



Editor: Kevin Kelleher

# B G S

n e w s l e t t e r

## Derry Delights

- the old and the new

**A** packed and varied scientific programme, liberally laced with traditional Irish entertainment - what are you waiting for - book now!

**Our rapidly approaching Spring meeting, on 21 - 24 April, promises to be another winner in the Society calendar, so if you have not already made your booking I suggest you do so without delay, as places are going fast.**

### Travel

It really could not be easier. In fact, I got to Derry for our final site meeting in less time than it takes to get from London to Liverpool. A

short hop from Heathrow (just 55 minutes) will find you in Belfast, where a fleet of cars, specially laid on for Spring Meeting delegates, will whisk you through delightful landscapes and tidy green fields packed with sheep, to Derry/



**The hand of reconciliation**

Londonderry.

This second part of the journey takes just over one hour, depending on the number of tractors on the road. Of course, you can choose to travel direct to City of Derry airport, which is just a short taxi ride from the city itself.

### The location

The city of Derry/ Londonderry has a colourful and eventful past, to which is now added a growing convention industry. The Society has taken over two strikingly different venues for the event. First there is the Millennium Forum – a place of marble, glass and light and a tremendous location for the trade exhibition, poster viewing, receptions and small breakout sessions. Right next door is a period change represented by St Columb's Theatre, built in 1886 and still boasting original stained glass windows and intricately carved staircases. This will be the venue for the

### contents

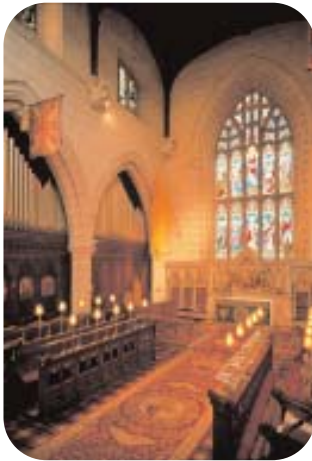
<b>Editorial</b> .....	<b>3</b>
<b>President's column</b> .....	<b>4</b>
England Council Update .....	7
National Council Reports .....	8
Online abstract submissions .....	9
BGS President Elect - Election procedure .....	10
Geriatric Medicine in the European Union .....	12
BGS logo - who may use it .....	15
Trainees' pages .....	16
King's Fund Inquiry into Care Services .....	18
Cerebral and Mental Health SIG Update .....	19
<b>NOTICES</b> .....	<b>20</b>
Academic Medicine and Research Strategy .....	22
Health Care Accreditation Programme .....	25
Keele University launches Institute for Ageing .....	27

**President:** Prof Robert Stout **President Elect:** Dr Jeremy Playfer

**Honorary Secretaries:** Dr Kevin Kelleher and Dr David Beaumont **Meetings Secretaries:** Dr Juanita A Pascual, Dr Janice O'Connell and Dr Michael Vassallo

**Honorary Treasurers:** Dr Ian Sturgess and Prof Margot Gosney **Chief Executive:** Alex Mair **Sub Editor:** Recia Atkins

specialist medical society for health in old age



St Columba's stained glass windows

main lectures and sessions. The old and the new combine well together to give the city a quite unique flavour.

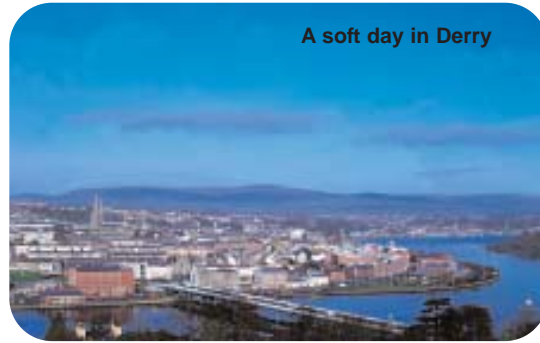
**Programme**

The local organising committee and the Spring meetings secretary deserve a lot of credit for compiling a well balanced programme around exciting sponsored symposia; indeed, one symposium will feature the well know TV presenter Michael Barrett, in what promises to be

an innovative and "live" programme. Guest lecturers include Prof William R Hazzard, Professor of Medicine at the University of Washington in Seattle, Prof Tony McGleenan, who holds the Chair of Law at the University of Ulster and Prof Davis Coakley, from Dublin. Add to this the parallel sessions involving a good number of the SIG's and sections, including the newly "branded" Cardiovascular Section in collaboration with the Falls and Bone Health Section. As usual, delegates will be spoiled for choice and are assured of another BGS conference where matters medical are to the fore.

