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**Don’t forget!**

*Old Age Faculty Annual Conference: Glasgow, 25-27th March 2015*
The pace of NHS change is so fast and there is more ahead. New plans include the *NHS Five year forward view* [http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf], *Everyone Counts: Planning for patients 2014/15 to 2018/19* [http://www.england.nhs.uk/wp-content/uploads/2013/12/5yr-strat-plann-guid-wa.pdf], and *Frail older people – Safe, compassionate care* [http://www.england.nhs.uk/ourwork/pe/safe-care/], which begins to look at longer term integrated care and the management of chronic disorders. These proposals are optimistic and relevant to older people and emphasise the importance of prevention. This should extend to secondary prevention for older people with chronic illnesses and frailty, to help maintain independence and avoid institutional care.

However, does expert secondary prevention, such as that provided by older people’s mental health services, lag behind what could be provided and achieved? Could we be more assertive to the Clinical Commissioning Groups (CCGs), emphasising the benefits of old age psychiatry teams, especially regarding long term support for people with mental illness? There is evidence that expert support - medical psycho-social and educational - can help prevent ‘social’ admissions for minor physical problems to expensive acute medical or geriatric beds, by alleviating the real problem: that the family is at the end of their tether with the caring role. Fortunately there might be more public awareness and consideration of this sort of issue: journalist Rose George commented in the *Guardian* (28 October 2014) that one study revealed that ‘an Admiral Nurse saved the health service £443,593 in a year, in reduced contact with GPs and nurses, and in the eight mental health bed referrals that were avoided.’ [http://www.theguardian.com/commentisfree/2014/oct/28/solve-dementia-crisis-paying-gps](http://www.theguardian.com/commentisfree/2014/oct/28/solve-dementia-crisis-paying-gps)

New plans for the NHS include the Better Care Fund (BCF) ‘A single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and local authorities’. This is potentially beneficial to older people with chronic illnesses, although the BCF has already run into some difficulties [http://www.bmj.com/content/349/bmj.g6745](http://www.bmj.com/content/349/bmj.g6745). One also wonders that, if more resources from a single finite pot go into expensive long stay ‘social’ and institutional care, it might further divert resources from active, interventionist specialist mental health services which might prevent or delay use of those services. Older people and the health and social care economy could benefit from more old age psychiatry services not less. How are we going to achieve it?
Competition! With prizes!

…. calling all psychiatrists!

*Old Age Psychiatrist* wants to hear about your experiences of working in the specialty as a trainee.
We would like you to tell us in no more than 800 words about your expectations and apprehension, elation, delight, heart-sink, fear or other emotions before you worked in old age psychiatry and if and how these changed or were confirmed over time when after you started work in the specialty.
Please focus on your personal experience, highlighted with anecdotes. Perhaps a particular patient or consultant or other member of staff changed your view for the better? (or worse!)

First prize £150
Runner up £50

The winning articles will be published in *Old Age Psychiatrist* in September 2015, and we will publish as many of the others as we can in that and subsequent issues.

The competition is open to doctors who have worked in old age psychiatry, including Foundation Doctors and Core Trainees.

Please email your submissions to David Rigby, trainee editor of *Old Age Psychiatrist* at david.rigby@eastlondon.nhs.uk by 30th April 2015
Friends, CQUINs and enhancements

Alistair Burns, National Clinical Director for Dementia, NHS England

It has been an exciting time over the summer. A few weeks ago, it was a privilege for me to visit Eccles in Salford, Greater Manchester, to meet Tony and Joy Watson. Joy has a diagnosis of dementia and has decided to transform the environment around Eccles and, in particular, in the businesses in the town centre. Joy had a negative experience in some local businesses because of her symptoms and so, rather than complaining that someone else should do something, decided to take action herself. It started with a town meeting where most of the businesses signed up, providing them with information including a guide to dementia and a sticker for the window to show the shop was dementia friendly. I saw at first hand how transformative it has been and it was very heartening to see how changes can be effected. The picture shows me in front of what, arguably, could be the world’s first dementia friendly fish and chip shop.

In September 2014, we (led by Simon Thacker from Derby Royal Infirmary and myself) held a meeting about the hospital dementia CQUIN (Commissioning for Quality and Innovation). The CQUIN is the hospital initiative which incentivises clinical leadership, identification of people with dementia and the provision of information to their carers. It has been in existence now for three years and, while there is inevitable discussion about the implementation of it, most people would agree it has transformed awareness about dementia in the general hospital setting.

Three points emerged:

- the dementia CQUIN, in general, was welcomed as an initiative to broaden the profile of the disorder in the general hospital, had excited discussions around cognitive impairment and had been a stimulus to improve care;
- while dementia is a powerful concept, there was a need to capture the profile of delirium in order to deliver optimal care;
- looking across health and social care and emphasising quality was regarded as key.

A lot of public and professional interest surrounds the National Enhanced Service which incentivises GP practices to the tune of £55 for each new dementia diagnosis, announced in October 2014. The Service is to support activity to reach people who are being denied a diagnosis, the benefits of which include: empowerment to make their own choices; access to the right care packages including medication; avoidance of unnecessary emergency care home or hospital admissions; provision of accurate clinical information across health and social care; advance care planning. It is a modest payment recognising the additional work involved, is entirely voluntary and is paid to GP practices not to individuals. We have written a primer for GPs and are giving out further guidance about potential diagnosis in primary care and possible initiation of anticholinesterase drugs.
So, it continues to be an exciting time for dementia while, at the same time, the Chief Medical Officer’s report has highlighted the importance of mental health problems in older people and the providence of old age psychiatry as a discipline.

Finally, it was a special month for me in November in that I was awarded the Honorary Fellowship of our College. Thanks to JS Bamrah for all his support and to all colleagues without whom the work will not be as much fun.

Joy and Tony Watson with myself (head to one side as usual) and the manager … outside the world’s first dementia friendly fish and chip shop in Eccles, Salford, Greater Manchester
I was delighted to receive the Honorary Fellowship of the College on 6 November 2014. Pictured here next to my personal trainer and special Advisor, JS Bamrah.

What happened between pictures 1 and 2?

a) JS took off his 1970’s Slade Platform shoes  
b) I took advantage of the dias  
c) The award instantly increased my stature

Comments and responses always welcome to Alistair.Burns@nhs.net
Report from James Warner, chair of the Old Age Faculty

After two years of good service to the faculty George Tadros has resigned as Vice Chair. George did a lot of work behind the scenes. We are not allowed to hold an election until the next scheduled elections in 2016 so I have co-opted Sandra Evans as VC until then. Sandra is a redoubtable and experienced member of the faculty executive; I hope you will join me in wishing her well in the post.

Some really important and uplifting news is that the GMC are on the verge of agreeing to recognise old age liaison training for endorsement. This rectifies a profoundly unfair (I would say discriminatory) state of affairs whereby trainees in general adult psychiatry were recognised for training in a way older adult trainees were not. They require a new liaison curriculum which will now include dementia! This is pretty much sorted. Huge thanks to Ann Boyle, George Tadros, John Holmes, the liaison faculty and the Dean, Wendy Burn, for work on this and for putting up with my nagging!

Another bit of great news is the old age section of the Chief Medical Officers report which focussed this year on mental health. Various faculty members had a hand in this, led by our former academic secretary, Rob Stewart. The underlying message is “Don’t forget the 2/3 of older people with mental illness who do not have dementia”.

Perhaps more importantly, Dame Sally Davies, doyenne of evidence-based policy says in the introduction:

Mental health problems in older adults are common, often undiagnosed but as amenable to established treatments as in other groups. Helping people with combined physical, psychological and social difficulties in the context of ageing and end of life requires specialism. This could be compromised by any move to generic ‘age-less’ services.

I take this as a real vote of confidence in our specialty. Incidentally we are continuing to apply pressure on politicians; the latest is a letter from Simon Wessely and me to Jeremy Hunt deploring the erosion of old age psychiatry in the UK.

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Tariff based commissioning: do old age services cost more? In association with Ramin Nilforooshan, we undertook a survey of costs utilisation (using modified Client Services Receipt Inventory) across five trusts looking at two acute (non-dementia) clusters comparing younger adult and old age patients. Many thanks to all the trainees who helped with data collection and to the faculty for funding this (it didn’t cost much) and Central and North West London Trust for providing admin support. Preliminary results suggest older people do cost more (possibly much more) at least for the depression cluster. Younger people may cost more for psychosis clusters. The importance of this is that the Department of Health and commissioners should not use a “one-size-fits-all” approach to tariffs. If we do not heed this older people may yet again be the poor relations in funding reorganisation.

***Our next conference is in Glasgow 25th-27th March 2015. A varied and interesting programme is already taking shape, so make sure you book your place and encourage colleagues to attend***

A good result I think from Health Education England/Centre for Workforce Intelligence regarding old age training needs. They have accepted our argument that old age psychiatry is a) viable and b) a real area of growth. We now need to work on maximising recruitment to the specialty. I am becoming increasingly convinced that nurturing our existing trainees, and encouraging new ones into old age, is by far the most important task ahead for the executive.
Illness narratives of Alzheimer’s – can these improve care?

