



BGS

n e w s l e t t e r

Devolution - the UK and the BGS a statement by the President

As the Society moves to 2003, one of the challenges facing it will be implementing the new Constitution.

That is assuming that the new Constitution is endorsed by the Extraordinary General Meeting at Aberdeen in April. As members are now well aware, the Constitution recognises the devolved structure of government in the United Kingdom. It is perhaps worth recalling that Northern Ireland has had a devolved administration with its own Ministry of Health, under a variety of names, since 1921, and even under direct rule, when ministers come from Westminster rather than from a local parliament or assembly, the administration remains

devolved and the Civil Service has remained separate from the Civil Service elsewhere in the UK. Scotland has also had a considerable amount of autonomy with respect to health matters for many years. Geriatric medicine is a specialty which is very closely related to administration of both health and social services and as it seems likely that policies are increasingly going to diverge, the Society will have to take account of this.



England Quo Vadis?

In many ways the biggest challenge is England. There is no local devolved government for England, although there are moves to create regional government. It is somewhat paradoxical that within the Cabinet of the United Kingdom there are Secretaries of State whose roles are UK wide, eg. Foreign Secretary, Chancellor of the Exchequer, and Defence Secretary, and others whose remit extends only to England, including the Secretaries of State for Health, and for Education and Skills. It is not always realised, even in the devolved parts of the United Kingdom, that announcements by the Secretary of States for Health or for Education and Skills, whether they are on budgets or policies, only apply to England.

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specialist medical society for health in old age



Nevertheless, England contains over 80% of the population of the UK and accounts for over 80% of public expenditure, and what happens in England has a great influence on what will happen in Scotland, Wales and Northern Ireland. Often the policies will be applied in either unchanged or slightly modified form, usually a little later than they have been introduced in England. The main differences are in structures.

The new Constitution of the Society is intended to reflect the new reality. There are already **BGS** structures in Scotland, Wales and Northern Ireland which differ somewhat, partly reflecting the size of the specialty in each country. Each has been asked to produce a constitution to be submitted to **the existing UK Council** of the BGS in January. There has not so far been an all-England structure. An interim administration, chaired by Cameron Swift, was set up to prepare the way for an **England** Council. We initially thought that this might take up to two years but in fact the work has taken place very smoothly and quickly and preparations are in place to elect a Council to assume its responsibilities as soon as the new constitution is accepted. Because **of the size of England** there will continue to be a regional structure in England. The Chair of the **England** Council will be a busy and important post, as **will that of** the other office bearers, and the BGS Office is available to provide assistance.

Four nations - common ground

One of the challenges over the next year will be to work out the responsibilities that are UK wide and those that belong to each of the national councils. Of the four **UK standing** committees, the Finance, Education and Training, and Academic and Research and Policy Committees have UK wide remits and I anticipate that the work of the first



three will continue as before. The Policy Committee's role will change and perhaps become even more important as it will be responsible for setting out the general principles of the care of older people which are just as applicable in one part of the United Kingdom as another. It is hoped that in this way the Policy Committee will be able to help the National Councils in their relationships with their administrations. Responses to government initiatives which apply only to one of the four nations, will be the responsibility of those nations, as has been the case in Scotland, Wales and Northern Ireland for some time. **The National Councils may wish to allocate the specific responsibility for policy to designated members of the Council.**



The role of the President

The role of the President has also to be considered. The President is the president of the whole Society and will lead in discussions where the whole Society is involved, e.g. with Royal Colleges, or where meetings take place with the Presidents or equivalent officers of the other societies. Liaison with the Department of Health in London, however, will be led by the Chair of the **England** Council, and this will be the case whether the President comes from England or not. To take my own position as an example, I attend the Northern Ireland

Branch of the BGS as a member, not as President, and if representatives meet the Department of Health, Social Services and Public Safety of Northern Ireland, the Chair and Secretary of the Northern Ireland Branch would do this.

It is essential that the Society does not break up into four societies and we must not allow that to happen. The Spring and Autumn Meetings are when the Society comes together and I hope members will make a special point of attending these meetings. The **existing** Council of the Society will disappear under the new Constitution, to be replaced by the four National Councils. For many years the Council held an



annual study day in May or June. It has been decided to continue this, at least in the mean time, as a means of bringing together representatives of the four Nations to talk about matters of UK wide importance. It is planned to hold the meeting in each of the four Nations of the UK in turn, starting with a meeting in Wales in 2003.

Change often brings uncertainty. Some regard change as a threat; others welcome it as a challenge. The changes proposed have been unanimously endorsed by the **existing UK Council and Executive**, and were strongly supported at the

Extraordinary General Meeting of the Society in Telford last April. There will undoubtedly be teething problems and I hope members will be patient as these are worked through. I also hope members will welcome these changes, not least as a means in which they can become increasingly involved in the Society's activities.

I wish you all a happy and successful New Year

Bob Stout
President

Editorial

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As we awaken bleary eyed from the excesses of the festive season, we find ourselves in a new era of the BGS.

The pace of our Society's modernisation marches on and when in April, the new constitution is endorsed (hopefully) at the Extraordinary General Meeting in Aberdeen, the BGS will set itself firmly on the path to devolution. Where Scotland, Northern Ireland and Wales have led, England will follow with the formation of the England Council. As Bob Stout so eloquently explains in his column, the trick is to maintain the good in the current structure while assimilating the benefits to be had from the New Order. I have no doubt that we will strive together with the Executive team to progress this.

What's in a name...

And perhaps we see the resurrection of an old chestnut, namely our name! Almost as a throwaway line (or perhaps not), Cameron Swift ably resurrects the discussion of nomenclature. Do we pick up this gauntlet once more? Should we indeed be reconsidering the name of our specialty, and

through our society's name reaffirm what we stand for as a professional association? I am reliably informed that the issue of nomenclature receives

serious consideration every few years. Those with longer memories may even recall a referendum or two. Personally, I think the time is coming to revisit this thorny issue, but I would be keen to hear the thoughts of my colleagues. In particular, I would like to hear from the younger generation of geriatricians - newly appointed consultants and SpRs. Please let me have your views through the BGS office (info@bgs.org.uk) or direct to me at chandi.vellodi@cfh-tr.nthames.nhs.uk. We may well form a forum in this newsletter for an airing of the views we receive.

Our next NSF survey is progressing well. My thanks to all of you who have already responded. And to those of you who have not yet done so, I have only this to say, watch out for the tenacious Louise, who will be on your trail! Our last survey had a 75% response. While this was a good yield for any survey, we are keen to beat this figure.

Interestingly, a DoH survey of Directors of Nursing (reported in David Black's update - page 11) suggests that 50% of Trusts are of the view



that standards of care have improved since the introduction of NSF. This is one of the issues on which we seek feedback in our NSF survey.

And staying with the NSF, our National Director, Ian Philp, encourages more geriatricians to become Champions. Our first NSF survey indicated that of the 92 Champions appointed at the time, 86 were geriatricians.

Finally, I would draw your attention to an excellent document, the **“Medical Aspects of Intermediate Care”** report, produced by the Federation of the Royal Colleges of Physicians of the UK. The messages contained in the report

are well considered and balanced. It goes some way to addressing issues which have caused concern, namely the role of medical input and comprehensive assessment in Intermediate Care. It also covers the vital issue of clinical governance within Intermediate Care. We are fortunate to have had many able and eminent members of our Society on the Working Party. Our thanks to them for their vital input.

And to end, I would wish you all a successful and fulfilling new year.

Chandi Vellodi

Modernising older people's services - Conference report

Organised by the NHS Modernisation Agency, the conference was held in Brighton in November last year.

Delegates were split up into six different working groups: challenges to change; modernising older people's care; health; MA/change programmes; and primary/intermediate care and improvement work.

Challenges to Change

Delegates attending the workshop on 'challenges to change' heard presentations on whole systems working, integrating health and social services using section 31 flexibilities in the 1999 Health Act, working with service users with communication difficulties to develop services and partnership work – health, social care and local government.

Modernisation and mental health

The workshop on “modernising older peoples' care” had presentations on leadership for modernisation, new light through windows, dignity – a fundamental human right and findings from the frontline. The workshop on 'mental health' had presentations on

looking to the future of dementia care in the community, developing mental health services for older people, improving the dementia pathways and access to services for older people with mental health needs.

Redesigning the service

The 'change programmes' group heard presentations on implementing improvements in access, booking and choice, changing roles in order to meet the requirements of the National Service Framework for Older People, pursuing perfection or striving for mediocrity (by Dr Jacqueline Close) and involving patients and carers in service redesign.

Primary/intermediate care

The workshop on 'primary/intermediate care' had presentations on specialist training in the care of older people in care homes, health communities collaborative pilot, taking a whole systems approach to hospital admission and discharge planning and intermediate care.

Presentations on whole systems, small changes leading to big impacts, through the service user's eye and changing roles: empowering frontline staff were made in the workshop on 'improvement work'.

Annette Guerda-Fischer
BGS Office

The BGS Plan 2000-2002:

- personal reflections by our immediate past President

In a mutually unguarded moment, the BGS Executive required me to provide a personal retrospective on the BGS Plan 2000-2 that spanned my term of office.

Any positive conclusions to be drawn reflect the combined strengths of colleagues on the Executive and Council, the team at HQ, and many individual contributors across the BGS membership. For the Plan's deficiencies the buck stops here. In the context of these comments, I have decided in general not to mention names but I wish immediately to single out the support, hard work and enormous commitment to the Plan's implementation provided respectively by the Society's current President, Bob Stout, and by the Administrative Director, Richard Lynham.

As a preliminary reminder, the Plan had a somewhat "New Labour" style evolution through the convening of exploratory "focus groups", consultation across the UK and the England regions, modification to reflect feedback, final refinement towards consensus, and the eventual full endorsement of the UK BGS Council. Speaking personally (with no political bias) I have in retrospect no doubt of the validity of that approach in this particular context. I'll do my best here to avert any charge of spin!

