**JOINT ROYAL COLLEGES OF PHYSICIANS TRAINING BOARD (JRCPTB)**

**Annual Specialty Report for Geriatric Medicine to The Postgraduate Medical Training Board (PMETB) for August 2007 to July 2008**

## 1. Establishing Schools

Each deanery in England and Wales has established a school of medicine though in Scotland organisation remains within programmes in deaneries. The specialty is not aware that there have been any problems with these developments.

## 2. Triggered Visits

The specialty has been involved with one deanery triggered visit. A team visited and produced a report which is being put into effect and monitored by the deanery

## 3. Effect of changes to the specialty

a. The main issue is the developing need for a countrywide, 24 hour, 7 - days a week acute stroke service including access to thrombolysis. Individual health districts are still deciding on how to respond to this but in many districts it has been necessary to form a separate rota of senior doctors capable of responding to the needs of these acute patients. This means there have in some districts been difficulties dividing the general acute work from the stroke work due to inadequate numbers of consultants on the rotas. This depends very much on how the district is organised. We are working with the Stroke subspecialty-SAC to enhance stroke specialist training and we are developing additional training posts including stroke. There is uncertainty as to what extent we should further develop stroke training for trainees who are not expressing a specialist interest in stroke. It is possible we may have to do more work on the stroke grid in our main specialty curriculum but we cannot overload the curriculum which is already very demanding, so any additions could make it difficult for trainees to achieve completion in the 5 years of our combined training programme in Geriatric Medicine with Acute/General Internal Medicine.

b. A second issue is the developing Dementia Strategy (currently only formulated in England). Patients with dementia appear in many of the hospital and community services. Geriatricians provide care for the large numbers with cognitive and physical problems and some geriatricians provide a service for people where dementia is the primary problem. It is not certain whether all PCTs will want to have a physician in their local hospital leading on dementia, but if so, this will have a significant impact on the need for appropriately trained consultants. Only a few of our trainees currently have a major subspecialty interest in dementia, though all are expected to reach sufficient competence in that topic to support their work at consultant level. We have modified our curriculum to include a specific dementia grid and adjusted other grids to put increased emphasis on dementia.

c. A third issue is the changes brought in by some PCTs in England and particularly the Welsh Assembly who wish to provide a different type of acute service for older

people with more community emphasis. There is an evolving requirement for additional community sessions in existing job plans and those of newly-appointed consultants for this. However in many areas commissioners are looking for only a short term increase in consultant community sessions but Trusts have to offer long term appointments to consultants thus creating a potential conflict.

d. Developments in the management of urinary incontinence e.g.TVTs, minimally invasive surgery for prolapse, periurethral injectables etc are potentially very beneficial for the many older people with this problem. The development of services to case-find and deliver these interventions are rudimentary and currently not widely available. It is unclear whether service users or indeed the specialty itself will exert sufficient pressure to drive these developments.

**4. Key concerns for the future of the specialty**

We have concerns about our relationships with the Acute Medicine subspecialty as in some areas the first 48 hours of care is being provided by acute physicians, some of whom are also geriatricians. Acute medicine has to cope with the burgeoning increase in the number of frail, dependent older people who present to the hospital. Our trainees are increasingly used to bolster the acute care rotas in hospital. Therefore, it is possible there will be a dichotomy between the experience that trainees get which will be heavily weighted towards Acute Medicine and the need for consultants with subspecialist skills in areas of the service with less emphasis on Acute Medicine. At present our training programmes can just about absorb this tension, though in future there will probably be a need for readjustment on service rotas to protect training in the non-acute aspects of the curriculum. There are concerns that with the pressure for early discharge that full multidisciplinary “comprehensive geriatric assessment” will become more difficult to deliver which may mean trainees lose this essential skill.

Other concerns are:

a. The uncertainties about how PCTs will respond to the pressures that acute hospitals are under with the increased numbers of acutely ill old people.

b. The increasing withdrawal of specialists from longer term care for older people in care homes. This is more obvious in England but is becoming an issue in the other countries of the UK. The medical care in care homes is poorly co-ordinated in much of the UK. There are now fewer training opportunities for long term care support, including that within care homes. With the predicted demographic pressures ahead and the requirement to support the primary care of a frail, complex and vulnerable population there is a need to re-engage in this area . Such involvement would support the goal of reducing inappropriate unplanned admissions from care homes, as well as improving the quality of care provided in such settings.

c. In spite of government desires for closer working between social services and health services, in many cases the relationships are deteriorating rather than improving. This is neither good for patients nor for the training of geriatricians.

d. Geriatric Medicine has now one of the highest percentages of female trainees amongst the medical specialties. This feminisation produces some uncertainties for the future as to the percentage of consultants who may wish to work full time. However currently the increase in numbers in part time training is only modest.

e. The European Working Time Directive is producing particular challenges for the specialty as it is increasingly difficult to deliver continuity of care for older patients whose complex needs, high prevalence of chronic disabling disease, social dimensions to their problems and multiple hospital admissions indicate a higher need for continuity of care. Some areas of the UK e.g Northern Ireland are having above average challenges to meet the hours of work targets demanded by the directive.

f. Recruitment to the specialty in many parts of the United Kingdom notably in Scotland is good. However Wales is reporting difficulty in recruitment possibly resulting from the trainees' views that organisation in Wales is different.

**5. RITAs/ARCPs**. The following includes the responses we have received from the Heads of Specialist Training for this specialty

All trainees for this specialty have had successful RITAs/ARCPs. For the 509 trainees enrolled in Geriatric Medicine it was been reported that 2 RITA Ds were issued, one of whom then joined the Specialist register via the CESR route.

**6. European Working Time Directive (EWTD):** The following includes the responses we have received from the Heads of Specialist Training for this specialty

It has been reported that this specialty is EWTD compliant

**7. Training Programme Director Report information**

We have not received these reports for every Deanery for this reporting period but intend to include the themes in subsequent reports. However, we have received various Education Committee meeting minutes for this specialty which highlight no training or assessment concerns.

**8. Examinations**

We do not have examination data available for this reporting period.

**9. Assessments**

Workplace based assessments for the medical specialties including Direct Observation of Procedural Skills (DOPs), mini CEX, and Multisource Feedback (MSF) have been in place since 2005. Although there have been concerns within each specialty with regard to the time involved to complete these, their use has been widely encouraged so that PMETB standards are met. We continue to pilot further workplace based assessments.

**10. e-portfolio**

Pilots for the specialty e-portfolios have been completed and the eportfolio for Geriatric Medicine is now live and available for use by enrolled StRs. During the transition period trainees had been advised to complete paper records or to continue to use their CMT e-portfolio.