Noel Collins, SABP NHS Foundation Trust, Berkeley House, 11-13 Ockford Rd, Godalming, Surrey GU7 1QU

Alzheimer’s disease (AD) results in progressive decline in memory, executive brain function, and behaviour. It is also a significant life event which can be understood within the context of an individual’s lifespan and current circumstances. Although personal narratives of dementia are generally absent in scientific literature, interpretative accounts are thought key to understanding the individual experience of the disease (Beard, 2004). The individual perspective of AD can also be understood in terms of the social meanings or constructs attached to the illness. For example, expectations of normative behaviour by society and carers will impact on whether the behaviour of a patient with latter stage AD is viewed as normal or as a pathology requiring treatment. AD is both a biological disease and a social experience (Vittoria, 1999). In this essay, I will discuss AD from the perspective of the individual rather than the traditional biomedical view. I will examine whether this perspective can improve care of people with the condition.

Individual experience is framed by the psychological, social and cultural context of the individual. An individual’s reaction to a diagnosis will be influenced by their existing understanding of what AD is and predictions of how it will affect their life. The meaning that an individual will ultimately apply to their memory decline will be a function of their expectations and experience of dementia and concurrent difficulties (Lingler et al., 2006). Memory loss may be accepted as a normal part of ageing in one individual or be of great concern to another (Begum et al., 2012). Individual
personality and how adversity has been previously navigated in life will also influence coping style.

Individual perspectives of AD not only help in understanding the subjective experience of AD, but insights can also be used to improve the system of care and to critically challenge societal views of AD. Individual perspectives of AD provide insight into how people experience and navigate the condition. They provide fundamental understandings of how people negotiate death and illness (Vendler, 1994), maintain identity (Beard, 2004), use coping mechanisms (Liptak et al., 2013), as well as the impact of the condition on others (Clare et al., 2012). Interpretative perspectives, such as Kontos’ work on the embodiment of self of patients with AD, counter the presumed disintegration of selfhood in AD and ‘critically challenge the widespread presumption of the loss of agency’ in dementia (Kontos and Naglie, 2007: p.846). These insights offer real hope to both patients and doctors in the face of a difficult diagnosis (Byszewski et al., 2007). This is in contrast to a more ‘mechanistic model of biomedicine which has precluded a systematic examination of the socio-cultural or emotional components of illness’ (Beard, 2004: p.416).

Illness narratives may improve AD treatment from diagnosis to death. Understanding the diagnosis experience may improve coping skills (Aminzadeh et al., 2007) and enhance person centred care (McKeown et al., 2010) and assist end of life planning (Goodman et al., 2013). The individual perspective can also be used to measure the quality of health care itself (Horton, 2008). Outside of health care, understanding and sharing illness narratives of AD can generate solidarity between sufferers and enhance a sense of community (Rodriquez, 2013). Listening to narrative accounts of AD may change societal perceptions of the disease and encourage more political activism from other AD sufferers (Beard, 2004).

Using a social constructionist view of AD may also help avoid inappropriate treatment of behavioural and psychological symptoms of dementia (BPSD). BPSD include a constellation of difficulties such as agitation, aggression, wandering and shouting. These are conceptualised as symptoms using the biomedical approach and thus are often treated in nursing homes with medication such as anti-psychotics (Barnes et al., 2012). These ‘symptoms’, however, can also be conceptualised using constructionist model as unmet need or purposeful attempts at communication. This in turn can generate alternate approaches in dealing with these challenging behaviours and maintain the personhood of the dementia sufferer (Perry, 2005).

In the community, a more holistic view of dementia behaviours may challenge societal norms of behaviour and improve understanding when they occur. It is also hoped that this will improve visibility of patients with dementia and challenge stigma (Gilmour and Brannelly, 2010). Beard comments that ‘when we are receptive to both listening to and valuing what people living with AD have to tell us, we will be well on the way to affording them the space necessary for a visible ... role’ (Beard, 2004: p.415).

AD represents a complex challenge to individuals, society and health care. It causes much distress and fear for some patients, whilst others (and their families) seemingly negotiate the condition with dignity and hope. Iliffe and Manthorpe (2004) comment that the ‘task for health and social care providers is therefore to recognise the diversity of’ patients with AD so that the experience and care of the condition can be improved for all’ (Iliffe and Manthorpe, 2004: p.283).
References


Meet Keith Oliver – user/carer representative on the Executive of the Old Age Faculty.

In July 2014 Keith addressed the Executive. His notes for that meeting are reproduced here. The notes are self explanatory, including about who he is and what he does. We have much to learn from him. Read on … …

Notes for a meeting at the Royal College of Psychiatrists 10 July 2014

I welcome opportunity of joining you today to bring with me a perspective of someone living with dementia. I hope that you find my little presentation interesting, thought-provoking and informative, and that it will provide me with a platform to make a useful contribution to this committee.

Who I am – 58 yr old person, husband, father, grandfather. Live in Canterbury – Enjoy a wide range of hobbies and interests – Travel regularly in Europe and Australia – The latter is significant because the day I was initially diagnosed the neurologist advised me to cancel a forthcoming trip to our favourite second home – we didn't and have with a little increased support and understanding made 4 more wonderful trips since. I read a lot but don't remember as much as I used to, this did worry me but now I try and enjoy the moment with the book rather than get frustrated. I love my garden and spending quality time with friends and family. I collect British and Australian stamps, research and correspond on the computer, thrive on beach and country walks and I do a lot of voluntary work.

It's the latter which I'm going to share something of with you today.

About 1/3 of my life currently is spent on doing things which I really enjoy, about 1/3 is spent doing voluntary activities relating to dementia and 1/3 is spent getting over the other 2/3s. During 2010 I was diagnosed with Alzheimer’s Disease at the age of 55 causing me to retire in April 2011 from being head teacher of a large primary school in Canterbury and drop out of successfully studying for an MA in educational leadership at Canterbury Christ Church Uni. Once I came to terms with the diagnosis I was keen to utilize the skills I have developed through my life and work, to support efforts both within the NHS and the voluntary sector to better engage with people with dementia (pwd) to ensure a better service for all those being and been diagnosed. My life has further been touched by Alzheimer's as my mother who died aged 81, 2 months ago had dementia and bi polar which was diagnosed as manic depression 40 years ago. Both have had an impact upon me and my attitudes and thoughts. Through this and my frequent visits to her in her nursing home I got a further perspective of how dementia affects older people. My wife is 73 years of age, and consequently our social circle contains many people in their 70s and 80s.

My route through diagnosis both with the neurologist and the clinical psychologist at the local memory clinic was very well managed and I was extremely well supported and informed. This takes time in complex cases like mine. I am very good at screening my symptoms, using my skills and intelligence and being positive – all despite the very significant challenges that my progressive dementia presents on most days. One passion I have revolves around post diagnosis care and support for all
people with dementia. I seek a care plan worthy of the name, rather than one merely monitoring my medication, which in my case is Reminyl, soon to be the more generic form of Galantamine now the GP is prescribing.

Since May 2012 I have developed a unique voluntary role, that of Kent and Medway NHS Partnership Trust (KMPT) Dementia Service User Envoy. With the support of a clinical psychologist, and since last Sept, with some exceptional psychology students on placement with the Trust from Kent Uni, I have carried out some amazing activities connected to raising awareness amongst professionals, the media and the general public alike of what it is like to live with dementia, and in turn to seek ways of constructing improved services for folk in the same situation. These activities include conference talks, media work on TV, printed press and national radio. I have read and commented upon some crucial literature and sit on a number of boards and committees at a national level, not least of which is the one which directly advises the Prime Minister (mention recent Radio 4 You and Yours programme alongside the PM – exciting but not as exciting as my 6 yr old grandson's response to hearing me on the radio and the response of a former pupil from 20 years ago.) Speaking of former pupils – tell story of former pupil – now consultant psychiatrist. I am also the only non professional on a 5 person board – advises Channel 4 on a forthcoming major documentary series on dementia which is likely to be broadcast in the UK and worldwide in the new year. There are heaps more but I won't go through them all now. Once a teacher – always a teacher … … I deliver guest talks at both Kent Uni (social care under-grads) and at Canterbury Christ Church Uni (occupational therapy under-grads)