**Social**

The Irish need no introduction as being folk who make visitors to the Emerald Isle feel at ease. There will be pipers, traditional Irish dancing, a performance from Different Drums and a jazz band spread over the two main days. If you prefer something a little quieter, how about a game of golf. If you're feeling less sporty, take a



A soft day in Derry

walk around the inner walls of the city or, getting into the Irish spirit (no pun intended), take a distillery tour.

**Where giants dwell**

Add to this the magnificent beaches and Giants Causeway just a short drive away. Situated on the Antrim coast the Causeway is one of the



Giants Causeway

wonders of the natural world, having been added to Unesco's World Heritage List in 1986. This

spectacular rock formation is made from thousands of columns of basalt rock. Around 60 million years ago, underground volcanic explosions forced the molten basalt to the surface which, as it cooled and contracted, formed into the polygonal columns that are found in the area today. That's the scientific explanation anyway. More intriguing is the Causeway's links with myth and legend. Many of the formations carry their own colourful and evocative names like "Giants Well", "Giants Organ" "Wishing Chair/Giants Chair".



Crafts, cobble stones and Guinness in Derry

So we are assured of all the ingredients for an enjoyable stay. Indeed, why not add a night or two onto your trip and make a long weekend of it? Whatever your plans, I am sure you will enjoy the experience; I look forward to meeting many of you there.

**Alex Mair**  
Chief Executive

# Editorial

page



“There is always a connection but, if the link has never been made before, nobody knows it’s there.”

James Burke made his name by finding connections and making entertaining and educational programmes for television and popular science journals over the last few decades.

As I read this month’s newsletter and the latest missive from my medical defence organisation, I too made connections.

## Regulation, accreditation, measurement

The European Community continues to grow, ten new countries to become member nations shortly. The influence of the community on our personal and professional lives is increasing. For most of us, the inexorable creep of influence is largely invisible, but at some time in all our lives, we suddenly wake up to the fact that the Union dictates a large part of our civil and professional lives. It would not be unkind to say that many citizens see the European Community as an ever-expanding bureaucracy, obsessed with regulation and its soul mates accreditation and measurement.

You can read in Ian Hastie’s article (page 12) there is much going on in Europe in relation to the

speciality of geriatrics, as the continent rises to the demographic challenges that face us all. Ian’s article outlines the organisations which have evolved in the last number of years, dealing with such issues as training, service delivery and organisational developments. Those interested in our speciality in Europe now have an ever-increasing dialogue and there is much to be learnt and pondered. Our members, not surprisingly, have been at the heart of this burgeoning communication and the



Society is now considering its role in these endeavours. The membership should have cogent views on this as the Society beds down devolution and looks outward in planning its strategy for the next number of years.

What then of the epistle from my defence organisation? Editorial comment to members in their latest casebook reminded me that doctors are undergoing an

unprecedented change in the ways of working in the Health Service and its regulation. \*CHAI, NCAA, GMC, revalidation, job planning, CPD, PA negotiation and performance management, NPSA, NICE are just a few that come to mind before I start feeling quite tired.

Soothing tones were offered to remind defence organisation members that their Society was well

**In the interests of inclusivity, should we have “patients’ representatives” on some of the BGS committees? I would like to hear from committee members, current and past.**

\*CHAI - [www.chi.nhs.uk](http://www.chi.nhs.uk)  
 NPSA - [www.npsa.nhs.uk](http://www.npsa.nhs.uk)  
 NICE - [www.nice.org.uk](http://www.nice.org.uk)  
 NCAA - [www.ncaa.nhs.uk](http://www.ncaa.nhs.uk)

\*\*Character in Winnie-the-Pooh

placed to help with any of the challenges these new developments provided. The underlying message exhorts readers to think positive and maintain professional self-confidence.

Therein lies the connection between European issues and medical defence organisations.

\*\*Eeyores amongst us will see an ever-increasing bureaucratisation of our professional lives with a questioning as to how this improves our patients' experiences of the Health Service. More positive

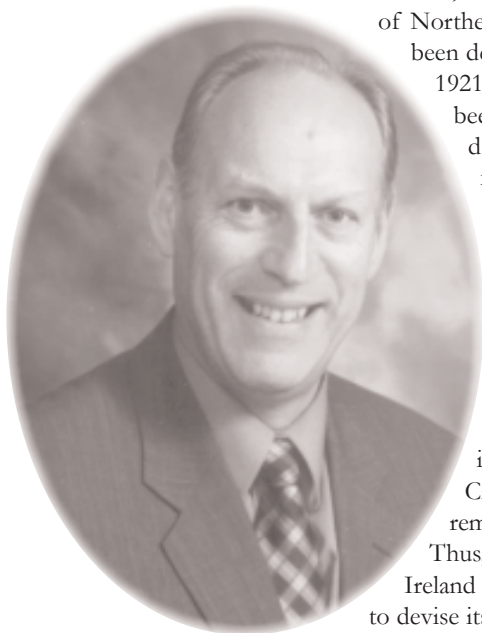
folk may see that increased collegiality with our European neighbours and our professional colleagues is an allowance to ensure that we can maintain our professional self-confidence and deliver on best care to our patients.

