July 2003

Editor: Kevin Kelleher

BGS newsletter

Four-Nations Council

2003 Study Day - Cardiff

The first ever combined Council Study Day of the four devolved nations of the BGS was held on a splendid summer's day, and hosted by our colleagues in Wales in Cardiff.

Coming from London it's a well versed ruse in a social setting, as an ice-breaker, to mention one's engagement with public transport.

I got ready to travel to Cardiff by getting up at 5.30 a.m. and then spent the journey into London Paddington reading the Independent. It was reporting on the latest information concerning the travails of the railway industry, as it tries to deliver on its promised targets. The front page was splendid, surely an award winner. I absorbed the account and arrived in London Paddington at 6.45 to catch the 7 a.m. train.

As I purchased my ticket, the official informed me that no trains were leaving Paddington that morning as there had been a points failure, and there was going to be a possible delay of between ½ and one hour.

Like many a commuter before me, I ran a quick appraisal/assessment in my head of other methods that would serve me to get to Cardiff by 10 a.m. and came up with very few.

However the information available suggested that potential passengers should wait for further announcements, which I decided to do, crossing my fingers and saying a few prayers. I noticed after 5-10 minutes that someone, whom I knew was going to Cardiff, was boarding a train on Platform 3 and I immediately jumped aboard, whereupon the train departed at 7.20 with an announcement that this was the delayed 7 a.m. to Cardiff. I breathed a sigh of relief.

However, the spectacular surroundings that our hosts in Wales had picked for us, Victorian Government buildings in the middle of Cardiff, soon cleared any lingering travelling concerns.

We began our meeting a little later than advertised, as a previously circulated draft of the programme of the day, 4 months old, had somehow escaped from the electronic ether and led some people to think that the meeting was due to begin at 11 a.m. and finish at 3 p.m. The perils of email!

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President: Prof Robert Stout **President Elect**: Dr Jeremy Playfer
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Honorary Treasurers: Dr Ian Sturgess and Prof Margot Gosney **Administrative Director**: Richard Lynham **Sub Editor**: Recia Atkins

Education and Training

The topic for our Study Day this year was the education and training of the specialist in geriatric medicine. The day was introduced by our President, Prof Bob Stout.

The morning session was begun by Dr Kit Byatt, Consultant in Age Care in Herefordshire, previously of Kings Lynn. He covered the issues of appraisal and mentorship. He proved yet again that it is always worthwhile, with an audience interested in education, to tease out the meanings that we may have around distinguishing differences between assessment and appraisal. These issues are often muddled in the medical arena.

Kit then went on to discuss the value of mentorship, which again has long been used in the business area, and is now getting a lease in the medical world.

It appears to be of value to senior SpRs and new consultants and indeed, the NHS is running a pilot scheme for mentorship for newly qualified GP's and consultants as we speak.

Following Kit, was Dr James Wilkinson, attending on behalf of the Royal College of Physicians. James is a Cardiology SpR in North East Thames and currently is on a sabbatical, working as an Educational Research Fellow at the RCP in London. His topic was on assessment and gave us a very up to the minute review of the College's pilot study into new assessment methods for SpRs. This pilot is currently running and due to end in September 2003, and has basically three arms, namely that of the Mini-Cex, DOPS - Direct Observation of Procedure, and 360° Appraisal (we see the assessment and appraisal boundaries blurring). This is a very important piece of work and will clearly influence the thoughts of the PMETB as it begins to operate later in the year.

Intra-professional teaching

Before lunch Ms Liz Stubbings, Educationalist at the University of Greenwich and Queen Mary's Hospital Sidcup, gave us an authoritative talk on the principles, philosophy and successes of intra-professional education, which is currently reaching prominence in both the health and social care field in the UK. This was an up-to-date review of a fascinating topic and we eagerly await the evidence base and research which will support its success or otherwise.

First after lunch was Dr Steve Allen, Consultant in Geriatric and General Medicine in Bournemouth since 1986. Steve, of course, is the Chair of the BGS Training Committee. His brief was to cover the agencies and personnel who deliver and oversee medical specialist education. Without blinking or pausing for breath, Steve was able to give an erudite run through all the various bodies who oversee the training and education of the modern specialist. This is an ever evolving field and extremely difficult to keep up with, even in terms of the acronyms alone. However Steve had no trouble explaining the issues to the audience and indeed, overlaid his presentation with some personal views based on his experiences. He spoke of the potential change that PMETB may bring, which may almost go un-noticed initially, at grass roots level.

Following Dr Allen, Dr Zoe-Jane Playdon, who is Head of the Education Department at the Kent Surrey and Sussex Department of Post-graduate Medical and Dental Education, spoke on the philosophies and practicalities which underpin the education of the modern specialist.

"If you don't evaluate, you stagnate"

Zoe-Jane has a background in both pure education as well as in industry, commerce and human resource issues.

She outlined some of the philosophies underpinning the current systems that play in medical education in the UK, and particularly outlined her talk with the Kent, Surrey and Sussex Deaneries Consultant Development Programme based on certification, diploma achievement or indeed, Masters achievement.

Zoe-Jane based her presentation on evaluation of 1000 Consultants now put through this programme in South East England.

She delivered a particularly interesting view on the notion of competency based assessment and

emphasised throughout the very special difference between a training and educational process.

Her talk particularly illustrated the many differing approaches that Deaneries in particular are taking in the UK in terms of "training the trainers".

IT changes everything

Our afternoon finished then with a splendid presentation by Dr Jeanette Murphy from CHIME, Senior Lecturer in Health Informatics at the Royal Free University College Medical School London.

Jeanette gave a splendidly spirited presentation with the use of over 70 slides, breaking all the rules, but getting through them all at a rapid but informative pace. She indicated how the rapid and ever changing field of IT would radically alter both the delivery of clinical care and the education of the future specialists, and she illustrated her talk liberally with the vast resources now available on the Internet to support self-directed learning for the emerging Specialist, much of it now highly peer reviewed and authoritative.

Jeanette performed the remarkable feat of finishing at exactly 3.30 p.m., as requested by the Chairman, to allow the new English Council to meet for the second time, chaired by Dr David Black which commenced only 45 seconds after the adjudged Agenda starting time - a remarkable testament to the discipline of all our speakers and the tenacity of the Chairman.

The British Geriatrics Society will publish the presentations on its website, and we hope to work up the Study Day to a publication over the next few months.

Dr Kevin Kelleher

Editorial page

Coming into the summer, one is always looking for a little inactivity, but of course, in the world of geriatric medicine this is never the case.

We have a report on the first combined Council Study Day held recently, hosted by our splendid hosts in Cardiff, Wales. The subject was a pertinent one concerning the development of specialists in elderly care in the future.

We carry an update on survey results on the "Community Geriatrician", and are privileged to view the sticky business of the Single Assessment Process from the perspective of three of our consultant members, in different parts of the country.

As a Newsletter, we try to be informative and stimulating about all the current issues in the care of older people. There is, of course, a huge range of policy issues and organisations, committees and individuals, who spend a great deal of energy in their development. However, what we do lack is a 'letters page', and as an Editor I am very keen to develop a **"Letters Page"** in this Newsletter. When one meet colleagues at meetings all over the country, they express many pertinent and interesting views – much of it based on their own local experience and not necessarily the bigger picture. May I urge the readers of the Newsletter to start writing to us with their polemic on issues that get under their skin, and their matters of the moment.

Richard Lynham's article on the **EverCare Project**, for instance, is surely an issue on which those involved in the care of older people should want to put pen to paper.

We also have an update on the Clinical Effectiveness Forum and the Chairman of the new English Council reports on the first two meetings.

There is much more besides, and I would encourage readers to reply by letter or electronic form, so that we can get a healthy correspondence page going.

May I wish all members a happy summer break.

Dr Kevin Kelleher
Editor

President's column

2003 will be a significant year in the history of the Society as Richard Lynham, our Administrative Director will be retiring in the Autumn.

Richard has been the Administrative Director for over 13 years, and during this time has guided the Society through many important changes, as well as the equally important, but less dramatic work of keeping the Society's affairs in order on a day to day basis. He is dedicated to the Society and will be very difficult to replace. We will be paying tribute to him at the Autumn Meeting in London. In the mean time, procedures are in place for seeking his successor, and a small team, led by the President Elect Jeremy Playfer, is handling this.

Four Nation Council Study Day

For many years the Society has held a Council Study Day in May or June of each year. With the adoption of the new constitution in April this year, there is no longer a BGS Council for the United Kingdom as a whole. It is, however, important that the representatives from throughout the Kingdom should continue to meet and a **Four Nation Council Study Day** has been initiated. It is intended that the site of the meeting rotate around the four countries of the United Kingdom, with each country's BGS Council hosting the event. The first Four Nation Council Study Day was held on Tuesday, 17th June in Cardiff City Hall. An excellent programme on the topic of education and training had been devised by **Kevin Kelleher**, the Honorary Deputy Secretary, who also chaired the meeting, and the arrangements were made by the Welsh (Cymru) BGS Council under the leadership of **Ed Wilkins**. The setting was magnificent, the weather was beautiful, and the meeting was highly successful. Education and training are core interests of the Society as they are the means by which we maintain standards and bring along new members to our specialty. The speakers included members of the Society and guests. The speakers covered their subjects in a clear and informative way and there was a lively discussion after each presentation. BGS Wales has set a very high standard and we look forward to future study days around the United Kingdom.