Since November 2012 we have had an exceptional new initiative in East Kent – that of the Forget Me Not network. Grown from 7 to 19, despite 3 or 4 having to drop out due to progress of their illness. From all walks of life and aged from 49 to 84. Men and women. Interview KMPT staff, read and comment on literature, speak at conferences – including a European dementia conference. Discuss and make recommendations relevant to KMPT work and beyond, e.g. only group of pwd consulted by the House of Lords when they were recently revising the Mental Capacity Act. We are often called upon by the voluntary sector to support their work as well. By the way, we are great friends now and provide some genuine understanding, friendship and support for each other. The group is co-chaired by myself and 2 clinical psychologists. The group have already developed a national and international reputation through its efforts and publications/conferences. Our Trust are becoming proud of our achievements and the positive way we are facing the many challenges dementia presents us with, to live as well as possible with dementia and challenge all the negative stereotypes which so often surround this condition. This allows me to utilise key skills which I retain from my former professional life around looking at issues, concerns, and positives not just from my perspective but from that of others as well. In my experience over the past 3 years, despite hearing some excellent, emotive presentations from service users often they don't move beyond their own experience. I am keen to join this Exec committee and would much rather do so as part of perhaps a 3 or 4 person network model who can bring a range of experiences to the benefit of you professionals and then in turn to the broader community. This will have greater impact and is more sustainable.
A new project is the **Life Writing Project**, the background to which is a desire by myself and seven other people with dementia to write with support our thoughts about our past, our present and our futures. It followed soon after my completion of a life writing course at Canterbury Christ Church Uni and the inspiration this provided. We have a tutor who has brilliantly led us through a series of writing exercises, and she and the writers are very ably supported by five psychology under-graduates from Kent University who are on a one year placement with KMPT. Funding for the course came from DEEP (Dementia Engagement and Empowerment Project) which is funded by the Joseph Rowntree Foundation, and this was followed by a larger grant from the Alzheimer's Society to move the project from a course to a published book. This is the first time anywhere in the world that a project has done this, i.e. take a group of people with dementia, teach and support their life writing and then publish this writing in a book which can be purchased by any one. The eight writers are aged from 56 to 82 from many varied walks of life and backgrounds, and they have a range of dementias. The book is currently being prepared by the writers with the one to one support of the students. An editorial team is established – the tutor, myself, a published author, a clinical psychologist and the students. The intention is to take it to international/national conferences starting at Alzheimer’s Europe in Glasgow in October 2014. Waterstones in Canterbury have been supportive and are keen to host a local launch around the same time with local media interest beyond that of the national media through BBC Radio 4 and the Alzheimer’s Society press team. We certainly feel that this project challenges negative stereotypes around dementia and is proving exciting for all who are involved.

**Life Writing Project: Book now available!**

Title: *Welcome to our World: a collection of life writing by people with dementia*, with foreword by Jo Brand, £5

THE DIPLOMA IN GERIATRIC MEDICINE

Dr Martin Curtice, consultant old age psychiatrist, examiner for the DGM clinical examination and old age psychiatry representative on the DGM board.

New Haven, Princess of Wales Community Hospital, Stourbridge Road, Bromsgrove, Worcestershire, B61 0BB

Martin.curtice@hacw.nhs.uk

The Diploma in Geriatric Medicine (DGM) is one of two diplomas awarded by the Royal College of Physicians of London, the other being the Diploma in Tropical Medicine and Hygiene (DTM&H). It is available to all registered doctors. The DGM examination is designed to give recognition of competence in the provision of care of older people to general practitioner vocational trainees, middle grade doctors working in non-consultant career posts in departments of geriatric medicine, and other doctors with interests in or responsibilities for the care of older people. This latter group includes doctors involved in old age psychiatry. The diploma in particular provides an opportunity to review and consider all aspects of the care of older people and to be recognised as having such knowledge. The DGM Board suggests this is particularly important at a time when the proportion of very elderly people in the population is rising dramatically. Hence it is an excellent addition to the career development of an old age psychiatry trainee or those in old age psychiatry non-consultant career posts (or even consultants!) as well as providing an in depth understanding of the major disorders in geriatric medicine which we routinely see in our patient group. The minimum eligibility requirement for the DGM written examination is 2 years’ post-qualifying experience prior to the date of the written examination, or candidates who have had 4 months’ experience in a geriatric medicine post in a hospital or in another post (e.g. as a GP) in which they see a lot of older patients. Overseas doctors who fulfill the entry requirements are encouraged to sit the examination but are made aware that, as the examination may include questions relating to health and social care systems in the UK, and the syllabus requires knowledge of the Mental Capacity Act.¹

The exam format
The exam consists of written and clinical parts. The written examination must be passed before proceeding to the clinical examination. A candidate has two years after passing the written exam to pass the clinical, but if they fail to do so in that time, they are required to re-sit the written examination again.

Part 1 – Written Examination
There are 100 ‘best of five’ questions covering the published syllabus of geriatric medicine, community care of older people and problem-solving of clinical and social

¹ There is not currently a Scottish DGM.
dilemmas. Importantly, the questions are not designed to catch candidates out nor to test obscure aspects of geriatric medicine (and sitting on the examination Board I can confirm the emphasis is indeed on testing knowledge of commonly occurring problems). The written examination is three hours long. Sample questions can be accessed from the DGM website below. The written examination seeks to assess an understanding of medical knowledge as it relates to the physiology of ageing and the diagnosis and treatment of the older person. It includes common clinical areas such as falls, incontinence, pressure ulceration and osteoporosis, as well as common problems encountered in old-age psychiatry such as depression, delirium and dementia.

**Part 2 – Clinical Examination**

The clinical examination consists of a four-station standardised examination (very similar to the Objective Standardised Clinical Examination – OSCE – format). The exam lasts about an hour in length. The stations are:

1. **History-taking station** – taking a concise yet comprehensive history from a patient or an actor and presenting findings and discussion about diagnosis, management and investigations. The emphasis is on being able to assimilate information to produce relevant problem and differential diagnosis lists, and demonstrating an understanding of older adult issues in the round.

2. **Clinical examination skills** – this involves the examination of a neurology patient and discussion of clinical signs elicited and diagnosis and management. This station also includes a 5-minute Structured Practical Assessment (SPA) sub-station in the form of written answers to set questions. The SPA aims to assess the knowledge of equipment, aids and appliances for various disabilities and rating scales commonly used in clinical practice in the UK.

3. **Communication skills and ethics** – this station involves a given scenario e.g. ethical or legal, and the candidate interviewing an actor and then discussing the case with the examiners.

4. **Clinical examination skills** – two patients are selected from either a cardiovascular or respiratory patient and then from either a dermatology or musculoskeletal patient. The emphasis is on examination technique and discussion of the case in terms of eliciting clinical signs and diagnosis and management.

At the end of 2015, Station 2 will be changed to test the principles of the Comprehensive Geriatric Assessment (CGA), where the candidate will be presented with a clinical scenario which they will discuss with the examiners to demonstrate that they can manage and plan care for complex frail older patients.

The clinical examination also importantly considers the candidates approach and attitude and ‘bedside manner’ with patients and treating them with courtesy and respect. Any management plan would need to take account of, and be tailored around, the particular needs of the older person in question. Each of the four stations will have two examiners, one who will take a lead role and one who observes. Clinical examiners will be consultant geriatricians, consultants in old age psychiatry\(^2\) or GPs.

\(^2\) They do not need to have the DGM or MRCP, but they need to show on their application interests in wider older adult issues. Evidence of teaching helps.
Consultant old age psychiatry examiners can take the lead role in any of the stations being examined.

Having examined in many DGM clinical exams I believe it is a fair and very ‘doable’ exam for any doctor in the specialty of old age psychiatry and would be very advantageous for their knowledge and skills base and for their career progression. The DGM Board also welcomes expressions of interest from consultant old age psychiatrists in becoming examiners for the clinical examination. A consultant will be provided with appropriate training and would be expected to be available to examine at least once a year (there being two exam sittings each year).

The DGM website explains in detail about the diploma:
https://www.rcplondon.ac.uk/medical-careers-training/postgraduate-exams/diploma-geriatric-medicine

For queries about the exam or consultants becoming clinical examiners please email: 
dgm@rcplondon.ac.uk

*Thanks to Dr Ronnie Barber, outgoing chair of the DGM Board for advice on this article*
How useful are workplace based assessments in old age psychiatry?

David Rigby  
CT2 Core Trainee in Psychiatry  
London Deanery  
David.rigby@eastlondon.nhs.uk

The typical patient?
A new admission arrived on the ward, a 69 year old man called Stephen. He was brought in after a concerned GP noticed that he had not attended the practice for several months and had not collected recent prescriptions. Stephen was found to be living in squalid conditions, had lost over 10% of his body weight and no food was found in the fridge.

Stephen was initially seen in the accident and emergency department where he was found to be dehydrated and hypothyroid. He spent 1 day being rehydrated and an infective source was ruled out before being transferred to the psychiatric ward where he exhibited challenging and aggressive behaviours, appeared to be responding to hallucinations and was disoriented in time, place and person.

The GP stated that a few months ago Stephen was fully independent and lived alone. He had a history of ischaemic heart disease, hypertension and hypothyroidism and a family history of depression. The GP also stated that Stephen only had one daughter, from whom he was estranged after a family rift, and he has few close friends. The ward nurses were keen for some sedation to be given for his challenging behaviours. Shortly after that, the daughter arrived on the ward demanding to know what had happened to her father.

