‘vanguard’ sites piloting new care models within parameters set out by the Forward View. Of these, nine are Integrated Primary and Acute care systems, intended to join up GPs, hospitals, communities and mental health services; thirteen are Multi Speciality Community Providers intended to move specialised care out of hospitals into communities; and six provide Enhanced Care in Nursing Homes, intended to offer older people better joined-up health, care and rehabilitation services. Many members of the Society have been implementing innovative care models pre ‘Vanguard’. Others are now participating in the work of the Vanguard sites.

As the Nuffield Trust has highlighted, the NHS lacks a consistent approach to effectively monitoring innovation and distilling reliable evidence about “which ideas make progress towards the desired outcomes”. This is an issue for the Vanguard sites in general but also relevant to members of the Society who are involved in the delivery of innovative care models. They are continually building tacit knowledge and insights that are relevant to the policy narrative taking shape in the context of Five Year Forward View. Key policy themes include the relationship between specialists and generalists in healthcare; the promotion of self-care and patient control; flexible and multi-disciplinary team working; systems approaches to the management of frailty, multi-morbidities and complex needs; care closer to home (with obvious implications for intermediate care); the access of nursing home patients to healthcare and the support and training needs of nursing home staff. The policy narrative that is now being shaped is ripe for fresh input from the perspective of professionals with expertise in the healthcare and support of older people. The challenge is to ensure that their local level learning is harvested and disseminated nationally.

Before the election, the BGS also called for adequate investment in healthcare and social support for older people. The Government’s commitment to invest an additional £8 billion per annum in the NHS has been welcomed but outstanding questions remain, not least about the £22 billion in efficiencies required of the NHS over the next five years. There are major concerns about the funding gap in social care, estimated to reach £4.3 billion by 2020. As BGS members know better than anyone, older people’s access to end-to-end care pathways is entirely dependent on effectively functioning and aligned health and social care systems. The Summer Budget on July 8 will reveal more in terms of the Government’s intention to cut £12 billion from public expenditure but, at time of writing, the prospects are for a deepening crisis in social care with negative consequences for older people and their carers.
Another election promise generating considerable heat is the commitment to a 7 day NHS and 7 day GP access. This promise has been followed by a focus in public debate on the shortage of GPs and nurses. These are serious issues but, from a workforce skills and planning perspective, a broader focus is needed. One of the BGS calls has been, and will continue to be, for staff across all care sectors to develop competencies in the management of older patients. We have work to do to ensure that this message builds traction over the lifetime of the new Parliament.

Finally, the BGS had called on the incoming Government to measure the dimensions of care that matter to older people and their families. This call was underpinned by a concern that an excessive focus on quantitative targets (e.g. the A&E 4 Hour Wait Target) fails to capture important data about care pathways, patient experience and outcomes of care received. These concerns are shared by many other stakeholders. The Health Foundation, for example, has also recommended an overhaul of the current reliance on performance management to improve quality. There is a window of opportunity for influence since Government will be preparing a new Mandate to the NHS for 2016 onwards and the Mandate will be accompanied by new Outcome Frameworks. The BGS will continue to highlight the issues so watch this space!

If you have any comments or questions arising from this article, I would be delighted to hear from you.

Patricia Conboy
BGS Policy Manager
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References:

Better dementia screening needed in A&E
BGS endorsed report by the Royal College of Emergency Medicine

A report published by the Royal College of Emergency Medicine (RCEM) in May shows that older people attending Emergency Departments are not being regularly screened for dementia or delirium.

The RCEM audited a total of 13,748 records on patients aged over 75 years from 170 Emergency Departments.

RCEM Chair of Quality in Emergency Care Committee Dr Adrian Boyle said “Only 11 per cent of patients are being screened for dementia/delirium. It is clear that as a specialty, we need to consider how best to build this into our processes.”

RCEM President Dr Clifford Mann added, “A key initiative is to routinely screen for dementia/delirium in the Emergency Department so that we can ensure appropriate care from the very start of the patient’s journey. While reluctant to add more ‘routine’ data collection to over-burdened clinical staff, we can see there is a clear clinical benefit to this, and therefore support it.”

Dr Mann said “We are delighted to follow up with an audit to demonstrate our commitment to better meeting the needs of older people in acute care.”

There was one Fundamental (‘must achieve’) standard in the audit – that all patients over 75 must have an Early Warning Score assessment.

RCEM Chair of Standards and Audit Subcommittee Dr Jay Banerjee said “While there is room for improvement [in Early Warning Score assessment] with a national median of 82%, we were pleased by this performance as it was the first time this audit had been attempted.”

The results of the audit also suggest that Emergency Departments do not yet have a consistent mechanism for communicating the results of assessment to carers or other medical professionals.

Sam McIntyre
Spokesperson for the RCEM
Sam.McIntyre@rcem.ac.uk
This was Isabel Hardman writing in *The Times* following the outrage expressed over the campaign to discuss with patients, their wishes in the event of a crisis resulting in a decision as to whether or not to resuscitate.

Ms Hardman goes on to extol the necessity for broaching the subject of DNR with patients and their families, while they are able to consider their options in a cool, objective context.

Taking the issue of patient involvement a step further is a new campaign launched by the Academy of Medical Royal Colleges called *Choosing Wisely*. Its premise is that patients should be encouraged to ask if tests are really needed, that doctors should discuss potential harms of treatment with patients, and the campaign calls for experts to develop lists of common practices that should be stopped.

Originally a US initiative, now launched in the UK, the aim is to encourage and support doctors to stop using interventions which have no benefit, and to help tackle the threat and waste of resources posed by over-diagnosis.

Unnecessary care occurs when people are diagnosed and treated for conditions that will never cause them harm. As geriatricians we are only too familiar with the harmful effects of polypharmacy, be it drug-induced hypotension leading to falls or recurrent hospitalisations due to adverse drug reactions. A culture of 'more is better', has significantly undermined the age old tradition of 'Do no Harm'.

Participating organisations will be asked to identify five tests or procedures commonly used in their field, the necessity of which should be questioned and the risks and benefits of which should be discussed with patients before using them.

The findings will be compiled into lists and it is suggested that the "top five" interventions for each specialty should not be used routinely or at all.

The campaign’s objective is “to translate the evidence into clinical practice and truly wind back the harms caused by too much medicine.”

The twin of over-diagnosis is, of course, under-diagnosis, under-treatment and under-care. It is probably most obviously prevalent in mental health services and, to some extent, in older people in a slightly different context.