GPs with a special interest

One of the notable features of the British Geriatrics Society is the amount of expertise and talent among its members. This means that the Society is able to contribute to debate and policy in a wide number of areas. One area which is currently being actively pursued covers the proposals for general practitioners with a special interest in the care of older people. Joe Neary, a member of the Society, is taking the lead on this on behalf of the Royal College of General Practitioners. The Special Interest Group on Primary and Continuing Care, led by Jacqui Morris, is acting as a think tank, debating the issue and making suggestions, suggestions which the Policy Committee incorporates in its discussions on this topic with the Royal College of General Practitioners and the Department of Health. David Black, on behalf of the Joint Committee between the Society and the Royal College of Physicians, is looking at the Diploma in Geriatric Medicine to see whether it might become a suitable qualification for general practitioners with a special interest in the care of older people. The combined input of all of these members and their colleagues will form a very strong basis for this important initiative.

Bob Stout
President

National COPD audit 2003

Planned to start in September 2003, this audit of the hospital management of COPD is to be jointly run by the British Thoracic Society and the RCP London Clinical Effectiveness Unit.

It follows on from previous audits conducted in 1997 and 2001. All acute hospitals in the UK will be asked to take part.

Although it is anticipated that respiratory physicians will usually be able to take a lead role in each hospital, geriatricians are also encouraged to take part, and given the demographics of hospital admissions for acute exacerbation of COPD, it would seem very appropriate for us to do so. The British Geriatrics Society has been represented in the design stage of the audit.

Each participating centre will be asked to collect data on the management and outcome of 40 consecutively admitted patients with acute exacerbation of COPD, with a start date of September 1st 2003. An electronic database will be supplied and it will be possible to transfer data electronically, direct to the RCP.

The potential local benefits of participation are to enable comparisons of process and outcome with national and regional colleagues, and to identify possible gaps in local resources (particularly if these relate to differences in outcome). It is possible that participants will gain CME credits.

Many respiratory physicians and geriatricians have already expressed an interest in taking part, and thus for those reading this who are interested, it would probably be best to check with local colleagues to establish whether your hospital is already registered. If it is not, or if you are unsure, and you wish to take part, then please contact one of the following (regionally):

North of England and Scotland:
Dr Harold Hosker, Consultant Physician
Airedale Hospital, Keighley
West Yorkshire, BD20 6TD
Email: **Harold.Hosker@anhst.nhs.uk**

South:
Dr Mike Roberts, Consultant Physician
Chest Clinic, Whipps Cross Hospital
London E11 1NR
Email: **Michael.Roberts@whippsx.nhs.uk**

or

Katharine Anstey
National COPD Audit Coordinator
Royal College of Physicians
St Andrew's Place
Regent's Park
London NW1 4LE
Email: **Katharine.Anstey@rcplondon.ac.uk**

Martin Connolly
Manchester Royal Infirmary

Prof Kay-Tee Khaw-Fawcett CBE

Prof Kay-Tee Khaw, Professor of Clinical Gerontology at the University of Cambridge, was awarded the CBE for services to medicine in the Queen's birthday honours' list.

A person of many talents and interests, Prof Khaw has a reputation as a leading authority in the art of ageing well.

The BGS congratulates her on receiving this honour.

Evercare

philosophy and practice

The seminar, organised by the National Primary and Care Trust Development Programme (Natpact), in conjunction with the United Health Group Evercare, was held on 10 June.

Chaired by the National Clinical Director for Older People's Services, Prof Ian Philp, the seminar was attended by a variety of professionals with an interest in the care of older people, GPs, Social Services staff, DoH representatives and a small but select number of geriatricians.

The USA experience and UK pilot studies

The seminar comprised four parts, a presentation by Prof Robert Kane, Minnesota, entitled **Improving Chronic Care in England: The Potential of the Primary Care Trusts**, related to the experience and research in the USA, a summary on the progress made by the Evercare team in the 10 pilot sites in England, a report on a 'home-grown' precursor project in Halton (Runcorn), and subsequent discussions. Space only allows me to do justice to the first two.

The USA experience and UK pilot studies

The key messages Prof Kane sought to put across were that: a) chronic disease (related to an ageing population) is here to stay, so we have to learn to 'fix it'; b) to achieve this will require significant changes to the traditional health care systems – he described predominant acute care models as 'baroque/broke' or more formally as 'ill suited to chronic disease care'; c) there is evidence to show that better care is possible; and d) the 'managed care principles' applied in the USA might work in another context, i.e. the UK.

There was much in Prof Kane's presentation that is the very basis of geriatrics, namely, the goal of managing disease to reduce exacerbations; to prevent or minimise the transition from impairment to disability, and to avoid iatrogenic effects. Prof Kane stressed that the more complex a patient's condition, the greater the need for specialist care and the need for care teams of specialist/non-specialist professionals, breaking away from 'organ' focused medicine to a whole systems approach. In addressing alternative ways ahead in the management of chronic conditions, Prof Kane stressed the importance of sharing with the patient, the responsibilities of managing chronic disease - of 'empowering the patient'.

The intention is to ensure continuous contact with (monitoring of) the patient, but not face to face physician/patient contact, with the goal of promptly identifying any change in the patient's condition and **then** ensuring prompt medical intervention. The ultimate goal is both to attend quickly to a patient where there is a change in condition, and to ensure that the physicians focus on those patients who need attention and ideally give these patients more time related to their needs than is currently the case with a 15 minute norm; this will serve the patient better and make better use of the scarce physician time/resource with a consequent reduction of unnecessary hospital admissions.

One has to accept that with chronic disease there will be a decline in the patient's condition over time; what is important is to establish, in advance, the course of the disease that one might expect, and measure against this the observed development of the patient's condition, thus enabling any sudden deviation to be identified. It will also serve as a measure of the success in managing the chronic disease.

Against this background Prof Kane stressed the need for a good doctor-patient relationship (patient more likely to follow a regimen where the doctor is liked), the need to train patients to make observations, the requirement for physicians to develop new roles/skills, and a change to the traditional practice of care being administered in a certain specific place. At the same time, what is needed is a seed change from the high profile of the 'firefighters', rewarded for acute interventions, to

greater recognition of the success of chronic disease management. Nevertheless, Prof Kane acknowledged that the latter is harder to measure, but that one has to make it clear to carers that the long term decline in a patient's condition does not reflect a lack of success.

Prof Kane dwelt on the need for good information systems and in particular the need to get information on a patient, to a doctor in a way that will attract the doctor's attention and focus on the relevant information the doctor requires. Prof Kane also drew attention to the 'amazingly' bad state of communications, both within hospitals and between hospitals and primary care, on a patient's medication. The problems of inappropriate medication were also addressed, coupled with the suggestion that there be a 'pre-programme' of medication to overcome the risks of drug-interactions.

Looking to the future

Prof Kane advocates, inter alia:

- 'outcomes accountability (to apply equally to Social Services as to Health Care – both services need to have the same shared goal to 'provide what the patient lacks', and to make the partnership succeed)
- a role for case management; the development of a strategy to address Primary Care (See Fahey, BMJ, 2003)
- an active role for geriatrics consultants in LTC,
- Nurse Practitioners and better trained GPs
- interdisciplinary team care; and
- more consumer education.

Prof Kane perceives the PCTs as 'positive managed care models' with the capacity to overcome adverse incentives and merge disease and case management. In discussing the use of case management in the USA , Prof Kane warns of the dangers of attracting only the 'sicker clients', which distorts the overall cost of care.

Prof Kane devoted some time to the financial aspects, emphasising that one should look at the longer term effects of change rather than short term pressures. He believes this change in focus will result in a more cost effective outcome (albeit that this is expressed in American terms of 'profit'). He identifies the fact that there will be a redistribution of finance between secondary and primary care, and between the health sector and Social Services, i.e. 'spending in one area yields savings in another'.

UK Evercare pilot sites

Marcia Smith, on behalf of the United Health Group, explained the purpose of the 17 month pilot scheme in England, starting from 1 April 2003. Nine of the sites focus on the high risk older people and improving the care pathway, while one site focuses on the capacity for planning, with the outcome being formally evaluated by the National Care Research & Evaluation Centre of the University of Manchester. The goal of Evercare is to offer a system that will 'optimise primary care of older people and, in the process, **reduce avoidable admissions to secondary care**.

The principles of the programme are:

- individualised whole person approach (function, independence, comfort, quality of life)
- primary care the central organisation for all care
- care provided in the least invasive manner
- adverse effects of polypharmacy avoided
- decisions based on data

Focus of the programme including preliminary results in England

Patient related objectives:

♦ To identify those people most at risk and monitor outcomes. There is no set way of doing this; they started in England by identifying people over 65, who had been in hospital (emergency admissions), and ascertained that on the data provided by the PCTs, 2-3% of the over 65's age group accounted for 30% of the hospital admissions the previous year. It was intended to identify other high risk patients that the GPs would know about.

♦ Collaborative partnership GPs and qualified nurses. Thirty-six nurses have been hired and are being trained in their new role, which includes a more clinical focus, i.e. taking patients' histories, effecting physical examinations and reporting abnormalities to the GP, communicating across the health care system (not just vertically), and acting as the patients' champion. This is seen as a collaborative venture with the GPs, who have embraced the concept with varying degrees of enthusiasm, some very supportive, others less so and some 'may be'.

Routine education and training for the nurses (a week at a time) is in place, supported by US nurses. Eventually the initial 36 will themselves, become trainers. The response from the nurses under training has been favourable, with the nurses welcoming a

more proactive role and the greater clinical involvement.