This vignette at first glance looks highly complex. The doctor is dealing with a patient with complex medical and psychiatric problems, a long list of differential diagnoses, social issues, risk, concerns and family and confidentiality issues all rolled into one clinical scenario. Yet such a case can be quite typical on an older adults psychiatry ward and exemplifies the skills needed by a clinician in this field.

Trainee assessment of the complex patient
Being able to take into account multiple clinical problems and formulating a management plan that keeps the patient and others safe, respects confidentiality and helps narrow the differentials, as well as providing symptomatic relief, is a crucial skill set to acquire for the trainee in old age psychiatry. Current practice in the UK training system would suggest using a ‘Workplace Based Assessment’ (WPBA), supervised by a consultant, to assess performance. A mini-CEX (Mini Clinical Evaluation Exercise – also known as Mini Assessment of Clinical Expertise (mini-ACE)) would allow the consultant to watch the trainee taking the history and performing the examination. Or, the CBD (Case Based Discussion) would allow the trainee to sit down with the consultant after the clinical encounter and discuss the management plan and documentation. It seems that, on the surface at least, the WPBAs provide a perfect framework to assess trainee competence and identify a failing trainee. However, when one looks at the situation on the ground, taking into account the availability of time and other pragmatic factors, there is some evidence to
suggest that WPBAs are not entirely fit for their purpose and that maybe another approach should be taken.

Problems with WPBAs
WPBAs were introduced in the UK after the General Medical Council’s introduction of Modernising Medical Career’s (MMC) in 2005. MMC stated that assessment of doctors should be ‘competency based’ and WPBAs offered a way of standardised and reproducible assessments based on clinical competencies. Whilst WPBAs seem an excellent way of meeting MMCs criteria on paper, some evidence suggests that the reality is different.

Wilkinson et al\(^2\) conducted a study of 655 junior doctors undertaking WPBAs in the UK and found that for the mini-CEX to be a reliable instrument, it must be ‘observed by at least 8 different assessors observing at least 2 encounters each for it to be statistically reliable.’ The Royal College of Psychiatrists asks for only 4 mini-CEXs / mini-ACEs to be performed per year and makes no stipulations on how many different people should assess. Even if a studious trainee were to meet Wilkinson’s criteria for reliability, this would most likely occur at the end of Core Training, making it difficult for this WPBA to identify a struggling junior in a timely manner.

So, if a trainee puts in a good performance in a mini-CEX in the case of Stephen, it might be because the trainee is competent, but equally it could be because the assessor is lenient or the trainee has a lot of knowledge in one area but gaps in another or a variety of other reasons.

Perhaps a Multi Source Feedback (MSF, also known as 360 degree feedback) might be a better way of assessing the competency of a trainee and to identify a failing one? It seems reasonable that one assessment from a wide variety of peers, over a long period of time in multiple domains offers a more reliable assessment of a trainee’s performance.

Wilkinson et al\(^2\) suggest that ‘feedback from 12 assessors is necessary to achieve reliability in the MSF’. This is a much more achievable goal. Core Medical Training and the Foundation Programme in the UK ask for 12 assessors for a MSF. However, Core Psychiatry Training currently only asks for 8. I believe that there are a set of important respondents that are completely left out: the patients! A great proportion of the MSF questions ask peers about their opinions on the trainee’s clinical and communication skills with patients. This is third hand information; surely collecting some information from the patients themselves would provide a deeper level of insight into these skills.

I think that this is especially important in psychiatry where the doctor / patient relationship is perhaps more crucial to treatment success than in any other branch of medicine. Having said that, the cohort of patients seen in older adult psychiatry wards presents more difficulties in obtaining reliable and valid feedback than in most other disciplines. For example, patients with significant cognitive impairment may not be able to complete the forms. MSF tend to be online based and this may cause difficulties in completion for older patients. Although only a minority of older adult inpatients on psychiatric wards tend to be detained under the Mental Health Act, this
group of individuals tend to have a negative view of their stay in hospital and may project these feelings in the MSF.\(^3\)

The MSF probably has the best evidence of being an accurate, valid and reliable source of gathering information about trainee performance. Making the MSF truly a 360 degree feedback by including patients’ and relatives’ feedback should improve what is already a highly useful assessment. Such practice is already common in countries such as Canada and also forms a part of UK consultants’ revalidation requirements. To overcome the specific difficulties in older age psychiatric patients, perhaps the clinical supervisor could select which patients should provide feedback for the MSF. This would help eliminate problems due to cognitive impairment or undue negative bias and would also prevent the trainee from cherry picking their favourite patients. As we shall see, this can also be a pitfall of WPBAs.

**Hiding the truth?**

OK, so WPBAs might not be the most reliable way of assessing the trainee but reliability is difficult to achieve in the real world of clinical psychiatry. What is more important is that the WPBAs assess the trainee in a real life situation, potentially making it a much more useful assessment tool than a multiple choice question exam.

However, it may also be the case that decent scoring WPBAs from a trainee might lull the clinical supervisor into a false sense of security about their trainee’s clinical competence. A key problem with the WPBAs is that the trainee gets to pick the clinical scenario and who they want to assess them. This inevitably leads to trainees picking clinical situations with which they are more comfortable, and selecting peers who are more likely to give a positive assessment of them. So if the trainee in Stephen’s case did not feel competent in handling this scenario, he could avoid being assessed in it and instead select a patient he felt more comfortable with.

Mitchell et al\(^4\) found that trainees in difficulty were more likely (Odds Ratio (OR): 4.0 (95% CI: 0.75-21.26)) to pick easy scenarios for the mini-CEX than their colleagues who were not deemed to be failing. In addition, trainees in difficulty were less likely (OR 0.62 (95% CI: 0.05-7.33)) to choose nurses to assess them in MSFs than their counterparts.\(^3\) Other studies have shown that nurses, compared to other team members, are the most proficient at identifying a failing trainee through the MSF method.\(^5\)

Perhaps allowing supervisors, instead of trainees, to have control over what is assessed and by whom, a clearer picture of the trainees strengths and difficulties will emerge. This is especially important for the trainee in difficulty.

**What do the assessors think?**

Whilst there are a lot of positive comments about WPBAs from clinicians at all levels, there are also some concerning comments and statistics that cast further doubt on the usefulness of the WPBA.

Wilkinson et al\(^2\) asked assessors if they thought that the WPBAs ‘provided any useful information about the trainee that they previously did not know’. Only 40% thought that this was the case for the mini-CEX and 25% for the DOPS (Direct Observation of Practical Skills). Bindal et al\(^6\) conducted some qualitative research in this matter with common themes occurring such as ‘WPBAs lower the goalposts and make juniors less
willing to try at procedures they are not comfortable with’ and that ‘bad doctors can
actually look better if they perform assessments less frequently.’

What is the answer?
Clearly there are problems with WPBAs but they still offer a practicable means of
assessing trainees in a wide variety of ways. I don’t think that they should be scrapped
but they could be improved upon. Educational and clinical supervisors should have
more of a say in who assesses the trainees and what they are assessed in. Patient
opinions and feedback should also be included in all of the assessments conducted by
the trainee.

There is a tendency for assessors to rely on the WPBAs as the primary piece of
evidence that a trainee is doing well but they are not good enough tools to be used for
this purpose. They should form a supporting part of the total assessment only. The
importance of the clinical and educational supervisor’s judgement of general
performance over a placement should be given more weight in the annual assessment
of clinical competencies. In psychiatry in the UK, currently this is overlooked in place
of the WPBAs. Perhaps a detailed report written by the educational supervisor at the
end of the placement, including feedback from peers and patients would be a useful
accompaniment to the WPBAs.

Trainees in old age psychiatry will often work in teams where there are only a small
number of consultants available to perform WPBAs. This could be used as an
opportunity to develop and be assessed in a variety of skills by other colleagues with
specialist knowledge. For example, a trainee could be required for perform a cognitive
assessment on a patient under observation by a neuropsychologist or to give advice
regarding administration and monitoring of lithium whilst being assessed by a
pharmacist.

Having feedback from patients will provide useful information for a 360 degree MSF
feedback. However, in old age psychiatry, educational supervisors could ensure that
some of the feedback includes carers’ opinions, especially when significant issues
with cognitive impairment have been identified. Educational supervisors could also
stipulate that WPBAs should cover a wide variety of both functional and organic
difficulties. This would help alleviate the problem of the trainee potentially avoiding
scenarios with which they are uncomfortable as well as providing them with new
learning opportunities. For example, many old age psychiatry training jobs only
include inpatient work with little or no opportunity for outpatient or community work.
By asking that WPBAs cover these areas, supervisors will give their trainees a
broader clinical experience in the specialty and may also give the trainee a more
positive experience of their placement.