The initiative raises certain questions. Is this new movement the beginning of a cultural shift towards shared decision-making, rather than merely identifying a “do not do” list? Will NICE and other organisations be crucial in developing such tools?

Getting this nuanced narrative correct for the media and the public is crucial. At a time when the NHS is in a transitional phase (again), will this movement not be perceived as a top down cost cutting measure?

Alternatively, could this be the biggest step towards patient-centred medicine in the UK or could it fizzle out in a bout of squabbling over the necessity of this treatment or that?

The only way it can succeed is if it genuinely involves patients at every stage and every level. It should raise awareness among doctors of the real benefits and harms of treatments and care pathways and support them in discussing prospective interventions with patients in a way...
that meets their concerns, goals and preferences.

The British Geriatrics Society has been working with the Picker institute towards developing Patient Reported Experience Measures (PREMs). Could this become a key quality measure?

It will mean establishing mutual trust and treating guidelines as advice and not as tramlines. We need to re-establish the value of wisdom and kindness and look at how best to teach and disseminate these, as well as teaching and disseminating the best evidence to guide practice.

Geriatricians are well placed to do this. This is a movement to which geriatricians could give a serious thought.

Amit Arora
Consultant Physician and Geriatrician
University Hospital of North Staffordshire, Stoke on Trent and an Honorary Clinical Lecturer at Keele University

NHS Benchmarking Network for older people in acute settings

In July last year, the BGS announced its partnership with the NHS Benchmarking Network. The project collected data looking at the journey that older people take from A&E, through to short term assessment units, elderly care wards and support discharge processes. Here, Leigh Jenkins comments on the progress of the initiative.

Wouldn’t it be great if you could benchmark the acute services provided for older people in your hospital, against others trying to do similar things? Might this be the start of a quality improvement process, allowing you to see how other hospitals do things differently and possibly better?

This month saw the publication of a report which moved us closer to that ideal. The NHS Benchmarking Network has completed the first phase of a national benchmarking project looking at the care of older people in acute settings. Developed in conjunction with the British Geriatrics Society, the project explores the pathways that older people take through hospital by looking at four key areas of the acute pathway; admission avoidance in A&E, assessment units, inpatient care and supported discharge.

Over the course of the summer of 2014 the Network collected data from 47 Trusts and Local Health boards on a range of metrics. Within each area of the pathway the service models, activity, workforce and finance data was explored. A number of key quality and safety indicators were also collected, and participating trusts were encouraged to share any good practice and innovation that was happening locally. The findings of the first phase of the project provide a robust, up-to-date picture of the care of older people in acute settings in the UK.

We were keen to explore the availability of different teams in A&E who are dedicated to admissions avoidance. The results show that 24 per cent of the Trusts who participated in the project have a dedicated geriatric team located in the A&E department, typically available for 9 hours per day during the week, falling to 6.5 hours at weekends.

Nearly two thirds of the 47 participating trusts have rapid access to social workers in the ED to support early turnaround and admission avoidance. Whilst commendable, this means that over a third do not have this facility - already an important comparator and a stimulus to discussion in those trusts.

We collected data on assessment units, with a particular interest in the use of Comprehensive Geriatric Assessment (CGA). Twenty-nine per cent of participants have a frailty unit, and 90 per cent are using CGA on the frailty unit. Senior medical cover on the frailty unit averages 13 hours per weekday, and 10 hours at weekends. It is perhaps disappointing that more than 10 per cent of specialist geriatric units do not provide CGA - again food for further discussion in those trusts.

Seventy-seven per cent have a short term assessment unit (up to 12 hrs expected LoS), with 44 per cent...
of these performing CGA on this unit. Senior medical cover is available 17 hours per day during the week, and 6 hours at weekends. Finally, 85 per cent report having an ‘other’ assessment unit (12 to 72 hours expected LoS), with around a third of these units performing CGA. Senior medical cover availability averages 15.4 hours on weekdays and 14.4 hours at weekends.

It was also found that 87 per cent of elderly care wards deliver Comprehensive Geriatric Assessment, which reduces to just 23 per cent of speciality wards delivering CGA, suggesting that outlying patients are not receiving CGA.

We were also interested in the staffing skill mix at each element of the pathway, particularly the nursing staff ratio. We found a richer nursing skill mix is available at the front and back end of the hospital, with the use of unregistered nurses significantly higher within assessment units and care of the elderly wards. In the admissions avoidance teams in A&E, the ratio of nurses was 80 per cent registered and 20 per cent unregistered, compared to 55 per cent registered and 45 per cent unregistered on the elderly care wards.

Excitingly the Network has already made the decision to repeat the audit this summer, and we anticipate increasing momentum with a greater number of trusts and health boards getting involved. The BGS Clinical Quality group are working alongside the project team to develop the measures of quality in several domains – we are keen to see how routinely collected data can help to assess efficiency, effectiveness and safety. We are looking at developing a Patient Reported Experience Measure (PREM) and examining how this could practically be incorporated into the project.

Data collection will open on 3rd August 2015, and is open to all member organisations of the NHS Benchmarking Network. To find out if your Trust is a member or for more information on the project please contact Leigh Jenkins of the NHS Benchmarking Network on leigh.jenkins@nhs.net, 0161 266 2113.

We don’t have all the answers – but we are starting to understand what questions we should ask. Please get involved and take a look at the report and contact us if you have things to say. We really want to hear from you.

Leigh Jenkins
Assistant Project Manager
NHS Benchmarking Network

Hundreds more metrics may be found in the full report which may be downloaded from: http://tinyurl.com/pg8w2te

The Advisory Committee on Borderline Substances

The Advisory Committee on Borderline Substances is looking for a geriatrician who can contribute to the Committee’s work. The ACBS approves products that can be prescribed under certain circumstances but are also available over the counter. These include products for nutrition and dry mouth as well as others such as skin products and gluten free products. The Committee is currently made up of pharmacists, dietitians (paediatric and adult), a gastroenterologist, a dermatologist and a geriatrician. There are three fixed meetings a year. See www.gov.uk/government/groups/Advisory-Committee-on-Borderline-Substances for the official process. For informal discussion contact Steve Jackson on stephen.jackson@kcl.ac.uk.