♦ facilitating fast track care in community and hospital, proactive management of high risk caseload, and systematic tools/processes. There will be 60 -70 patients per nurse; nurses will initially spend 5 hours making a patient assessment and developing a care plan to be checked by the GP. Patients will be expected to 'phone the nurse in the event that there is a change in their condition; in the case of those patients deemed most vulnerable the nurse will contact the patient if there is no call from the patient. Thus a hospital admission, for example, pneumonia will be seen as a failure of the system, as one would expect this to be 'picked up' before it becomes critical. Medication will be checked and the patient's choices will be reviewed as the chronic nature of the disease progresses.

What the studies show so far

Marcia Smith summed up the lessons learned to date.

- 'speed is possible in the NHS'
- resistance has come from 'predictable entities'
- population–based data is available but has not been analysed
- nursing values and philosophies are closely aligned between UK and USA
- the interest in training needs has been larger than was anticipated
- progress made has been proportional to the PCT resource invested

Was the UK there first? Chronic Care Management in Runcorn

Jayne Penny spoke with great enthusiasm on what was clearly a precursor to the Evercare system, an initiative undertaken in Halton by (then Fundholding) GPs in which, as a nurse, she had played a pivotal role. It comprised a system of targeting patients and funds, making assessments and a case plan, interventions as necessary, and an evaluation of the outcomes. Ms Penny cited two case studies of what was adjudged a success, attracting interest from other areas of England. The results were reduced hospital admissions, shorter lengths of stay, closer working with Social Services and between Primary and Secondary Care, and improved patient access to services. Jayne drew attention to the subsequent fit with the NSF in terms of patient centred care, Intermediate Care and the promotion of healthy living

Richard Lynham
BGS Administrative Director

New arthritis group, *SOAR,* is launched in May to address 'sub-optimal care' in the UK

A new, multi-disciplinary group called SOAR (**S**tandards **o**f **A**rthritis **R**elief) comprising leading GPs, consultants, nurses and pharmacists in the field of arthritis, launched in May to address sub-optimal care of arthritis in the UK, a condition which accounts for 1 in 5 visits to the GP.

The launch of this unique group is particularly timely in the light of survey results presented at the British Society of Rheumatology (BSR), which revealed that 57% of musculoskeletal pain sufferers are in constant pain. SOAR is committed to supporting primary care teams through the provision of expert advice, education and tools to aid the effective management of arthritis.

The survey presented at BSR in April by the Arthritis Action Group (AAG) questioned 798 patients with musculoskeletal pain about both diagnosis and treatment options and showed that many seeking medical help receive little information, are dissatisfied with the effectiveness of treatment and underestimate the risks involved.

SOAR launched their first initiative, a 'Standards of Care' template, designed to help primary care teams implement optimum standards of arthritis care in the UK. The template will provide a user-friendly, comprehensive and concise reference source for primary care teams. SOAR has reviewed current guidance, and gone one step further by developing the template to cover all aspects of osteoarthritis (OA) and rheumatoid arthritis (RA) management, from informing patients, diagnosis and referral to treatment decisions.

'Arthritis is a debilitating condition and the impact on patients' quality of life is often underestimated. The SOAR group was convened to address sub-optimal arthritis care in the UK and has sought input from a multi-disciplinary team to effectively meet this goal." says Dr Neil Amin, Chair, SOAR.

Copies of the SOAR 'OA/RA Standards of Care template' are available from the SOAR hotline 020 7313 6377.

For a downloadable pdf copy of the template, see the BGS on line newsletter at: www.bgsnet.org.uk

Diabetes SIG

Eleven years on

The Diabetes Special Interest Group (SIG) was founded in 1992 by a small group of committed geriatricians with expertise in diabetes and endocrinology.

One of its main aims was to highlight the importance of delivering high quality diabetes care to vulnerable older adults by providing first class postgraduate educational events. With this in mind, the SIG meeting in Aberdeen, attended by more than 200 delegates, met this aim and provided a session which was not only stimulating, but highly educational.

Dr Simon Croxson, a consultant physician in Bristol (Chair, SIG-Diabetes), delivered a short, practical, unique but occasionally eccentric review of insulin treatment in older people. His messages were clear: insulin treatment should not be delayed; most older patients can manage insulin pens; all insulin preparations should be available to older 'folk'; and consider the newer insulin analogues which have some theoretical and practical advantages.

The background and methodology of the GIST (Glucose Insulin in Stroke Trial) was then discussed eloquently by **Dr Jon Scott**, a specialist registrar from South Shields. Jon had previously been a Northern region Research Fellow at the University of Newcastle, one of those prized appointments that seem only to be available in the North East! His review of the area of cerebrovascular disease and diabetes was fascinating and pointed out that in acute stroke, a glucose level of > 5mmol/l at presentation in subjects without a previous diagnosis of diabetes, may have adverse consequences in terms of mortality. About 800 subjects so far have been recruited to this RCT which is investigating the benefits of tight glucose control versus usual care in the first 24 hours of admission on three monthly outcomes.

Dr Geraldine Brennan, a consultant physician with a special responsibility for diabetes in Tayside, completed the session by providing a splendid overview of the DARTS/Memo project. This has given us a tremendous insight into the burden of diabetes on a population basis, and led to the first effective diabetes register being developed. This project appears to have four facets: a Register; an Audit tool; a Data Management Tool; and Research. Her presentation was enlightening and provided delegates with the information to go away and set up their own audit tools for their diabetes practice, and gave helpful tips on how to improve the integration of diabetes care into their geriatric medical practice.

At a time when the NSF for Diabetes is in its early stages of implementation, and when our own discipline is re-examining our roles in intermediate care, community care including care homes, there is a clear opportunity for exploring how we can manage older people with diabetes in new environments. Many thanks to Simon Croxson for organising this enjoyable event.

Professor Alan Sinclair
University of Warwick
Executive Officer of BGS Diabetes SIG

To join the British Geriatrics Diabetes SIG, contact the Chairman:

Prof A Sinclair
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Health Services Studies
University of Warwick
Coventry CV4 7AL

Email: Sinclair.5@btinternet.com or chssasai@wbs.warwick.ac.uk

Geriatricians as trainers

Warwick meeting to be held in November

The response to a preliminary announcement in the May issue of the Newsletter has been heartening.

This meeting, the first of its kind, will act as a milestone and a catalyst in medical education as it affects older people's care. Generations of consultants have devoted time, energy, and experience in training future consultants. In the light of major changes in the NHS, and with the institution of the European Working Directive, it would be opportune to open the debate on developing improved training schemes.

There are still 80 places for consultants and specialist registrars who are particularly interested in pursuing a career in training future SpRs in geriatric medicine.

The chief guest will be Sir Liam Donaldson (CMO), who will set the scene on the theme, "The doctor of the future : today's challenge". Professor Bob Stout, BGS President, will give the opening address.

Mrs Kathleen Way, an ex-patient and prominent in many voluntary organisations in Warwickshire, will speak on the theme of "A Consumer's Perspective". Dr Peter Ferry, current Specialist Registrar, and Dr Paula Turnbull, a consultant in her first year and also doing long-distance learning, will share their views on training and how this is being translated into practice.

Other speakers include Professor Peter Crome on **Undergraduate Training**; Professor Alan Sinclair on the **Value of Research Methodology for Geriatricians**; and Dr. Steve Allen on **Preparing Trainees for Intermediate Care**.

Confirmation from three other speakers is awaited. There will be ample time for discussion and we hope that the meeting will be interactive.

There will be a special Novo Nordiskâ lecture in Diabetes Mellitus. Confirmation by the speaker is still awaited.

Meeting Venue: Scarman House, University of Warwick, Coventry, CV4 7AL

Date: Friday, 28th November, 2003.

Contact Details: Pamela Bayne, Secretary to Dr Harshad Desai, South Warwickshire General Hospitals NHS Trust, Warwick Hospital, Lakin Road, Warwick, CV34 5BW

Telephone: 01926 495321 extension 4341

Email: pamela.bayne@swh.nhs.uk

Database of Audits - RCP London

The Royal College of Physicians (London) Clinical Effectiveness Forum is developing a central register of audits.

Much audit is never published and thus its findings remain unknown beyond the team carrying out the work. The aim of the register is to be a resource to facilitate the sharing of experience, and obviate duplicated work. The establishment of the register would enable health professionals to consider the quality of audit in terms of collecting useful data. It is hoped the register will also help to facilitate changes in practice.

The BGS is fully supportive of the aims of this database, recognising the importance of audits in stimulating the analysis of current practice and stimulating debate. A new category of abstracts, 'Clinical Effectiveness', was therefore added to the category of abstracts presented at BGS meetings. Thirteen posters in this new category were displayed for the first time at the Spring meeting in Aberdeen.

We therefore kindly ask members involved in **multi-centre** audit, past and present, to fill out the enclosed questionnaire. The Clinical Practice Evaluation Group (CPEG), a sub-committee of the Academic and Research Committee, will collate the list of audits submitted by BGS members and forward them to the Clinical Effectiveness Forum.

Thank you for your help!

Dr Jonathan Potter
Chair, CPEG

Clinical Effectiveness Forum

Update

The Royal College of Physicians (London) has a Clinical Effectiveness Forum constituted of representatives of the 36 specialist societies within the College.

The Clinical Effectiveness and Evaluation Unit (CEEU) administers the Forum. The aim of the Forum is to support and facilitate clinical effectiveness within the specialist societies and its current work is progressing down 3 lines:

Database of Guidelines

The Forum has established a database of guidelines developed by specialist societies or relevant to the work of the specialist societies. The database can be accessed via the Royal College website at **www.rcplondon.ac.uk/college/ceeu/ceeu%5Fncgd%5Fhome.htm** (Alternatively go to www.rcplondon.ac.uk and use the phrase "clinical guidelines database" in its "SEARCH" facility).