The discipline of old age psychiatry involves looking after complex patients like
Stephen as a routine part of the job, combined with an often busy clinical environment
with minimal time for formal learning and assessment. Proper evaluation of the
trainee is often equally complex and there will always be issues in balancing
appropriate assessment of trainees with service provision. The key to success in this
field is not to rely too heavily on one mode of assessment and to be aware of the
numerous difficulties with ‘competency based assessment’.
References


Psychiatry recruitment update with reference to old age psychiatry (OAP)

Gianetta Rands, Consultant Psychiatrist, Camden and Islington NHS FT, Honorary Senior Lecturer, UCL. Elected member of OAP Faculty Executive committee and London Division Recruitment committee Chair 2009 - 2014
Gianetta.rands@candi.nhs.uk

The College’s recruitment strategy is now in its 4th year (2014-15). The details of this 5 year plan are at http://www.rcpsych.ac.uk/pdf/Recruitment%20Strategy%20-%202010092013.pdf

The strategy targets 3 main groups:
- sixth formers and their careers tutors
- undergraduate medical students
- foundation trainees.

This is a summary of the current recruitment situation for psychiatry in general and old age psychiatry in particular.

Recruitment to psychiatry specialist core training, CT1-3

Recruitment to psychiatry specialist training is mainly from foundation year 2 (FY2) doctors who apply for our 3 year basic training as core trainees (CT1-3).

Table 1 shows the number of posts available and the number of applicants; the ratio of these two numbers is the competition ratio. Not all applicants are suitable for these posts so the ‘fill rate’, the percentage of available posts filled, is included. The current recruitment system means competition ratios cannot now be more than about 2 as every applicant applies to 2 Deaneries.

Table 1: CT1 psychiatry specialist training (national data)

<table>
<thead>
<tr>
<th>Year</th>
<th>CT1 posts available</th>
<th>Number of applicants</th>
<th>Fill rates % (n)</th>
<th>Competition ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>469</td>
<td>2027</td>
<td>76.3 (358)</td>
<td>4.3</td>
</tr>
<tr>
<td>2010</td>
<td>500</td>
<td>1331</td>
<td>67.2 (336)</td>
<td>2.7</td>
</tr>
<tr>
<td>2011</td>
<td>441</td>
<td>869</td>
<td>84.1 (371)</td>
<td>1.9</td>
</tr>
<tr>
<td>2012</td>
<td>441</td>
<td>828</td>
<td>84.4 (372)</td>
<td>1.9</td>
</tr>
<tr>
<td>2013</td>
<td>469</td>
<td>905</td>
<td>97.0 (455)</td>
<td>1.93</td>
</tr>
<tr>
<td>2014 (incomplete)</td>
<td></td>
<td>About 800</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: www.rcpsych.ac.uk

There should be some rejoicing that the number of CT1 psychiatry training places was the same in 2013 as it was in 2009. Contrary to rumour, we have maintained our CT1 training numbers. The College recruitment strategy may be influencing fill rates from 2012.
London
London has always been different. London trains a quarter of all psychiatry core trainees. Data since 2009 show that recruitment to psychiatry core training has not been a problem in London (Table 2).

Table 2: CT1 psychiatry specialist training applications for London

<table>
<thead>
<tr>
<th>Year</th>
<th>CT1 posts available</th>
<th>Number of Applicants</th>
<th>Fill rates % (n)</th>
<th>Competition ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>90</td>
<td>424</td>
<td>90.0 (81)</td>
<td>4.7</td>
</tr>
<tr>
<td>2010</td>
<td>86</td>
<td>241</td>
<td>98.8 (85)</td>
<td>2.8</td>
</tr>
<tr>
<td>2011</td>
<td>120</td>
<td>270</td>
<td>100 (120)</td>
<td>2.2</td>
</tr>
<tr>
<td>2012</td>
<td>125</td>
<td>253</td>
<td>91.2 (114)</td>
<td>2</td>
</tr>
<tr>
<td>2013</td>
<td>118</td>
<td>242</td>
<td>105.9 (125)</td>
<td>2.05</td>
</tr>
</tbody>
</table>

Second foundation year (FY2) doctors’ career destinations

The career destinations of FY2 doctors are analysed every year by the UK Foundation Programme Office (UKFPO). Data are presented in a number of ways including medical school and foundation school origins. Tables 3 and 4, taken from their 2013 report, summarise some key points about foundation training:

- about a third FY2s do not progress immediately to specialty training. This is increasing year on year.
- Core psychiatric training has one of the worst fill rates.

Table 3: FY2 career destinations, 2011-2013

<table>
<thead>
<tr>
<th>Destinations for FY2 doctors</th>
<th>2013</th>
<th>2012</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialty training in UK - run-through training programme</td>
<td>29.9%</td>
<td>33.5%</td>
<td>34.0%</td>
</tr>
<tr>
<td>Specialty training in UK - core training programme</td>
<td>29.6%</td>
<td>30.5%</td>
<td>34.0%</td>
</tr>
<tr>
<td>Specialty training in UK - academic programme</td>
<td>1.5%</td>
<td>1.6%</td>
<td>1.5%</td>
</tr>
<tr>
<td>Specialty training in UK – FTSTA*</td>
<td>0.2%</td>
<td>0.8%</td>
<td>1.1%</td>
</tr>
<tr>
<td>Specialty training in UK - type of programme not specified</td>
<td>2.6%</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Specialty training in UK - deferred for higher degree</td>
<td>0.2%</td>
<td>0.1%</td>
<td>0.1%</td>
</tr>
<tr>
<td>Specialty training in UK - deferred for statutory reasons</td>
<td>0.5%</td>
<td>0.5%</td>
<td>0.5%</td>
</tr>
<tr>
<td>Sub-total for specialty (incl. GP) training in UK</td>
<td>64.4%</td>
<td>67.0%</td>
<td>71.3%</td>
</tr>
<tr>
<td>Locum appointment for training (LAT) in UK</td>
<td>0.6%</td>
<td>0.7%</td>
<td>0.4%</td>
</tr>
<tr>
<td>Specialty training outside UK</td>
<td>0.6%</td>
<td>1.1%</td>
<td>0.8%</td>
</tr>
<tr>
<td>Service appointment in UK</td>
<td>3.5%</td>
<td>3.3%</td>
<td>2.3%</td>
</tr>
<tr>
<td>Other appointment outside UK</td>
<td>4.8%</td>
<td>6.6%</td>
<td>7.4%</td>
</tr>
<tr>
<td>Still seeking employment as a doctor in the UK</td>
<td>7.6%</td>
<td>7.4%</td>
<td>6.3%</td>
</tr>
<tr>
<td>Still seeking employment as a doctor outside the UK</td>
<td>6.5%</td>
<td>5.5%</td>
<td>3.7%</td>
</tr>
<tr>
<td>Not practising medicine - taking a career break</td>
<td>9.4%</td>
<td>6.1%</td>
<td>4.6%</td>
</tr>
<tr>
<td>Not practising medicine - permanently left profession</td>
<td>0.3%</td>
<td>0.2%</td>
<td>0.1%</td>
</tr>
<tr>
<td>Other (e.g. anatomy demonstrator, higher education)</td>
<td>2.3%</td>
<td>1.9%</td>
<td>3.0%</td>
</tr>
<tr>
<td>Total signed off, known destinations</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

* Fixed Term Specialty Training Appointment
A recent report (Checkley et al, 2013) analysed foundation programme leavers and found that most wanted time abroad or were unsure of their long term career plans. Many were disillusioned with working conditions, some were aspiring academics and others needed a career break. Nearly all those later returning to UK specialty training rated their time out as highly useful. There are no data about the number of leavers who eventually return to specialty training in any discipline. This group may be well suited to psychiatry and we could amend our CT1 person specifications to encourage them and other late choosers and doctors wanting to change specialty (Rands and Stringer, 2011).

There are not enough psychiatry training opportunities in foundation programmes. In 2009, only 155/5954 first year foundation doctors (FY1s) (2.6%) and 356/5714 FY2s (6.2%) did any psychiatry training. That is about 1 in 8 foundation trainees (Lowe and Rands, 2012). The Collins Report initiated the first national push to improve this and this is now continuing with the Shape of Training (http://www.shapeoftraining.co.uk/).

It is important to emphasize that the purpose of increasing psychiatry training in foundation programmes is to improve overall quality of medical training and to emphasise parity of esteem, rather than as a means of solving the recruitment problem, though this would also be a good outcome.
Higher training in general adult (GA) and old age psychiatry (OAP)

Table 5, about recruitment to higher training in psychiatry specialties shows that competition ratios and fill rates are much better for dual GA and OAP ‘Certificate of Completion of Training’ (CCT) training than for OAP single CCT training, and even better than GA in 2013.

