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THE RESPECTIVE ROLES OF THE GENERAL ACUTE AND GERIATRIC SECTORS IN CARE OF THE ELDERLY HOSPITAL PATIENT

REPORT OF A STUDY DAY HELD AT THE KING'S FUND CENTRE ON

4th June, 1982

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King Edward's Hospital Fund for London is an independent charity founded in I897 and incorporated by Act of Parliament. It seeks to encourage good practice and innovation in health care through research, experiment, education and direct grants.

The King's Fund Centre was established in I963 to provide an information service and a forum for discussion of hospital problems and for the advancement of inquiry, experiment and the formation of new ideas. The Centre now has a broader interest in problems of health and related social care and its permanent accommodation in Camden Town has excellent facilities for conferences and meetings.

KING EDWARD'S HOSPITAL FUND FOR LONDON

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Section One The Purpose of the Study Day

In late 1981, the D.H.S.S. published simultaneously three policy studies entitled: "The acute hospital sector"[1]; "Community care"[2]; and "The respective roles of the general acute and geriatric sectors in care of the elderly hospital patient"[3]. During the summer of 1982, three study days were held at the King's Fund Centre, each focussing on issues arising from one of these publications. The study day held on 4th June 1982, was the first in this series and was concerned with the policy implications of the third of these documents. During the morning, short presentations were given by individuals with considerable experience and interest in the provision of hospital medical care for elderly people. In the afternoon, participants divided into smaller groups to discuss, in more depth, the issues raised by the study and by the speakers' contributions. Some questions were devised to provide a focus for these group discussions. These are reproduced in this document at Appendix I. The day ended with a plenary report back session. A total attendance list is included at Appendix II.

Section Two The Speakers' Contributions

Chairman's Introduction Marshall Marinker, Professor of General Practice in the Department of Community Health, University of Leicester and a practicing G.P.

In his opening remarks Professor Marinker pointed out that as a general practitioner he was highly interested in the subject for the day - the provision of medical care for elderly people - but was, at the same time, disinterested in the relationship between the general acute and geriatric sectors of medical practice. The provision of care for old people was complicated in that it spanned several boundaries - between hospital and community, between types of diseases and between areas of professional specialisation. The boundaries between acute general medical specialties and between them and geriatric medicine had been determined by different considerations: the former had resulted from developments in scientific research, the latter through social concern for the elderly.

That boundaries exist, said Professor Marinker, should not be regarded as a necessarily negative factor: boundaries could often be redrawn.

Professor Marinker then handed over to the first speaker for the day who was one of the D.H.S.S. officials responsible for the production of the "respective roles"study[3].

Overview of the "Respective Roles Study" Margaret Edwards, Principal, Department of Health and Social Security

Miss Edwards pointed out that the intention of the "respective roles" study was not to set out policy in a prescriptive way, but rather to stimulate new ideas and debate. Its concern was the care of elderly people in hospital. It concluded that since geriatric hospital services were unlikely to be able to absorb more than a proportion of the additional load which would fall on the acute sector as a result of demographic change, in many areas elderly patients would have to continue to rely on the general acute services for hospital care.

The study was essentially a piece of "desk research" based on the activity data available to the DHSS. Using broad trends together with manpower indicators, a picture of possible national provision by I99I had been built up. The study should not be treated as prescriptive but rather as purely illustrative, since the data and assumptions on which it is based might turn out to be deficient. For example, average lengths of stay have fallen much faster than projected in the study, assumptions relating to nurse staffing levels could prove to be inappropriate.

One of the most striking demographic findings had been that during the next decade there would be a marked shift in numbers towards the very elderly, that is, those aged over 75. This would have a major impact on geriatric services and any shortfall here would hit this age group above all.

The current strategy for hospital services for elderly people was based on an active approach to treatment and rehabilitation. The key feature of a modern geriatric medical service was an acute assessment unit in the main DGH building with a full range of support facilities.

The study indicated levels of provision with which an effective geriatric service might be achieved. Where there was a good acute geriatric service, fewer long stay beds were required. During the period from I972 to I978 activity rates in the geriatric sector had increased. This had been due to a large proportionate increase in manpower in the specialty and more geriatric beds being provided in acute hospitals. The turnover of patients had increased, resulting in a 25% reduction in average lengths of

stay and a 30% increase in the number of cases treated, despite a small reduction in the overall number of beds.

40% of all general acute beds were occupied by elderly people; half of these by the 75+ age group. As with the geriatric sector, average lengths of stay for elderly patients in the acute specialties had decreased, with the exception of orthopaedic surgery and in some other cases for the 75+ age group. The proportion of very elderly patients cared for by geriatricians was increasing. However, the continuing substantial need to care for elderly patients in the general acute specialties should be taken into account in resource allocation, if services for the population as a whole are not to come under pressure.

In considering the future supply of manpower for the geriatric sector it was clear that a shortage of suitably trained staff, particularly medical and nursing, would be the major constraint on future growth in hospital geriatric services. In I979 there were 379 whole-time equivalent consultants in geriatric medicine, less than half the estimated requirement. By I99I, 800 w.t.e. consultants would be needed. There was no prospect of achieving this and at best there was likely to be a shortfall of 260 consultants.

In nursing there was a continuing imbalance between qualified and unqualified staff, currently 44% qualified and 56% unqualified (including learners). The study calculated that on the basis of planned levels of expenditure on hospital geriatric serv ices and the existing ratio of qualified to unqualified staff, adequate numbers of geriatric nursing staff in total could be provided by I990.

Figures for the number of remedial staff working with elderly hospital patients were not reliable and there were known to be shortages in many areas. However, prospects were generally encouraging.

The general impact on the acute sector of the expected shortfall in provision of the geriatric sector required urgent study. Manpower implications and operational policies would have to be reviewed. The study discussed alternative models of providing care. No set pattern could be expected to serve the needs of all districts. In some places the integration of general and geriatric medicine might

be appropriate, in others it might be necessary to rely on physicians with special responsibility for elderly patients.

If the central finding of the study was borne out, that is, that a large number of elderly patients would continue to be dealt with by general acute medical services, it could be necessary for medical and surgical specialties to develop policies for, and expertise in, dealing with the growing numbers of elderly patients with whom they will be called upon to deal; and consideration might also need to be given to the possibility of some integration of general and geriatric medicine. The debate about the respective merits of pure geriatric medicine and integrated general and geriatric medicine was continuing. The Department considered that a body of doctors trained in the special skills and approach of geriatric medicine remained an essential objective. However, ways of achieving this would have to take account of the career wishes of doctors in training and the wide range of service patterns.