The editor therefore leaves you with the question this month "Whither British Geriatrics Society and geriatrics in Europe"?

Kevin Kelleher

## President's column

With the Spring Meeting 2004 being held in Londonderry, I thought it might be of interest to give some background on geriatric medicine and medical services in general, in Northern Ireland.



Although we think of devolution as being a recent event, the administration of Northern Ireland has been devolved since 1921 and health has been one of the devolved functions. Even under direct rule, when Ministers are from outside Northern Ireland, the administrative structures, including the Civil Service, remain distinct. Thus, Northern Ireland has the ability to devise its own systems,

although it tries to ensure that its citizens receive the same standards as those elsewhere in the UK. However, policies from the Department of Health in London do not automatically apply to Northern Ireland, nor does funding. Northern Ireland receives its funding from the Exchequer in the form of a block grant and Northern Ireland Ministers distribute it among the different programmes according to their own priorities.

Local government was one of the most contentious areas in Northern Ireland until the early 1970s. This problem was resolved at the time, by removing a number of the important functions from local government and transferring them to agencies with appointed boards. The major functions which were removed were education, which is administered by five Education and Library Boards, housing, administered by the Northern Ireland Housing Executive, and social services. At the time of the re-organisation of local government a re-organisation of the health service was also taking place. From 1948 – 1974 the Northern Ireland health services were administered in a tripartite system with different structures for hospitals, general practice, and public health. In 1974 four Health and Social Services Boards – Eastern, Western, Northern and Southern were established to administer health and social services, including public health. GPs remain independent contractors. Northern Ireland

followed the 1991 changes in the health service with the introduction of health and social services trusts, some being for hospital services, some for community services, and some for both, with the four Boards becoming commissioners of services. The more recent changes have not occurred in Northern Ireland and we have no definite information as to how services might change.

### Prof George Adams

Geriatric Medicine developed in Northern Ireland at the onset of the NHS in 1948. Professor George Adams, the second President of the British Geriatrics Society, was the pioneer, working in the Belfast City Hospital. The Belfast City Hospital was the former workhouse for Belfast and, as elsewhere, had a large number of 'chronic beds' occupied by older patients with long standing disabilities. From these Professor Adams developed a modern rehabilitation service and designed the first purpose built geriatric unit in the UK, Wakehurst House, opened in 1959. He took a particular interest in patients with stroke and published a number of influential papers on prognostic factors in stroke. In 1974 he brought his work on stroke together in a book called, 'Cerebrovascular Disability and the Ageing Brain'. It is notable how much of the content of the book is still valid today.

With the passage of time, geriatric units developed in hospitals elsewhere in Northern Ireland and there now is a comprehensive geriatric service with specialist units in all general hospitals. The larger hospitals have full time specialists in geriatric medicine who provide acute care for older patients as part of a comprehensive geriatric service, while in the smaller hospitals the geriatricians take part in the general medicine rota. In all hospitals there now

are stroke rehabilitation units and acute stroke units are being developed. There are active training programmes and recruitment to specialist registrar posts is highly competitive.

### Specialist Training

The University Department of Geriatric Medicine came into existence in August 1976. The permanent staff consists of a professor, two clinical senior lecturers, a non-clinical senior lecturer with an interest in statistics and demography, and a non-clinical lecturer who is a bioscientist. Most trainees in geriatric medicine undertake research in the University department, usually leading to an MD degree. In recent years

they have joined Dr Passmore's research team on dementia. Undergraduate teaching of geriatric medicine has taken place for over 40 years. The pattern of geriatric medicine is fairly uniform throughout Northern Ireland. Geriatric teams are involved in the acute care of older patients, have rehabilitation beds, and in most cases have



day hospitals. They also undertake community outreach with home assessment visits. Many units still have some continuing care beds although most continuing care takes place in nursing homes. There are the usual problems of delayed discharge, and of unacceptable waiting times in A&E departments. We do not have a national service framework in Northern Ireland and intermediate care as a policy has not been introduced, although, as already mentioned, rehabilitation beds have been retained. Although there is still some old accommodation, most of the geriatric units are in relatively modern purpose-built facilities.

### Londonderry awaits

We look forward to welcoming as many of you as possible to the Spring Meeting.

**Bob Stout**

# England Council

- Update

The England Council has finally had its first meeting at BGS headquarters, having previously travelled to Scotland, Wales and Hammersmith.