Table 5: Recruitment to higher training for GA and OAP

<table>
<thead>
<tr>
<th></th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>GA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Posts available</td>
<td>103</td>
<td>94</td>
<td>160</td>
</tr>
<tr>
<td>Competition ratio</td>
<td>3.1</td>
<td>2.6</td>
<td>1.4</td>
</tr>
<tr>
<td>Fill rates %</td>
<td>94.1</td>
<td>96.8</td>
<td>63.1</td>
</tr>
<tr>
<td>Number appointed</td>
<td>94.1</td>
<td>91</td>
<td>101</td>
</tr>
<tr>
<td>OAP</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Posts available</td>
<td>47</td>
<td>39</td>
<td>23</td>
</tr>
<tr>
<td>Competition ratios</td>
<td>1.5</td>
<td>0.9</td>
<td>1.7</td>
</tr>
<tr>
<td>Fill rates %</td>
<td>63.8</td>
<td>30.7</td>
<td>63.0</td>
</tr>
<tr>
<td>Number appointed</td>
<td>30</td>
<td>12</td>
<td>29</td>
</tr>
</tbody>
</table>

Source: www.rcpsych.ac.uk

Dual OAP and GA higher training posts are popular but not available everywhere e.g. Scotland. They offer more security to trainees in terms of future careers e.g. GA CCT is acceptable globally whereas OAP CCT is not. Many trainees fear that OAP CCT may limit their future careers to dementia only services so dual training is preferable in an uncertain future job market.

A further concern for OAP trainees is that their liaison training experience does not at present make them eligible for a liaison endorsement whereas it is endorsed if they are GA higher trainees.

How can old age psychiatrists and trainees help this situation?

Here are some ideas:
As a Faculty we must continue to pursue the liaison endorsement and argue at all levels for more joint OAP and GA higher training posts. As a Faculty and as individuals we can support recruitment initiatives for example:
- offer to train foundation doctors: OAP covers many aspects of the foundation curriculum
- tell medical students and FY trainees about the RCPsych student associates web page and benefits of membership (free on line journals, notice of events, networking, prizes) and encourage them to join
- tell both students and FY trainees about their local Medical School Psychiatry Societies (MedPsychSocs) and support these events
- encourage students interested in psychiatry careers to apply for Pathfinder Fellowships, worth up to £5,000 each, over 3 years (the Pathfinder Fellowship...
award includes mentoring, funding for an elective or research project, free journal subscriptions, free conference attendance and much more).

- contribute to careers fairs, summer schools, medfest (the annual national psychiatry film festival organised by our trainees), local MedPsychSocs, Xmas debates
- be ambassadors for psychiatry e.g. inform your children’s careers tutors that 6th formers interested in the mind could do medicine first then psychiatry rather than psychology degrees, and direct them to the College website for more information
- suggest students and FYs apply for prizes e.g. essays, research ideas, or to attend conferences
- we need to show that OAP consultant posts really are desirable and to be charismatic role models.

More ideas:
- as a Faculty we could add more to our website and the student associate websites about OAP training and available posts
- we could provide some specific OAP training material for these websites and advertise events
- we could sponsor students and FYs to attend our annual conference
- we need to think carefully about why a third of FY2s do not progress to specialty training: could psychiatry welcome returners when they are ready?
- we need to be honest about the uncertain future of services in the UK, but whatever the service structures there will always be older people getting ill and needing professional assessments and treatments from people like us.

What worked historically? Claire Hilton has reviewed the history of OAP and suggests that inspiring role models, investment and training in good services, opening doors to people changing career paths, service optimism, workforce data displayed to show OAPs, all help with recruitment to our specialty.

References:
Debbie Browne and Kathryn Milward, Why is recruitment to old age psychiatry poor? Presentation to Executive Committee (July 2014)

Eleanor Checkley, Hannah Williams and Paul Baker, What happens to the foundation trainees who don’t move straight into specialty training? BMJ Careers (2 Nov 2013)


Gianetta Rands and Sarah Stringer, It’s never too late … to become a psychiatrist. BMJ Careers (30 April 2011)

www.foundationprogramme.nhs.uk

http://www.shapeoftraining.co.uk
More about recruitment

The Centre for Workforce Intelligence (CfWI): *In-depth review of the psychiatrist workforce*

This work was commissioned by the Department of Health and Health Education England and sets out to forecast and analyse the supply and demand for the psychiatrist workforce in England between 2013 and 2033.

There are two reports:

The research suggests:
- Total patient demand for psychiatrists with a certificate of completion of training ('CCT holders') could grow by 7 per cent by 2033 from 2013 to around 4,340 full time equivalent (FTE) staff.
- In contrast, we project supply will only increase by around 2 per cent to around 4,160 FTEs by 2033. This suggests that if recent trends in trainee numbers continue, the supply of the consultant psychiatrist workforce may not be sufficient to meet future patient demand.
- In particular, psychiatry of old age faces the greatest risk of undersupply of the six main specialties of consultant psychiatrists. We believe that there could also be a workforce undersupply in general adult psychiatry, child and adolescent psychiatry and psychiatry of learning disability for around 10 years without intervention. Areas of potential oversupply include forensic psychiatry and medical psychotherapy.

The report therefore suggests a need for Health Education England to consider options to:
- increase the number of doctors in training taking up posts at core psychiatry training level (CPT1)
- improve progression into higher specialty training (ST4) from core psychiatry training (CPT3), particularly in under-served Local Education and Training Board (LETB) regions
- improve retention of consultant psychiatrists by working with the Royal College of Psychiatrists
- consider appropriate strategies such as run-through training programmes for the geographical areas most at risk of undersupply (with the RCPsych)
- consider a wider review of the current psychiatry training programme to ensure it is robust and enhances development of clinical skills, knowledge and expertise where applicable in order to encourage retention of psychiatrists in training.
Based on this analysis, here is James Warner’s message to all consultants,

The suggestion of increasing core training posts is good, but we need to make sure this growth is disproportionately greater in Old Age.

This is where you come in. If CT posts increase in your area (or the opportunity arises for change), please use this report to influence that growth in OA.

Progression to higher training is also a worry but fill rates at the last recruitment (August 14) were not significantly different from GA or CAMHS (all about 50%) but fill rates for dual posts were nearly 100%. The message is obvious; please lobby for dual posts.

I think Old Age as a discipline is looking far more secure; there is mounting evidence that OA services are better for older people; the Chief Medical Officer’s 2014 report specifically supported OA Psychiatry as a specialty; and exciting opportunities with integrated care and liaison should mean more trainees beat a pathway to our door. The key issue is that existing specialists need to continue to advocate for, and be positive about, Old Age specific services. Please help with this!
Late October’s highly politicised debate over whether to pay GPs for diagnosing dementia was for some who are against the idea also suffused with a persistent therapeutic nihilism: ‘Why bother to diagnose, when nothing can be done?’

It is into the post-diagnostic support space that we launched *The dementia guide: living well after diagnosis* in July 2013. The 120-page booklet, written for people with a diagnosis and their carers, seeks to offer practical information and advice on topics people are likely to want covered soon after diagnosis. Even in the absence of a cure for dementia, there is of course plenty that can be done. A little more than a year on, how has the guide fared?

Demand for copies, particularly among the key channel of memory services, started strong and has remained so, with more than 200,000 booklets made freely available since July 2013. Print and distribution on this scale has been possible only with initial funding from the Department of Health and generous subsequent support from Lloyds Banking Group.
In promoting the guide we were fortunate to have had the support of both the Memory Services National Accreditation Programme (MSNAP) and the RCPsych, who (along with the Royal College of General Practitioners and the Association of Directors of Adult Social Services) endorsed the content. This has helped the uptake of the booklet by memory services, many of whom have taken repeat bulk orders (one large Trust routinely orders 3000 at a time), for passing on to service users. Overall, in fact, more than two-thirds of the 200,000 print copies have gone out via NHS organisations, primarily memory services or community mental health teams. (Uptake among GPs is, perhaps inevitably, more variable.) Most of the rest of the copies have been distributed by Alzheimer’s Society staff such as Dementia Advisers or our National Dementia Helpline, with smaller numbers being ordered direct by people with dementia, their families and carers.

Qualitative feedback suggests that the guide seems to have been broadly successful in its aims, which were to provide some headline information, offer a realistic reassurance about living well with dementia, and signpost people to sources of more detailed information. A quote from a member of Society staff in the Southeast is typical:

We use The dementia guide in two memory clinics. Most patients and carers are very pleased to take a book that provides enough information for them to get an understanding about dementia. We encourage them to think about planning ahead including getting organised with legal matters and applying for benefits, and the information in the guide [there is a 10-point checklist] acts as reminder for when they get home or want to discuss matters with other relatives. It may help with tackling the tasks we all put off doing. All the staff in the memory clinics including nurses, doctors and admin have a copy of the guide and in the hospital they have dementia champions on several wards who also have a copy.