Policy documents

An organisation like ours has to function in both strategic and "response" modes, and the period of the Plan saw the impact of perhaps unprecedented extrinsic activity and change driven by public and political awareness and the publication of numerous policy documents. Examples of such activity (to which you can surely add) include the following:

- ◆ The progressive devolution of Health policies and Departments across the UK,
- ◆ The publication of the NHS Plan in England (to include the concept of intermediate care and the

inauguration of the Commission for Health Improvement).

- ◆ The sanctioning by the Scottish Parliament of free personal care for older people in nursing homes,

◆ The launch of the 10-year programme of the England National Service Framework for Older People,

- ◆ The concurrent production of similar reviews of health and social policy for the care of older people in Northern Ireland, Scotland and Wales,

◆ Greatly increased prominence in the agendas of the Medical Royal Colleges of matters to do with the medical care of older people,

- ◆ The implementation of major reviews of clinical governance and the health care workforce across the UK,

◆ The 2001 Research Assessment Exercise,

- ◆ The welcome emergence of Stroke Medicine as a defined subspeciality of our own and other specialities,

◆ Not least: A general election, the Golden Jubilee, and the 2nd World Assembly on Ageing (preceded by the Valencia Forum).

The above were additional to the usual steady trickle of not always edifying press coverage (everything from alleged scandals of care in hospitals and homes to the health concerns of the late Queen Mother), and regular events (such as the IAG Congress). In such a climate there is always the risk of strategy falling victim to response.

A rehash of the corresponding Annual Reports of Council (to which you are referred) would be unpractical and pointless here. The Plan's specific initiatives predictably resemble a "rolling" BGS agenda (Thematic elements of the 2000-02 strategy) based on certain core objectives. The essential question is whether, if at all, its implementation advanced the cause of the speciality in line with those objectives as follows: (1) A common shared purpose, (2) Policy influence – national and international, (3) Public awareness and engagement, (4) Academic and professional



development, (5) Effective collaboration and (6) Effective structure and infrastructure?

Advancing geriatric medicine through a common shared purpose

How within the Plan did the BGS score against this ostensibly self-evident parameter? On the whole I believe pretty well, especially amongst the growing ranks of trainees, with whom the future rests. Both at the launch stage of the Plan and subsequently however, consensus statements were difficult to elicit and formulate, and were muted to a degree suggesting that our field is still not entirely at ease within itself. While creative tensions might reflect healthy diversity, a lack of recognisable core principles would, conversely, pose more of a problem. Key issues of speciality identity on which geriatricians agree were eventually endorsed by your Council and I sought to summarise them in an early “President’s Column” (see the fuller listing in the January 2001 Newsletter):

- ◆ Comprehensiveness - the consistent application of specialist geriatric medical skills and training to the health needs of older people across the spectrum of care (acute, intermediate care and continuing care),
- ◆ A genuine commitment to multidisciplinary,
- ◆ The promotion of effective interrelationships between all providers of health and social care for older people,
- ◆ The translation of these principles into viable, efficient local services within realistic resources (ensuring access for older people without delay at the point of need),
- ◆ The embodiment of the above within the knowledge base of undergraduate medical teaching, postgraduate training and academically led research into ageing.

That is to say, without each and all of these you do not have geriatric medicine in a developed form. In case they seem at first sight too broad and philosophical, you might, for example, care to test their applicability to current discussions about the

balance of geriatrician deployment between acute hospital and community aspects of specialist practice. They have been (and remain) highly germane to the Society’s advice to Government. I suggest that their rehearsal (the equivalent of the ubiquitous “mission statement” remain part of any future strategic review).

Advancing geriatric medicine through policy influence

Against this objective significant progress occurred over the period of the Plan. Formal devolution triggered the consolidation and further

development of already strong advisory and working links between the BGS and the Departments of Health in Northern Ireland, Scotland & Wales. England, with a history of only tenuous links to its DoH, (and with no England Council) faced particular new challenges and opportunities with the highly structured initiatives of the NHS Plan, the NSF and the National Directorate for Older People. Both collectively and through the involvement of individual members, the Society had a substantial input over the period. As President, I had opportunities to work closely with the National Director, to meet with Ministers, to be involved in key policy groups and to present evidence to Commons Select Committees. A formal, unprecedented mechanism for regular consultation of the BGS with

the Directorate and the DoH in England is now in place, albeit very much in parity with other “stakeholders”.

Thus across the UK the plan’s practical goal of enhancing the political interface has been significantly realised.

The parameters of political engagement, however, continued (and continue still) to present challenges across the UK, as follows:

- ◆ In determining standards, where lies the margin between specialist expertise and “general” enhancement of awareness, attitude and basic training for all involved in health and social care?

THEMATIC ELEMENTS OF THE 2000-2002 BGS PLAN

Review and update of the Society’s aims and objectives

Enhancing the public, political and media interfaces

Establishing an effective central information, research & development facility

Promoting leadership in matters academic

Multidisciplinarity - the next steps

Developing the regional and local roles in peer support

Adjusting BGS structures and procedures in line with the agenda

Development of a business plan

- ◆ In consequence, how best should limited financial resources be selectively deployed?
- ◆ How does the specialty (represented by individuals or groups) work with Government, but sustain and promote its own independent values and standards where there is perceived variance?
- ◆ To what extent do geriatricians at local level with limited time and manpower engage with laudable but historically untested initiatives? Many such initiatives may readily be seen to have a partial or marginal impact on core need. While involvement may be desirable to inform and influence, it may be at risk of lending unjustified credibility and of diverting their own and other scarce resources.

Internationally through representation on the Councils of the IAG, the BGS has continued to have a voice. You may possibly recall however, the concerns I identified at the Valencia Forum about the apparent narrowness of commitment to hospital-based secondary care for older people within (for example) the forward programme of the WHO (see President's Column, May 2002).

Advancing geriatric medicine through public awareness and involvement (including the media)

Although your Council favoured a major and professional drive in PR, progress over the period has been tempered by funding constraints, but perhaps also by a measure of reticence within the ranks. That said, the commitment, energy and skill of the Administrative Director and the HQ team working with office bearers, standing committees and others have resulted in professional, timely and influential responses to most emerging media issues to an unprecedented degree. These have included rapid response press releases and media interviews, where relevant in tandem with other organisations (see collaboration below).

Our history is one of a predominantly medical professional society, nonetheless enjoying fruitful relationships with other groupings concerned with advocacy for older people. Compared with other specialities of medicine (and we are currently the largest), we have perhaps been rather reticent in promoting the field to a wider public and even to older people themselves. Perhaps we should ask “why?” since in today’s climate of concentrated high-pressure communication, survival and development might come to depend on strong public support.

There was general agreement that the opening of Marjory Warren House by the Secretary of State for Health, and the presence of guests and

representatives at the occasion from a wide spectrum of organisations and backgrounds contributed usefully to the recognition and awareness of the Society’s importance nationally.

Strategies under this heading that were not pursued systematically within the Plan included (for example) (1) the Society’s possible role as a charity in the raising of funds for Research & Development, (2) the pro-active pursuit of public information or education campaigns about health, medical need and ageing, (3) any systematic reconsideration of the Society’s nomenclature. A commonly voiced view (that I do not wholly share) is that (1) & (2) can remain de facto “delegated” to other major charities and organisations, such as Age Concern and Help the Aged (without necessarily any strategic collaboration). Useful groundwork towards these goals nevertheless took place within the plan in consultation with office bearers and other colleagues in these organisations.

Part of the agenda entailed a review of the relationship with our Patron, HRH the Prince of Wales (who is Patron of four other charities in ageing). A measurable enhancement of the Society’s interaction, both with His Royal Highness and his staff, as well as with the other “Prince’s charities” was achieved.

On (3), (a recurring topic of informal exchange, though not an explicit item in the Plan) I’ve taken the liberty of commenting separately (see Appendix).

Advancing geriatric medicine through academic and professional development

The Plan coincided with a period of unprecedented pressure and change affecting many clinical academic disciplines and departments. In pursuing the objective of promoting academic leadership, the issues for academic activity in our own field were thoroughly analysed in a paper presented for the Association of Professors of Geriatric Medicine (and subsequently Council) by Bob Stout, concluding with 13 recommendations. These constitute a clear forward agenda. Involving the Society’s academics corporately in the development of a shared strategy has so far proved elusive. Currently an increasing number of academic departments is facing closure, and this remains a source of grave concern for the future of the speciality.

It has, however, proved possible to strengthen the Society’s special link with the charity, Research into

Ageing during the transition to its more integral relationship with Help the Aged. We were indebted to them for supporting the first highly successful Research Masterclass for BGS trainees, and more are planned. RIA has also now joined with the BGS (via the Dhole Bequest) in funding a two-year clinical fellowship. The position of Hon Medical Advisor to RIA continues to be held by the Chair of the Scientific Committee.

The Plan prescribed the development of a BGS 5-year rolling CPD programme to support members in readiness for governance and revalidation. This is now largely in place, thanks to the imagination and persistence of the Society's CPD Director and others. It depends on a range of resources, including national meetings, branch and regional activity and the BGS website. Distance learning and assessment capability is now being piloted in collaboration with (and with support from) the Novartis Health & Age Site. The possibility of a web-based CME supplement to Age & Ageing is currently under consideration by the Editorial Board.

The Plan stressed the developing role of Sections and SIG's as catalysts for the focusing of expertise, research, and collaboration with other professions, organisations and scientists. All the indicators, including the emergence of new SIG's, suggest this continues to be a fruitful strategy.

Advancing geriatric medicine through effective collaboration

The Plan set out to explore how the collaborative and multidisciplinary ethos of the specialty might be better supported and more clearly developed and expressed in BGS activity at national level. Progress was achieved in a number of directions.