The two key roles for the council are to ensure two-way communications with the England regions and to do everything possible to influence the Department of Health with the views of consultant geriatricians in England. To this end, members of the council have the opportunity to meet with Ian Philp and civil servants from the Department of Health twice a year. The last meeting in November covered reimbursement, the work of the Change Agent team, the Government's "Choice" Project, progress with Evercare and concerns about evaluation of the Evercare projects before their funding comes to an end. Your council member will be able to give you more information about all of these issues which have received considerable discussion at recent council meetings.

## Meeting the Parliamentary Under Secretary

In December, as Chair of the England Council, I was invited to meet with Stephen Ladyman, Parliamentary Under Secretary of Health, to discuss geriatrician's concerns about the progress of Intermediate Care. I concentrated on the issues of intermediate care and the progression of the NSF in hospitals. The main points I tried to put across to him were that:

- ◆ Within hospitals geriatricians are now not only

leading on stroke and falls, but taking an extremely large load of the emergency take

- ◆ The efficient and effective management of older people across the spectrum of care from home to hospital, and back home again, is absolutely key to unlocking the congestion in hospitals and delivering the other aspects of the NSF Plan



Dr David Black

- ◆ the "technology" of geriatric medicine is comprehensive assessment, and specialist geriatric input is completely integral to that process

- ◆ Much of the Intermediate Care that has been delivered is patchy, small scale, does not involve specialist geriatric input, does not have a single point of access, and

in many places, is not significantly contributing to overall whole systems approach

- ◆ There appears to be no national governance of Intermediate Care. The Government has no idea how many schemes there are; how many patients are going through them; or the outcomes in terms of institutionalisation, death or discharge home

- ◆ Much of the implementation of the NSF is unfortunately approached as a tick box or non-critical activity by PCTs. Funding is not flowing through, as it is in cardiology and oncology. An illustration of this point is stroke care, comparing the proportion of stroke patients getting into a stroke unit (30 - 35%), with heart attack patients getting into a coronary care unit (95% plus)

Our discussion then moved on to the nature of comprehensive geriatric assessment, its linkages with the Single Assessment Process and indeed, Mr Ladyman and the Government's believe that if the NSF is delivered, then all patients will receive



Dr Steven Ladyman

comprehensive geriatric assessment as part of the single assessment process before, for example, entry to long term care. The reality on the ground was set out by both Ian Philp and myself. I believe the Minister listened and is sympathetic to the argument that Intermediate Care needs to be improved. On the other hand, there is the tension between wanting to take more central action and

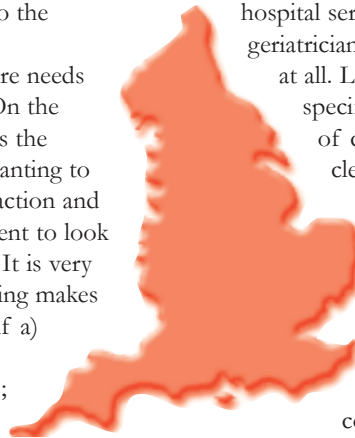
the increasing drive of the Government to look for local solutions to local problems. It is very difficult to know if a half hour meeting makes any difference but the proof will be if a) any more initiatives on Intermediate Care transpire in the next six months; and b) whether he follows up on his offer at the end of the meeting to see a representative of the BGS at least twice a year.

### Single Assessment Process

At January's council meeting, **Mr Ray Wharburton**, who has led the Single Assessment Process for the Department of Health attended to update geriatricians on progress and to hear our experience. He made a number of points - one of them being that it was never the intention to have a single tool but there is now a single assessment summary that must be used by all Health and Social Care Communities in England. There are now three accredited assessment tools for overview assessment, namely **MDS Homecare, Easycare** and **FACE**. A major piece of ongoing work is the linkage between the Single Assessment Process IT Systems and the NHS Care Record Service. We are fortunate in geriatric medicine in having Beverly Castleton seconded to the Department of Health to work

on this detailed and complex project, and a number of members of the England Council have volunteered to offer their advice and help the implementation process. It was emphasised that although the SAP must be implemented from this April, most communities will be using interim solutions, which may still be paper based, until the NHS core IT system is in place. There are going to be a number of SAP roadshows involving the department and Ian Philp over the next 6 months.

The message Mr Wharburton took away from the England Council was that it would appear that although a lot is going on in the community, so far this has had very little impact on hospital services, and indeed in some areas geriatricians are still not aware of progress at all. Linkages with mental health is a specific issue that was raised as being of considerable importance. It is clear that the department wishes to engage with all doctors and I hope that we will be able to publish over time, good practice examples in the BGS Newsletter.