To equip the general acute specialties to meet the special needs of elderly patients, consideration should be given to how the expertise of the geriatric sector staff could be disseminated through those other parts of the hospital service which were caring for elderly patients. Such dissemination was likely to be best achieved where a department of geriatric medicine was situated in the same building as other specialties. This had important planning implications i.e. that hospital provision for elderly patients should be properly sited. It was important that there be a viable unit for assessment and acute treatment of elderly patients in the DGH. The multi-disciplinary approach of the geriatric specialty was a useful starting point for dissemination.

The Department was holding a conference later in 1982 on the skills of geriatric medicine to stimulate a debate on the contribution of geriatric medicine to the care of elderly hospital patients and its role in relation to other specialties.

In conclusion, it was emphasised that the continued development of departments of geriatric medicine remained a major policy objective. The multi-disciplinary geriatric team was at the heart of service development for elderly patients. The "respective roles" study was intended as a stimulus for discussion about how the needs of elderly hospital patients were to be met appropriately and how services generally were to be able to respond to the increasing pressure from the over 75 age group.

"Models" of Geriatric Care - Advantages and Disadvantages Peter Millard, Eleanor Peel Professor of Geriatric Medicine, St. George's Hospital Medical School

The next speaker was Professor Peter Millard whose major theme was the advantages and disadvantages of particular models of geriatric provision. He prefaced his remarks by saying that his views were influenced by an emotional response to the elderly patients for whom he cared. The challenge to provide appropriate facilities for the care of elderly people was world-wide - but Britain, he said, was running away from it.

Professor Millard likened hospital services to a bath into which water was continually entering through the tap (the admission rate), and leaving through the plug-hole (the long-term death rate), through the overflow (the acute death rate) and by being returned to source by a recycling mechanism (rehabilitation and discharge). The rate of inflow is gradually increasing and one could only cope by turning down the inflow, increasing the size of the bath or by speeding up the recycling mechanism. Turning off the flow of elderly admissions into the health care bath has been tried - by domiciliary assessment visiting. But this approach has now become overwhelmed. Increasing outflow by killing long-term patients, advocated by some, is ethically abhorrent and would signal the destruction of the caring society. Thus, unless the number of beds is to be increased, turnover will have to be speeded up and length of stay shortened still further.

Since I948 consultants in geriatric medicine have acquired skills in developing rehabilitation services for long-term patients and have shown that severely disabled people can be helped by a multidisciplinary team to return home. By doing this they have enabled the acute services to continue to function. The relationship is symbiotic, and districts without a good geriatric service are disadvantaged. Nationwide, the average length of stay of medical patients has reduced from 85 days to II days, and of geriatric patients from 365 days to 85 days (4 patients per bed per year). The D.H.S.S. target is for a further reduction in geriatric services to 6I days in the next decade (5 patients per bed per year). This implies that there will have to be fewer places for long-term care within the hospital. Disabled people requiring care will thus be at home, or in local authority residential homes, or will need to turn increasingly to the private sector. The government is encouraging the development of

the latter but it must be remembered that it is not in the interest of a private nursing home either to encourage discharge or to deal with difficult problems. In addition, there is no "sieve" before entry and people will be admitted to long-term care who do not require it.

Everyone, said Professor Millard, is dependent on others and it is a myth to assume anyone is "independent". The degree of dependence varies as does the acceptance and tolerance of each social network. To be able to help an elderly person who is ill, it is necessary not only to diagnose the disease but also to understand the social network. This implies that hospital doctors must learn to work more closely with doctors in the community in developing services and in seeing illness in perspective. Elderly people are often referred to hospital not because they wish to go, but because others perceive them as a problem. There are three major categories of problem : standing up (psychiatry), lying down (geriatrics), falling over (acute), and any of these can be accompanied by incontinence. The present separation between psychiatry, geriatrics, general medicine and orthopaedics is, said Professor Millard, illogical.

However, in the last few years the trend has been to encourage development of general physicians with an interest in the elderly rather than geriatricians with responsibility for the elderly. It is responsibility which is the key however, for if a doctor feels responsible he will struggle to develop services for his patients.

The advantages and disadvantages of different models of care for elderly hospital patients were summarised by Professor Millard in a chart which is reproduced on the following page.

The career wishes of doctors were to go into general medicine as opposed to geriatrics. This was regardless of the fact that the country actually needed more doctors in geriatrics. The British geriatric service had been pioneered by the contribution from overseas doctors and although the source of overseas doctors was now drying up, their immense contribution should be recognised.

Postgraduate training continued to favour the development of general medicine at the expense of geriatrics.

The issues to be tackled today were on the one hand, training and responsibility, liaison with orthopaedics and psychiatry etc; and on the

other hand, the wishes of doctors, recruitment, and allocation of finance.

Tackling the problem, said Professor Millard, will require commitment and it needs government to put more resources into the appropriate training of all staff in all grades associated with the care of the elderly.

Advantages and Disadvantages of Different "Models" of Care for Elderly Hospital Patients

	General Medicine	Physician with interest in Geriatrics	Geriatrician	Geriatrician (age related)
Responsibility for Elderly	o	+	+++	+++
Experience in Rehabilitation	o	+	++	++
Appropriate Training	o	+	++	++
Liaison with :				
Orthopaedics	o	+	++	++
Psychiatry	o	+	++	++
A & E	++	+		++
Organ Specialty Experience	++	+-	-	-
Relations with :				
Social Services	o	+	++	++
G.P.	+	+	++	++
Recruitment	+++	++	+	++
Post-Graduate Training	+++	++	+	+

The next major theme to be covered was:

Implications for the Acute Sector of Caring for Elderly Patients
Peter Horrocks, Consultant in Geriatric Medicine in Hull and Secretary of the British Geriatrics Society

Dr. Horrocks began by picking up a point of reference in the "Respective roles"[3] document. The lack of homogeneity in the category of people defined as elderly was mentioned in the document but not adequately emphasised. The needs of those over 75 were very different from those over 65 and deserved more of our attention. It was those over 75 who generally had multiple pathology and needed special techniques in their care. It was also this age group which would increase rapidly in the coming years.

A second point of reference was that of patients cared for in acute beds-at most one in five was over the age of 75. It was therefore a minority of patients in these wards who had special needs.