Currently the Forum is going through a process of "kite marking" the guidelines using the "AGREE" methodology (Appraisal of Guidelines, Research and Evaluation). See **www.agreecollaboration.org** for details. This process assesses various aspects of the guideline production, including: the rigour of the literature search, the appropriate representation of the guideline development group, the impartiality of the guideline and the presentation.

Database of Audits

The Forum is now developing a database of audits. (See page 10). The aim is to provide a reference source for departments wishing to audit aspects of practice so that they can identify what standards others have used in carrying out similar audit, compare their results with other departments and identify how others have endeavoured to change practice.

Currently the only criterion for the audits is that they should be multi-centred. The recent audit by the BGS, of the use of bisphosphonates to prevent steroid induced osteoporosis is one example of such a multi-centre audit.

This project is at an early stage. The BGS has been asked to be one of 3 pilot societies to test the system for collecting details of such multi-centre audits.

It would be very much appreciated if anyone who has details of a multi-centre audit, would contact Annette at the BGS (**Annette-guerda-fischer@bgs.org.uk**) so the required details can be obtained and entered onto the database.

Proposals for NICE Guidelines/Appraisals

Recent efforts within the Forum have been aimed at raising awareness, within specialist societies, of the opportunity to influence the work programme of NICE with regard to Guidelines and Appraisals. At the last meeting Gillian Leng (NICE senior executive responsible for Guidelines) spoke to the Forum about the submission of proposals.

The process for submitting is now the same for both appraisals and guidelines. In general, appraisals relate to one specific drug or intervention whereas guidelines relate to the management of a condition. The work of NICE is relevant only to England and Wales. Scotland and Northern Ireland have their own arrangements.

Guidelines once developed by NICE will have an important bearing on clinical practice and the resources that are directed towards practice. It is

particularly important that the needs of older people are appropriately considered in the guideline programme. Current examples of guidelines under development include:

- Cardiac Failure
- Chronic Obstructive Pulmonary Disease
- Type 1 Diabetes
- Falls
- Epilepsy
- Parkinson's Disease

NICE guidelines are developed with great rigour over two years, and at a cost of approximately £250,000. In England and Wales it is hard to match this in any other way because of the constraints on funds and time. There is a considerable incentive therefore, if any specialist group feels that there is an area of clinical importance for which a guideline should be developed, for trying to get it adopted by NICE.

Details of the system for submitting proposals can be found on the DoH website at: **www.doh.gov.uk/nice/consultation2002**

There are some points to bear in mind in making a proposal:

- The Department of Health receives a large number of proposals for NICE guidelines/appraisals from all clinical areas. It pays to prioritise submissions from any one clinical area to increase the chance of acceptance.

- To obtain and maximise the Society's support for proposals, they should be routed through the Academic and Research Committee before submission to the Department of Health. Please contact Annette (**Annette-Guerda-Fischer@bgs.org.uk**)

- Support from different sources – professional and non-professional – is helpful.

- Consider carefully the criteria by which any proposals will be judged (see DoH web site)

- The Committee assessing proposals is largely non-clinical (see DoH web site). It is important to bear this in mind in the constructing of the proposal.

Although not as glamorous as research, the processes of clinical effectiveness in general, and of NICE in particular, are beginning to have a significant impact on clinical practice and resources. It will pay the Society to be involved in these processes. I would be interested to hear from any members of the Society who would like to be actively involved in this area of activity, either within the Society's Clinical Practice Evaluation Group (CPEG) or the Royal College Clinical Effectiveness Forum.

Jonathan Potter
BGS Representative,
RCP Clinical Effectiveness Forum.
jonathan.potter@ekht.nhs.uk/
jonathan.potter@rcplondon.ac.uk

University of Nottingham: Lecturer post vacant

The Lecturer post in Medicine for Older People at the University of Nottingham is currently vacant. It is a relatively unusual post in that post holders are expected both to train in General and Geriatric Medicine and develop a high quality research portfolio and academic career. We are looking for clinically able people with research experience and ambitions – including those who are already on a SpR scheme.

If you have research experience, and feel that this might give you the opportunity to develop academically, then please **contact Dr John Gladman to discuss the post (john.gladman@nottingham.ac.uk, Tel 0115 924 9924 x42618/41411)**. Note that the job is not currently advertised, and the date of advertisement will depend upon the expressions of interest received.

Research active specialist registrars in geriatric medicine

Irish Gerontological Society
Golden Jubilee Celebration - 2002

The Irish Gerontological Society (IGS) held its 50th anniversary conference in Cork in September last year.

Many members will remember the occasion of the 1999 Spring meeting of the BGS when nearly 650 BGS members and guests descended on Cork. The Cork conference machine remains well oiled and, as with the BGS meeting, Lucette Murray did a superb job, this time with Dr Denis O'Mahoney, now the Secretary of the IGS. Drs Cillian Twomey and Michael Highland, the latter three more years into his retirement, were much in evidence.

The scientific sessions started, following the Presidential address by Dr John Lavan. This was followed by multidisciplinary platform presentations from both north and south of the border and a symposium based around the **PROSPER** study which was partly coordinated locally. Sadly the results were embargoed until the American Heart Association meeting in November. Following a cardiovascular platform presentation session and poster viewing, Prof Sir John Grimley Evans gave the Willie Bermingham lecture entitled **"Geriatrics: dreams and realities"** where he skilfully developed some of the themes he has previously addressed. This lecture has been a centrepiece of the IGS meetings for many years and honours the memory of an inner-city Dublin firebrigade ambulance driver. As a result of his experiences, he set up ALONE (A Little Offering Never Ends) dedicated to the care and support of frail older people living alone. It was refreshing to talk, over drinks, to the academic head of the University who was nothing but supportive of the contribution of geriatric medicine to the objectives of the University.

For those who were up to it, Saturday morning platform presentations occupied the first part of the Saturday programme. These were followed by the AGM and the award of Presidential medals to Ms Jenny Cronin for her presentation entitled, **"The effect of a balance retraining programme on falls risk"** and Dr Suzanne Timmons for her presentation entiled, **"The prevalence of anticonvulsant use in elderly nursing home residents."**

The conference dinner was a black tie affair where guests were made to feel very welcome. The guest speaker, Dr Gary Lee, a pathologist from Mercy Hospital, Cork, could be described as having given a performance rather than a speech. Despite his wit, the BGS is perhaps not quite ready for him. I would be interested to hear what readers think about making the BGS dinners black tie events, particularly as many of our Scottish members do already, in their own distinctive way.

Prof Steve Jackson
King's College Hospital

BGS Gastroenterology and Clinical Nutrition SIG

The 2003 annual scientific meeting of the Special Interest Group in Gastroenterology and Clinical Nutrition was held at The Marriott St Pierre Hotel & Country Club in Chepstow in June. The meeting was accredited with 6 CME hours.

The first session was on **"The Effects of NSAIDS on the Gut"** and the 2nd session was presented by members of the group, including:

- Age related changes in the circadian rhythm of gut hormones.
- Changes in the circadian rhythm of the cytoprotective trefoil protein TFF2 with age.
- Videoconferencing for upper GI cancer care & remote centres.
- A Multi-Disciplinary Approach to maintaining weightloss.
- A helping hand – do feeding co-ordinators make a difference?
- Faecal Incontinence
- Ischaemic Colitis
- An unusual case of perforated DU

The meeting as adjudged successful. **We look forward to seeing you at the BGS Autumn Meeting - details of the topics to be covered can be found on the Notices page (p15)**.

Pain in older people

19 August 2003

Hartshill, Stoke on Trent

Institute of Ageing 8th National CME Conference

Includes:

- **Epidemiology of pain**
- **Treating the pain of osteoporosis**
- **Pain and cognitive impairment**
- **Pain and ethics**
- **Development of National Guidelines in pain for older people - the USA experience**
- **The treatment of pain in older people in the UK - the way forward**

CME has been applied for

Chaired by Professors Margot Gosney and Peter Crome

Contact:
Mrs Olwyn Mander
School of Postgraduate Medicine,
Thornburrow Drive, Hartshill,
Stoke on Trent ST4 7QB

Tel: 01782 554 995
Fax: 01782 747319
Email: mea07@keele.ac.uk

EUROPEAN GERIATRIC MEDICINE

2nd Congress of the European Union of Geriatric Medicine Society

27-30 August 2003

Florence, Italy

Best clinical practice and multi-dimensional approach.