Deprivation of liberty: Sign up for webinar to learn about proposed Dols replacement

A Community Care webinar on 7 July (http://tinyurl.com/nsrjueh) will showcase Law Commission’s initial proposals to reform law on deprivation of liberty. The webinar will be delivered by one of the authors of the plans. Social care professionals can sign up now to the webinar to learn about a proposed new legal system for authorising deprivations of liberty that will be proposed by the Law Commission as part of a government-commissioned review. The webinar will take place from 10am until 11.30am on Tuesday 7 July, the day that the draft proposals are set to be unveiled. Tim Spencer-Lane, a lawyer at the Law Commission’s public law unit, will give an overview of the commission’s proposals and take questions.
It has been a busy few months, as always, for the Society’s communications and media work.

Of course, the biggest BGS event in recent months has been the Spring Meeting in Nottingham. Social media was abuzz with discussions, learning points and interesting information from all of the sessions; 750 different people sent 4,000 tweets across the three days of the conference, reaching more people than ever before and breaking all of the records we set at the Autumn 2014 meeting in Brighton.

However, I did speak to a couple of people in Nottingham who were either sceptical about getting involved with Twitter, or unsure of exactly how it works! I thought this column might be a useful opportunity to highlight one particular example of the benefits it can bring:

One of the most popular and most widely-shared tweets from the conference was a photo of a word cloud presented in Wednesday’s nutrition session. Nurses had been told to ask patients “What one thing can I do right now to improve your stay in hospital?”. Surprisingly, the most popular answer was “Water”.

Clearly, this struck a chord: after posting the photo of the word cloud, people continued to share and discuss it, talking about their perspectives as professionals, patients or carers, and in one instance copied in the Hydration Lead at their local NHS Trust to continue the conversation!

Social media can be a slightly daunting and chaotic place if you’re not familiar with it, but it can also open up wonderful possibilities: in this case, a slide presented in Nottingham may well have ended up informing clinical practice in Cornwall.

If you’d like a quick primer on getting to grips with Twitter, or becoming more active if you are already familiar with it, then please feel free to get in touch with me at communications@bgs.org.uk

The other event filling the headlines has of course been the General Election. From a communications perspective, the BGS message remains the same - namely that amidst limited resources and increasing demand, the NHS will only prosper if excellence in older people’s care is placed at the very heart of policy-making.

To help underline this message, we have been commissioning and writing press releases, blogs and other articles to help highlight some of the exceptional work being done across the UK. You will find a piece about Brenda Stagg, winner of the 2015 BGS Special Medal (page 29). It was written after I spent the day with her in Liverpool, finding out about some of the fascinating work she does for older people with dementia living in the city.

In similar fashion, the BGS blog continues to go from strength to strength, with writing covering everything from a new poetry collection responding to dementia, to geriatric medicine in Malta and treating dysphagia. BGS President Professor David Oliver has been a regular presence on radios across the world, appearing on LBC to discuss care homes, Radio 4’s You and Yours to talk about visiting hours, and as far afield as Ireland and Canada to compare each country’s approach to geriatric medicine with ours.

We have also been working closely with a number of other organisations and groups on collaborative projects. Dr Gill Turner and I recently attended the initial meeting for partnership organisations within the Coalition for Collaborative Care, which draws expertise from organisations across health and social care as well as the third sector. Our communications and member services review is also ongoing, conducted by Forsters, and should provide some useful insights on how to communicate the Society’s work even more effectively in the future!

Ed Gillett
PR and Communications Manager
AHSNs are catalysts and facilitators of change across whole health and social care economies, with a clear focus on improving outcomes for patients.

Eastern Academic Health Science Network has chosen “older people” as one of the two priorities focus areas for our Patient Safety Collaborative. We launched our PSC in October 2014 at an event with colleagues from across the region. Speeches from the presenters at the event, including Dr Mike Durkin, National Director for Patient Safety at NHS England, are available on our YouTube channel.

Our first task following the launch was to work with partners across the region to establish local priorities. This work led to our establishing the high level aims for the PSC including:

- To develop a Quality Improvement infrastructure which will support continued service improvement and innovation. To be driven forward by:
  - A Board Leadership programme
  - Nomination of EAHSN Q Initiative Fellows
  - A suite of QI capability building programmes

- To listen to and address the safety concerns of frail older patients in the community, in hospital and in care homes. The programme will encompass:
  - Medications safety
  - Safer transfers in care
  - Identification and response to deterioration

Local design work will continue and we are linking with other AHSNs working on the same topics and clinical processes.

Recruiting a clinical lead
We are looking for a clinical lead for our patient safety collaborative. We envisage the post at about three days a week and we want to recruit someone who is a practising clinician in a relevant field. If you are interested in this role please contact us for a job description.

Learning event: 23 June, Newmarket
Our first learning event was held on Tuesday 23 June at Newmarket Racecourse. At this event we discussed with colleagues from our region what the next steps for our older people work should be.

Please sign up to the Eastern AHSN newsletter to get updates on all our work, including the patient safety collaborative. Also there is more information about our PSC on our website www.eashsn.org. And follow us on Twitter at @EAHSN.

Susan Went
Director, Eastern AHSN Patient Safety Collaborative
Lifetime achievement award
for BGS Vice President of Research and Academic Affairs, Professor Gordon Wilcock

The International Association of Geriatrics and Gerontology has awarded the Silver Medal for lifetime achievement to Professor Gordon Wilcock, Vice-President for Academic Affairs at the British Geriatrics Society.

Professor Wilcock’s career spans 45 years as a geriatrician, researcher and national clinical leader. He has been a practising doctor since 1970, and a consultant specialising in Geriatrics and General Internal Medicine since 1976. He was Professor of Geriatric Medicine in Bristol from 1984 to 2006, then Professor of Clinical Geratology at the University of Oxford from 2006 to 2013, where he still holds an Emeritus Chair. He established pioneering memory disorder clinics at both universities, and a specialist memory ward in Bristol, as well as major programmes of research with a focus on Dementia.

Professor Wilcock was also the Founder Chairman of the Alzheimer’s Society, which grew under his leadership to become one of the UK’s most prominent and influential charities related to care and support for people with Dementia, and he was editor for over five years, of Age and Ageing, the medical journal of the British Geriatrics Society.

Speaking at the IAGG-ER’s international congress in Dublin, Professor Wilcock said: “I’m surprised and very honoured to receive this award. I’m also very grateful to the British Geriatrics Society, which has allowed me to contribute to many of its activities over the years, and to the large number of BGS members who have supported my work during this time.