A third point of reference was that the outcome of treatment or intervention depended essentially on the management of the patient in the earlier stages of the acute episode. Correct techniques then could prevent patients developing disabilities requiring long-term care.

In Dr. Horrocks' own department where acutely ill elderly people, mostly over the age of 75, were admitted directly it had been proved that by meeting the special needs of elderly patients from the point of admission potential long-term problems could be prevented.

Attitudes to Elderly Patients

1. Acceptance of responsibility - staff on wards which took any elderly patients should feel they were welcome on that ward. Elderly patients should not be made to feel unwanted or "in the wrong place".

2. Preconceptions - staff caring for the elderly should re-examine their preconceptions about illness in old age and resist the temptation to make snap decisions about diagnosis or prognosis in such patients. Elderly patients were ill - served by their image in hospital. No one was a "hopeless case" until defined as such by a specialist, and even then only after prolonged attempts at treatment.

3. Optimism - therapeutic optimism was a vital tool for staff treating an elderly pationt. Old people in hospital typified the self-fulfilling prophecy: if they were expected to do badly they would, and if expected to do well they would respond to that more positive attitude.

4. Persistence - staff expectations in an acute ward were that patients would generally get better quickly. The tempo of recovery in older people was often much slower and the staff should adapt to this.

Essential Policies for Care of Elderly Patients in the Acute Sector

I. Assessment - assessment must be comprehensive, including social, mental and physical assessment as well as medical assessment. It must be carried out as quickly as possible and is the corner stone of successful care of the elderly patient.

2. Medical policies - some treatment policies had to be adapted for elderly patients. They are not the same as younger people. The differences between elderly and younger patients are crucial and constitute much of the special knowledge of geriatric medicine.

3. Rehabilitation - rehabilitation should not be seen as something extra to the care of the patient, done only by specialist staff. It required a particular attitude towards the patient from all the staff involved. Its aim was the restoration and maintenance of the patient's function and priority should be given to this aim. This attitude is foreign in many acute wards but is essential. The ward environment had a very important part to play in rehabilitation and preservation of function.

4. Discharge arrangements - the point of discharge of an elderly patient from hospital provides a major challenge for caring services. It must be carefully planned with multidisciplinary involvement. Follow up of the discharge is very important and should include feed-back to the ward staff. Discharges of elderly patients from the acute specialties were often not well managed.

5. Approach to families and friends - the importance of families and friends was usually undervalued. Attitudes from all staff should be positive and encouraging. This notion was revolutionary in some acute wards; many families and friends suffered from a dearth of information

about the treatment, progress and expectations for their relatives.

6. Day care - wherever possible treatment should be given on a day care basis for an elderly patient. The social and functional consequences of admission to hospital were often disasterous.

7. Continuing responsibility - the notion of continuing responsibility for the individual's care after he has left hospital should be accepted more readily by staff in the acute sector.

Practical Points for Care of the Elderly

I. Space - elderly patients need considerably more space than other acute patients. Space is needed for their wheelchairs, walking aids and for assistance to be given by other people, for instance in toilets and bathrooms. For a typical acute ward to cope successfully, bed numbers might have to be reduced.

2. Environment - for elderly patients beds were often too high, chairs equally too low. It was important that toilets should be easily identifiable. Carpets reduce incontinence levels in addition to providing a more homely environment.

3. Apparatus - the acute wards successfully treating an elderly person will need to have a variety of apparatus such as wheelchairs, walking frames and other aids and wherever possible these should be individually available for patients. Apparatus for the prevention of pressure sores should be available.

4. Clothing - it is essential that elderly patients are encouraged to be dressed in their own clothes from the earliest stage of their hospitalisation, even on acute wards. This often has dramatic effects on the rate of recovery as it maintains independence and improves self esteem.

5. Outside advice - it is important that the acute ward handling elderly patients should know when to seek advice from the specialist geriatric department. Good communication is essential between the general acute and geriatric departments. Early referral of patients likely to prove difficult would be welcomed by the specialist in geriatric medicine.

While these suggestions were put forward for the benefit of the elderly

patient in the acute ward many of these techniques could also usefully be applied to younger patients.

Dr. Horrocks's presentation was followed by one on the theme:

Opportunities for Mutual Support and Collaboration Between the General Acute and Geriatric Sectors John Grimley Evans, Professor of Medicine (Geriatrics), University of Newcastle

There were, said Professor Grimley Evans, two types of opportunities: those to be seized and those to be created. It was important to know how to recognise both types. This could only be done by having the right approach to the problem being tackled. Professor Grimley Evans believed that the right approach was to think of geriatric and general medical services together. In most areas these two services had to share the care of the elderly patient and in all areas the facilities were shared.

In Newcastle the logic of this approach had been applied. In the west end of Newcastle there were three medical units which were the acute medical reception units and each was run by a team of three consultants: a physician with special responsibility for the elderly (PSRE), a general physician with some other specialist interest and an organ specialist who undertook specialist investigations. These units took all people who needed urgent hospital admission regardless of age or any other factor. They dealt with all the customary problems of acute medicine and also had a special responsibility for undertaking geriatric assessment.

Of the elderly people coming to the units, about 94% were able to be dealt with by the units. Of these, about one-fifth died and about two-thirds were discharged back to the community. About 6% required longer term rehabilitation - many were stroke patients, and they were transferred to specialist geriatric rehabilitation wards. The key element in this system was that there were no consultants' names on beds in any of the units. Patients could be admitted under any one of the three consultants but patients requiring longer term rehabilitation came under the management of the PSRE. The PSREs also ran the long stay facilities, the day hospital, out-patients and the multi-disciplinary home visit system which was used for assessment and very often for follow-up work in preference to the out-patient clinic. Most of the patients in the rehabilitation wards were referred from the acute

assessment centre, but these wards also provided for admissions on a respite basis and for intermittent admissions from day hospitals.

Professor Grimley Evans outlined the advantages of this system as follows:

I. A single point of referral for general practitioners.

2. It avoided the stigma attaching to "geriatrics". Patients did not feel they were being labelled.

3. The acute phase of patient management was integrated with the outcome of treatment. This gave essential feed-back on results.

4. Optimal use was made of resources. Research showed that IO% more bed usage could be obtained from the same resources by running an integrated service rather than two separate but parallel services.