An issue that has caused considerable debate at both the last two meetings, has been the interface of geriatric medicine with acute medicine, and pressures in A&E and Intermediate Care. This is linked to concerns about training and career progression as consultants. This interfaces with the issue of acute physicians that is being currently debated within the RCP London. The Council is keen to hear the current views of consultants and trainees in England. By the time you read this you will probably have seen and returned a questionnaire. From this it is hoped that we will start to develop guidance to help people think through these issues at a local level.

Finally, the council is continuing to review significant issues and ensure BGS input wherever possible. These include Evercare, the NSF for chronic diseases, reimbursement and the CHI review of the National Service Framework.

**David Black**  
Chairman : England Council

# Round and about the UK

## - National Council Reports



### Scotland

The Scotland Council has held its Annual General Meeting with two representatives demitting, to be replaced by Drs Liz MacDonald and Angela Crawford.

#### Raising the profile

Following the Scottish Members of Parliament elections in June, the BGS Scotland Council has written to all MSPs with a view to raising the Society's profile as a source of expertise on older people's health.

Prof Marion MacMurdo and Dr Brendan Martin have met with Ms Christine Grahame, Chairman of the Health Committee of the Scottish Parliament. The meeting was fruitful and has resulted in several written questions to the Health Minister, Malcolm Chisholm, on matters concerning medical care of older people.

Quality control is organised through a body called NHS Quality Improvement Scotland (QIS). This incorporates organisations such as SHAS and CSBS (Clinical Standards Board Scotland). BGS members are active in both these bodies. The CSBS's report

on Acute Care of the Elderly was launched in late February.

#### Scotland Council online

BGS Scotland continues to add to its own revamped website, with Dr Brendan Martin having been designated "gatekeeper" for material posted to the site. In particular, the trainees have complimented the model for academic centres which the site deploys.

#### Should auld acquaintance be forgot ...

In December, the members of BGS Scotland paid their own tribute to Richard Lynham, the Society's retired Administrative Director, with a retirement gift timed to arrive for Christmas.

Depicting as it does, both the beauty and mystique of Scotland, the Caithness Glass paperweight defies all attempts to photograph adequately, its complex patterns, the BGS logo and the inscription of "Sincere thanks - BGS Scotland", but Richard has asked us to convey the message to Scotland members that their "gift has pride of place" on his desk, whilst the generosity of Scottish members warms his heart.

**Donald Farquhar**  
BGS Scotland Council

### Wales

The National Service Framework for the Elderly Implementation Group has now been established at Assembly level. Standards will be based on the English NSF but two of the standards will be revisited, namely that of Intermediate Care and Mental Health Services.



#### Wanless Report

The Review of Health and Social Services in Wales (the Wanless Report) has now been published. It identifies a number of key areas. Per capita spending in Wales is more than England but there is a higher prevalence of ill health. The report outlines the importance of disengaging from a strategy of a service over-dependent on acute hospital care. The

Council believes that this will be a key area of involvement for geriatricians. The report also stresses the need for better information systems as a key to the future. The Assembly are about to launch an “Informing Health” strategy.

Geriatricians wish to engage with the Intermediate Care Strategy of Care rather than Intermediate Care as “components” of service support.

### Intermediate care in Wales

The Council will stress, in its meeting with the

CMO, the importance of not viewing Intermediate Care as simply a way of avoiding hospital admission or supporting the back end of the hospital process. It is the Council’s wish to develop the strategy based on care pathway development, engaging at the level of the frail older patient, a strategy which will link the resources and services of primary and secondary care, and reinforce the key role of geriatricians.

Ed Wilkins  
BGS Wales Council

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# Moving with the times

BGS abstract submissions goes on line

**F**or veteran researchers there may be residual unhappy memories of the old procedure for submitting abstracts for the Spring and Autumn meetings.

For several decades, submitting an abstract meant having a good supply of “camera ready” forms (only originals would do!), and considerable skill in marrying up wordprocessor and printed form. The more recent emailed submissions process was easier for the submitter, but put considerable pressure on the BGS office, but we are now pleased to announce that the Society is joining the ranks of a growing number of scientific associations, including the International Association of Gerontology, in moving our abstracts submissions onto a streamlined web-based system.

The web-based system will be found on the BGS website towards the end of March 2004, in time for abstracts to be submitted for the Autumn 2004 meeting. Members may still submit their abstracts to the BGS on floppy disk, but email submissions will no longer be accepted. Apart

from following the example of other scientific/medical organisations, the increasing problem with virus infected email attachments makes this necessary.

### Interactive

One of the chief benefits for authors submitting abstracts online will be the instant feedback as to whether or not their abstract broadly conforms to the guidelines. Authors will also receive, by automatically generated email, the crucial reference number which confirms that their abstract has been logged.