Commenting on the award, BGS President Professor David Oliver said: “Professor Wilcock has made a truly outstanding contribution to the care of older people, especially those with Dementia, and is recognised by his peers internationally and throughout the UK. He is probably the most eminent and accomplished Academic Geriatrician in the UK over the past thirty years, and the British Geriatrics Society is delighted to see this contribution formally recognised by the IAGG-ER.”

The full title of the award given to Professor Wilcock is the Award and Honorary Diploma for Advances in Gerontology and Geriatrics, given for excellence and achievements in the Science of Ageing and in recognition of his outstanding contribution to the development of Gerontology in Europe.
BGS SENIOR OFFICER VACANCIES

Deputy Honorary Meetings Secretary
of the British Geriatrics Society

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

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

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

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

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

BGS EVENTS

REGIONS AND SIGS

BGS Trent
8 July 2015, East Midlands Airport, Derby

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

BGS Falls and Postural Stability Conference
See full notice on this page

BGS Yorkshire (2015 - 2016)
16 September, Hull Royal Infirmary; 23 March, Pinderfields Hospital

BGS West Midlands (2015-2017)
17 September 2015; 17 March 2016; 22 September 2016; 16 March 2017; 21 September 2017
(All venues still to be advised)

BGS Oncogeriatrics Special Interest Group
18 September 2015, London
(See full advert opposite)

BGS Scotland Autumn Meeting
2 October 2015, Edinburgh

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

2016 BGS Spring Scientific Meeting
11 - 13 May 2016, Liverpool

2016 BGS Autumn Scientific Meeting
23 - 25 November 2016, Glasgow, Scotland

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

British Geriatrics Society
16th Falls and Postural Stability Conference
11 September 2015
London Hilton, Wembley

This annual event is widely recognised as the premier UK national meeting for clinicians working in the field of ‘Falls and Mobility’ medicine. Previous conferences have been resounding successes with over 200 participants year after year.

The meeting will combine scientific discussion alongside best clinical practice to a multidisciplinary audience and there will be workshops on behaviour change; dizziness; osteoporosis; and interactive gaming interventions.

Programme and online registration available at www.bgs.org.uk [Select Conferences and Events/Falls]
CPD accreditation will be applied for
Email queries to: conferences@bgs.org.uk
LAUNCH OF THE BRITISH GERIATRICS SOCIETY ONCOGERIATRICS SPECIAL INTEREST GROUP

18th September 2015
London

Why participate:
- Understand more on the key areas and challenges faced in cancer treatment for older people
- Hear focused presentations on core areas of oncogeriatrics
- Present the latest scientific research to professionals involved in the care of older people with cancer
- Network and socialise with other cancer related healthcare professionals

Sessions on:
- Epidemiology of cancer in older people
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- Surgery and chemotherapy in older adults

Keynote talks by:
- Sean Duffy
- David Oliver
- Case presentations facilitated by oncology trainees

Accreditation will be applied for from the RCP (London)
Email: conferences@bgs.org.uk
www.bgs.org.uk (Select Events)

BGS CARDIOVASCULAR SECTION

16th Annual BGS CV Section Meeting
18th September, 2015
Royal College of Obstetricians and Gynaecologists, London

‘Failing Hearts and Minds’

Sessions include:
- Delirium in older people
- Cognitive decline and heart failure
- Optimal medical treatment for systolic chronic heart failure before Paradigm
- Identifying failing heart by echocardiography

http://bgscv.org.uk/meetings/

GERIATRICS FOR JUNIORS

Updates in Elderly Medicine for FY and CMT Doctors
7th November 2015
Park Plaza Hotel, Leeds

G4J is a one-day conference, designed for Foundation Doctors and Core Medical Trainees.

What will be covered?

Front door geriatrics - how to be a medical detective; Frailty & the ageing body; Dizziness - the do’s and don’t’s; Common-sense continence care; Community geriatrics - life outside the hospital; Parkinson’s Disease - a junior doctor’s survival guide; Ask a registrar: med reg fears working and living as a geriatrician; and more...

See www.bgs.org.uk (Select Events)
CARE HOMES

Enhanced health in care homes
2 July 2015
King’s Fund, London

Many people living in care homes are not getting their health needs regularly assessed.

Showcasing successful case studies which have proven to reduce hospital bed use and improve quality of life, this conference will examine the new care model set out in the NHS five year forward view, in which the NHS works in partnership with care home providers and local authority social services departments to develop new shared models of care and support.

Key speakers include: Professor David Oliver

www.bgs.org.uk [Select External Events]

EPILEPSY

Epilepsy SpR Teaching Weekend
19th - 20th Sept 2015
Oxford

Every two years over the last 28 years the International League Against Epilepsy UK Chapter have organised an epilepsy teaching weekend for Specialist Registrars in neurology, neurosurgery, paediatrics, learning disabilities, rehabilitation and geriatrics. The teaching weekend comprises a series of lectures, video sessions and informal seminars covering the most important areas of clinical Epilepsy practice in 2015. The speakers are all internationally recognised experts in their fields and previous participants have found the teaching weekends both stimulating and enjoyable.

www.bgs.org.uk [Select External Events]

SYNCOPE, VERTIGO, BALANCE

Dizziness for the Physician: syncope, vertigo and balance
8-9 October 2015
Novotel, Newcastle upon Tyne

This CPD approved course is designed for physicians, trainees and associated health care professionals seeing the older dizzy patient in Syncope units, Falls services, TIA clinics and Outpatients.

www.bgs.org.uk [Select External Events]

EUGMS

11th EUGMS Congress 2015
16-18 Sept 2015
Oslo, Norway

Geriatric medicine for future Europeans - Successful ageing creates new challenges.

The program consists of sessions about the healthiest older persons, health optimisation, prevention as an underused intervention, organisation of acute geriatric care in different countries, and tailored drug treatment.

www.bgs.org.uk [Select External Events]

BONE RESEARCH

3rd Joint Meeting of the Bone Research Society (BRS) and the British Society for Matrix Biology (BSMB)
1st-3rd September 2015
Edinburgh

Our keynote speakers are of international standing and come from a wide range of disciplines, reflecting the interests of both societies. The science presented at the meeting should be enlightening and stimulating for both clinical and basic scientists.

www.bgs.org.uk [Select External Events]

HIP FRACTURE

The 12th Peterborough Hip Fracture Conference Hip Fractures: Towards Optimum Care
2 October 2015
Peterborough

The 12th Peterborough Hip Fracture Meeting with an international faculty will cover many aspect of hip fracture care including topics on different models of care, rehabilitation, management of surgical complications and fracture prevention. Cost is £80 including lunch and refreshments.

www.bgs.org.uk [Select External Events]

www.bgs.org.uk [Select External Events]
Increasing participation of older people in research

Andy Clegg, Senior Lecturer at Leeds University and Consultant Geriatrician at Bradford Royal Infirmary, describes how use of the innovative cohort multiple randomised controlled trial (cmRCT) design may help increase participation of older people in research studies.