5. Good ambience for teaching. All disciplines of staff benefitted from working in a unit where consultants were interested in, and enthusiastic about, the care of the elderly. It might be the only time in their training when they could gain this type of experience, particularly if a junior doctor was going into for example, orthopaedic surgery. This advantage might transpire to be one of the most important in the long term.

6. Good environment for recruitment. Several junior staff had discovered the rewards and satisfactions from looking after elderly people and had followed a career in geriatric medicine.

The price-tag for this type of service was that the face of general medical wards was changed. More elderly patients came into these units than was usual on a general medical ward. 60% of patients admitted were over 65 and an increasing proportion of these were over 75. However, the mean length of stay was less than to be expected from the national average performance of general medical and chest units as a whole. Professor Grimley Evans believed this was due mainly to effective management, as hold-ups in the process were minimised.

This model of care was not necessarily the ideal for the whole of Britain said Professor Grimley Evans. It was particular to the deficiencies and opportunities presented in Newcastle. The crucial element in running any successful service was having adequate resources. With the right resources a service could be run in several different ways and the

choice is dependent on local factors.

The evidence for this statement came from an analysis of three successful services in Hull, Oldham and Sunderland. The resources that were being used for the over 65 population by all the medical specialties had been examined. The number of designated geriatric beds compared with the national average was not significantly different in these three areas. However, the proportion of geriatric beds with DGH facilities (that is with resident medical staff, same-day laboratory results and x-ray facilities on site) in these three areas was much higher than the national average. Also, the number of beds in the medical specialities made available to the elderly patient was not strikingly higher than the national average for the three areas. However, if the geriatric beds with DGH facilities were added to the general medical beds available to the elderly, the proportion was almost twice the national average. It appeared therefore, that the sine qua non of successful medical services for the elderly lay in the availability of DGH medical beds for the elderly. However, current DHSS planning would not facilitate most Districts to come up to the level of DGH beds provided by these three services. DHSS policy had not been to expand the number of DGH beds available to the elderly, but to give priority to geriatric services, which were defined as continuing care services. This was not where extra resources were needed. An expansion was needed in acute beds for the elderly.

Although the results from the Newcastle system appeared encouraging, the service was not as successful as Hull, Oldham and Sunderland. There was tremendous pressure on beds and some patients who were being managed in the Day Hospital probably should be admitted. Some work had been done to see whether this was a result of inefficiency or shortage of resources. It was apparent that the number of DGH beds available for the elderly in Newcastle was slightly higher than the national average but nowhere near as high as the other three Districts. In Newcastle, the number of DGH beds available for the elderly had been achieved through integration of services; general medical services had been diverted to the needs of the elderly. It was possible that the integration of general medical and geriatric services might bring about a real reallocation of resources in favour of the elderly without the horrors of "bed blocking".

The concept of integrating general medical and geriatric services could open up many opportunities for development. However, this in no way suggested the abolition of geriatric medicine as a specialty. There would continue to be a need for specialists in geriatric medicine for research, standard setting, training, exerting influence on other services, and on geriatric services, including day hospitals and long stay units as well as for involvment in planning, particularly joint planning with social services. Geriatricians have a specialist guiding role in the care of the elderly analogous to the cardiologist in the care of heart failure.

People other than geriatricians, concluded Professor Grimley Evans, would continue to be involved in the care of the elderly and it was important to ensure that they did it as well as was possible.

The next theme to be discussed was:

Some Professional Implications of Caring for Elderly People in an Acute Hospital

Contributions on this subject came from members of the nursing and remedial professions. The first to speak was:

Pamela Hibbs, District Nursing Officer, City and Hackney District Health Authority

Miss Hibbs pointed out that the increasing numbers of elderly people, especially those over the age of 75, had particular significance for the nursing profession. Elderly patients had special needs which were not always recognised in acute wards, partly due to lack of knowledge about the ageing process. The question she posed was: would future services be able to cope with these needs ? Miss Hibbs identified the following as the main problems for nurses looking after elderly patients in acute wards:

1. Lack of knowledge of the elderly person's special nursing needs.
2. Standard nursing ratios insufficient for their needs. Some wards, e.g. orthopaedic and medical wards had a large proportion of elderly patients and needed to be staffed as geriatric wards.
3. Lack of day facilities and space for special equipment such as

high/low beds, hoists, wardrobes and lockers, etc.

4. Sanitary annexes badly placed and often not adapted for those with physical disabilities or for those who were very frail.

5. Difficulties in providing facilities for day clothes.

6. Lack of other members of the multi-disciplinary team to help the elderly, e.g. occupational therapists who could provide skilled help to rehabilitate. Physicians often misunderstood this role, they saw it too often as diversionary therapy. Also there was insufficient physiotherapy and chiropody.

7. Unsuitable ward routine. A pace that was too active and did not allow for periods of rest or the extra stimulation that old people required. The timing and the speed of meals was inappropriate and often the food itself was not what old people would choose.

The idea of joint departments of general and geriatric medicine was, said Miss Hibbs, attractive in principle but she was doubtful about how it would work in practice. She pointed out that interest and resources are always directed to acute departments, and yet there was now little difference between the patients cared for on some medical wards and on acute geriatric wards. However on general wards attention tends to be concentrated on the acutely ill - those who would recover quickly. Nurses found difficulty coping with patients whose recovery was slow or whose illness became chronic. It was necessary for them to learn how to provide good continuing care and for this they could look for guidance to the long stay units. However the standard of care in these units was also often the subject of criticism. It was necessary therefore to provide resources to improve the quality of care on long-stay units so that in turn the quality of care for elderly people on acute wards could also improve. To improve care on acute units it was also necessary to change attitudes towards elderly people. The attitude that the resources of a major hospital were inappropriately directed towards elderly patients could percolate down through all grades of nursing staff, said Miss Hibbs, and must be changed. She then identified some ways in which positive action could be taken to tackle the problem of improving the care of elderly people in acute hospitals.

I. Improving staffing ratios on acute wards admitting large numbers of elderly patients so that they were the same as on geriatric wards.

2. Education and training - More skilled nurses needed to be encouraged to remain working with the elderly and untrained staff should be reduced further. Nurse managers needed to stimulate general interest in the care of the elderly. This could be achieved by regular workshops and by tackling particular problems patients experienced. All nurses, not just those in geriatric departments, should be encouraged to attend post basic courses such as the JBCNS Care of the Elderly. There should be more in-service education into specific problems, e.g. pressure sores and incontinence. A planned programme of social activities should revolve around the geriatric wards with other patients and nurses being encouraged to participate.