Visit www.eugms.org to register on line

Contact:
MF Congres
8 rue Tronchet
75008 Paris
France
Tel: + 33 (0)1 40 071 121

LATINAMERICAN GERIATRIC CONGRESS

3-6 September 2003

Santiago, Chile

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

FALLS AND POSTURAL STABILITY

4th National Conference on Falls and Postural Stability (organised by the Falls and Bone Health SIG of the BGS)

9 September 2003

London

Contact:
Hampton Medical Conferences Ltd
127 High Street
Teddington
Middlesex TW11 8HH
Tel: 020 8977 0011
Fax: 020 8977 0055
Email: hmc@hamptonmedical.com
Web: www.hamptonmedical. com

PREVENTING CARDIOVASCULAR DISEASE IN THE OLDER ADULT

12 September 2003

Royal College of Physicians, Glasgow

Contact: Kirsty Paterson
Event Co-ordinator, RCP (Glasgow), 232-242 St Vincent St, Glasgow G2 5RJ
Tel: 0141 221 6072
Email:
kirsty.paterson@rcpsglasg.ac.uk
Web: www.rcpsglasg.ac.uk

DEMENTIA WITH LEWY BODIES AND PARKINSON’S DISEASE

17-20 September 2003

Newcastle upon Tyne

A key meeting aiming to consolidate international opinion about the status of Dewy Lewy Bodies and Parkinson’s Disease and the relationship between them. An excellent networking opportunity between dementia experts and movement disorders specialists as well as scientists who are working on a common understanding of alpha-synuclein-related disorders

Contact: DLB/PDD Conference Office, Benchmark Communications Ltd, 63 Westgate Rd, Newcastle upon Tyne NE1 1SG. Tel: +44 (0) 191 241 4523

GERONTOLOGY

Irish Gerontological Society

51st Annual Conference

26-27 September 2003

Dublin, Ireland

Contact:
IGS Secretariat
William Stokes Unit
Adelaide & Meath Hospital
Dublin 24
Ireland
+353 1 414 3215
Email: igs2003@amnch.ie
Web: http://indigo.ie

RESPONDING TO CHANGING NEEDS OF OLDER PEOPLE

4th International Symposium on Chinese Elderly People

13-15 October 2003

Beijing, PR China

Contact:
Fax: + 86 10 625 15213
Email: ageing@mail.ruc.edu.cn

BGS AUTUMN MEETING

16-17 October 2003

Novotel, Hammersmith, London

Contact: Hampton Medical Conferences Ltd, 127 High St
Teddington, Middlesex
TW11 8HH
Tel: 020 8977 0011
Fax: 020 8977 0055
Email: hmc@hamptonmedical.com
Web: www.hamptonmedical.com

MORE MEETINGS

Visit www.bgsnet.org.uk

for details of

- conferences
- jobs in sunny places

GASTROENTEROLOGY & CLINICAL NUTRITION A BGS AUTUMN MEETING PARALLEL SESSION

Thursday, 16 October 2003

Novotel Hotel, Hammersmith, London

Includes the following presentations:

- Fatty liver
- Refeeding syndrome
- Non-Cardiac Chest Pain

Contact: See registration details for the British Geriatrics Society Autumn meeting

CLINICAL NUTRITION

Annual Meeting of the British Association for Parenteral and Enteral Nutrition

19 - 20 November 2003

Telford

CME approved
Initial announcement enclosed with this newsletter

Contact: Sovereign Conference Secure Hold Business Centre, Studley Road, Redditch, Worcestershire B98 7LG. Tel: 01527 518777. Fax: 01527 518718 Website: www.bapen.org.uk

STROKE

2nd All-Wales Stroke Conference

28 November 2003

County Hall, Cwmbran, Gwent

A multi-disciplinary event

CME and PGEA applied for

Registration is free of charge

Contact: Dr E A Freeman
St Woolos Hospital
Stow Hill
Newport
South Wales
NP20 4SZ

SYNCOPE

International Conference

20-22 November 2003

Newcastle upon Tyne

Contact: Nicola Railton, Conference and Events Manager, Syncope Conference, Benchmark Communications Ltd., 63 Westgate Road, Newcastle upon Tyne NE1 1SG. Tel: 0191 241 4523. Email: syncope@benchcom.co.uk Website: www.syncope-conference.co.uk

GERIATRICIANS AS TRAINERS

28 November 2003

University of Warwick Coventry

Consultants with a training responsibility welcome. Also 20 places reserved for senior SpRs with an interest in medical education

Contact: Pamela Bayne, Dept of Medicine, Warwick Hosp, Lakin Rd, Warwick CV34 5BW. Tel: 01926 495 321 x 4341. Email: pamela.bayne@swh.nhs.uk

BGS English Council

Update

The English Council, set up under the reform of the British Geriatrics Society has now held its first two meetings - the first in Aberdeen and the second in Cardiff (neither in England!)

The Council is made up of the regional representatives (listed below) together with an elected Chairman, Dr David Black and elected Vice Chairman, Dr James Barrett. The three major challenges facing the English Council over the next two years will be:

- Ensuring good communication with the UK BGS structures, including the Policy Committee and the UK Management Committee.
- Getting to work on its main agenda as an interface for the British Geriatrics Society English members, with the English Department of Health on policy issues regarding older people in England.
- Trying to improve communication within and between the English regions and all English members of the BGS.

Dr David Black

The Council recently made decisions and progress in each of these areas. There will now be agreed cross-linkages directly from the English Council to the UKMC, with Dr Duncan Forsyth joining Dr Black and Dr Barrett on that committee. The Council will also be identifying people to attend the Policy Committee. As current English members demit from other BGS committees such as Finance, and Scientific, the English regions will be be invited to put forward and support names, and the English Council will then elect representatives from those supported volunteers.

With regards to policy, the council members have clearly stated that they wish to be more directly involved, and to take some individual responsibility for pursuing policy issues on behalf of the English Council. This is to be greatly welcomed and should make the role of the council member far more rewarding for a little harder work in the future. When areas of responsibility have been clarified, these will, of

Composition of the BGS England Council 2003

Chair:	Dr David Black
Deputy Chair:	Dr James Barrett
East Anglia::	Dr Duncan Forsyth
Mersey:	TBC
NE Thames:	Dr Sara Lightowlers
Northern:	Prof Rose-Ann Kenny
North West:	Prof Ray Tallis
NW Thames:	Dr John Platt
SE Thames:	Dr Jonathan Potter
South West:	Dr Harbans Bhakri
SW Thames:	Dr L McInnes
Trent:	Dr Tim Hendra
Oxford:	Dr Adam Darowski
West Midlands:	Dr G Matharu
Wessex:	Dr I Gove
Yorkshire:	Dr Eileen Burns
Trainee:	Dr Jon Treml
Trainee:	TBC
Ex officio:	
President Elect:	Dr Jeremy Playfer

course, be reported through the newsletter. In the meantime, Council members will be reporting back to their regions and getting more information on Evercare projects, activity on the Single Assessment Process, and will be debating the role of geriatric services in the A&E department at the next meeting.

Finally, the English Council is very keen to improve communication and to be entirely open about its discussions and debates. To this end, there will be more Newsletter articles such as this, but we hope, in the fairly near future, to make all documents and minutes fully available in a members only area attached to the BGS website.

I very much hope this will encourage debate and involvement in the Society's political activities through the members of the English Council.

Dr David Black
Chairman : BGS England Council

'Love thy neighbour'
gets the 21st century treatment

Intelligent homes with technology able to warn elderly occupants of impending hazards, and a 'quid pro quo' care trading network were among the subjects discussed by the world's leading experts on ageing at a debate held by Pfizer UK and RSA in May.

The event, which explored the challenges and opportunities posed by rapidly ageing populations in the 21st Century, took place fifty years after the discovery of DNA when the average age of a European was 29.5 years. Fifty years from now it will be 49.5 years. In the UK alone, one in five people will be over 65 by the year 2020, and almost half of these will be 75 or over.

Professor Heinz Wolff of Brunel University took the notion of 'love thy neighbour' into the 21st century, proposing a revolutionary new care network in which volunteers without any blood ties, care for older people, in return for a down payment for their own care in the future, or some other support or service.

He also talked about the 'Millennium Homes' Project. The 21st century version of the Stannah stairlift, this is intelligent robotic housing, enabling older people to live independently in their own homes, which can alert the occupier to hazards and prevent accidents.

WHO's three pillars

Dr Alex Kalache of the World Health Organisation explored the global contradiction that "the developed world became rich before it became old, and developing countries are becoming old before they become rich". He also discussed the 'three pillars' of the WHO's policy for active ageing: health, security and participation.

Miranda Kavanagh, Director of Corporate and Public Affairs at Pfizer UK, commented: "One of the first challenges of the ageing population is to move public thinking on from the current preoccupation with youth, and engage people with the vision of a more active and empowered ageing experience.

"The facts speak for themselves: by 2050 more Europeans will be over 65 than under and in Germany, Spain and Italy there will be more people over 80 than under 20. As the Oxford Institute of Ageing has recently pointed out, this demographic change provides not only challenges but also opportunities to harness the experience, expertise and creativity of such a large number of older people".

"This RSA lecture is part of our ongoing

commitment to better understanding the phenomenon of ageing and finding ways of improving the quality of life in older age. We look forward enormously to welcoming these leading commentators on ageing and helping take the debate forward."

For more information, interviews or pictures, contact Simon Burton, Liz Hawker or Jenna Frost on 020 7839 4321 or Sally Goodenough at Pfizer on 01737 331537.

Extract of Press Release by Pfizer

Community geriatrician

Survey results

After 10 years working as an 'acute hospital' geriatrician, I had the opportunity last year, to spend a six month secondment working with newly developed intermediate care teams in Leeds.

Dr Eileen Burns

The aim of this secondment was to "scope the job" and identify what support the teams needed to operate safely and efficiently. It led to agreement that there was a clear need for such posts, and the plan for the first of these is currently well developed.

This experience led to an interest in the role of the community geriatrician. Discussion with colleagues locally and nationally revealed a lack of information regarding such roles. So, with the support of the BGS (and the invaluable, practical assistance of Louise who has now left the BGS staff), Peter Belfield and I, with assistance from Sue Harris (a professional market researcher), surveyed lead clinicians in England regarding community geriatrician posts in their area.

We asked about the number of posts which had community responsibilities; whether such posts were "full time" in the community or shared across the acute/community divide.

We also asked about the content of these posts and we asked colleagues what the stimulus for the development of these posts had been; we asked what the benefits of the introduction of such posts had been and what problems they had created. We asked colleagues who had no community sessions why such posts had not been developed in their area.