The joint working group and subsequent joint publication with the Royal College of Nursing on the Gerontological Nurse Specialist were major steps forward. Not only was there a strengthening of the relationship between the two organisations on which to build, but the concept of nurse specialisation in the field was, it is to be hoped, significantly nurtured and encouraged.

Organisational bridge-building has also continued with the representative groups for physiotherapy (via AGILE) and occupational therapy (via OCTEP), speech and language therapy and dietetics. Discussion has also begun with the College of Optometrists.

The open membership of Sections & SIG's

continues to be seen as one of the best avenues to develop and consolidate cross-professional research and CPD interests, and to involve other professions in the Society's activity. The interdisciplinary days at Autumn and Spring meetings have so far enjoyed variable support both from physicians and from the professions allied to medicine and are under review.

Over the period of the plan, the proximity and effectiveness of collaboration with the Medical Royal Colleges has increased considerably to mutual advantage. Training, workforce and CPD matters, but increasingly also issues of national policy, have on numerous occasions (where relevant) been approached jointly with enhanced influence as a result. There is a strong functional link with the Clinical Effectiveness and Evaluation Unit of the London College through our own Clinical Practice Evaluation Group now reporting to the Scientific Committee. I wrote recently (September 2002 newsletter) about the excellent start that has now been made in working together with the Royal College of General Practitioners, and of course our colleagues in the Section of Psychiatry of Old Age of the RCPsych share common cause with us in the Brain Ageing and Mental Health Section.

The Sections and SIG's have also fostered links with related learned societies, for example the National Osteoporosis Society, British Cardiac Society, British Thoracic Society, British Pharmacological Society, Diabetes UK, Parkinson's Disease Society and others.

The potential of closer collaboration in the UK with our "relatives" in Biological and Social Gerontology (through the BSG and the BSRA) has yet to be fully realised in spite of significant efforts on the part of the respective executives. This is partly a fact of history – the emergence of three strong and autonomous groups in Britain, in contrast with some other settings internationally where a more natural shared evolution (partly for reasons of critical mass) has occurred. But we will probably remain impoverished both scientifically and perhaps politically if this logical affinity cannot be realised.

It was gratifying that the BGS finalised its joint project and publication with the American Geriatrics Society in the development of agreed guidelines on the prevention of falls. Collaboration is also underway with the National Institute of Clinical Excellence (NICE) through the involvement of individuals in Guideline

Development Groups. This is in addition to the responses provided by the BGS as a recognised stakeholder in a variety of topics on the NICE agenda (coordinated by CPEG in conjunction with Sections and SIG's).

A further example of the inherent strength of working closely with other major charities was the Joint Report on 'Implementation of the National Service Framework and Intermediate Care seen from Geriatricians' and Older People's perspectives' published by Age Concern and the British Geriatrics Society in 2002. Data were collated from two separate national surveys – that of Age Concern on the involvement of older people themselves in the local implementation of the NSF, and our own on the involvement of geriatricians. In this way the Society was able with minimal resource commitment to balance its proper involvement with Government against independent scrutiny of the impact of policy (from the perspectives of the service users and of our own professional speciality).

There can be no doubt (in spite of the workload involved) that this broad growth of networked activity and of external collaboration is in the best interests of the BGS.

Advancing geriatric medicine through effective BGS structure and infrastructure

Members will be well aware of the structural changes which have now been formulated and which are essential to future effectiveness. They are detailed in previous newsletters and I will not rehearse them here. The need for structural review to meet the Society's strategic objectives was a defined remit of the Plan and the proposals now in the final stages of implementation should serve us well. These have, as you know, been driven principally by the combined requirements of (1) charitable status, (2) UK devolution and (3) the need to regain momentum academically. With respect to (3) the President and the revised Academic & Research Committee should be better enabled by the new structure to take forward the major challenges with respect to academic geriatric medicine.

In the area of infrastructure, the Administrative Director and the HQ team (currently the best and strongest the Society has ever had) deserve enormous credit for what has been achieved. After a period of stringency, the finances are showing

signs of renewed vitality, with significant inroads already made on the premises mortgage and the possibility of a whole range of more creative resource deployment ahead. Marjory Warren House is more than justifying every penny invested in it, and still has considerable potential for exploitation as a resource. Considerable progress has been achieved with minimal investment (other than hard work) in setting in place the Central Information and Research Database to support research collaboration and also to inform and strengthen the Society's networking of expertise. The support for the Society's Committees is now even more refined and effective.

As we have already seen, England faces particularly complex challenges in the shake up of the Regions and the resulting lines of accountability for the standards of local services. Regional branch activity is fundamental and crucial, both to the delivery of effective peer support to the membership, to the CPD programme, and to lines of communication within the Society. The England Council has now been configured (as a key component of restructuring under the Plan) and should be fully elected and operational by spring 2003. Alongside its role in national and UK policy, it will provide leadership in the evolution of relationships with Primary Care Trusts, Strategic Health Authorities and Health & Social Care Directorates. Regional data collection has already proved an invaluable resource in monitoring the impact of health policy on practice and services in our speciality and it is to be hoped that this will become even stronger.

Conclusion

The "ship" undoubtedly moved along over the period of the 2000-2002 Plan. Time will judge the extent to which the direction of travel the Plan charted was the desired one. Strategy may have occasionally fallen victim to "response mode". It was, however, for me an unforgettable privilege to convene and gather some of the incredible wealth of expertise within this Society that brought the Plan into being. That support and the Plan itself served as invaluable anchors and made my task more straightforward.

I wish my successor and the whole leadership team well in moving on to the next phase. I hope very much that their shared experience will prove as rewarding as mine certainly was.

Cameron Swift
Immediate Past President

And looking to the future

..... the myth of "a rose by any other name...." - Cameron Swift reflects

We live in a culture where names have become important (whether we like it or not)

Any reconsideration of nomenclature should be closely argued (as to its functions and appropriateness) before any "referendum". A rational option appraisal might, after groundwork and open debate, be put to the membership with a recommendation from the governing body.

Any new nomenclature would after 50+ years seem very strange for a while and entail a difficult period of readjustment and "identity" both for us and for others. There would need to be a very real appetite for change to survive this.

We should decide on the basis of a clear rationale or shelve further debate for a further 5 years

Nomenclature is targeted at a wide variety of "consumers". These include:

- ◆ Ourselves. Our current nomenclature is steeped in history and tradition of which we are (or should be) rightly proud. We hold the term geriatrics and our identity as geriatricians with deep affection and esteem. It has specificity and brevity. It invariably triggers a response and often an opportunity for education amongst those we meet. It defines us professionally.
- ◆ Our patients. Our own affection for current terminology is probably not widely shared by patients.
- ◆ Professions allied to medicine, not all of whom share the long tradition of specialism now built up by physicians. How helpful is the current terminology to them?
- ◆ Politicians and management. We are engaged in a recurring cycle of laborious re-education of successive generations of both. Current

terminology probably predisposes to "stereotypic ageism" within the respective organisations.

◆ The general public and the press. Current terminology has become pejorative and devalued. At best it is equated with self-deprecatory stoicism and at worst with stigmatised and outdated concepts of custodialism. Overall it is probably a barrier to public education.

◆ Potential resource donors. The earlier penchant for charitable endowment of units and academic chairs has largely waned in the UK, though is still strong in the USA and in countries where a strong need to "do something" by way of kick-starting standards in the care of older people is still perceived. There is a need in this country to "move on" in the battle for resources. The current terminology may not be helpful.

◆ Academic institutions. Other than highly prescriptive endowments, organised clinical academic endeavour in the field as currently identified is struggling to survive. In particular, the knowledge base defined by current terminology is commonly characterised as a loss leader, as lacking academic focus, or both. There is also a need to focus academic endeavour on clear programmes which address the important questions presented by medicine and ageing.

The main problem historically has been to come up with acceptable alternatives that might gain support as an improvement.

Solely to trigger debate (again!) and to test the appetite for change, I offer some options that have emerged in informal discussion with colleagues:

- ◆ We might re-label the field of knowledge and research (and academic departments, divisions or groupings) "medical gerontology", meaning the understanding and study of ageing as applied to the science and

practice of medicine. This focuses the knowledge base on ageing and its consequences for individuals and populations. "Medical" here is no less multidisciplinary than "geriatric medicine" (the birthplace of meaningful multidisciplinary practice!) has always been. The term brings the field academically into harmony with biological gerontology and social gerontology, whilst ensuring the centrality of medicine to its identity. "Clinical" (as an alternative to "medical") has little meaning to the wider public and to allied professions outside the ranks of physicians. "Geratology" is for demographic reasons linguistically correct (very Oxford!) in its derivation, but possibly a touch esoteric in the marketplace? People would ultimately get used to physicians who are also medical gerontologists.

◆ We might re-name NHS departments, "Departments of Ageing & Health", either within or incorporating medical inpatient, outpatient and day-patient facilities.

◆ We might re-name the Society "Ageing and Health UK". This rather modernising radical departure asserts the Society's remit to embody expertise in health and ageing and opens its profile to wider public, multi-professional, political and media support. We already have open membership (for example in SIG's). It does, however, lose in the name much of the focus on medical specialisation. It is also rather like "Diabetes UK" which originates from patient rather than medical representation. The "British Society of Medical Gerontology" is longer, rather stuffy, more inward directed, but more accurate and possibly more geared to professional expertise and training. It could be incorporated within "Ageing & Health UK" as the repository of voting rights.

I could probably live with at least some of the above. Others will doubtless have better ideas.

Or not? Do we really need or want to change?