3. Adopting individualised nursing care plans, involving nurses having responsibility for individual patients rather than tasks, would do much to highlight individual patient's needs. Experience of this type of care has shown that remarkable results can be achieved.

4. Equipment - Special equipment, for example, pressure sore preventing aids must be available on all wards. Experience at Hackney Hospital had shown that patients were developing pressure sores on acute wards which required subsequent treatment on geriatric wards often for periods long outlasting the original acute illness. If steps were not taken to prevent pressure sores as soon as an old person was admitted, months of unnecessary hospital care could ensue which could be extremely damaging to the independence of an old person. This issue also indicated how some good practice originally intended for elderly people could usefully be extended to all patients. The Norton scale originally developed to guage pressure sores in elderly patients could be used for all age groups.

5. The environment - it was, said Miss Hibbs, very important that careful consideration be given to the future planning of facilities to meet the needs of the elderly on all wards. This included providing easily identifiable and adequately equipped toilets, suitable bathrooms, a choice of places to sit during the day, wardrobes, and chairs and beds of variable heights. Elderly people in acute psychiatric wards, a group who had not been given any attention in the "Respective roles"[3]

study, were often at a particular disadvantage in this respect, said Miss Hibbs.

The next speaker considered professional implications of caring for elderly people in an acute hospital from an occupational therapy viewpoint. She was:

Dorothy Thomas, District Occupational Therapist, Brent Health District

Many heads of occupational therapy departments, said Miss Thomas, had their feet in the camps both of acute services and geriatric medicine and have had to support and train junior staff to deal with the tensions that arise between the two services. These staff could form prejudices about "misplaced" elderly people without a complete understanding of the whole situation. The study day provided an opportunity to discuss this subject in full and hence to help towards resolution of the problems involved.

People who lived on to old age were making greater demands on the support services, as predicted. It is no surprise, said Miss Thomas, that 60% of adult admissions, other than maternity, were people aged 60 and over. If there were not sufficient beds catering for the elderly, inevitably they would turn up in acute beds regardless of the treatment they required. In the past occupational therapists had been trained to work in acute rehabilitation and to expect a rapid return to health and home for patients. However, elderly patients often had greater difficulty in recovering quickly and therefore were in greater need of the skills of therapists to achieve an adequate level of personal independence, although this might be slow and take a long time.

The occupational therapist had a contribution to make in the geriatric field, and this contribution was much greater than that of helping patients to pass the time in custodial care. An occupational therapist had the opportunity of using the widest variety of her skills in a geriatric unit. The pace might be slower but there was time for assessment and problem-solving in a truly multi-disciplinary environment. With this sort of experience in a geriatric sector, was it naive to wonder why the same service could not be given to the elderly in acute wards ? Acute wards generate pressure to make beds available. Good turnover had become a measure of efficiency. Pressure did not allow time for the appropriate

activities to take place to enable the slower, older person to be prepared for discharge and for the necessary support arrangements to be made.

An example of this might be that of an elderly patient referred for occupational therapy on Tuesday, and needing a home assessment to go home on Friday. The sheer practicalities of organising a home assessment and laying on the necessary support services at home were usually impossible at such short notice. It could take 48 hours to get transport for an assessment visit. Meals on wheels, home help, etc. had to be arranged through the Social Services and a commode supplied from the Red Cross. The first few days at home were crucial. If the support services were not laid on, readmission might result. No information exists on the success or otherwise of discharges however, since readmission figures are not kept.

When Brent District Planning Team for the Elderly looked at the requirements for elderly patients in acute wards, said Miss Thomas, it was feared that the need for more resources would be revealed. However, research had shown that a discharge planning scheme could be implemented for patients over 65 without additional resources. A pilot scheme was started with a multi-disciplinary approach. The social worker initiated the case identification on the following criteria:

I. Over 75

2. Living alone

3. Recently bereaved

4. Immobile

5. Muddled

In three months 96 patients were identified, of whom 5I were over 75 and modifications were made to the criteria.

During this period the Occupational Therapy Service operated more effectively, despite it being a period of considerable staffing problems. The referrals were coming in earlier giving more time to assess priorities and to plan all the activities associated with discharge.

In conclusion, Miss Thomas stressed that a national shortage of occupational therapists existed and would continue as the number being trained was still too low. Meanwhile, therefore this resource must be used as effectively as possible and expertise gained in one field was best shared with those working in another. However, this principle must apply to all the disciplines involved and depended on good communication.

The final speaker on the theme of the professional implications of caring for elderly people in an acute hospital considered it from the physiotherapy standpoint. She was:

Helen Ransome, District Physiotherapist, Greenwich District Health Authority

Several years ago, began Mrs Ransome, she had experience of working in specialised geriatric units which had developed considerable expertise in rehabilitating elderly people. Patients would arrive from acute wards in general hospitals labelled as "long-stay" whom the multi-disciplinary team on the geriatric unit were able to rehabilitate and successfully return to the community. It was, said Mrs Ransome, mystifying. Despite the general hospitals concerned having adequate establishments of physiotherapists, they were unable to rehabilitate these elderly immobile patients.

In her view, the problem was caused by the traditional method of organising physiotherapy services in an acute hospital whereby physiotherapists had responsibility for a geographical area comprising a number of acute wards with different types of patients accomodated in them. Therefore impossible choices had to be made - whether to give priority to a patient in respiratory distress or to an elderly disabled patient. However, in reality there was no choice. The respiratorily distressed patient came first and meanwhile the elderly disabled patient who needed considerable time and the full attention of an unhurried physiotherapist became more immobile.

This organisational problem could be solved without extra staff, by organising physiotherapy work in specialties. Specialist senior physiotherapists with junior staff on rotation were made responsible for

entire groups of patients irrespective of geographical area, for example stroke patients, amputees, the elderly with multiple disabilities, etc. This removed the need for impossible choices between the acutely ill patient and a patient requiring rehabilitation. There was no doubt that the elderly patient received significantly improved rehabilitation in the DGH if services were organised this way. The system was more complex and required highly organised communication. However, the results justified the effort.

It would, said Mrs Ransome, be ideal if the appropriate disciplines could form multi-disciplinary teams in the District General Hospital, focussed on the special needs of the elderly patient. However, because of the vital importance of mobility, physiotherapists could improve the quality of rehabilitation for these people even without the support of the multi-disciplinary team.