There are many challenges involved in recruitment of older people to research studies, particularly randomised controlled trials. Study exclusion criteria and refusal rates are a major issue and the presence of cognitive impairment and ethical decisions adds complexity. Concerns with study information and consent procedures are the most common reasons given for not participating in clinical trials. Understanding and weighing up the complex information about randomisation and control groups is not easy, particularly in the presence of sensory and cognitive impairment.

An extra problem in many randomised controlled trials is that it is not possible to achieve blinding of participants and assessors. This can mean that participants randomised to the control arm may be disappointed and perform less well in assessments or may be more likely to drop out of the trial. Additionally, if assessors are unblinded this may influence decisions when performing assessments.

The cohort multiple randomised controlled trial

The cohort multiple randomised controlled trial (cmRCT) design has been developed to address some of the problems of existing trial designs. This design may be especially appealing in research into conditions of ageing, for example frailty, falls and dementia. The cmRCT design has some key features:

▶ A large cohort of people with the condition of interest (e.g. frailty) is established
▶ Participants give assent for involvement in future trials of treatment options for the condition of interest when they join the cohort
▶ Participants are regularly assessed for outcomes that are also relevant for clinical trials.

For subsequent trials, eligible participants are selected at random and offered the intervention/treatment. The outcomes for these participants are then compared with those who were not offered the treatment (see box for example).

A cmRCT design is considered particularly relevant in situations in which the aim is to inform healthcare decisions in routine practice, the clinical condition is chronic and several trials are needed, and for studies where previous trials have struggled with recruitment. The design may therefore be
useful in research into many of the chronic conditions of ageing.

Additional advantages
► The process of offering treatment is more closely aligned with the method of offering and providing treatment in routine healthcare, potentially increasing generalisability of results.
► Although recruitment rates in clinical trials for common conditions in older age have often been low, recruitment to cohort studies involving older people has remained relatively high, usually above 50 per cent.
► The design enables better alignment of observational research; qualitative studies and clinical trials.

Possible limitations
► Very large cohorts may be needed to test a series of interventions, which has considerable cost implications. However, use of more efficient methods such as postal questionnaires, telephone interviews and linkage to routine clinical data may help sustain the cohort.
► For a successful cmRCT, consensus is required on the assessments and follow-up schedule. This is relatively well established in some conditions, for example dementia, but less so in others, for example sarcopenia.

The cmRCT design has considerable potential to improve the recruitment of older people with a range of conditions to clinical trials. However, there are possible limitations that first require consideration, potentially through pilot work. If successful, it is possible that this innovative design could help improve the participation of older people in research studies across a range of common conditions in older age that have major impact on health and social care systems internationally.

Andy Clegg

Invitation to research active members

As part of the BGS’s research strategy, we invite research active members to contact us. We would like to know how you became engaged in research; how you found your research project; the obstacles you had to overcome and what your research is about. Here, Terence Ong, Research Fellow at Nottingham University Hospitals NHS Trust describes how he became an ‘accidental academic’.

I think of myself as an ‘accidental academic’. I never considered research as a particular career path, tending to focus more on my clinical training. However, a chance encounter with Prof Opinder Sahota led to him asking me if I was interested in taking time out of programme to work as his research fellow for twelve months. For me, it came at the right time as all the clinical training was leaving me a little jaded. I therefore saw Prof Sahota’s offer as a way of beefing up my CV without extending my training too much.

During the twelve months under Prof Sahota’s supervision, I had the opportunity to participate in a range of research projects, worked on a Masters and turned a couple of research ideas into projects. While it may have added substance to my CV those twelve months gave me a different insight into what I can achieve in my career. Prof Sahota taught me to appreciate the value of research. As a geriatrician, I know that I am able provide good clinical care at the front door, but with high quality research, I can do much more to provide good clinical care on a wider scale. Hence, having had a taste of research, I decided towards the end of my time out of programme to seek further research opportunities.

How did you choose your research/audit or was it chosen for you?
I was encouraged to seek funding through research fellowships to pursue my research interest in bone health. I was inspired by Prof Sahota to think of orthogeriatric medicine beyond hip fracture. Hence, I wanted to explore the role of orthogeriatric medicine and its underlying principles in the management of spinal fragility fractures. My personal experience with spinal fragility fractures in hospital is that they are suboptimally managed and that the model of hip
fracture care where a geriatrician and a surgeon working together putting the patient at the centre of their care is the way forward. The research call by the Dunhill Medical Trust two years ago fitted with what I wanted to do and with the advice and support of Prof Sahota and Prof John Gladman I was successful in securing one of its research fellowships. Applying for the fellowship was one of the most challenging processes I have ever experienced.

What does the project involve (what are you testing)? At what stage are you in the project?
My research (and PhD) will begin post-CCT in August 2015. Currently, work revolves around the getting things ready (networking, scoping review, literature reading, etc). The research will use mixed methodology to define a spinal orthogeriatric inpatient model of care. The methodology here will bring together existing scientific evidence, and current clinical practice nationally and locally, to develop a framework for managing these fractures. The research will be divided into separate phases which will contribute to the overall study. It will begin with a literature review to identify an evidence-base of care, followed by an expert panel consensus of how spinal fracture care should be, and later on with a cohort study that will identify the care processes that older people with fractures receive in hospital by different clinical teams.

Terence Ong

Interview with Brenda Stagg
awarded the first BGS Special Medal

Ed Gillett speaks to Brenda Stagg, the winner of the BGS’s Special Medal - an award which was inaugurated in 2015 to celebrate the achievements of people who are not members of the Society, who promote the health and wellbeing of older people throughout society.

It’s a warm summer afternoon in Toxteth, and I’m standing in a church hall breaking out my best disco moves to Dancing Queen by ABBA. It’s fair to say I hadn’t planned for the day to turn out quite like this.