How to get your copies!
The dementia guide is freely available to NHS organisations in England where people with dementia are diagnosed and treated, including memory clinics. Professionals should order from the Health and Social Care Publications Orderline (use product code 872) or for bulk orders (more than 25 copies at a time) contact Alzheimer's Society direct (tim.beanland@alzheimers.org.uk).

Members of the public affected by dementia can order single copies for free from Alzheimer’s Society by emailing orders@alzheimers.org.uk or phoning 0300 303 5933.

Anyone can also visit www.alzheimers.org.uk/dementiaguide to view the content online. The content is also now available in Hindi, Punjabi, Urdu, Bengali, Chinese and Welsh; go to www.alzheimers.org.uk/dementiaguidetranslations.
The ‘Patient Journey’ for People with Alzheimer’s Disease – exploring early signs and diagnosis
A study carried out by the Mental Health Foundation for the Alzheimer’s Society

(Free to download)

Reviewed by: Dr Ronald Ng, CT2 Trainee, East London NHS Foundation Trust

Synopsis
This paper offers an insight into the lived experiences of dementia, from the early signs to diagnosis and beyond. It reports on a survey commissioned to the Mental Health Foundation by the Alzheimer’s Society and sponsored by the UK arm of the US Pharmaceutical Company, Eli Lilly. The survey predominately consists of a postal questionnaire completed by 397 people living with Alzheimer’s disease (AD) and 686 carers. In addition a smaller set of qualitative interviews were carried out with 6 people with AD and 8 carers.

The focus here is very much from the patient’s and carer’s perspective, for example exploring the emotions occurring around diagnosis and how people cope with AD. The clinical pathway is also examined: – noticing first symptoms, presenting to health services and the diagnostic process.

Highlights of the paper
• Presentation to a doctor: In this section, there are useful observations for physicians making diagnoses. For example, only 15% of those diagnosed with AD suspected that it could have been a possible explanation for their symptoms. This proportion was even lower for older patients. A third of those diagnosed waited longer than a year before seeking medical advice.
Common reasons for not presenting earlier were that symptoms were ‘part of getting older’, denial (not wanting to think there was something wrong) and that it was not impacting upon their lives.

- **Diagnosis and treatment**: The diagnosis was normally given by staff at the memory clinic. Half reported they received a diagnosis by 6 months after presentation to health services. A quarter of people with AD did not disclose their diagnosis to friends or family. Only 14% of patients and 15% of carers stated they were offered counselling.

- **Emotions and coping styles**: ‘Sadness’ was the emotion felt most strongly by people with AD and their carers. This was even stronger in younger people who were also more likely to feel ‘lost’ and ‘alone’. The qualitative data included numerous quotes which really brought to life the emotions of living with AD e.g. ‘I didn’t like it that I couldn’t remember things, you know, I would hesitate with people. It makes conversations difficult.’ (page 44)

**A brief critical appraisal**

The paper fulfils its aims to help clinicians, patients and policy makers analyse the challenges faced by a person with symptoms of dementia. However, the survey population was self-selected from members of the Alzheimer’s Society and had a 18% response rate (1,086 of 6,000 distributed), not uncommon for a postal survey. All data were gathered from those with Alzheimer’s and their carers, including clinical questions such as the proportion of those having a head scan or time from presentation to diagnosis. Recall bias and the presence of memory difficulties within the survey population might impact upon the quality of data. For example, the paper states it could not determine who filled in the questionnaire (the carer or person with AD) and there was some duplication of data when both parties replied from the same household. The use of collateral information from GP and memory clinics will reduce recall bias of clinical-related questions that feature, particularly in the ‘Diagnosis and Treatment’ section. Although 1086 survey responses is substantial, there is a lack of statistical evidence for the validity of the data (e.g. use of confidence intervals and sampling sizes).

**Conclusion**

The paper offers a well presented account into the thoughts and emotions surrounding AD. The focus on carers as well as people with Alzheimer’s is appreciated. GPs, neurologists and mental health workers (especially those who are starting to work with elderly people) will find this useful in developing their understanding of the emotions and difficulties that patients and carers go through around the time of diagnosis.

If you only read part of this the paper, I highly recommend reading the various quotes from carers and people with Alzheimer’s. They are not only touching but give a vivid picture of the difficult journey those involved go through. In terms of the future, I hope is that this paper inspires similar patient and carer focused research into other chronic mental health conditions. An expanded follow-up survey with patient responses paired with clinical data from their health providers (e.g. GPs, memory clinics) would be most welcome. This will further its aim to be an educational and service planning tool for dementia services.
Reading Well, Books on Prescription for Dementia: Coming soon to a library near you!

Deirdre Bonner, Locum Consultant Psychiatrist, Community Mental Health Team, CNWL NHS Foundation Trust, St Charles Hospital, Exmoor Street, London W10 6DZ
deirdrebonner@nhs.net

Introduction
Reading Well Books on Prescription (RWBOP) for dementia will be available in public libraries from January 2015. The booklist of 25 titles includes professionally endorsed information and advice for people diagnosed with dementia, their carers, and people worried about symptoms or wanting to find out more about the condition. It provides cost-effective support for existing health services and an efficient way of delivering early intervention care in the community.

Public libraries and dementia friendly communities
Public libraries deliver communities unrivalled access: 37% of the population in England has visited a library in the past 12 months, providing a strong base from which to deliver dementia services to the wider community. Around 50% of public library authorities in England currently deliver designated dementia services and
support. Initiatives include Memory Lane kits featuring picture and scrapbooks to create personal stories, DVDs and photographs, support groups and reading groups for people with dementia and their carers.

All of these have the potential to improve the quality of life for those participating by:

- Enhancing the day to day experience of living with dementia by encouraging socially responsible services that have better links to the community.
- Raising awareness, reducing stigma and minimising isolation of those living with the effects of dementia.
- Providing positive stories and role models for the public to challenge the negative stereotypes and fears surrounding diagnosis, and enable meaningful social engagement for people with dementia.
- Reconnecting communities and ensuring a better use of existing public resources and assets. Encouraging intergenerational use of publicly owned spaces, for example, leisure facilities, parks, museums and galleries.
- Reducing isolation by providing increased opportunities for taking part in community life.

**Reading Well**

RWBOP is a new English public library mental health service development. It originally provided self-help reading for adults based on cognitive behavioural therapy for a range of common mental health conditions, including anxiety and depression. Books can be recommended by GPs or other health professionals from an expert endorsed core list. They can be borrowed with or without ‘prescription’. The model is based on the pioneering work of clinical psychologist Professor Neil Frude. The original self help book prescription list was developed in 2004 on the basis of extensive consultation undertaken with mental health professionals to identify the titles they had used and found useful, and on the basis of efficacy being shown in research. From these suggestions an original list of 35 titles written predominantly by clinical psychologists, psychiatrists and psychotherapists was constructed.

RWBOP is delivered by an independent charity The Reading Agency, working in partnership with the Society of Chief Librarians (SCL), representing all English public libraries, and health partners including the Royal College of GPs, Royal College of Psychiatrists, Royal College of Nursing, The British Psychological Society, Mind, the British Association for Counseling and Psychotherapy (BACP) and the Improving Access to Psychological Therapies programme (IAPT).

The scheme was launched in June 2013, and since then there has been an increase of 113% in loans of core list titles with over 275,000 people accessing the scheme.

**Dementia books on prescription**

The scheme is funded nationally by Arts Council England as part of their support for library development. A consultation was carried out by The Reading Agency between April and May 2014 focusing on what the policy framework should be. It aimed to explore the evidence base, the existing availability of self-help books and guides, and which issues and areas associated with dementia might be addressed through the scheme. A total of 47 organizations and individuals were sent a letter inviting them to complete the consultation questions. The aim was to build on existing
knowledge, delivery models and book stock in libraries, while local commissioning and funding models were used to take the project forward.

The initial consultation process looked at the National Dementia Strategy and considered several of the objectives of particular relevance to RWBOP:

- Improving public and professional awareness and understanding of dementia.
- Providing good quality information and support for those diagnosed with dementia and their carers.
- Supporting carers.
- Improving the quality of care within people’s homes, hospital wards and residential homes by better staff training and more appropriate psychosocial interventions.

**Book selection**

As a member of the Old Age Faculty executive, I became involved after the initial consultation process as part of a dementia experts group. This included members of the Alzheimer’s Society, the British Psychological Society, Innovations in Dementia, Dementia UK, Admiral Nurses, a person with dementia and a carer. Graham Turpin, Professor of Clinical Psychology at Sheffield University, who was involved in the first Reading Well scheme on common mental health problems and who was part of the consultation group, was also involved.

Our first meeting was in July 2014 with the aim of eventually creating a short list of 20-30 books. Prior to this, Debbie Hicks and Rose Vickerage of The Reading Agency had compiled a draft long list from a review of all of the existing public library lists and recommendations from the dementia stakeholder consultation process. This list of 80 was reduced to 50 by Janet Baylis of the Alzheimer’s Society. Books were excluded for a variety of reasons including being out of print and titles with negative content. Celebrity titles, local publications and those specific to another country were also rejected.