However, Mrs Ransome pointed out that even with the organisational problem solved, there were still three fundamental problems posed for physiotherapists by the location of elderly patients on acute wards. These were:

I. Expertise; 2. Pace; 3. Environment;

I. Expertise

There is a lack of expertise in working with elderly patients in most acute hospitals and therefore more physiotherapists need to gain experience in this area. It should, said Mrs Ransome, be part of their pre-registration training and basic grade rotation schemes. These schemes help to break down the isolation of many geriatric units and enable good practice to be disseminated throughout the institution.

2. Pace

The fast acute ward pace must be slowed down for elderly patients for rehabilitation to be possible. Physiotherapists could be instrumental in this as they are very aware of the danger of immobility. Close cooperation with nurses is necessary since they are involved with the patient 24 hours a day. Physiotherapists need to be closely linked to a ward to ensure that patients are referred at the earliest stage and also to help ward staff establish the current functional level of each individual patient so that in the absence of the physiotherapist, they

can encourage the patient to keep up to it. Communication with nurses therefore allowed the appropriate rehabilitation pace for each patient to be maintained. Working with patients on the ward could demonstrate to the nursing staff that an elderly patient would make progress, although this might be much slower than in younger acute patients. Nurses needed to be shown how to do basic tasks, for example helping a patient to get out of bed in a mobility-encouraging way, with an actively involved patient, not just the humping of a passive patient.

The physiotherapist could be the key person in slowing up the frantic premature discharge process which could be so damaging to an elderly patient's rehabilitation programme. The counselling of relatives, particularly preparing them realistically for the future could also get lost in the fast pace of the acute ward.

Contact with medical staff to inform them about the rehabilitative progress was vital in preventing unplanned discharges. Education was needed in this area.

All these elements were found in good geriatric practice which provided the ideal pace for elderly patients. However they needed constant reiteration in acute wards and although working with elderly patients in such wards makes the physiotherapist's job more difficult, he/she was ideally placed to help slow the pace to meet the needs of the individual patient.

3. Environment

The physiotherapist, said Mrs Ransome, had considerable responsibility to create the best possible environment for the elderly patient, even in the essentially hostile and independence-robbing atmosphere of the acute ward.

* Beds - an elderly person must be in a variable height bed. Not all acute wards provided this essential facility.

* Chairs - acute wards usually have totally unsuitable chairs, impossible to get out of and unsafe to get in to. These encouraged immobility and incontinence. There was no standard chair suitable for all elderly patients. Each patient must have a chair matched to his or her needs and the physiotherapist was a key person

in making this choice. There must be a store of various types and heights of chairs to enable individual selection.

* Wheelchairs - some elderly patients may need wheelchairs, either temporarily or permanently. They may need various attachments which must be used appropriately and not mislaid.

* Walking aids - these must be carefully selected and labelled for the individual patient and must be kept available for use by that patient at all times, to preserve mobility and continence.

The physiotherapist had responsibility for selecting, teaching and monitoring the use of appropriate bed, chair, wheelchair, walking aids and appliances and so on, which could be particularly difficult in busy acute wards.

Despite the difficulties of keeping outdoor clothes in acute wards, the physiotherapist and occupational therapist must insist that patients had their own clothes and dressed themselves in them every day with as little help as necessary. This was essential for mobility, the maintenance of dressing skill, and as a vital reminder and motivation to the patient and staff that rehabilitation was continuing and that progress was expected.

Summing up, Mrs Ransome said that physiotherapists must organise their chief and scarcest resource - staff - carefully and flexibly to meet the physiotherapy needs of elderly patients in acute wards more effectively and efficiently. The objective of the physiotherapy service in this context, as in the geriatric unit, was the assessment, maintenance and if possible, the improvement of the total functional ability of the patient. To spread expertise in working with elderly patients to the acute hospital, all students and junior staff must have the opportunity to gain experience in dynamic geriatric units. A validated post-registration course in the specialty was currently being developed. To ameliorate the fast pace and unsuitable environment of the acute ward, physiotherapists must work closely with the multi-disciplinary team to fulfil the individual needs of each elderly patient as closely as possible.

The final contribution came from a former consultant physician who was currently a health authority chairman, and was on the general theme:

Implications for Health Districts John Royds, Chairman Mid-Surrey Health Authority, formerly Consultant Physician at Ashford Hospital

Dr Royds placed the issues, being raised at the study day, in the context of the planning responsibilities of the newly formed District Health Authorities. They were, he said, matters to be considered in the strategic planning period, that is over the next ten years. District health care planning teams would have to look at the needs of elderly patients, not just in geriatric units but wherever they were being cared for. There appeared to be a lack of cooperation between the geriatric and acute sectors. Dr Royds felt that there was a need for health authorities to encourage integration of general medical and geriatric services whilst maintaining the separation of surgical specialties. He pointed out that the Royal College of Physicians[4] had stated "the acute medical services for the elderly sick will require changes in attitude, flexibility and rethinking of established practices from everyone" and that this applied both to general physicians and geriatricians.

Following reorganisation of the N.H.S. in April I982, Districts had adopted Unit structures for the organisation of health services. Some Districts had created geriatric units of management, which in Dr Royd's view was a mistake, since this hindered the integration of general medical and geriatric services achieved for example in Newcastle, as described by Professor Grimley Evans. In Dr Royd's district - Mid-Surrey - the acute sector included the geriatric services.

District Health Authorities were also required to liaise with local authorities and this necessitated the institution of complex liaison mechanisms between health authorities, county councils and district councils so that health needs could be related to housing and other personal social circumstances.

Another major issue facing Health Authorities, was the question of national resource allocation. In I977 the Resource Allocation Working

Party[5] had produced a formula for the geographic redistribution of resources away from "over-provided" Regions in favour of "under-provided" Regions. This system had been successful to a certain extent but was not sufficiently sensitive for application at District level. In South West Thames, a method was being worked out to take into account the distribution of resources between the local priority services.

Financial prospects for the next few years, said Dr Royds, are of minimal even negative growth, in the South East of England. Any developments would have to be funded out of existing or even shrinking allocations. The geriatric sector was identified as a priority area, requiring special treatment, and resources would have to be taken from the acute services. This would meet with great resistance since all the acute specialists would say they were already providing services for the elderly. If resources were to be shifted, this must be done very gradually to prevent great upheavals in services.