I’m in Liverpool to meet Brenda Stagg, a Dementia Support Manager at the Alzheimer’s Society: she has recently been awarded the 2015 British Geriatrics Society Special Medal in recognition of her work with older people across the city, and I’m here to find out more about her work.

I meet up with Brenda at the Neurosupport Centre, an office hub which houses several different organisations focused on neurological disorders. It offers support services, resources and meeting spaces for colleagues from healthcare, social care, the third sector and service users alike. Over a cup of tea in the library, Brenda explains how she came to work for the Alzheimer’s Society: “I started working for Liverpool City Council twenty-one years ago, eventually managing a homecare support team working with older people in the community, so I’ve always worked predominately with older people in a social care setting.

In my last 10 years at the council, I specifically worked with dementia, not only with people who’d been diagnosed, but with their carers and families as well. There have been lots of changes in the Council over the years though, mostly due to
“A lot of people, when you ask them about dementia, view it as terribly negative thing: they don’t always realise that even after they’ve had this diagnosis, an older person can still live a fulfilling life in the community, still go out and see their friends, just as long as they have the right support.

“There’s that saying: when you meet one person with dementia, you’ve met one person with dementia. You can’t apply lessons from one person to another, or use the ethos of how you’d wish be treated.

“I think you just have to treat people with dignity and respect. A big thing is making sure that they’re not talked above, that they’re included in decisions: sometimes there’s that sense of frustration when people get missed out or don’t have involvement in their own care.

“It can be little things: making that phone call to someone who was really upset and talking things through with them can just give them such a sense of being listened to, even if you can’t solve all the problems. Or it could be someone’s been given a diagnosis but hasn’t fully understood it, and you’ve sat down with the family and explained everything, and helped move the situation on for them a bit and improved their quality of life.”

By happy coincidence, I’m able to see this person-centred approach in action later in the day. After our conversation in the library, Brenda shows me around the Alzheimer’s Society office, and introduces some of her colleagues.

Even so, it’s clear that earlier comments about front-line work being the thing which truly inspires her are true. Brenda’s face lights up when I say that, contrary to her assumptions, I’d love to go along to a meeting: before you know it we’re out the door and whizzing across town to a music and singing session in Toxteth.

Once there, Brenda’s in her element: chatting away to people living with dementia, their carers, and other Alzheimer’s Society staff and volunteers. Rosie, the musical facilitator, explains that their original session on Fridays got so full that they had to start a second one on Thursdays, with a whole...
group of new faces joining today. The atmosphere is so warm and welcoming that I would have assumed everyone had been friends for years. And so, before long we’re busting out “Living Doll”, “Da Doo Ron Ron” and a collection of other classics. I’m fairly sure my haphazard singing is letting the side down a little, and the less said about my “Dancing Queen” in particular the better, but no-one seems to mind.

I meet Steven, who now cares for his best friend after he was diagnosed with early-onset dementia five years ago, and Meg, who was a nurse for 25 years before being diagnosed herself with dementia. “It’s so important” she tells me “to have people around you who understand. I’m lucky, in that I know how hard people work, and I’m so grateful that they’re looking after me now”.

We sing “Stand By Me”, and its lyrics about fearlessness and love in the face of an encroaching darkness feel beautifully poignant. Something quite overwhelming and difficult to describe sweeps across the room: wistful in some regards, but also optimistic and cheerfully defiant.

Earlier in the day, I’d asked Brenda what one change she’d make to improve dementia care.

“That’s such a tough question, there are so many things. Obviously there’s a key question about research, about trying to help people understand why they’ve got this diagnosis, or provide better treatments; there’s been no real movement on medication in 20 years.

“And the other thing is for proper investment in social and support services for home: there are sometimes very few services available, either due to budget cuts or the assessment process, so people can’t always get the services they need at home.”

More important though, is what she leaves unsaid: that those services are often only as good as the people running them. The other thing I learn very quickly about Brenda is that she’s exceptionally modest: quick to downplay her own work, or gloss over any mention of her award whenever anyone asks.

She has to explain everything when we arrive at the music and singing session, and when everyone cheers and claps for her you can see she’s delighted, but a little embarrassed too.

I ask Brenda what’s next for her career, where she goes from here:

“Well, I don’t know, really… would I like to be in a more senior role? I suppose so, maybe, but then strategy’s not really my forte, and I’d miss that day-to-day connection with people”.

The implication is clear: why climb the ladder when you’re already doing the thing you love? It rather sums up Brenda’s approach: quietly spectacular, unassuming, and absolutely focused on the older people she cares for. Seeing her in action is both humbling and inspiring, and brings home just how thoroughly deserved her award is: just don’t rely on her to tell you about it herself.

Ed Gillett
GP loneliness scheme cuts fifth of consultations with older patients

A programme set up by GPs cut consultations with a group of older patients by a fifth after encouraging lonely older people to set up social groups.

The scheme took place across four practices in Warwickshire, where people over 75 were contacted for a ‘wellness check’ to see if they were socially isolated.

Those who were thought to be suffering from loneliness were then put in touch with each other and took part in social events like tea parties, and set up their own activities, such as mosaic-making.

The project, Prime75+ was set up by company PrimeGP and has been running for three months, and GPs have reported a drop consultations with the 40 patients involved.

The founder of the programme, PrimeGP is Karen Clarke. She said: ‘These are difficult patients that you know are going to take 30 to 45 minutes in the middle of a busy day and you haven’t got that time – but the patients need it.’

The PrimeGP team is collecting data from local hospitals to see if the number of admissions has dropped for the patients involved.

The project could be expanded to other age groups suffering from social isolation, or could be rolled out to chronic disease groups and in other parts of the UK, Dr Clarke said.

‘It would be very easy for other CCGs to take this project on board. GPs haven’t had to do anything extra – PrimeGP has done the work and GPs can refer their patients to us.’

Published in GPOnline

Scotland: Safety standards

Health Improvement Scotland is looking to develop standards for pressure ulcers. The scoping exercise will end in July; draft standards will be developed from August to December with publication set for February 2016. This will be followed by a consultation phase from March to May 2016 with the final standards being published in November 2016.

On another front, Health Improvement Scotland published in June, new standards for NHS Scotland which aim to improve the care of older people in hospital. A key goal of the standards is strengthening the involvement of patients and carers in discussions and decisions about the care that is delivered.

NHS boards in Scotland are now expected to work towards meeting these standards. Each standard includes a statement of the level of performance that NHS boards are to achieve. The new standards build on the previous standards from 2002, with a greater focus on initial assessment on admission and more complex aspects of care.