The system will speed up the turn-around time in getting all the submitted abstracts to the adjudicators.

The Academic and Research Committee is currently revising the abstract submission guidelines. The new guidelines will be publicised in the May edition of the newsletter and will also be displayed on the BGS website.

**The deadline for submission of abstracts to the Autumn 2004 meeting is 1 June 2004.**

Annette Guerda-Fischer  
BGS Office

# Called upon to serve

## - Electing the President Elect

In 2002, the BGS changed its constitution to allow for the President Elect to be nominated and elected by individual ballot.

At the Society's AGM in October, our President will be handing the reins of office over to our President Elect, Dr Jerry Playfer. In accordance with Article 29 of the Society's Articles of Association therefore, nominations are now invited for the post of President Elect of the Society, effective from the 2004 Annual General Meeting.

### Job Description

The job description of the President Elect takes account of the job description of the President as the President Elect will serve for two years followed, subject to endorsement by the membership at the Annual General Meeting, by another two years as President.

### Duties

- ◆ Vice-Chairman United Kingdom Management Committee (UKMC) Meetings
- ◆ Ex-Officio member of all standing committees
- ◆ Represent the Society at meetings of other professional organisations and government bodies as necessary
- ◆ Deputise for the President at Regional BGS meetings as necessary
- ◆ Attend and possibly chair any special working parties that may be set up
- ◆ Provide guidance to the BGS Office when the President is not available

### Time commitment

- ◆ UKMC; 6 meetings a year, each usually lasting about 3 hours
- ◆ National Council meetings; TBD and 1 full Study Day each year

### Strategic Projects

Dependant on matters arising, the President Elect

may, in agreement with the President, wish to use the two years leading up to his/her presidency to plan future projects

### Workload of the President

The President Elect should be aware of the subsequent workload associated with the position of President. This includes:

- ◆ Raising the profile of the Society and working to enhance its image
- ◆ Chairing UKMC meetings 6 times a year
- ◆ Helping to formulate BGS policy on a wide range of issues
- ◆ Chairing sessions at BGS Scientific Meetings, chairing the BGS AGM and presiding at BGS Meeting dinners and at other events
- ◆ Providing urgent responses to national political issues related to health and welfare of older people and acting as spokesman for the BGS in media interviews and articles

The following may arise from time to time:

- ◆ Giving lectures on geriatric medicine and the care of older people in response to invitations from other professional organisations, and representing the Society at their meetings or receptions
- ◆ Liaising with government departments, senior civil servants and Ministers on age care issues
- ◆ Liaising with other geriatrics societies abroad, especially Australasia, Europe, North and South America
- ◆ Encouraging support for age care in the developing countries
- ◆ Liaising with the Royal Colleges in the UK
- ◆ Liaising with other professional organisations such as the BMA
- ◆ Liaising with voluntary sector organisations, particularly Age Concern and Help the Aged
- ◆ Maintaining regular contact with regional BGS groups wherever possible
- ◆ Signing cards, certificates, etc
- ◆ Contributing a column to the BGS Newsletter 6 times a year
- ◆ Spending time with other officers and with the BGS Chief Executive
- ◆ Giving support to the BGS Office

## *BGS President Elect : Procedure for nominating candidates*

Prospective candidates need not apply to their respective regions or Councils to be nominated. Members are also free to self-nominate. The only requirement is that a nomination must be supported, in writing, by 5 other members who are eligible to vote at an AGM of the Society.

Along with the written statements of support, the candidate must submit a statement of consent, in writing, to the effect that: "I, ..... do hereby consent that my name be put forward for nomination to the post of President Elect of the Society for the period 2004-2006".

The statement of consent and supporting signatures must be received by the Company Secretary, at the registered office of the Society, **no later than Friday 30 April 2004**. Late or incomplete nominations will not be accepted and email submissions are acceptable.

Should there be more than one nomination, a ballot will be held. All successful nominees will be encouraged to submit a statement supporting their nomination, together with a photograph, which will appear with the ballot paper.

Full details concerning a ballot will appear in a future issue of the Newsletter.

### **President's Time Commitment**

The commitment of the President to the Society's work takes, on average, one day a week, including responding to correspondence, e-mails etc., but with occasional visits all round the UK and the odd one abroad. It is necessary to keep in close touch with the BGS office even during the holiday periods.

The post provides substantial scope to influence the development of the BGS, the specialty and age care.

The post does require a heavy commitment to the Society and will involve late arrivals home, absences from home and a considerable burden on top of clinical commitments. It is necessary to be a good forward planner, to be well organised, able to delegate effectively, a good communicator and a good team leader.

Any queries should be directed to the Chief Executive ([alexander-mair@bgs.org.uk](mailto:alexander-mair@bgs.org.uk)).