Speaking as a physician, Dr Royds felt that the acute phase of an elderly person's illness could be managed by the general medical services. However the main shortfall was in the ability of general physicians to rehabilitate elderly patients. This was better done in geriatric units than acute medical units. Dr Royds' experience of cooperation with the social services was generally good, but one drawback of being a general physician as opposed to a geriatrician was that the former was not in a position to negotiate patients and beds with the social services. The key to successful rehabilitation was multi-disciplinary team involvement by way of case conferences where all the disciplines involved could educate and support each other. The use of day hospitals was very important and this should be available for all specialties, not just geriatrics. A shift of resources to the community sector was very important, noted Dr Royds, in maintaining old people in their homes and keeping them out of hospital.

Commenting on a memorandum produced by the British Geriatrics Society[6] in 1982, Dr Royds referred to its recommendation that

consultant appointments should be either entirely in geriatric medicine or be of physicians with a special interest in geriatrics, but that the two types of appointment should not be mixed in any one District. This, said Dr Royds, appeared to be an unjustifiable restrictive practice and should be reconsidered. The training in general medicine of doctors intending to practice geriatrics was very important. General medical teams should liaise closely with geriatric teams.

In concluding Dr Royds noted that the "Respective roles"study had not considered psychogeriatric problems and that the organisation and provision of services for elderly people requiring these services would pose increasing problems in the future. This subject needed urgent consideration.

Section Three Questions and Discussion

The speakers' presentations were followed by a period of questions and general discussion.

Professor Grimley Evans commented on the recommendation of the British Geriatrics Society[6] that different types of geriatric service should not be mixed in one health district. He explained that this was as a result of evidence of unfortunate experiences in places where different types of appointment had been made in the same district. It had been found there if a physician with total responsibility for elderly people worked alongside a physician with partial responsibility, the former tended to have all the long-stay cases referred to him, and the latter all the short-stay. A health district should adopt either an integrated model or an age-related model but should not allow a mixture of systems, otherwise the service would have inefficient use of resources and strained working relationships.

Miss Edwards made two points relating to issues covered by Professor Grimley Evans in his presentation. Firstly, the question of a critical level of acute beds for the elderly within a health district had not been emphasised in the"respective roles" document.[3] The

number and siting of such beds was however of fundamental importance not only for appropriate patient care but for medical and nurse training. Secondly, Miss Edwards had in no way wished to imply that the integration of specialties would make geriatrics redundant as a specialty. On the contrary, specialist geriatricians would always have a crucial role with particular emphasis on training, dissemination of ideas and exemplification of good practice.

Professor Millard felt that there was a problem of commitment to our objectives in the training of medical staff. If junior doctors were trained to be geriatricians, then it was not right that districts should be free to advertise for general physicians with an interest in geriatrics instead of a geriatrician. Districts should not be allowed to remove acute work from geriatricians. He saw the "respective roles" document[3] as a back-track from geriatrics.

The first question from the floor concerned the DHSS experience of earmarking funds for specific improvements in particularly bad "black-spot" areas. The rapid improvement of, for example, building facilities, could have a dramatic effect on the service. Also, the questioner added, did the Department feel it was doing enough to ensure that its policy guidance was being adhered to when resources were being shared out at the local level, where clinicians from the acute services usually had more political clout than the geriatricians ? In reply, Miss Edwards said that some earmarked sums had been distributed in the early 70's. The latest policy document from the DHSS, "Care in action"[7], put the development of care for elderly people at the top of service priorities. It was for health authorities themselves to decide how money should be spent in the light of expressed policy directions. The new system of annual reviews was intended to assess whether services were moving towards their strategic objectives, and value for money being achieved.

Dr Horrocks commended to the audience a paper produced by the Royal College of Physicians in 1981 entitled "Organic mental impairment of the elderly"[8].

A member of the audience asked whether any of the speakers had experience of bed-trading as referred to by Dr Royds. Both Dr Horrocks and Professor Millard felt that bed-trading was a thoroughly undesirable

practice which did not take into account the needs of the individual. However, it inevitably took place if the geriatrician was really desperate, but as geriatric services become more established bed trading would diminish.

A question from the floor challenged the medical bias evident in the spirit of the conference. Was this entirely appropriate for the care of the elderly ? Their social problems were also of prime consideration. There was no clear split between the two.

The speakers felt that medicalisation, as opposed to hospitalisation, had radically reformed the geriatric services in this country. It had been demonstrated that elderly people had benefited from clinicians taking a lead in tackling the medical problems of the elderly to enable them to live as independent a life as possible, and to prevent them from being condemned to static, long stay care. However, medical training should incorporate an awareness of the environment, social factors and physical aids to daily living.

Section Four Discussion Group Reports

Appendix I lists the questions which provided the focus for the afternoon discussion groups. The main general points made in the report-back session were :

* Medical politics still largely determine which services receive most financial resources. As a result, in many districts money continues to be lavished on the acute services despite the needs of the geriatric and other "cinderella services".

* Lack of adequate resources causes severe difficulties for staff working in the geriatric sector, who may in despair resort to fight, flight or apathy.

* District Health Authorities must have genuine commitment to improve and support services for the elderly. This requires a consistent approach which can tolerate, without giving way to, objections from other currently better resourced specialties, in order to create a more balanced total service.

Considering specifically the acute care elderly people receive, the following points were made :

* There were many constraints on providing appropriate care for an elderly patient in an acute hospital, e.g. mismanagement of patients arising from absence of an admission policy, and absence of diagnostic and assessment facilities.

* Geriatric unit staff should act as a source of information and educate the hospital staff to seek advice in caring for the elderly.

* Nurses had taken the initiative more than any other discipline to ensure that staff were trained, at a basic stage, in caring for the needs of the elderly. Paramedical therapy staff had also made progress in adapting training to the needs of the elderly. The medical profession had done very little in this area.

* Experience of working with the elderly for trainee doctors and nurses should take place in the right environment. Day hospitals could be very useful training resources.

* The London medical schools were particularly poor in promoting a positive attitude towards geriatrics and the care of elderly people.

Two specific areas for improvement were also identified :

* The extent to which patients and their relatives are involved in the management of their care.

* The care of the terminally ill.

Section Five Chairman's Conclusion

In his concluding remarks, Professor Marinker stressed the importance of attitudes in the debate on the medical care of elderly people, which had been referred to by several speakers; The norms of the clinico/pathological approach were inappropriate. The chairman noted with regret the low level of representation by members of the acute specialties at the study day. Their contribution to the debate was essential.