National Service Framework

- Update

Audit Tool for Developing Services for Minority Ethnic Older People

This recently published DoH audit tool provides practice guidance for all councils with social services responsibilities, and other local stakeholders (including the housing and voluntary sector) aiming to improve services for minority ethnic older people.

www.doh.gov.uk/scg/race/audittool.htm

Stroke Service

What makes a good stroke service and how do we get there? This paper summarises a recent review identifying key factors in developing high quality stroke services. It is designed to help deliver the requirements of the NSF stroke standard.

www.doh.gov.uk/nsf/olderpeople.htm

Age Discrimination Benchmarking

This is the first version of a tool designed to help those responsible for commissioning or delivering services at a local level to compare patterns of treatment at different ages with those in other areas. It initially focuses on a number of acute hospital procedures and proposed further development includes the provision of an expanded tool to investigate potential age discrimination in primary care and social care. An explanation of how to use the tool and how you might interpret results is given in the user guide. This includes some worked-through examples to illustrate the kinds of information and questions that can be raised by an analysis of the data. The DoH is seeking comments on the new tool by 31 January 2003. The BGS Policy Committee is preparing a response to this.

www.doh.gov.uk/nsf/agediscrim.htm

Reimbursement arrangements for delayed discharge

During the second reading of the bill on 28th

November, Alan Milburn announced a transfer of an extra £100 million over the next three years to social services for each full year of operation of the new scheme to tackle delayed discharges. The bill now moves to the committee stage. The BGS response to these proposals was published on pages 14 and 15 of the November 2002 Newsletter.

Discharge from Hospital – good practice checklist

The Department will be publishing a revised and updated version of the ‘hospital discharge workbook’ which will contain detailed and definitive guidance and examples of good practice (Dr Finbarr Martin is representing the BGS on this group). In the meantime, the Change Agents Team are preparing a brief checklist as a practical tool to help councils and their NHS partners assess their current arrangements and identify what changes may be needed to make easier the introduction of the new system. This should be available early this year.

Champions Toolkit

The resource is in 2 parts; an information section containing base line information on the levels of health and social care provided to older people and an explanation of the current structures, with contact names at the various levels and secondly a ‘Developing Understanding’ section - designed to help Champions understand their overall role and to look at the development of implementation of each NSF Standard.

www.doh.gov.uk/nsf/olderpeople.htm

Forthcoming dates

24th - 28th March National Older People’s NSF Engagement Week

27th March National Older People’s Champions Conference, London

Dr Finbarr Martin (BGS NSF Focus Group)
Louise Wykes (BGS Office)

..*the friends that greet you

- Aberdeen welcomes you

Hear the pipes are calling loudly and proudly calling down thro' the glen*

A warm welcome awaits one and all this coming April, with plans at an advanced stage for the forthcoming UK Scientific Meeting. The Conference offers a stimulating academic programme with outstanding keynote speakers. Many are covering specific areas identified within the BGS rolling programme of CME topics. A wide variety of accommodation is available, to suit all pockets, with the conference being located at the International Aberdeen Conference and Exhibition Centre. The Social programme includes a Civic Reception at the Art Gallery (but it is essential to book early), a Ceilidh with a top class band and a Gala Dinner on Deeside. Book soon for what will prove to be a superb meeting (details and an on-line registration facility at: www.bgs.org.uk/meetings/meetdate.htm). For those interested in exploring the region an informative website provides some of the exciting opportunities in the region: www.castlesandwhisky.com

50 years of geriatric medicine A profile of the department

For the origins of the Department of Care of the Elderly in Aberdeen we have to go back to 1953 (by coincidence 2003 is the Golden Jubilee of the department, but no expensive gifts will be expected from those attending the conference!) - when two retired general physicians were appointed to look after the elderly in what was then called the Royal Aberdeen Hospital For Incurables. Two years later the first trained geriatrician was

appointed, the late Dr LA Wilson. Against public and professional opposition he transferred the focus of activity to the much less socially acceptable previous poorhouse, which was part of Woodend General Hospital, but where there was access to modern investigation and treatment facilities.

This hospital remains the base of the Department today and has approximately 460 beds of which around 360 serve older people. These mostly relate to acute assessment and rehabilitation - including specialist stroke services - as well as units caring for some longer-term patients; (the hospital is also the focus of the elective orthopaedic services for the region). The service is active in the nearby Aberdeen Royal Infirmary, supporting medical receiving arrangements with a step-down ward. Although Woodend Hospital is nearly 100 years old, there has been much modernisation and the new building and the present facilities are well regarded, serving a population of over 420,000. The department also contributes to community aspects of the service in the surrounding Aberdeenshire, with individual clinicians being linked to practices and supporting local community hospitals.

The recent photograph below illustrates how the complement of medical staff has expanded from the original one consultant and an SHO - it shows academic and NHS consultants and most of the specialist registrars only, not the nine SHOs and eleven pre-registration house officers! Although large, we remain a cohesive and friendly department.



We support a wide range of specialised clinical services and an ever-increasing teaching and research commitment. The present priority is to interface more effectively with community aspects of the service. Anyone who is interested in discussing some of our local initiatives is welcome to make contact.

Academia in Aberdeen

Although the University dates back to 1495, and had one of the earliest medical schools in Europe, our speciality is a relatively recent addition to the Faculty. The Chair in Medicine (Care of the Elderly) was set up in 1994 following a joint initiative between the NHS and the University of Aberdeen. It is supported by a lecturer and senior lecturer, and related research staff. Recent appointments are already opening up new research, teaching, and clinical areas with Aamir Qureshi taking a special

interest in falls and fractures and Martin Wilson becoming an expert on capacity and related ethical aspects. These new activities fit into the ongoing research themes in the department, which involve the elderly patient in hospital, relationships between primary and secondary care, and developments of techniques for assessing frailty and older people, particularly when they involve measuring quality of life.

Over the last two and a half years, the biggest single project has been the European-funded ACME^{plus} Project led by Research Fellow, Susan Campbell. The project is co-ordinated from Aberdeen and involves eight European centres with the overall aim of developing a standardised method of assessing case-mix and outcome in older people admitted to hospital for medical reasons. The project, which is due to report in May 2003, aims to provide the interested health worker with a tool that they can use to compare the performance of their own unit with others and any interested in this theme should make contact!

The Department's interest in measuring quality of life, alongside more traditional measures of function in older people with disabilities, began with an evaluation of the SF-36 in patients with rehabilitation needs. Newer studies have incorporated an individualised measure of quality of life, the SEIQoL, which has been developed by psychologists in Dublin and which allows the patient to identify and evaluate those areas of life that are most important to him or her. A pilot project, which will report in January 2003, is looking at the potential for applying the SEIQoL in routine hospital care. SEIQoL will also be an important measure in co-operative work between our department, the Department of Psychiatry in Aberdeen, and colleagues in Edinburgh, looking at a Fifth Wave Study of the Aberdeen 1921 Birth Cohort. This unique cohort study, set up by Professor Lawrence Whalley in Aberdeen and Professor Ian Deary and Dr John Starr in Edinburgh, took advantage of the fact that all Scottish school children born in 1921 underwent an "11-plus" examination in June 1932. By a variety of ingenious methods the three originators of the study have traced and examined survivors, now in their 80s, and we are looking forward to working closely with them in 2003 and 2004.

Willie Primrose
John Scott
Gwyn Seymour

**Scotland the Brave*

*Hear when the night is falling
Hear the pipes are calling
Loudly and proudly calling
Down thro' the glen
There where the hills are sleeping
Now feel the blood a-leaping
High as the spirits of the old highland men.*

*Towering in gallant frame
Scotland my mountain hame
High may your proud standards gloriously wave
Land of my high endeavour
Land of the shining river
Land of my heart forever
Scotland the brave.*

*High on the misty Highlands
Out by the purple islands
Brave are the hearts that beat
Beneath Scottish skies
Wild are the winds that meet you
Staunch are the friends that greet you
Kind as the love that shines from fair maidens eyes*

*Far off in sunlit places
Sad are the Scottish faces
Yearning to feel the kiss
Of sweet Scottish rain
Where tropic skies are beaming
Love sets the heart a-dreaming
Longing and dreaming for the homeland again.*

Emergency Care Reforms

- BGS response

Prof Sir George Alberti has been appointed as the Government's emergency care lead, with the task of leading development which could help deliver the reformed emergency care management so desperately needed in the NHS.



Professor Sir George Alberti

Of course these developments will apply to England and Wales primarily, but will have UK wide impact. The BGS believes that geriatricians could have an important role to play in the procedures for reforming emergency care, both by ensuring that older patients who need to be in hospital do get admitted, but also in helping to develop alternatives to acute hospital care for those older people who would be better off not being there at the time of their crisis. Furthermore, in line

with all our previously published policies, the BGS believes that geriatricians should be both gatekeepers to intermediate care and supervise the medical input to patients receiving it.

The Society's response can be summarised under three headings:

Managing crises (which cause hospital admission)

The quest of the geriatrician is to ensure that frail older people get access to specialist medical input as early in their pathway of care as possible. In some situations this could mean outside of hospital, possibly using Day Hospitals or their modern equivalent. This will ensure that:

- a) potentially reversible and often unrecognised illness can be actively dealt with from the beginning of the crisis.
- b) older people who would benefit from **not**

being in hospital (where they are exposed to a variety of **iatrogenic** and **nosocomial** illnesses) could have their crisis managed in an alternative way, such as intermediate care. Admissions to intermediate care could take place either immediately from the Accident and Emergency Unit or after 24 – 48 hours of acute hospital care, where this is what is needed to establish the diagnosis and address the medical problems. Our experience as geriatricians is that rapid transfer after a very short stay in hospital is likely to suit the clinical circumstances in a greater number of patients than immediate transfer to intermediate care from Accident and Emergency departments

c) other factors contributing to the crisis are recognised, i.e. factors besides the immediate medical problem, which resulted in admission. These can then be addressed early by a multi-professional team, resulting in shortened lengths of stay and reduced readmissions.