**Alex Mair**

## *Northumbria University Study : Specialist Services and Older People*

In a study funded by the Department of Health, Northumbria University is **inviting those who manage services for older people** to take part in the study, which aims to analyse the range and scope of multidisciplinary specialist roles and teams for older people in England, and to analyse the impact of specialist practice on services and on service users.

The NSF for Older People (DoH, 2001) emphasises multidisciplinary services for older people. Therefore, the developing workforce has changed, with specialist posts and services being created, and having been played out in different ways across professional groups and service provision.

The study involves two stages. The first is to conduct a national survey of specialist service provision for older people (web link below). This will inform the second stage of the study, a selection of six case study sites which will enable a specific focus on specialist nursing services and

will involve a range of stakeholder and service user interviews. The case studies will use nursing as an example of specialist development, from which multidisciplinary lessons can be learned.

**If you manage services for Older People** and would like to take part in this study, please complete the survey at <http://online.northumbria.ac.uk/faculties/hswe/ssops.htm>

Or for more information visit <http://online.northumbria.ac.uk/faculties/hswe/research/nmahp/home.htm>

Alternatively, contact [Pamela.inglis@unn.ac.uk](mailto:Pamela.inglis@unn.ac.uk) or [margaret2.cook@unn.ac.uk](mailto:margaret2.cook@unn.ac.uk)

Participants will be asked to give an indication of their willingness, in principle, to be involved as a case study site. Involvement will be negotiated with participants to ensure that it fits with the site characteristics.

# Geriatric Medicine in the EU

-serving Europe's ageing population

Older people make greater than average use of Europe's health services. About 7500 - 10,000 geriatricians provide services to the EU's growing population of older people.

The European Commission has shown an interest in specialist services for older people and has recognised geriatric medicine as a specialty<sup>1,2</sup>. However, among the member states there are large differences in structure, health care services and training facilities<sup>3</sup>. The Geriatric Medicine Section of the European Union of Medical Specialists (GMS-UEMS) has collected information from its members about the differences in geriatric medicine and other medical organisations within the member states of the European Union.

## Recognition of the specialty

Geriatric medicine has been recognised in Austria, Belgium, Denmark, Finland, France, Germany, Ireland, Italy, the Netherlands, Spain, Sweden and the UK. It has not yet been recognised in Greece and Portugal, although it is hoped that the specialty will be recognised in these countries in the future. However the debate over recognition has a political impact and needs the co-operation of the medical professions.

All aspects of care for geriatric patients, including rehabilitation and the care in residential and nursing homes, are covered by the same specialist in Finland, Italy and Spain, although not all geriatric patients may see a geriatrician. Other countries have different specialties covering the different parts of this spectrum of care. This highlights the unevenness of the approach to health-related problems in older people within the member countries. Problems which are met at home, in the residential and nursing homes, or in the hospital setting, pose the question of whether a uniform system across Europe is preferable to a culturally, socially and economically sensitive local system.

## Continuing medical education

CME is provided in all countries, however, only in Austria, Belgium, the Netherlands and the UK is it on

a formal basis. A system for accreditation has been organised in these countries along with France and Ireland. It might be expected that in order to guarantee the quality of health care, there would be an obligation in the future to establish formal programmes for continuing medical education (CME) and continuing professional development, with a similar system of accreditation in all member countries.



**Ian Hastie**  
President, Geriatric  
Medicine Section,  
UEMS

## Training

In most countries the training varies between 4 and 7.5 years. Austria is the exception, with a training programme of 8 weekends over a period of two years, with most of the trainees being general practitioners. In Belgium, France and Germany the training in geriatric medicine is in addition to the completion of specialist training in internal medicine. In nearly all countries the trainees have to spend at least two years in general or internal medicine. Here, Italy is the exception, as training in internal medicine is not required, although it is under discussion as to whether this will be changed. The differences in training have an impact for the exchange of medical specialists across the European Union. A free exchange has been agreed for all European Union member states, however, the differences in the training especially in Austria and Italy could lead to problems.

The UEMS recommends a period of four years specialist training in geriatric medicine. However a problem arises in the difference of opinion about the content of the specialty. In Austria and Italy most geriatricians are dealing with patients outside the hospital. In other countries most of the time is spent on inpatients, albeit sometimes with consultations at home and in nursing homes. The GMS accepted the general principle of needing four years specialist

training for geriatric medicine but this is in addition to two years of internal medicine. The curriculum for this training has been published in the brochure 'Training in geriatric medicine in the European Union'<sup>5</sup>. Included are the knowledge of basic care and provision of appropriate services in geriatric medicine, assessment and training, rehabilitation services, discharge planning, assessment for long term care and research. The brochure also describes the requirements needed for the recognition of training institutions and teachers.