He referred to the concept of team management described several times during the day in relation to the care of elderly people. The advantages had been stressed but he noted the possible danger of diffusing responsibility for an individual patient.

Finally he commented on the need for the geriatric lobby to gain more power in the medical-political arena. An ecumenical movement was needed, and to this end, the study day had been informative and constructive.

Lucy Hadfield
September 1982.

Questions Posed For Consideration By The Discussion Groups

A. Do staff working in the geriatric unit have a responsibility in relation to elderly inpatients elsewhere in an acute hospital ? If so, how should they exercise this responsibility ?

B. What are the obstacles in ensuring that elderly people receive the most appropriate and effective care throughout an acute hospital ? How can these be overcome ?

C. Are staff in training made sufficiently aware of the relevance of the skills exercised in the geriatric unit ? If not, how might this awareness be increased ?

Appendix II

KING EDWARD'S HOSPITAL FUND FOR LONDON

King's Fund Centre

THE RESPECTIVE ROLES OF THE GENERAL ACUTE AND GERIATRIC SECTORS IN CARE OF THE ELDERLY HOSPITAL PATIENT

Study day on Friday 4th June, 1982

Attendance List

Dr M R ALLISON	Specialist in Community Medicine	Crewe Health Authority
Ms I ANDERSON	Acting District Physiotherapist	Orpington Hospital
Mr W BARRETT	Health Tutor	London Borough Training Committee
Dr B K BHATTACHARYYA	Consultant Geriatrician	W Middlesex University Hospital
Mrs P BLIGHT	Senior Nursing Officer, Geriatric Services	Southwood Hospital
Dr M R BLISS	Consultant Geriatrician	Hackney Hospital
Mrs E BUSSEY	Member	Hampstead Community Health Council
Mrs D CARR	Ward Sister	St Luke's Hospital
Dr B CASTLETON	Senior Registrar in Geriatric Medicine	Frimley Park Hospital
Ms J CORBY	Sister	St Luke's Hospital
Miss L CROOKE	Senior Occupational Therapist	Southlands Hospital
Dr H P DAS	Consultant Physician in Geriatric Medicine	Morriston Hospital
Mrs B DAWSON	Senior Occupational Therapist	Harrogate General Hospital
Mrs D DOWLING	Senior Nursing Officer	St George's Hornchurch Hosp.
Mrs J M EARL	Clinical Nurse Specialist - Elderly	St Charles' Hospital
Miss M R EDWARDS	Principal	D H S S
Mr M B ENGLISH	Asst. District Administrator	N Birmingham H A
Ms Ann FOSTER	Project Officer - Planning	King's Fund Centre
Miss M E GAFFNEY	Retired Civil Servant	
Dr J M GRAHAM	Senior Medical Officer	D H S S
Dr J H GRANT	Director, Scottish Health Service Planning Unit	Scottish Home and Health Department

*	Professor J GRIMLEY-EVANS	Professor of Medicine (Geriatrics)	University of Newcas
	Dr H N C GUNTHER	Consultant Geriatrician	Ashford Hospital
	Ms L HADFIELD	Rapporteur	
	Mrs A HAYES	Senior Occupational Therapist	Scotton Banks Hospit
*	Ms P HIBBS	District Nursing Officer	City & Hackney D H A
	Miss C HICKS	Reporter	Nursing Times
*	Dr P HORROCKS	Consultant Geriatrician	Hull
	Dr D J HUNTER	Research Fellow - Department of Community Medicine	University of Aberde
	Ms A HYDE	Reporter	Health and Social Services Journal
	Mrs A ILSON	District Occupational Therapist	Royal Free Hospital
	Mr J JAMES	Assistant Secretary	HPSS Policy and Planning Unit
	Dr P KILBANE	S C M (Information)	N E T R H A
	Ms R LACEY	Occupational Therapist	New End Hospital
	Dr J LEAVER	Specialist in Community Medicine	N E T R H A
	Miss R LEWIS	Head Occupational Therapist	St George's Hospital
	Mrs J LOPEZ-VEGA	District Occupational Therapist	Hackney Hospital
	Mrs M C MACDONALD	Services Planner	N E T R H A
*	Professor M MARINKER (Chairman)	Professor of General Practice in Department of Community Health	University of Leices
	Mrs G McCULLOCH	Nursing Officer	Charing Cross Hospit
	Ms S MELIA	Occupational Therapist	Royal Free Hospital
*	Professor P MILLARD	Professor of Geriatric Medicine	St George's Hospital Medical School
	Mr A M MOON	Head of School of Administrative Studies	Ulster Polytechnic
	Dr J MORRIS	Consultant Physician	St Charles' Hospital
	Mr D NILAN	Occupational Therapist	Ealing Hospital
	Mr P PARKER	Reporter	Times Health Supplem
	Mr M PERRY	S W S O	D H S S
	Dr M PIPER	Consultant Geriatrician	Northwick Park Hospi

Dr J PILCHER	Consultant Cardiologist	Walsgrave Hospital
Mr R PURCELL	Senior Nursing Officer (Geriatrics)	Ipswich Hospital
Dr J C A RAISON	Community Physician	
* Mrs H RANSOME	District Physiotherapist	Greenwich D H A
Dr S J REDFERN	Lecturer in Nursing Studies	Chelsea College
Mrs B REILLY	Senior Physiotherapist	Highgate Day Hospital
Dr G C RIVETT	Principal Medical Officer	D H S S
Dr M J ROWE	Consultant Geriatrician	St Martin's Hospital
* Dr E J ROYDS	Chairman	Mid-Surrey H A
Mr D SAUNDERS	Secretary	Salop C H C
Miss A SEELIG	Nursing Officer	D H S S
Mrs A J SQUIRES	Superintendant Physiotherapist	St Francis Hospital
Ms A STOKES-ROBERTS	Head Occupational Therapist	Bolingbroke Hospital
Ms E SUTHERLAND	Head Occupational Therapist	New End Hospital
* Miss D THOMAS	District Occupational Therapist	Brent D H A
Miss A WEAVERS	Senior I Occupational Therapist	New End Hospital
Mrs E T WELCH	Senior Nursing Officer	St Michaels Hospital
Dr T C PICTON WILLIAMS	Consultant Geriatrician	St Thomas' Hospital
Dr E WOODFORD WILLIAMS	Retired Consultant and Ex Director of H A S	

* denotes speaker

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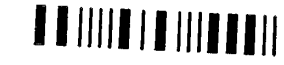


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