The Society sees potential to consider the value of streaming patients in the Accident and Emergency department, and Gill Turner will be meeting later this month with the BAEM to consider this further and in detail.

Whilst happy to embrace constructive change, the Society could not endorse any suggestion which denied ill older people admittance to appropriate acute hospital care. We believe that everybody irrespective of age, who suffers a breakdown in health, is entitled to a diagnosis and appropriate treatment. To implement this, sophisticated equipment and the skills of other specialists may be needed, and all patients must have timely access to such equipment and expertise, hence the need for access to an acute hospital.

As geriatricians we are keen to maximise the potential of intermediate care. At the moment this is limited by its lack of capacity and capability (due to a variety of factors). The BGS will shortly produce a paper summarising previous work it has done on intermediate care, looking at the further opportunities intermediate care could offer and outlining what is needed to exploit those opportunities.

Ongoing Care

Handling the immediate post acute phase of hospital care and the role that geriatricians should play:

The BGS recognises that over the last 10 years many models of geriatric service have evolved in response to local needs and opportunities. We would not want to be prescriptive about styles of service model, beyond defining the standards of care which are expected of specialist departments of medicine for older people (which we published last month and which can be accessed on our website – www.bgs.org.uk).

However, currently the BGS is examining the ways in which Standard 4 of the NSF is being implemented in order to see to what extent older people in hospital nationally, have access to a geriatrician and multi-professional team. This work is likely to be published within the first quarter of next year.

Working in the Community to prevent the crises which lead to requests for hospital admission

There is a much work to be done to examine the potential for preventative health care in reducing crises. Over the next two years this will become a major agenda for the BGS.

It is to be hoped that successful implementation of the Single Assessment Process will be of considerable benefit here.

The Society is very keen to ensure that older people get a fair deal. Developments along the lines discussed, whereby geriatricians act as gatekeepers to intermediate care, will be a major step forward in ensuring that only those older people who will benefit from **not** being in hospital, or those who will derive more benefit from the intermediate care itself, will receive such care. The introduction of a system of streaming should of course, mean that those older people who need to be in hospital under the care of a specialist (either a geriatrician, a stroke physician or any other specialist) get there more quickly; this we would therefore also commend.

The Society has drawn attention to the workload implications for this new, entirely appropriate role. Whilst the BGS recognises that specialist medical input into intermediate care could come from GPs with a special interest, there is limited scope for this. The developing roles of the geriatrician in the community in a preventative capacity will also increase the specialist workload. In the medium to long term this can be addressed through training numbers, but in the short term it is likely that there will have to be considerable role readjustment with the result that geriatricians will be less able to play a part in the ongoing care (in hospital or in out patients) for younger people admitted through the 'take'.

I will continue to monitor developments and keep members informed.

Gillian F Turner
Chair, Policy Committee

'Rising stars' recognised for innovative practice in thrombosis

Research fellow recognised for work on clot diagnosis

'Up and coming' health care professionals from across the UK were recently identified as the winners of the 2002 Thrombosis 'Leaders of the Future' Awards for their outstanding achievement or insight into the prevention, diagnosis and management of thrombosis.

The Awards, which have been established by the Thrombosis Quorum (TQ) and are supported by 13 Royal Colleges and learned societies, rewarded individuals from across the fields of medicine, pharmacy and nursing.

Dr James Kelly, Research Fellow in Haematology/Elderly Care at St Thomas' Hospital, was awarded first prize in the category of 'Management and Diagnosis of Venous Thromboembolism' with his entry entitled, **Magnetic resonance direct thrombus imaging: the future of diagnostic imaging for venous thromboembolism?** Dr Kelly receives a grant totalling £4,000, comprising £2,000 for individual professional development activities related to thrombosis, and £2,000 for his department to fund thrombosis-related education and equipment.

National Older People's Taskforce - Update

Many things are happening which should ensure that real change occurs in delivery of older people's care.

This was Prof Ian Philp's view at the quarterly meeting of the National Older People's Task Force - this despite the opinion expressed by the representative of Carers UK that carers were not yet seeing any change in older people's services.

Prof Philp said that one of the chief dangers was that of "superficial delivery" but he feels that the political commitment to change is becoming increasingly secure. Older people's services are fully embedded in the next three year plan from 2003-2006 and there appears to be a genuine engagement among politicians who realise that they can only change the NHS by full involvement in the problems of older people. Prof Philp sees an increasing role for users of the service and is trying to engage with them to encourage their involvement at local levels. Workforce development (not just of consultants) is still seen as being the key to long term sustainable change and that work is ongoing. Finally, Prof Philp is linking much of the work of the Modernisation Agency in all its guises.

Focus on Champions

There is a growing focus on Champions, who are seen as being "the grit" to ensure that local initiatives continue to reflect on the needs of older people. A Champion's resource pack has now been placed on the internet www.doh.gov.uk/nsf/olderpeopletoolkit.htm This is an excellent document not just for Champions but for any geriatrician and indeed, for any SpR. I do recommend that you look at this and you might even consider printing off the whole 100 pages. Surprisingly, the Department of Health has no database of Champions so they are trying to develop this. They will be appointing a national lead

for Champions who will keep them involved in the whole process of delivering the NSF, including NSF updates and an active web page.

Change Agents Team

A part of the Modernisation Agency is the "Change Agents Team" which has primarily worked with Trusts and Health Communities where there are perceived to be significant discharge problems. They are now working with 24 health economies across the UK. Their approach is to "do a lot of small things well" and "not come in with a single big new idea". Interestingly, they do have two questions which they now ask of organisations:

- do you know what services should be in place to prevent unnecessary admissions to hospital?
- are your services planned so that no older person who is admitted to hospital should be discharged directly to long-term care.

This second question is of course immensely powerful and gives a clear direction of travel that most geriatricians would sign up to. However, most places are still a long way from delivering.

We had an update on nursing and a presentation of a small Department of Health survey of Directors of Nursing about changes occurring as a result of both the NSF and the Essence of Care document. The key findings were that most Trusts had now appointed Modern Matrons, usually including a nurse lead for older people's services. Many Trusts are trying to implement essence of care and have undertaken skill mix reviews. A little surprisingly there is very little reported difficulty in nurse recruitment. Finally, 50% of Trusts feel that standards have improved and the rest believe that standards have been maintained. This survey was done in response to concern that, Standard 4: (General Hospital Care) was not improving at all as a result of the NSF, but was actually deteriorating. What is your view on this survey? Send me an e-mail: david.black@qms-tr.sthames.nhs.uk.

Dr David Black
Geriatrician Member
National Older Peoples Task Force

Call for Champions

- Ian Philp, National Director



We are entering a critical period for implementing the NSF for Older People in England.



Decisions about investment and reforms are being taken by Primary Care Trusts and Acute Trusts which will determine the future pattern of care for older people for many years to come. It is essential that geriatricians, old age psychiatrists and general practitioners with

special interests in the care of older people are well placed to influence these developments.

Recent organisational changes, which are still in a state of flux in many places, make it difficult to know where best to exert that influence but I hope that all members of the Society will be able to find out what the structures are locally and to find ways to make their views known, in PCTs, Strategic Health Authorities and in Trusts.

Another way of helping to shape the development of services is through the Local Implementation Teams for the NSF and the network of "Champions". In the next few months I will be setting up systems to help older

people champions to be effective in influencing changes in their local communities. I would urge those members of the Society who are not yet champions to offer their services as clinical champions within each local health and social care community. If you have strong interests in improving services for older people and think you could find the time and commitment to help make the difference, please email me at:

I will be appointing a national lead to support champions.

ian.philp@doh.gsi.gov.uk so that I can send you details of who to contact locally. **Those members who are already clinical champions and on the BGS register of champions** will be asked by the Society if it may pass their names to the Department of Health.

I will be setting up systems to help older people champions to be effective in influencing changes in their local communities.

Champions include practitioners from all staff groups, older people on patient advisory groups, non-executive NHS trust directors, local government champions and operational leads for older people's services.

We will be encouraging champions to network, to ask the awkward questions, to speak about the National Service Framework at local meetings and, if they wish, to the local media to celebrate good practice. I will be appointing a national lead to support champions and develop our database and communications with champions, and to provide champions with a toolkit which supports NSF implementation.

I look forward to hearing from you.

Ian Philp
National Director

Reform of the SHO grade

- Department of Health proposals

Summary of DoH proposals

The CMO's nineteen proposals to reform the SHO grade in line with the strategic intentions contained in the NHS Plan are based on five principles.

The principles state that **training should:**

- ◆ be programme-based (accountable, curriculum-based, formal entry, planned, assessed, time-limited)
- ◆ be broadly-based to begin with for all trainees
- ◆ provide individually-tailored programmes to meet specific needs
- ◆ be time-capped
- ◆ support movement of doctors into and out of training and between training programmes

Nineteen proposals to deliver the reform

- ◆ The 5 key principles should provide the basis for reform
- ◆ There should be sufficient opportunities for flexible (part-time) training
- ◆ There should be access to early and regular advice
- ◆ After graduating doctors enter a 2 year foundation programme of general training (the first year equating to the current PRHO, the second (post-reg) incorporating other generic training)
- ◆ After the foundation programme, doctors enter a Basic Specialist Training Programme (for 4 years) providing a breadth of education and training within certain broad clinical disciplines (probably 8 or so programme options)
- ◆ Limited number of placements on individual training programmes (remedial, re-entry, career change etc)

- ◆ After completion of the basic specialist programme, those unable to progress to higher (or GP) should be allowed a period of grace before leaving training
- ◆ Progress through programmes should be determined by assessment
- ◆ In the longer-term assessment should move toward a competence-based system
- ◆ The purpose of Royal College examinations should be reviewed, and externally accredited
- ◆ Programmes should be managed by programme directors appointed by, and accountable to, postgraduate medical deans
- ◆ Trainers should be supported and trained
- ◆ Key information on programmes must be available to all trainees
- ◆ Appointments to programmes should be the responsibility of deans, meeting nationally agreed standards and practice
- ◆ The SHO element of general practice training should follow a similar model
- ◆ The needs of non-UK doctors in training should be properly and fairly taken into account
- ◆ Urgent work to explore a seamless training grade, with appropriate progress checks, for the future
- ◆ The arrangements for awarding a CCST should be changed. New and shorter higher programmes should lead to an earlier CCST for the 'generalist' elements of a speciality, at which point a doctor could apply for a consultant post in 'general medicine' or 'general paediatrics' for example (or the doctor could choose to proceed to a CCST in the 'specialist' elements of the speciality)
- ◆ A review of the provision for non-consultant career grade doctors should begin soon

This article summarises the extensive consultation document which can be seen in full on the DoH website, www.doh.gov.uk/shoconsult

Dr Steve Allen
Chairman, BGS Training Committee



BGS Response to DoH proposals to reform SHO grade

There is broad support for the principles of improving the structure, content and delivery of postgraduate training for our senior house officers (SHOs) including the five underpinning key principles.