The results of the survey revealed a fascinating picture across England. We sent out 126 questionnaires and had a response rate of 77%. Only 23% of lead clinicians reported that colleagues within their trust had any community sessions, and of these most were working 2 or fewer community sessions.

The results of this survey clearly indicate a growth in the area of community geriatricians, with 15 of the 95 posts identified new, rather than replacement posts. A further 9 posts were "out to advert" and 10 were reported to be in preparation. The stimulus for development of these posts came from within geriatric medicine in 24 cases, and from PCTs in 10 cases. In 20 cases the community posts were reported to be a development in response to the NSF for older people.

The job content of such posts usually involved working with the local intermediate care team. Many lead clinicians also reported day hospital work, supervision of community hospitals and, in some cases, even home visits as community work, suggesting that some of the work performed in these roles may not represent a change in practice.

Many colleagues recognised potential benefits in such posts and some had attempted to develop them, but lack of support had hindered progress.

Some clinicians reported PCTs were unwilling to fund consultant expansion to meet this role.

However, the aspiration that general practitioners with a special interest may fill this role was not supported by the results of our survey. Although it is possible that there may be some GPs working with older people, who are not known to their local geriatricians, we identified only 8 general practitioners working in this role across the whole of England. There may of course be others who are awaiting the developments of training plans for GPwSIs before showing their hand.

Although most colleagues who responded regarded the development of community posts positively, a small minority of respondents (n=7) regarded the geriatrician's role as limited to the management of acute medical problems only. This narrow definition of geriatric medicine clearly does not encompass the range of services which the BGS regards as a essential to a complete geriatric service.

Eileen Burns

Catching them young

Undergraduate experience and geriatrics

As a medical student, my experience of specialist services for older people was limited to two visits to the geriatric medicine unit.

We were shown some "**good cases**". I do recall that one of the patients had Huntingdon's Chorea, but not much more. When I returned to work in the teaching hospital as a registrar, exposure to geriatric medicine had advanced so that half the medical students had tutorials on the "Geriatric Giants", whilst a few students were actually attached to a "Geriatric Medicine" firm. In other medical schools, the situation has been different, with all students having formal attachments to geriatric medicine departments, typically of a few weeks duration. During that time students would be taught the principles of geriatric assessment and rehabilitation, and the basics of multi-disciplinary team working. There were two principal aims – to teach the fundamentals to all students, and to enthuse the enlightened with the delights of a career in geriatric medicine or related specialties.

The Anxieties of Change

At recent meetings of the BGS Training Committee and of the Association of Professors of Geriatric Medicine, concern has been expressed about the present status of the teaching of geriatric medicine at the undergraduate level, which appears to be under threat. The anxieties centred on three main areas – the role of Academic Departments in Geriatric Medicine in teaching, the relatively low emphasis on the issues of older people within General Medical Council Guidelines, and the reliance on non-geriatrician mentors to inspire students about older people when supervising problem-based learning.

Role of Academic Departments

There are many medical schools that have failed to appoint to Chairs in geriatric medicine or have been "considering" the future of professorships within the specialty. Nottingham, Birmingham, St George's and Liverpool have all recently had Professors of Geriatric Medicine, but now do not. Of the new medical schools, only Keele and Warwick have Professors of Geriatric Medicine. Traditionally, departments in medical schools have had a broad academic remit that has included undergraduate education, postgraduate training, MD/PhD student supervision and research. Most medical schools now are closing smaller departments and amalgamating them into larger, primarily research focussed units. At Keele all

medical school researchers are now in one of three Institutes. The main driver for this change is to try and ensure the highest quality of research, thus achieving a high score in the next Research Assessment Exercise (RAE). Although the details of the next assessment are not finalised it is likely that there will be an even more selective distribution of research funding than was the case at the last RAE in 2001. The evidence suggests that bigger units do better than smaller units. Whether one likes it or not, the quality of the undergraduate educational experience is of lesser financial importance to a medical school given that there is still a two-to-one oversupply of applicants with the necessary Advanced level requirements of 2 As and a B.

The approach we have adopted at Keele is that the major responsibility for delivering the curriculum should rest with senior lecturers in medical education, drawn from a variety of disciplinary backgrounds, who have this task as their major academic responsibility. Such post-holders will be expected to undertake post-graduate training in medical education, at least to Diploma level.

Tomorrow's doctors

Last year the General Medical Council produced an updated version of their key document "**Tomorrows Doctors**": **www.gmc-uk.org/med_ed/default.htm.** Relevant points include the view that the core curriculum that all students take should be reduced to 65-75% of the course, with the remainder being "student-selected". The anxiety here is that the proportion of time devoted to compulsory attendance at geriatric medicine would be reduced. This is coupled with the clear view that the medical student can not be expected to learn ***everything*** and that factual information should be kept to a minimum. On the other hand, the ability to offer innovative and stimulating special study options in the remainder of the course may act as a counterbalance.

Geriatric Medicine is not mentioned specifically in **"Tomorrow's Doctors"**. However, the importance of understanding the particular problems of vulnerable groups, including the disabled and those with chronic conditions, is stressed repeatedly. Older people are mentioned specifically. There is a requirement to respect patients regardless of their lifestyle, culture, beliefs, colour, gender, sexuality, disability, **age**, or social or economic status. Young doctors must understand human development and areas of psychology and sociology relevant to medicine, including growing old. Graduates must also be able to take account of patients' understanding and experience of their condition, particularly vulnerable groups such as older people. Visiting an older person has been identified as good practice in early clinical involvement.

Problem based learning

Many medical schools have introduced problem-based learning as the major method of knowledge acquisition. Each week there is a problem e.g. an older person with dementia which the students collectively try and understand, utilising a variety of learning opportunities. Problem-based learning tutors may come from a range of backgrounds. Their role is to facilitate student-learning rather than to impart knowledge. The argument has been advanced at the meetings mentioned earlier in this article that it is essential that a geriatrician directs learning about geriatric medicine rather than leave this to clinicians from other disciplines who, although they may be trained in problem-based techniques, may still impart negative attitudes.

Next steps

There are clearly differences of view about the way forward, the two contrasting views being that all students must have a compulsory attachment to a geriatric medicine unit, or on the other hand, geriatric medicine is best taught by including issues of ageing and disability throughout the curriculum. The Association of Professors of Geriatric Medicine wish to undertake a survey of the present status of undergraduate geriatric medicine teaching, its organisation and the role of academic departments in devising, co-ordinating and delivering locally based curricula. We would hope to obtain a 100% response from Medical Schools. This information would be supplemented by a separate survey of the views of the members of the Training Committee and the Association of Professors on the way forward for the next decade. I have been asked by the Association of Professors to lead on this and I would be delighted to hear from anyone who has something to say on the subject.

Peter Crome
Deputy Head of the Medical School and Professor of Geriatric Medicine, University of Keele

Single Assessment Process

Good news for geriatricians?

For many, it may not feel like good news yet, but who can argue with the principles and objectives of the Single Assessment Process.

That's if the **"single"** means a coherent, linked, time saving, and widely understood process, rather than the "single" meaning one assessment tool for all purposes, done by anybody and for any purpose.

There is no doubt that the engagement of geriatricians and generally of specialist elderly medicine departments in the implementation of the SAP has been patchy. This was clear from the DOH's overview, based on reports from around the country in Autumn 2002 (available on www.doh.gov.uk/scg/sap/). Other points included difficulty in engaging general practitioners, frustrations with lack of progress in information technology, and the continuing ambiguity about how much freedom local health services have to develop tools of their own. All these issues are addressed in the articles below.

In many PCTs and boroughs, the SAP has become focused almost exclusively on the Overview Assessment., and in turn, the Overview Assessment has become focused almost exclusively on the use of a specific tool. Many people involved in this process have little theoretical understanding of the assessment technology, but on the positive side, there is plenty of evidence of a willingness to reduce repetitious assessments and improve communication.

Of course many geriatricians have been involved in forms of comprehensive geriatric assessments, tailored to particular tasks, such as assessment of acute inpatients. The SAP is an opportunity to review this work, and create more explicit links and more useful information for colleagues in community and primary care. Locally, our work has involved:

- Adapting the assessments to include domains specified in SAP guidance
- Identifying unnecessary differences in documentation (e.g. discharge summaries) between different, related parts of the local health service such as the elderly care units and the intermediate care teams.
- Revamping the appearance of these assessments so that they share some of the language of local overview assessment technology, thus making it easier for the important points in the comprehensive assessment to be understood by those working at a more generic level
- Clarify where an overview assessment simply doesn't do the job and comprehensive old age assessment should be employed from the outset.

For example, we used an overview assessment (*Easycare*) in the day hospital to assess new referrals. This proved useful to focus people on the issues, but was always too superficial to clarify treatment or care plans. Thus selective use of some of the oft neglected domains has been retained whilst core medical issues are dealt with in a more comprehensive way.

Three different focuses

Ian Donald's account of progress in Gloucestershire shows the importance of established successful inter-agency work. **Bev Castleton** describes the strategy and principles underlying IT developments both nationally and locally. In **Gill Turner's** piece, it is clear that developing coherent local services is the best basis to move forward to useful single assessment processes. Likewise, the single point of access to non-acute but specialist services in the

community seems a crucial step in service planning to really enable single assessment process to work for patients, rather than simply generating more paper.

A broader role for our specialty

These accounts show that the SAP can be a way of bringing much needed specialist knowledge and experience into a variety of community and intermediate care settings. After a decade or more of geriatric medicine increasingly becoming the backbone of acute medical services, to the detriment of its involvement in rehabilitation and less acute work, working collaboratively on the SAP is an opportunity to re-establish the broader role of the specialty.