Failing older people in Wales

Older People’s Commissioner for Wales, Sarah Rochira wants the law changed to make it easier to prosecute anyone who abuses or neglects older people or allows crimes to take place, such as health and social care providers and managers.

She claims that 18,931 crimes against people aged 60-plus in Wales were recorded in 2013-14 but just 2,561 arrests were made. Only 233 cases went to court and a mere 194 cases resulted in a successful conviction.

Ms Rochira said: “There have been a number of truly horrifying cases of abuse and neglect in Wales where, despite extensive investigations and evidence of significant concern, there has been a total failure to bring criminal charges. A key question needs to be asked of our justice system – just how bad does care, abuse or neglect have to be before it is considered criminal.

“As it stands, the law simply does not offer sufficient protection for older people who are the victims of substandard care, abuse or neglect, nor does it provide a suitable deterrent to those who deliver substandard care or to those who abuse or neglect older people. This is something that needs to change urgently.”
Migrant doctors have provided a significant contribution to the NHS workforce over the last 60 years yet their presence has been largely undocumented and their achievements unrecognised. Making good this deficit, researchers at the Open University have carried out 60 oral history interviews with retired and serving overseas-trained doctors from South Asian countries about their experiences of working as geriatricians in the UK National Health Service from 1948 to the present day. This ESRC funded project also links with an earlier project, carried out by Professor Margot Jefferys: 'The pioneers of geriatric medicine'.

The 60 retired and serving South Asian qualified doctors were or are employed by the NHS in England and Wales. Participants were recruited through networks of overseas doctors, through the British Geriatrics Society and through snowballing. The interview schedule used a life history approach, starting with childhood and education, going on to medical training, migration experience, working in geriatrics and career development in the NHS. The interviewees had obtained their initial medical qualifications in India, Bangladesh, Sri Lanka, Pakistan and Burma and, at the time of the interview, ranged in age between 40 and 91. All except two were, or are, consultants and some also held academic posts as professors. Along with Gail Wilson of LSE they also re-analysed an earlier set of interviews carried out by Margot Jefferys and colleagues in 1990-91 with 54 doctors who pioneered the geriatrics specialty. In addition, the project made extensive use of documents lodged in the National Archive as well as in archives relating to the medical profession. The new set of interviews will be lodged alongside the Jefferys interviews in the British Library.

Historical migration pathways
The doctors interviewed were following a long-standing tradition of movement between South Asia and the UK. Development of a medical career often involved experience of overseas work. Amongst the geriatricians interviewed by Professor Jefferys were several who had lived and worked in India during the colonial period.

From its inception the NHS has depended on recruiting staff from overseas. Since the 1960s race and immigration have been politicised. Immigration legislation in the 1960s and 1970s targeted migrants from the Commonwealth countries. However, new legislation on racial discrimination in employment (enacted in 1976) and concern about the cost of the NHS and staff shortages also influenced doctors’ career opportunities.

Key points
- Doctors coming to the UK from South Asia were taking part in a long-established tradition of movement in both directions for medical training.
- Working in the NHS was seen by many as an opportunity to practise in a system of healthcare provision which they perceived to be fair and equitable for both patients and doctors.
- Between the 1950s and early 1980s geriatric medicine was known as a ‘Cinderella specialty’ as it was not highly regarded by UK trained doctors.
- Nevertheless geriatric medicine offered opportunities for career progression to both the early geriatricians and the South Asian doctors.
- South Asian doctors encountered discrimination in their attempts to progress through the hierarchical system of the medical profession.
- Both the pioneers and the later South Asian geriatricians worked to change the quality of health care available to older people in the UK, emptying the old workhouse wards and introducing medical interventions which rehabilitated those who had previously been denied treatment.
In this context doctors could be seen as a mobile army of labour, particularly in the lower rungs of the medical hierarchy and in the less popular specialties, amongst which was geriatrics. A crisis of staffing from 1960s meant that by 1974 over 60 per cent of consultant geriatric posts were filled by overseas trained graduates. By way of comparison between 1964 and 1991 overseas trained non white doctors made up 3 per cent of consultants in general medicine and 9 per cent of all NHS consultants.

However, these developments were not always viewed positively:

In 1976, the Professors of Geriatric Medicine wrote to the Royal Commission on the NHS saying: ‘...the present pattern of education of medical students, nurses and other health personnel in Britain does not reflect the needs of this high risk group ... so that older people have grave difficulties in attaining the health care appropriate to their needs ... This concentration of overseas graduates in what remains a low status specialty is undesirable on many grounds and for the future it is not clear that plans for future expansion cannot be based on the assumption that the supply of such graduates will continue.’

Perceptions of NHS system of health care

In contrast many of the overseas doctors interviewed expressed great enthusiasm for the NHS. For some it matched their own value systems:

“I knew I was never going back. I had a lot to go back to - wealth, position, knowing people. I would have risen there then...much better, financially much better ... There is no institution like National Health.” (L028, born in Bombay 1927, arrived in UK 1953)

At the same time they appreciated differences in the ways doctors worked:

“And I had a very good relationship with the Ward Sister ... here we saw nurses more or less as equal and they were not subservient and you asked for their opinion about things that they were good at. You didn't tell them, you asked them. In the Indian scene ... doctors were only for doctoring and so a lot of things, even maintaining notes, we had in our hospital, we had a separate person like a clerk who went round with us and wrote down in the notes, medical notes.” (L022, born in Bangalore 1945, arrived in UK 1973)

Reputation of geriatric medicine

Geriatrics was known as the ‘Cinderella’ specialty. In the early days of the NHS, care of older people with chronic conditions was little more than tending and it took place in the back wards of large municipal hospitals, old Poor Law infirmaries and cottage hospitals. Patients might go for years without seeing a doctor and were often confined to bed permanently. The founders of the geriatric specialty attempted to change this situation, in part as a more humane approach to medical care and treatment in late life but also in response to a demand to find ways to release hospital beds for use by other patients.

The South Asian doctors soon became a part of the attempt to raise the status and evidence base of geriatric medicine and their accounts provide testimony both to attitudes generally and towards older patients:

“Geriatrics came to be seen as staffed by second class doctors delivering second class service for second class clients. I would not accept that. I used to get a great wad of letters saying: ‘Will you kindly see this patient and advise.’