However, members of the Training Committee and other members of the Society have expressed a number of concerns.

1. The proposals contained no detailed analysis, or estimates, of the resources (financial, time and manpower) to execute these reforms properly. Various members suggest broad estimates of between 10 and 20% loss of service time for trainees and consultants to provide such structured training programmes.
2. The degrees of flexibility outlined in the document might not be sufficient to allow junior doctors to change their career path before or shortly after entering higher professional training. Loss of the experiential or apprenticeship aspects of SHO training could be eroded to such an extent that “fitness for purpose” might be undermined rather than enhanced. It will be essential to get the balance right on that aspect of training.
3. The time capping of basic specialist training programmes might not take sufficient account of the fact that some trainees learn and mature more

slowly than others, yet eventually reach an entirely satisfactory level of competence. The individual programmes and period of grace outlined in the document might not be sufficient to allow for this.

4. The BGS is very concerned about the concept of an earlier award of a general medical CCST with the option of early appointment to a general medical consultant post. This could lead to Acute Admissions Units being staffed by relatively inexperienced doctors without supervision from more senior or experienced colleagues. The BGS would be particularly concerned about acutely ill elderly people (in whom acute medical conditions are often very complex) possibly not receiving adequate acute care.

5. The BGS strongly recommends that experience in geriatric medicine should be included in the foundation programme for all medical graduates and in the basic specialist programme for trainee adult physicians, to take account of the fact that a very large proportion of inpatients across adult specialities are elderly. We are concerned about a lack of clarity of the status of consultants who might be appointed to general medical posts (holding only a general medical CCST). If they then choose, at a later stage, to proceed with higher specialist training, would they then be consultants or specialist registrars?

Dr Steve Allen

Chairman, BGS Training Committee

Pour le merit - double honour for Alan Sinclair

Professor Alan Sinclair was doubly honoured in Madrid recently when he became the first geriatrician to receive the distinguished status of



‘Miembro de Honor’ of both the Spanish Society of Geriatric Medicine (SEMEG) and the Spanish Society of Endocrinology and Nutrition (SEEN).

Professor Sinclair, who is Professor of Medicine at Warwick University and a consultant geriatrician/diabetologist, attended a special ceremony in Madrid, Spain, on 21 October 2002, where his scientific contributions to geriatric medicine and his inspiring work in, and dedication to the treatment of diabetes in the aged were recognised.



Community Care

- RCGP/BGS Special Interest Group

A report on the Royal College of General Practitioners/BGS Special Interest Group in Primary and Community Care joint seminar.

Arranged by Joe Neary, Chair of the Royal College of GPs Clinical Network, this training day for GPs and hospital geriatricians was both informative and interactive.

During the first part of the meeting, the participants worked in small groups, defining their priorities for delivery of care in the primary care sector. There was unanimous agreement that there was need for considerable improvement and development in this area. The most important issues were thought to be primary prevention, the implementation of medication review, the care of older people with multiple pathology and multiple disability, and the interface between old age psychiatry, geriatric medicine and primary care in the care of older people with dementia. It was agreed that partnerships between geriatricians and general practitioners need to be developed to promote independence in old age, to provide effective care to older people with chronic disease and/or frailty, and to older people in the care home sector.

The groups went on to discuss undergraduate and postgraduate training and the importance of training medical students, both GP registrars and registrars in geriatric medicine, as well as nurses, in the essential components of good care for older people. Geriatricians were surprised to hear that until now some GPs had had little involvement in the national debate on single assessment. All delegates agreed that the difficulties in its implementation were compounded by the complexity of process. There was agreement that assessment procedures

need to be coherent, should take account of all functional dimensions including special senses, and could be used as a preventive tool.

Standardise single assessment process

Prof Ian Philp, the Tsar, then provided a very eloquent response to the plenary session. He agreed with some of the participants that there was a need for standardisation of the single assessment process. Ideally, he said, older people with complex and multiple needs required medical care from partnerships between general practitioners and specialist teams in both older people's physical and mental health. For the care to be effective, all teams needed to have the appropriate skills and competencies. There is therefore a need for an expansion of hospital specialists and the development of general practitioners with a special interest (GPSIs) in medical and psychiatric care of older people.

Prof Philp said that he regarded the key programme for the next few years, as workforce development. Skills for health care will focus on vulnerable older people with complex needs and will be addressing the learning needs of medical and social care professionals.

Having agreed that the interface issues between Primary Care Trusts and acute trusts, and between general community services and long term care facilities needed addressing, Prof Philp proposed that the new GPSI would or could provide a resource to bridge the boundaries. He was of the opinion that there was a need to train existing GPs/GPSIs to develop a special interest in older people's care. In answer to the priorities outlined earlier by the participants, he was of the opinion that locality collaboratives involving interested GPs, pharmacists and community nurses should be set up. He emphasised the importance of user and carer involvement in any planning and prioritising of services for older people.

Training GPSIs - a priority

Prof Philp encourages the development of centres of excellence in order to train and rotate through staff from all disciplines. But in order to address this complex programme early priority will have to be the training and employment of 150 GP specialists in the care of older people. This will require joint work between the BGS, the Royal College of General Practitioners and specialist colleges. Prof Philp said that the profession must take the lead in this exercise.

In the afternoon there were a series of outstanding presentations from Clare Royston, an

old age psychiatrist from Cambridge, Clive Bowman, Medical Director of BUPA care homes, Professor Idris Williams, author of the recent Royal College of General Practitioners' occasional paper entitled, **An evidence based approach to assessing older people in primary care** and Professor Chris Drinkwater, Professor of General Practice from Newcastle. The participants then finished the workshop by setting out their priorities for education, training and development to support quality care of older people (see box).

The workshop provided a welcome forum for a constructive exchange of information between GPs and geriatricians, and served to provide a number of important leads towards enhancing joint working between hospital and the community care of older people. All that we have to do now is make it happen - we shall overcome!

Jackie Morris

Chair: BGS SIG in Primary and Community Care

Joe Neary

Chair: Royal College of General Practitioners Clinical Network

PRIORITIES FOR EDUCATION, TRAINING AND DEVELOPMENT

- ◆ Improve the undergraduate experience and training in health care of older people.
- ◆ Specialist training for GP registrars and newly qualified GPs.
- ◆ Shared training for specialist and generalist registrars (GPs).
- ◆ Four week orientation for GPs and consultants and possibly specialist registrars new to an area (a little wishful thinking!)
- ◆ General Practitioners as trainers for specialist registrars – exchange of training.
- ◆ Specialist qualification for nurses working in care homes.
- ◆ Training for carers in care homes (the poorest qualified and the most neglected on the carer spectrum).
- ◆ Distance learning packs for the full range of professional roles.
- ◆ Team training on a locality basis
- ◆ Provision of more community geriatricians to involve all GPs at training level.
- ◆ Coordination of services for individuals with complex needs and information on services that are currently available.
- ◆ A twenty four hour single point of axis.



BUPA recognises excellence in the North West

The BUPA Foundation's annual awards are made in recognition of excellence in medical research and healthcare

in six categories including care of the elderly.

In 2002, the BUPA Foundation Care Award has been awarded to **Dr Jim George**, the nursing and therapy staff from the specialist medical ward Elm-B in the **Cumberland Infirmary** within the North Cumbria Acute NHS Trust, for the development of a specialist assessment unit set up to ensure effective diagnosis, treatment and support for elderly confused patients.

Since June 2000, confused elderly patients who are

admitted to the Cumberland Infirmary in Carlisle have been treated in Elm-B ward where they are assessed by a multi-disciplinary team of 20 specialists in the fields of acute care, mental health, occupational therapy, and psychiatry. Once they are well enough to leave hospital, patients' discharge is co-ordinated with therapists and community staff in order to ensure they receive the necessary support. Over 75 percent of patients are successfully treated and return home.

The principles of working with confused elderly patients developed on Elm-B ward have been shared with other professionals and Elm-B provides an advisory service to other hospitals setting up similar units. Guidelines on Elm-B ward for the management of confusion are now used widely in the UK and abroad.

Intermediate Care

- Royal Colleges of Physicians' recommendations

Intermediate care has been widely welcomed as an opportunity to reinvest in assessment and rehabilitation services particularly targeted at older people.



David Black

So begins the foreword of the recently published report, **Medical Aspects of Intermediate Care**¹.

Commissioned by the Federation of Royal Colleges of Physicians of the United Kingdom to report on intermediate care and its consequences for medicine and physicians, the Working Party, chaired by David Black and including several prominent names from the British Geriatrics Society, were given a remit to review the current progress in delivering the new intermediate care services envisaged in both the NHS Plan and the National Service Framework for Older People (NSF); and to make recommendations from a medical perspective to ensure future progress in delivering effective national intermediate care type services.