Introducing the Single Assessment Process (SAP) across the Health Community in Gloucestershire - by Ian Donald

In approaching the SAP, Gloucestershire was able to build upon its history of good working relations between health and social services, and upon their **"Joint Assessment of Care Needs"** document which has been used to describe people's needs as they consider long-term care or complex packages of care at home. Social Services wished to simplify their existing forms, the joint document was in need of review, and there was a desire to integrate the RNCC assessment into the process of assessment. Gloucestershire has sustained strong pockets of enthusiasm for the **Over 75 Health Check**, but with a diversity of approaches and an appreciation that the benefits could be broadened if clearer links were established between the Health Check and the provision of services. Within the hospital, there has long been an appreciation that improved quality of information, early in the admission, about the situation at home prior to the present crisis, could deliver better discharge processes – but no solution had been introduced.

No off-the-shelf tool

The SAP has been the catalyst to bringing these ingredients into a new integrated assessment system. We have not chosen an off-the-shelf tool, but have developed the components we require. Within the hospital, we have made use of our universal nurse assessment tool, the **Gloucester Patient Profile (**see **Age & Ageing 1999 Suppl 2),** which has an embedded Barthel score, to define triggers for the **Overview Assessment** tool. In the hospital setting, the Overview captures the person's home setting and their abilities prior to the current crisis. This provides a baseline to inform therapists in deciding about rehabilitation potential. When rehabilitation within hospital is complete, the Overview is updated, ready for transfer to the community or to the Intermediate care services.

Within the community, we have developed an 8-question screening questionnaire which can be used to trigger an Overview Assessment, both in the context of 'opportunistic screening' where a nurse is seeing someone, perhaps for an injection, and also within systematic case-finding of vulnerable older people. The screener can be used as a postal questionnaire, and to indicate if disability has changed.

Overview Assessment

The Overview Assessment itself amounts to a 16-sided booklet, including a 4-paged clinical section, and is frequently updated in the light of experience. It has been accepted as the principal assessment tool across the Health Community. One early success was the agreement and incorporation of the screening tools for dementia (**6-CIT**) and depression (**GDS-4**). It will reside in people's homes, in a folder alongside nurse assessments, information leaflets from hospital etc. A short supplement has been produced to cover specific areas relevant to admission into long-term care, including the **RNCC** assessment. It will help ensure that multidisciplinary assessment has been thorough before admission.

Going Electronic

Finally, we hope to launch the Overview Assessment in electronic format, on a platform accessible to the 3 existing Intranets in Social Services, Primary Care Trusts, and the Hospital Trusts. No-one will be surprised to learn that IT connectivity appears more challenging than "connectivity" between staff caring for older people!

Information technology and the NSF for Older People Single Assessment Process : IT - Help or Hindrance? - by Beverley Castleton

The Development of an Integrated Care Record Services (ICRS) is moving apace as a part of the National Programme for Information Technology. This requires a phased introduction. It is not planned for the full implementation of the shared record services to be in place until 2008.

The **National Health Services Information Authority** (NHSIA) has appointed a group to address the further development and implementation of the information strategies of the various National Service Frameworks and how they link to the ICRS.

This **NHSIA Information Strategy Group** has 6 Clinical Coordinators (one for each of the NSF published thus far). I was seconded in August 2002 to be the Clinical Coordinator for the Older People's NSF. I also have a link into the **Department of Health Information Strategy for Older People Advisory Group** and the Implementation Team, and I am the Chairman of the **External Reference Group of Clinicians** that advises on the Datasets developments.

The National Programme for IT, NSFs and the Clinical links

- Design Authority: "Gang of Six" – 6 Clinicians with technical and clinical backgrounds

Clinical Coordinators)
Strategy Analysts) **-from the NHSIA Information Strategy**
Group Clinical Leads) **Group**

- Clinician Advisors

There is a need to ensure that Information Policy and Strategy links with health changes, and the close working of the clinicians with those developing the technical side of the IT programme, is most encouraging.

In developing the strategies for the NSFs there are national issues, which need to be addressed within the NHSIA, and there are more local actions, which require major process change.

Developing Strategies for the NSFs

National Issues	Local Actions
Standards for content, quality, and readability	Information for Citizens
Decision support NeLH NHS Direct & Online	Promoting choice
NHS Direct & Online	Understanding what's available
Common data sets	Mapping information flows and needs
The Integrated Care Records Service	Information protocols
Security & Confidentiality	Governance and Audit

Information flows require the relevant technology support and nowhere, in the NSF for Older People, is this more important than in the development of the Single Assessment Process (SAP). However, waiting for the full ICRS programme is not an option. Getting the care pathways worked out; process mapping the work flows; agreeing common language; adopting agreed information sharing protocols; and working on the cultural differences, are pieces of work that need to be done if we are to get the SAP underway by April 2004.

To support this development of the SAP, the NHSIA Datasets Group has been working intensively on the data format for the Personal Information, Contact Assessment and the Summary Assessment. There is already draft guidance available on the content of these forms on the DOH SAP website. Although these datasets have to be piloted and refined, and finally signed off by the Information Standards Board, major changes to the data definitions are not contemplated.

Transitional Options for IT support for the SAP are being piloted using web browser technology. This should achieve connectivity between the GP systems, Community systems, Acute units, Mental Health Services, Social Services, and District and Borough Councils.

In my local area we are embarking on one of the **Framework for Multi-agency Environment (**FAME) projects funded by the Office of the Deputy Prime Minister, promoting the independence of vulnerable older people. This project will be scoping the processes necessary to get the SAP underway, and the IT support to improve the information flow.

The implementation of the SAP is a huge undertaking requiring resources, skills and a degree of joint working. This will require major cultural changes to take place. The sharing and timely flow of information is crucial to the process. The Education and Training programme that underpins the implementation of SAP will be massive. The ICRS development will be a catalyst for change, should improve processes and thus release time for the joint training that is needed and time to cascade knowledge effectively. IT is a help not a hindrance, a friend not a foe!

Single Assessment Process in the New Forest PCT - by Gill Turner

Firstly, it is important to say, we have not implemented the Single Assessment Process in the New Forest yet. However, we have every expectation that we will have most of the systems and processes in place for April 2004.

Background

As always, it is probably worth describing our local service in terms of its strengths and constraints. This may put into context the decisions we have subsequently made.
The positive features about the New Forest PCT are that we had already made a strategic decision to move to a locality team model of service. This means that (eventually!) there will be 'patch based' teams of rehabilitation therapists, geriatricians, social services care managers, CPN's and community nurses working with specific communities of patients and relating to specific general practices. Many of the discussions arising out of our locality team implementation have been entirely relevant to the implementation of the SAP.

Secondly, although for convenience, all the geriatricians working in the New Forest are employed by, and also work in, the acute trust, there has never been anything other than full participation by those in the community based services (whoever ran them - community trust or PCT).

Thirdly, we had been considering for some time, the need for a 'screening and prevention' strategy. The Single Assessment process was seen by the geriatricians as a route to achieving this and was eagerly seized on.

On the other hand, the local constraints are that the New Forest PCT is seriously broke! Implementing the SAP means employing a whole new project management team and investing in a costly IT solution. This does not mean that we don't want, one day, to consider and invest in a tool, but we are keen to sort out the processes first. In addition PCT patients are admitted into 3 local acute Trusts and we are right on the edge of the Strategic Health Authority (SHA) area, so we weren't sure that the guidance we received from them would be relevant to all our providers.

Finally, the New Forest PCT was in the unfortunate situation of not just having no community based information system, but inheriting an extremely poor system which is currently being decommissioned, and which has no relevance for the Single Assessment process.

What we've agreed so far

So what is to be done?

Firstly, one of our senior OT's has volunteered to lead this process and to be a project manager, which she does for 10 hours a week (as well as being a team leader). She set up a clinicians and practitioners' group which is examining and developing the processes. This group also led the pilot locally, of one of the national tools which I will describe later. There is also an SAP steering group which is a sub group of the Older Person's strategy group of the PCT. This steering group is chaired by a geriatrician.

Step by step to an SAP

Between the two groups, we've decided to make the Overview Assessment our main goal initially,

and we are working to merge this with the initial multidisciplinary assessment currently used by our community rehabilitation teams. We are examining the assessments used by all future members of the locality teams to consider areas of overlap before developing them into one single overview assessment, which will be used by whichever agency is approached first, or has the first referral. Obviously when the locality teams are formed and there is a single point of access for older people, this will be easier, but until then we are looking for convergence so that similar responses and actions will be taken after a similar positive pointer in the Overview Assessment. In other words the expectation is that if urinary incontinence, for example, is revealed in the Overview Assessment done by a social worker, the same action will be taken as it would be if the same symptom was revealed by a physiotherapist.

For most of the rest of this article I will use the word locality teams on the understanding that until they are formally in place, this is shorthand for any professional using the standardised Overview Assessment, who will become a member of the locality teams when they are formed.

If in doubt, file it!

As part of this work, the clinicians and practitioners group decided to pilot one of the National Tools on a small scale, using patients referred to our local rapid response team. We were keen to consider patient held records as part of the pilot and thus emphasised that patients being referred to other specialists should take the Overview Assessment with them for reference. Sadly our enthusiasm is not matched locally by the orthopaedic surgeons, who simply filed the assessment, dutifully brought to the clinic by a patient, since they had no idea what it was all about!!

Other feedback from the local practitioners was that the tool was not as rich in content as they would want an assessment to be, but that nonetheless it was quite cumbersome.