“They bloody well didn’t want my advice. They wanted me to remove the body blocking their beds. And I said to myself, I will never become a clinical undertaker.”

(L028, born in Bombay 1927, arrived in UK 1953)

This struggle to be recognised was also reflected in the Jefferys’ interviews. Professor Sir John Grimley Evans, born in the UK 1936, is quoted as saying:

“But it’s just a few years ago that I sat next to someone on a plane and we were going to a cardiology meeting and he was a cardiologist and he assumed I was - I didn’t enlighten him. We got talking about things and he said to me, Well, of course, my definition of a geriatrician is a doctor...
who is not good enough to be let loose on patients who matter. It isn’t all that long ago …”
(Sir Professor John Grimley Evans, born in UK 1936, Jefferys interview)

Such attitudes drove a strategy that saw the recruitment of marginalised groups of doctors such as GPs, women returners and migrants.

**Geriatrics as a vehicle for progression and promotion**
The doctors interviewed found that opportunities for career progression tended to be limited by NHS professional hierarchies – even at the time of writing, more than twice (42 per cent) as many white doctors as overseas non white (17 per cent) doctors are consultants in the NHS. Geriatrics, however, offered a way to progress. Many of those interviewed followed the pioneers in this respect, often taking the advice of senior colleagues as this doctor recalls:

“As because my consultant, who was exactly like me... he was a trained cardiologist but as there were openings in geriatrics, he quickly moved into that area. He said, ‘Look if you want to take the fast track up, this is a less crowded road.’” (L023, born in Madras 1958, arrived in UK 1996)

But professional advancement was not always the whole story – also important was personal achievement for both doctor and patient:

“… it took me five years but I got him back to work … I’m not joking, I cried that day. I cried that day when that fellow – he was a butcher – I got him back to work.” (P023, born in Kerala 1941, arrived in UK 1968)

**Discrimination**
The South Asian doctors talked not only of the stigma of working in geriatric medicine but also of personal encounters with discriminatory practices. They tended to focus on three areas where, as outsiders, they experienced discrimination: in getting their first post in the UK; when attempting to get a post as a specialist registrar; and in the allocation of discretionary merit awards and national positions as consultants.

Some picked out particular instances where interviews were unfairly conducted, promotions denied and work went unrecognised:

“… when I first came (to the UK) … I sent lots of applications with copies of my glowing reference from my consultant in Sri Lanka but it didn’t help at all.” (P021, born in Sri Lanka 1944, arrived in UK 1973)

Opportunities to secure promotion in the more popular specialties were few, even for experienced, well qualified doctors as preference seemed to be automatically given to UK trained doctors:

“Well, chances were nil. In those days if in an interview you found a local graduate you might as well walk off. You could only get the appointment if there was more than one post.” (L035, born in Haryana, 1947, arrived in UK 1975)

Many found it difficult to secure posts in London and the south east and instead opted to work in more peripheral areas such as the northwest and Wales and in non-teaching hospitals where there was perceived to be less competition from UK graduates:

Those interviewed were nearly all consultants and one way of measuring their success was through the receipt of clinical excellence awards - the four tiered financial awards given to consultants on the basis of recommendations from local, regional and national senior colleagues. They reflect the esteem and status of individual consultants and the highest award could double a consultant’s salary. Throughout the period of the OUP study it was well established that both South Asians and geriatricians were far less likely to receive merit awards than white doctors in other specialties:

“I think the main reason, without trying to be critical, is that the geriatricians had a hard, heavy, clinical workload and had little time left to do other extra work, like research, publications and in terms of giving awards these other aspects were given more importance than the guy providing a ‘bread and butter’ service, working hard from morning until evening. I think that’s the main reason really but without trying to be cynical, maybe old schoolboy ties and that sort of thing. (laughs) can play a part. But I better not say anything more than that.” (L037, born in East Bengal 1935, arrived in UK 1967)

Very few South Asian geriatricians received
recognition at a national level:

“We used to joke that going to the annual general meeting of British Geriatrics Society was like going to a meeting of the Indian Medical Association. It is still like that, you know? South Asian doctors have run the NHS really isn’t it? If you take general practice or, I mean, like our hospital here, probably thirty per cent are South Asian. NHS was about thirty/thirty five per cent South Asian. So there’s a massive contribution really ... The only South Asian doctors who achieved high office were Dr Banerjee who was the President of the BGS and then there are a couple of doctors in Wales, Dr Sastry (past Honorary Secretary of the BGS) and Dr Bhowmick. They are the ones who are quite high up at the College level or at the national level and all that, you know, but very few ... But it doesn’t represent thirty per cent of the population of South Asian doctors really.” (L035, born in India 1947, arrived in UK 1972)

The accounts they give suggest the need to understand discrimination and racism in the NHS as complicated by racism, the stigma of types of patient, competition for resources and the role of senior individuals acting as sponsors and supporters.

Developing service provision
Developing service provision in hospitals often meant struggling for resources for the care of older people. The idea of age-related admission to a unit which focused exclusively on older patients was one way forward, with doctors, nurses and medical students trained in old age medicine. Collaborations with GPs, social workers and other professionals were also seen as essential to improving service provision. However, the tension between providing an integrated service and one that focuses on acute care has never been resolved:

“... if people try to downgrade my specialty I stand up to them and say, ‘Tell me in what way my doctors, or my nurse, or myself, is inferior to you’. Nothing is elite. No work is less important in my view. So if I am treating older people they are no less important than if you are treating a person with a heart problem.

“And geriatric medicine is the last of the frontiers of general internal medicine. It is going now. In fact now I am a Royal College Examiner and we examine candidates and those who have done geriatric medicine tend to do much better in the examination because they have done proper clinical examination on the patient. They know how to sort out a frail patient, to which many other people have not been exposed. And I think all physicians should have training in geriatric medicine.”(L041, born in India 1946, arrived in UK 1976)

Relevance today
In this research we have focused on the experiences of migrant doctors through the second half of the twentieth century. Today, many of the issues that face the NHS and its doctors remain very similar. New immigration rules exclude non-EU doctors from training in the UK but the introduction of the European Working Time Directive has led to staff shortages, reminiscent of the earlier period.

The need to deliver high quality care for older people grows ever more pressing. It is now understood that older people with multiple comorbidities are the core business of the NHS and geriatrics as a specialty is growing in status. It is in this context that this project makes a case for the need to recognise the contribution which international medical migrants have made in the past and can continue to make to the NHS.

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