Endorsed by the Edinburgh, Glasgow and London Royal Colleges of Physicians, the Working Party's report:

- ◆ advises on the knowledge and skills required of doctors, whether in primary or secondary care, who work in intermediate care type services;
- ◆ suggests how this knowledge base can be achieved, including offering opportunities for career diversification and progression
- ◆ argues for a much greater emphasis on clinical governance in intermediate care type services and makes recommendations both at local and national level for those setting up such services.

Recommendations

The Working Party recognised that there had been a national proliferation of intermediate care type schemes and argues that these need to be formalised and organised, to ensure the future success and clinical safety of intermediate care and to meet targets set by the NHS Plan and NSF.

It **recommends** state that:

◆ Intermediate care needs to be part of a defined whole-system service within any local health and care community. Appropriate, coordinated, collaborative medical input from both primary and secondary care physicians from the inception of any service is needed to achieve the medical goals of intermediate care.

◆ Medical input from both primary and secondary care needs to be appropriate to intermediate care. Participating doctors need accreditable training in:

- clinical skills in the diagnosis and management of older people with complex needs
- team-building skills and leadership skills
- communication skills
- strategic understanding and judgement, particularly in the respective contributions to care in high- and low-dependency environments
- training and expertise in rehabilitation.

◆ Intermediate care may offer career opportunities for both general practitioners and consultants with appropriate skills, and may provide opportunities for career evolution for senior clinicians who have the necessary skills. Professional development required to support intermediate care services by existing doctors may require 'backfill', which requires serious consideration by the Workforce Confederations.

◆ All primary care organisations and commissioners of care will wish to ensure that a quality service is provided with appropriate medical input - a patient-centred service founded on the relevant evidence base*.

*Primary care organisations do not exist in Northern Ireland or Scotland; there is no commissioning role for primary care in Scotland.

◆ To provide clear clinical governance, intermediate care services need to be integrated with existing services to ensure a comprehensive system of care, usually with a single defined point of entry.

◆ The operation and management of intermediate care requires routine multidisciplinary groups with input from primary and secondary care as appropriate.

◆ In order to ensure clinical governance, improve the knowledge base, and to share experience,

intermediate care schemes should provide for the routine collation of local data. Governance should include a variety of quality indicators to reflect structures, process and outcome.

◆ The Department of Health should, through the development of appropriate information systems, provide the opportunity for audit and research on a local and national level in order to evaluate the impact of these developments in terms of process, clinical and non-clinical outcomes.

◆ All schemes must have in place clinical governance arrangements involving the use of national standards, programmes of audit and systems for recording clinical incidents. Pathways of care, integrated through primary and secondary care, may

facilitate the provision of care and the analysis of data.

The report goes on to set out a minimum set of standards on the medical aspects of intermediate care (see box.)

The full report, priced at £7.00 is available from:

The Publications Department,
Royal College of Physicians,
11 St Andrews Place,
London NW1 4LE

e-mail: publications@rcplondon.ac.uk

Minimum standards on the medical aspects of intermediate care

1. All patients within an intermediate care service should have contemporaneous medical records.

Conformance test: When audited, all patients in the intermediate care service should have a record which begins on their entry into the service.

2. The contemporaneous medical record should be available to any doctor visiting the patient for the purpose of care when the patient is an inpatient in an intermediate care service.

Conformance test: When audited, all inpatients in the intermediate care service should have a record which begins on their entry into the service.

3. The intermediate care service should have a clear statement of purpose, which as a minimum includes whom the service is for and what it intends to do.

Conformance test: When audited, the purpose of the service, as detailed by the doctor in medical charge, should be the same as on the supporting documentation of the service.

4. Any intermediate care service should be able to describe the components of the service.

5. The components of the intermediate care service should be defensible by evidence from research or from the standpoint of a reasonable body of medical opinion.

Conformance test: When audited and questioned, the doctor(s) involved in

the service should be able to defend the existing components of the service, or demonstrate that they have suggested better ways of providing the service.

6. The doctor who is medically accountable for the care in the service should be known to all the patients and staff.

Conformance test: When audited, any mentally competent patient or member of staff should be able to name the doctor medically accountable for the service.

7. The designated clinician who leads and is accountable for the intermediate care service should be known to all patients and staff.

Conformance test: When audited, any mentally competent patient or member of staff should be able to name the person who leads the intermediate care service.

8. The responsibilities for routine medical care of the patients in an intermediate care service should be made explicit and incorporated into a job plan if it involves a consultant physician.

Conformance test: When audited, any doctor who is involved in the intermediate care service should be able to produce a job description of their role, and if the doctor is a consultant physician a supporting job plan should be available.

9. The responsibilities for out-of-hours medical care of the patients in an intermediate care service should be made explicit,

and incorporated into a job plan if it involves a consultant physician.

Conformance test: When audited, the out-of-hours medical care should be set out clearly in the operational plan of the unit, and the unit should be able to demonstrate that it works well in practice.

10. Complaints about medical care should be investigated appropriately and remedial action taken. The doctor should play a full and active role.

Conformance test: When audited, all complaints about medical care should be available, and management should be able to show a thorough investigation, medical participation and responsive changes to the service and/or individuals within it.

11. The intermediate care service should be able to demonstrate that its outcomes are at least as good as the service it replaces.

Conformance test: When audited, the deaths, transfers and institutional care rates from the intermediate care facility should be better than the service it replaces, or existing comparative services.

12. Inpatient services should have an explicit policy with evidence of implementation on cardiopulmonary resuscitation (CPR).

Conformance test: When audited, case notes for inpatients should clearly demonstrate the decisions taken with patients with regard to CPR.

AN INNOVATIVE CONSULTANT POST IN NORTH BRISTOL

North Bristol Trust (NBT) are leading the way in addressing the need to reduce acute hospital admissions and make effective use of intermediate care.

Historically there has been a strong culture of community based rehabilitation in Bristol, with Hospital at Home and Social Services run residential rehabilitation units and community rehabilitation teams. With the drive to capacity expansion in intermediate care, the local PCT's (Bristol North and South Gloucestershire) and statutory authorities (Bristol and South Gloucestershire) wish to ensure that patients in intermediate care still have access to specialist geriatric assessment and management.



The new post will be based in the **Medical Assessment Unit and the Geriatric Day Hospital at Southmead Hospital**. It is planned that the post holder will work closely with GPs referring patients into the medical take, to plan alternatives to hospital admission and to work closely with hospital at home to provide medical care in nursing homes.

The post will be advertised in the BMJ in January 2003 but in the meantime further information can be obtained by contacting **Dr Theresa Allain, Consultant Geriatrician**, Southmead Hospital, Bristol BS10 5NB; phone 0117 9595374; email theresa.allain@blueyonder.co.uk

CARDIOVASCULAR DISEASE

Cardiovascular Disease Prevention VI

12-14 March 2003

Kensington Town Hall, London

Topics include: the size of the problem; Lipids and lipid lowering; stroke and its prevention; heart failure; multiple risk factor intervention.

CME and PGEA applied for.

Contact Details:

Email: [cvdp@hamptonmedical.com](mailto:cvd@hamptonmedical.com)
Website: www.hamptonmedical.com
Tel: 020 8977 0011

RESEARCH

Delivering research for better health services

19 March 2003

Church House, Westminster

Contact: Healthcare Events, 2 Acre Road, Kingston, Surrey KT2 6EF Tel: 020 8547 2300 Email: info@healthcare-events.co.uk

RESEARCH SKILLS

Research Skills Workshop

29 January 2003

a full introduction to the field of research

24 February 2003

a comprehensive guide to working as part of a research team, getting the help you need, planning ahead, handling results and career options

RCP (London)

Contact: Peter Taylor, Education Department, Royal College of Physicians, 11 St Andrew's Place, Regent's Park, London NW1 4LE Tel: 020 7935 1174 ext 308 Email: education@rcplondon.ac.uk

GERIATRICS IN AFRICA

Geriatric Care in Africa International Conference

29 January 2003

Call for papers:
www.uct.ac.za/depts/pgs-geriatrxafrica.html

6-8 March 2003

Cape Town, South Africa

Contact: Janet Sirmongpong, Conference Management Centre, University of Cape Town, Faculty of Health Sciences, Observatory 7925, South Africa. Tel: +27 21 406 6330 Fax: +27 21 448 6263 Email: jsirmong@curie.uct.ac.za

VIENNA CONGRESS

6th Vienna International Congress in Geriatrics

22-24 May 2003

Deadline for abstracts: 15 January 2003

Vienna, Austria

Contact: Ilse Howanietz, Ludwig Boltzmann Institute for Interdisciplinary Rehabilitation in Geriatrics, Apolllogasse 19, A-1070 Vienna, Austria. Tel: 00 41 1 52 103 5770. Email: ilse.howanietz@sop.magwien.gt.at

NORTH QUEENSLAND - AUSTRALIA
VACANCY - REGISTRAR IN GERIATRIC MEDICINE

The Townsville Hospital is seeking a Registrar interested in geriatric medicine. The Townsville Hospital has recently completed a major redevelopment phase with new facilities opened in Douglas. This institution is the largest in provincial Queensland.

The position assists in the provision of services to older people with acute and rehabilitative needs throughout the Townsville Health Service District in conjunction with the Aged Care Assessment Team, Department of Rehabilitation and Gerontology, The Townsville Hospital, Townsville Nursing Home, as well as various private institutions and general practitioners.