In summary, we have not yet therefore sorted out our local cut on the Overview Assessment but we know what we want.

Getting the GPs on board

The second issue we needed to grapple with was how we got the GP's on board. We knew that realistically, GP's were unlikely to do Overview Assessments and have therefore made the policy decision that all the Overview Assessments will be done by a member or potential member of the locality team. Thus, a GP or practice nurse who is concerned about an older person who appears to have more problems than the initial contact assessment has revealed, or who has one of the locally determined 'trigger' problems, can simply refer to the locality team for the overview assessment and onward referral. Plainly this begs the question of what happens to a patient who is referred by their GP to a hospital specialist for one problem, but who also has other issues which should have triggered an Overview Assessment. If the specialist is a geriatrician, the Overview Assessment will be done by us (possibly meaning a change in practice by us - the implications of which I am not sure we have taken on board). However, of course if the specialist is a urologist, for example, we have to think of other solutions. We are considering the implications of empowering the outpatient nurses to do Overview Assessments, or at least to refer people to the locality teams so as to reduce the number of people who fall through the cracks.

Specialist and summary assessments

We have no rules about the specialist assessment locally. However, we will be asking that a plain English, single paragraph summary of any specialist assessment and plan is produced, and this will also be available on the website together with the associated overview assessment. We have not yet made much progress in the implementation of this plan. Eventually when we have the appropriate resources to implement a mega IT solution, the summary assessment (as directed by the DoH) will be the one published on the website – at the moment we don't have the capacity to do this.

Inpatients

Finally, there is the question of inpatients. Plainly there is a need for a two way process here. The nurses on the wards looking after older people

who are already known to the locality teams need access to information we have already gathered, but also we need to access information which they and other health care professionals have gathered as part of their in patient assessment. For sharing information 'inwards', we are looking at using the PCT website to post the overview assessment (with appropriate confidentiality protection of course) so that it can be accessed by any care professional, but not updated – that will have to be done by the locality team base. We have not yet worked out how information from assessments done in hospital will be moved outwards to be shared with the locality teams. However, since one of the service strategies of the locality teams is to operate an inreach service (for home visits, etc.) this may not be such a problem.

What is untenable for inpatient teams is that they have to use a different assessment tool for each PCT's patients – however that remains a risk since even if we do adopt our host SHA decision (which is not yet made), we abut three SHA's. (Sometimes one wishes for a little more guidance from on high!). However, we believe this vindicates our decision not to go with a specific off the shelf 'tool', but instead, to go with an intuitive assessment.

Still to be done

Anyone reading this could be forgiven for wondering if we're seriously deluding ourselves about setting this up by next April. However, we still feel optimistic since we have spent the majority of our time working out how all the processes and different types of assessments will fit together. I believe that this is the most important bit to get right, and I am also sure that geriatricians need to be in there helping to sort it out. Certainly as a geriatrician, my motivation for this process is about ensuring people don't slip through the net, rather than getting bits of paper nicely aligned. We have full sign-up by a lot of coal face staff, and we know that there are complicated older patients whom the GP's and practice nurses don't really know what to do with - the SAP provides a simple process to solve this. There are also real anxieties about the amount of unmet need we will uncover, but as we all know, today's unmet need in the community is tomorrow's emergency admission, so it seems pointless not to at least try to tackle it.

Perhaps we'll be able to update you in a year.

European Union Geriatric Medicine Society (EUGMS) - Launch of the new EUGMS Section in the Journal of Nutrition, Health and Aging

The EUGMS has announced that, following a revised format, the Journal of Nutrition, Health and Aging (JNHA) will include a new section, affiliated directly to the EUGMS.
The section will be devoted to scientific articles and reviews on geriatric medicine and clinical gerontology. This will range from basic science to health services research. It is anticipated that the new format for the Journal will be available later this year and it is hoped that the launch will take place at the EUGMS Congress in Florence (see notices page 14).

It is very important that high quality manuscripts are submitted to the Section Editor (Prof Hannes Staehelin) from member states, as the editorial team wish to ensure a ready supply of publishable material for the forthcoming issues.

It is expected that there will be six issues of the JNHA per year, and between three and four papers in the EUGMS Section for each issue. It should be acknowledged that JNHA is gaining a world reputation for its scientific content.

We would ask you to let other colleagues know about this development and to consider submitting papers

We would also urge members to consider submitting manuscripts to other sections of JNHA, since in particular cases, they many be more appropriate to the sections "Nutrition" and "Neurosciences".

Prof Alan Sinclair
Academic Director, EUGMS
Prof Hannes Staehelin
EUGMS Section Editor, JNHA
Prof Bruno Vellas
Chief Editor, JNHA

BGS Scottish Council Update

The Scottish Council has been established for some time now and meets regularly.

RIA/BGS Masterclass

Two sessions have been organised; the first was held in Bristol in May; the second will be held in Glasgow on 21 November. Local applicants will be given preference for places in Glasgow.

Alliance for better management of confusion

A paper has been prepared for the Council's approval and early discussions with Age Concern Scotland, HEBS, Alzheimer's Scotland - Action on Dementia, and Old Age Psychiatry, have been positive. There is general agreement to proceed with a meeting of interested parties.

BGS Scotland website

The Scottish Council is registering its own domain name and will be developing a new, improved website. It will no longer be housed on the BGS website, but there will continue to be a reciprocal link between the two sites.

BGS Scotland Council

Age and Ageing Editorial Team - Posts vacant

Assistant Editor

After many years of invaluable service to ***Age and Ageing***, Professor Francis Caird has decided to step down and fully take advantage of his retirement. ***Age and Ageing*** invites applications from those interested in taking over the role of Assistant Editor.

The role consists of:
- ♦ offering expert opinion to the Editor, including re-assessing revised papers;
- ♦ proofreading a significant proportion of *Age and Ageing* papers accepted for publication;
- ♦ some re-writing of papers with a poor level of English;
- ♦ occasional refereeing and book reviewing

This role would suit a geriatrician with excellent English skills and an interest in general geriatric medicine. The post is accompanied by an honorarium.

Book Review Editor

Following his election as President Elect of the BGS, Dr Jeremy Playfer has decided to relinquish his role as Book Review Editor for ***Age and Ageing***. We are looking for someone with a literary flair and a wide circle of professional connections to take over this role.

Duties include:
- ♦ Assessing books and other publications for suitability for review in Age and Ageing
- ♦ Sending books out for review to appropriate reviewers
- Assessing the reviews

This role is accompanied by an honorarium to cover administrative expenses.

Supplements Editor

We are inviting applications for someone to take over from Professor John Potter as Supplements Editor. Supplements make a vital contribution to **Age and Ageing**, both academically and financially. The Supplements Editor is responsible for overseeing the supplement process by liaising with guest editors, arranging refereeing of supplements articles, and liaising with the publisher through the production process.

For further details about any of these posts or to apply please contact the Editor at the address below.

We would be grateful to receive expressions of interest by the end of July.

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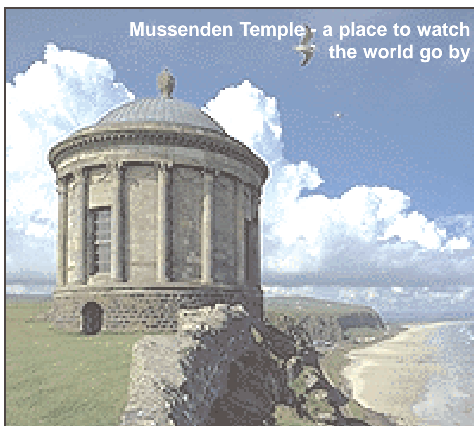
Derry, city of history and beauty

venue for the 2004 Spring Meeting

Derry is an attractive modern city, of great historic interest, in surroundings of outstanding natural beauty.

In 1999, Cork in the Republic of Ireland hosted one of the most well attended BGS Spring Meetings in the Society's history. It is now the turn of Northern Ireland, specifically Derry. Derry is one of the longest continuously inhabited places in Ireland (the earliest references date to the sixth century A.D.) Its name derives from the old Irish word meaning an oak grove on an island totally or partly, surrounded by water or peat bog.



Mussenden Temple - a place to watch the world go by

In 1613, King James I of England, granted a charter to London companies which changed the name to Londonderry. The name has been divisive ever since, some seeing 'Londonderry' as a symbol of British history and heritage, others as an unwelcome reminder of a colonial past. The issue has been defused by a local broadcaster who refers to the city as Derry/Londonderry (pronounced "Derry-stroke-Londonderry"), and shortens it to **"stroke-city"**, a suitable venue, one might think, for a BGS meeting. Most people, not trying to make a political point, tend to use the shorter name, a policy which will be adopted here.

Lying across the border from Donegal, Derry is famously friendly. Dubbed "the prettiest looking town I have seen in Ireland", by the Scottish historian, Thomas Carlyle, Derry is situated on the River Foyle. It has seen a renaissance in community activity, especially in the arts. The 20ft city walls, complete with watch-towers and cannon are marvellously intact. Having had to withstand some serious sieges (as city walls do), two failed sieges in the 17th century earned Derry the name "maiden city".[1]

Apart from the excellent programme being planned by the 2004 Spring Meeting organising committee (more on this to follow in future issues), Derry is the gateway to County Donegal, one of the most beautiful counties in Ireland. Whether your pleasure is castles, ancient (12th century) ruins, museums or long walks in woodlands or on beach, Derry has something to please.

So watch this space and diarise 22-24 April 2004.

Prof Bob Stout

1. *Insight Guide - Ireland*

PUBLICATIONS INFORMATION

The BGS Newsletter is published every second month by:

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