We had several meetings over the summer in the lovely surrounds of St Katherine’s Dock in the Alzheimer’s Society library. The selection in their library is vast and varied and Janet could probably give you an in-depth review of any book there. The selection process was a thoroughly enjoyable one and mostly harmonious (no Man-Booker like revelations I’m afraid!). Any discord was usually around the level of difficulty and discussions about whether we were “dumbing down” or alienating potential readers by including more professionally orientated books. There were a few contentious titles and we had several interesting discussions about whether we should include a book that was loved and loathed in equal measure. Unfortunately, as with all good book lists I am not allowed to name the particular books but you can scan the list yourself when it is released to surmise which books these may have been.

We discovered a number of interesting facts along the way. We couldn’t include ring binders or slim volumes in libraries: not robust enough for repeated loans and nowhere to place the bar code. Library shelves do not accommodate extra large or wide books and some authors still use the term dementia sufferer! We also realised that there are a dearth of titles on dementia for people with learning disabilities. The selection process was helped greatly by the participation of Keith Oliver, service user
envoy from Kent and Medway NHS partnership trust; EDUCATE reading group and numerous libraries.

**Book list**
The list was eventually whittled down to 25 books covering a number of areas:

- Information and advice
- Living well with dementia
- Personal stories
- Support for carers
- Shared activities
- Caring in the final stages

Reading Well Books on Prescription for dementia will also signpost to a “mood boosting” list comprising a reader-recommended list of fiction and poetry. A separate “professionals list” will be created, which will be made available on the Reading Well website and linked to the Alzheimer’s Society online dementia catalogue.

I am afraid you will have to wait until January 2015 to see the final list for yourself but I would urge you all to recommend it to patients and carers whether they are library members or not. Although essentially a book list, it has the potential to be much more. Public libraries can play a key role in building dementia-friendly communities, providing support for carers and building a general awareness of and understanding about the condition. They provide a trusted and non-stigmatized public space within communities, community outreach and dementia aware staff, expert in information management and community engagement. Encouraging people affected by dementia in any way to find more information on the subject and to engage with others in the community can only help to destigmatise the condition and make our communities more dementia friendly.

User leaflets and leaflets providing information for prescribers will be available from local libraries from the end of January 2015. Health professionals can email readingwell@readingagency.org.uk to find out local library contact details. There will be a range of supporting resources for prescribers including information about featured titles and digital resources at http://readingagency.org.uk/adults/quick-guides/reading-well/
PALLIATIVE CARE SERVICES FOR PEOPLE WITH DEMENTIA – UK NATIONAL CALL FOR EVIDENCE OF LOCAL PRACTICE

The Supporting Excellence in End of Life Care in Dementia (SEED) programme aims to support professionals, both commissioners and providers, to deliver good quality, community-based end of life care in dementia, through the development of an Integrated Care Pathway (ICP).

The SEED programme is funded by the National Institute for Health Research (NIHR) under its Programme Grants for Applied Research Programme (RP-PG-0611-20005) and is led by Professor Louise Robinson at the University of Newcastle in collaboration with partner organisations including University College London, the University of Hertfordshire and the National Council of Palliative Care.

In order to provide a strong foundation of practical knowledge for the development of the ICP, we want to hear about good local practice in different care settings.

An on-line call for evidence of UK services that provide end of life care to people with dementia is now underway. We would be very grateful if you could help us with this national mapping exercise.

To answer the call, please go to https://opinio.ucl.ac.uk/s?s=32653

With your permission, a shortlist of selected services will at a later stage be approached for more in-depth evaluation. Our final report on palliative care services in the UK for people with dementia will be provided to participants should they so wish.

For further information about the SEED programme please visit https://research.ucl.ac.uk/seed/ or contact Dr Sarah Amador at s.amador@ucl.ac.uk
Tips on writing for *Old Age Psychiatrist*

or

Your editors love editing the newsletter, but do not want to be school teachers!

The comments here are based on the experience of editing *Old Age Psychiatrist* (*OAP*) in the past 2 years. We receive many articles on important subjects, but some are badly written. In particular, they are too repetitive, are poorly structured, and grammar is often incorrect. Others have no direct relevance for psychiatrists working with older people.

Suggested types of article:

- Innovations / interventions which have or have not worked.
- ‘The spice of life’
- ‘How to survive the current round of NHS changes’
- ‘The best thing I’ve done in the last month’ (work related!)
- Case studies: they are not accepted by many journals, but for some people they can be thought provoking and a good way to learn. Case studies must be accompanied by a statement of consent from the patient or their representative and must be anonymised.
- Reviews of relevant clinical and research topics not readily found in text books or academic journals.
- Reviews of books, films and websites.
- Someone who has inspired you.
- Recent experiences and papers read recently: what has inspired, angered or influenced you which other people should know about?

What we do not want:

- Clinical research
- Papers with masses of statistics
- Audits

These should be published in peer reviewed journals.

Please do not send articles to more than one College newsletter! If an article is relevant in more than one Faculty, we can include a link.

Word length

500 to 1,500 words is good.
Illustrations are welcome, provided they do not infringe copyright.

Submission
Please use Microsoft Word and e-mail the article to us.

Include
Title
Names of all authors
Contact details
Page numbers

Style
We can be flexible about style, but please be consistent, including with capitalisation, referencing and punctuation.

Tips on writing

• Use language which shows you are passionate about your subject.

• Most of us have to put time into our writing. Regard your writing as a piece of art which has to be perfected to have the right impact.

• Sometimes finding the right words is a bit like pulling teeth. On line or Microsoft Word synonym finders can be very useful.

• Use a word processing package which automatically checks grammar and has a spell-checker set to UK English.

• Is your argument crystal clear and logical? Readers will want your message ‘up-front’ and will not have the patience or time to search for your meaning. Use headings to help structure your argument.

• Do not send an article to us the second you have written a first draft! Put it away for a day or so, re-read it, and think about the style, the argument and the message you are trying to put across and improve it. Do that a few times. Get someone else to read it through and give you feedback. You may know what you are trying to say, but that does not always come across.

• Avoid words like ‘obviously’, ‘certainly’, ‘clear’ etc – if it was all so obvious there would be no need for the article.

• Weigh up the pros and cons of using ‘patient’, ‘client’ or ‘user’ in the specific context of your article. They are not synonymous!

• Define all abbreviations and acronyms: Old Age Psychiatrist (OAP) is read by old age psychiatrists abroad and by people in other disciplines.

• Write concisely e.g.
He was’ rather than ‘He appeared to be’
• ‘He walked’ rather than ‘It was also reported that he walked’
• ‘He described’ or ‘He told us’ rather than ‘He also gave further details regarding’
  • Use positives rather than negatives: they convey more information and are less wordy e.g.
    • ‘They had little contact’ better than ‘They had not had much contact’

References
Not all articles need references. Consider if they will add to your article. If so, a little bit of effort in referencing to substantiate your arguments is well worth the time. Please ensure that you have read and understand the article cited, not just the abstract! Your style of referencing must be internally consistent. That includes layout, punctuation, abbreviations, use of italics. If you need a format to follow, then use the style of the Psychiatric Bulletin http://pb.rcpsych.org/site/misc/ifora.xhtml

Revising your article
Some of the articles we receive are sent for peer review, others are just read by the editors. Most will require some revisions, once or twice. Most people regard their writing as good and hate making revisions, but please make the changes the editors suggest. Don’t just skip over them! If you disagree with our suggestions then tell us. Please ensure that the up-dated, corrected version is e-mailed to us.

Useful reference about writing
For some good, brief tips, see Tim Albert, Getting published: 10 things to do before you sit down to write, BMJ (13th October 2012) http://careers.bmj.com/careers/advice/view-article.html?id=20009242

Mind your language … or ‘Let’s abolish “the elderly”’!
Introducing a heterogeneous group of people with a homogenising definitive article is unacceptable!
The journal Age and Ageing gives relevant guidelines on language: ‘Try to avoid language that might be deemed unacceptable or inappropriate (e.g. 'older people' is preferred to 'the elderly', the word 'senile' is best avoided). Take care with wording that might cause offence to ethnic or cultural groups.’ http://www.oxfordjournals.org/our_journals/ageing/for_authors/index.html
By all means give us your views on this matter….

Claire Hilton, editor
David Rigby, trainee editor
This is YOUR newsletter

*Old Age Psychiatrist* wants well written informative, lively and practice relevant articles rather than research which would be better placed in peer reviewed journals.

Please send your ideas, thoughts, creative writing, pictures, reports and other matters which you think will interest your colleagues to claire.hilton@nhs.net (editor) or david.rigby@eastlondon.nhs.uk (trainee editor)

Don’t forget!

Next copy date: 28th February 2015

Competition entries by 30th April 2015

************Save the date************
Next residential Old Age Faculty Annual Conference:
Glasgow, 25-27th March 2015