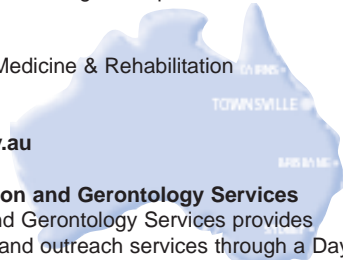
Enquiries can be addressed to:

Dr Paul Goldstraw, Director of Geriatric Medicine & Rehabilitation

Phone: +61 7 4796 2636

Fax: +61 7 47962621

Email: paul_goldstraw@health.qld.gov.au



About Townsville Hospital Rehabilitation and Gerontology Services

The Townsville Hospital Rehabilitation and Gerontology Services provides inpatient, in a ward setting, plus inreach and outreach services through a Day Rehabilitation Service. Its service is designed to meet the needs of particular patient groups through a strategy of Focused Intensive Rehabilitation Service Teams (FIRST).

Rehabilitation and treatment is provided by a multi-disciplinary team in a rehabilitation environment. The ward accommodates 14 inpatients with space to increase to 20. This includes an Independent Living Unit, which will provide an opportunity for the patient and their carer to simulate their home environment and routine prior to being discharged from hospital.

Opportunities for research by all the multi-disciplinary team, singly or together are supported as practical links to James Cook University (JCU) are developing.

For further information regarding the rehabilitation unit and Townsville itself, a .pdf brochure may be downloaded from the BGS on-line newsletter site: www.bgsnet.org.uk

CLINICAL PHARMACOLOGY

8th World Congress on Clinical Pharmacology and Therapeutics

1-6 August 2003

Brisbane, Australia

Contact: CPT Secretariat, Attn. Prof R Day, Dept of Clinical Pharmacology, Vincents Hospital, Darlinghurst, Sydney NSW 2010, Australia. Email: R.Day@unsw.edu.au. Website: www.cpt2004.com

BGS DISPLAY STANDS

The Society has a display stand (impressive by most standards) for medical careers fairs held at universities or hospitals.

The stand outlines the steps to a successful and rewarding career in geriatric medicine be it as a consultant physician or academic lecturer. The stand can also be adapted with a more general display highlighting key aspects of the work of the Society.

The stands are available free of charge on request. The BGS office arranges courier'd delivery and collection of the stand. It can also arrange for someone to assemble and dismantle the stand if required. For example, last year the careers stand was used for careers fairs at the University of London and the University of Edinburgh. The general stand was used at the BGS Autumn meeting, the Modernising Older People's Services conference in Brighton and a conference on stroke in Cwmbran.

To book a display stand, please send an e-mail to: annette-guerda-fischer@bgs.org.uk with the following information:

Careers stand or general stand (please specify); date and location of meeting; and contact and delivery details.

PSYCHOGERIATRICS

Affective, Behaviour and Cognitive Disorders in the Elderly

3rd Bologna International Meeting

10-21 June 2003

Bologna, Italy

Contact: G&G International Congress Sri, Via G, Squarcina, 300143 Rome, Italy. Tel: + 39 06 5043441. Email: cngressi@gegcongressi.com/abcde

GERONTOLOGY

European Congress of Gerontology

Abstracts deadline: 31 January 2003

2-5 July 2003

Barcelona, Spain

Contact: Congress Secretariate, Eriag Barcelona 2003, C/Aguirre, 1-1º izqda, 28009 Madrid, Spain. Tel: + 34 91 781 20 74 / 8790 Email: barcelona2003@biotour.es

PARKINSON'S DISEASE

Conference

15 July 2003

RCP (London)

Contact: Sally Bradley, Medical Education Partnership Ltd., 53 Hargrave Road, London N19 5SH
Tel: 020 7561 5400 Email: sbradley@mepltd.co.uk

EUROPE

European Geriatric Medicine

27-30 August 2003

Florence, Italy

Abstracts deadline: 1 May 2005

Contact: MF Congres, 8 rue Tronchet, 75008 Paris, France
Tel: + 33 (0)1 40 071 121
Online registration at: www.eugms.org

ELDER ABUSE

Action on Elder Abuse has updated its website

www.elderabuse.org.uk

including:

- ◆ a downloadable Powerpoint presentation on the 'Partners in Protection Conference' held in November 2002
- ◆ Elder abuse is daily and horrendous (highlighting issues that appear in the press)
- ◆ Responding to abuse in residential and day care settings. AEA have produced a new guidance booklet for workers in these settings.
- ◆ Action on Elder Abuse Conference 2003

Contact Details:

Tel: 020 8765 7000
Fax: 020 8679 4074
Helpline: 080 8808 8141

SOUTH AMERICA

Latinamerican Geriatric Congress

3-6 September 2003

Santiago, Chile

Registration fee: US \$100

Contact:
Email: lmartinez@tajamar.cl
Website: www.socgeriatria.cl

CHINA

4th International Symposium on Chinese Elderly

Responding to the changing needs of the elderly

13-15 October 2003

Beijing, PRC

Contact:
Fax: +86 10 62515213
Email: ageing@mail.ruc.edu.cn

A doctor's visits

- by Dr Ian Brown



"Undoubtedly in the fifties, Britain had the best health service in the world and I was proud to be labelled 'UK' when I travelled abroad... Nowhere else in the world had such a high standard of medical care available except in centres of excellence where costs were high." - Ian Brown

You have heard Dr Ian Brown speak at the 2002

Autumn meeting dinner. Now read his autobiography to be published at the end of January 2003.

It provides a valuable insight into the "behind the scenes workings of the NHS.

Title: A Doctor's Visits
Class: Autobiography
Pubn: 30th January 2003
Price: £16.95
Author: Sharon J. Kirk
ISBN: 1 85776 693 8
Pages: 256
Distributed through:
Vine House Distribution Ltd, Waldenbury, North Common, Chailey, East Sussex BN8 4DR
Email: sales@vinehouseuk.co.uk

Marjory Warren House

- at your service



Meeting Rooms at Marjory Warren House

The Society has three meeting rooms at **Marjory Warren House**, available for hire.

The Lord Amulree room

Located on the ground floor, the Lord Amulree room accommodates 20 people in boardroom style format and 30 people in theatre style format. The room is fully equipped with air



The Lord Amulree Room

conditioning, laptop, presentation and overhead projectors, flipchart, conference phone, and pointer for Powerpoint presentations. Meetings can also be recorded to facilitate the taking of minutes. A research consortium, the Parkinson's Disease Section, the Royal College of Physicians Incontinence Working Party and Occupational Therapists all held their meetings in this room in 2002.

The Trevor Howell room

Located on the third floor, this room can accommodate 12 people in boardroom style format. This room is equipped with a flipchart and a conference phone. The room has mainly been used for Committee meetings in 2002.

The George Adams room

The George Adams room (second floor) can accommodate 8 people in boardroom style

format. This room has recently been refurbished and can be equipped with a flipchart and laptop. The Department of Health (England) Liaison Group and BGS/Novartis meetings were held here in 2002.

All proceeds raised go towards the income of the Society. Members may care to note that we raised £1,600 in 2002.

Costs of Room Hire at Marjory Warren House:

(all prices include VAT and are per meeting)

The Lord Amulree room:

Commercial (sponsored by pharmaceutical companies or funded research) meetings: £200

Not for profit companies (charities, medical societies and other professional bodies): £58.75

The Trevor Howell room:

Not for profit bodies: £47.00

Not available for commercial meetings.

The George Adams room:

Commercial meetings: £75.00

Not for profit bodies: £30.00

For members of the Society, SIGS and Sections, use of the facilities is free.

Tea and coffee is provided free of charge for all meetings. A buffet lunch can be arranged at a reasonable cost.

Anyone wishing to book any of the rooms, please contact either **Louise Wykes:** louise-wykes@bgs.org.uk or **Annette Guerda-Fischer:** annette-guerda-fischer@bgs.org.uk

Trainees' Column

Update from the Scientific Committee

During 2002, the BGS Scientific Committee's activities included circulating new guidelines for research training for SpRs, and to developing a database of research active geriatricians.



It is hoped that the database will encourage research collaboration and provide budding researchers with contacts appropriate to their area of interest. Suzanne Sorensen from Research Into Ageing addressed trainees at the Autumn Meeting in October, about the two-year fellowship which is being funded jointly by the BGS and RIA. There have been few applications for this generous grant, which is available for any area of research in ageing and

would be ideal for a SpR project leading to an MD or PhD. As always, BGS start up grants are also available for smaller projects, and the amount has been increased to £2500.

The Eli Lilly award, previously granted to assist with expenses in attending a meeting outside the UK to present either a paper or poster, is no longer available owing to a lack of sponsorship.

The Autumn Meeting also hosted a Research Surgery, chaired by Dr Richard Lindley, with Dr Steve Parry, Dr Rajkumar and myself on the "panel". It was gratifying to see an increased number of attendees compared to previous meetings. On this occasion 26 SpRs attended and we had an international flavour with three Dutch SpRs attending (I was quick off the mark in attempting to set up exchange schemes with them)! Following an introduction by Dr Lindley, an informal discussion took place between the audience and the panel. SpRs asked about specific issues such as identifying appropriate supervisors, determining project areas most likely to lead to publication and higher degrees, and the differences between PhDs and MDs. We also covered issues such as applying for grants, the most appropriate time to go out of programme, and how much notice the regional training committee

requires.

In forming the Research Surgery Panel, we sought to have it comprised of a diverse group - doctors with differing backgrounds (teaching hospital and district general), at different stages in their career (SpR, recently appointed NHS consultant, established NHS consultant and Senior Lecturer) and with different research interests (stroke, falls, cardiovascular). We hoped to provide a balanced range of opinions. We certainly felt the meeting was a success and hope that the attendees thought so too. We would be grateful for feedback and ways in which you feel the meeting could be improved. We had a number of personal queries at the meeting and will be answering these as soon as possible. If anyone else has a question with regard to research please do not hesitate to contact me.

Jugdeep Dhesei

On behalf on the Trainees' committee

PUBLICATIONS INFORMATION

The BGS Newsletter is published every second month by:

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London EC1M 4DN

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editor@bgsnet.org.uk

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