The use of a logbook is recommended in most countries and provides useful information about the facilities of the training centre and departments where the trainee has been trained. Only in Germany, Italy and the Netherlands is a logbook not used. The GMS advises a combination of clinical and theoretical training as the best method<sup>5</sup>. Most countries have this combination, but Denmark, Finland and Germany suffice with clinical training alone. The value of a final examination is a matter for debate. At present only five countries have introduced an examination to mark the end of training. The need for, and the benefits of, a European examination at the end of training in geriatric medicine require discussion. Some medical specialties have an examination but on a voluntary basis and it is seen as providing a European standard especially for those specialists who potentially want an academic or international position.

The United Kingdom and Italy have by far the greatest number of specialists and corresponding professional societies for geriatric medicine.

### Geriatrics Fora within Europe The European Association of Gerontology (IAG)

The objective of the IAG is to promote gerontological research in biological, medical, behavioural and social policy, and practice fields. It has a close relationship with the United Nations programme on Ageing. The IAG has five regional divisions: Europe, Africa, North America, Latin America and the Caribbean, and Asia/Oceania, and different sections have been established for social sciences, biological sciences and medicine. A world congress is organised every four years, the next being in Rio de Janeiro, Brazil, in August 2005. Regional congresses are organised in the intervening years

### European Academy for Medicine of Ageing (EAMA)

In 1995 the EAMA started a programme for teaching and training the teachers in geriatric medicine. It was thought to be the best way of stimulating education in geriatric medicine for both medical students and

specialist training. Each course is divided into four one-week sessions spread over two years. Geriatric medical issues, over a wide range, are covered during the four weeks, and include a large variety of medical problems, ethics, preparing and judging an article and aspects of management and education.

The executive board selects about 35 candidates on their functional abilities and their positions within educational or training institutions. The training consists of lectures by the students, and chairing and reporting the results of discussions in small groups. Highly renowned scientists are invited as teachers and participate in the discussions with the 'students' after the presentations. An individual evaluation is given by a tutor after all 'students' activities'. Five courses of four one-week sessions have been completed. The excellent feedback has encouraged the EAMA to continue this training<sup>6,7</sup>.

### Geriatric Medicine Section of the UEMS

The statutory purpose of the UEMS is the harmonisation and improvement of the quality of medical specialist practice across the European Union. Education is a key element in this field, with the aim of studying, promoting and defending the free movement of specialists in the European Union. The UEMS collaborates with the Standing Committee of Doctors in Europe and with the European Union of General Practitioners and encourages information exchange between medical specialists<sup>4</sup>. Special attention is given to the quality of specialists' training and continuing medical education<sup>8,9</sup>. Medical specialties that have been recognised by at least eight European Union member states can be accepted as a section by the UEMS, and 36 sections have so far been established.

The main goals of the GMS are to provide a European view on geriatric medical services to the UEMS, to provide recommendations on training requirements in geriatric medicine and to encourage discussion of issues affecting older people across European Union countries. The GMS has developed guidelines for specialist training<sup>5</sup> and has prepared a chapter on geriatric medicine for the European Manual of Internal Medicine<sup>10</sup>, which is aimed at all trainees in specialties that incorporate a period of training in internal medicine. The GMS is now preparing guidelines for the accreditation of specialist training in geriatric medicine. The requirements for the specialty are laid down in the Charter on Training of Medical Specialist in the European Union<sup>8</sup>. National authorities are responsible for the selection and approval of training institutions and teachers in accordance with their national rules, European Union legislation and the recommendations from the GMS.

The guidelines include site visits as an instrument of quality control <sup>11</sup>.

### European Union Geriatric Medicine Society (EUGMS)

Between 1999 and 2001 there were discussions between the national geriatric medicine societies of the European Union member states, when the general feeling was that there was a need for an umbrella medical society for geriatric medicine in the European

Union. These discussions led to the launching of the EUGMS in August 2001. The mission of the EUGMS is to develop geriatric medicine in the member states of the European Union as an independent specialty caring for all older people with age-related disease. It will develop evidence-based guidelines for preventive and treatment strategies for older people within the European Union.

### Unification of Diversity

The expected demographic change in the world will have a high impact on social and economical aspects of life. Part of the expected consequences of these increasing numbers are the associated health-related problems. Between the European Union countries there are great differences in geriatric medicine, regarding the structure, content, services, undergraduate and postgraduate training, and continuing medical education. The national governments are autonomous in their health care systems, yet it is accepted that there is free migration and exchange of medical specialists. Consequently the national geriatric medicine societies agreed to form the EUGMS. However, this society is not the only player in this field. The ER-IAG, the GMS and the EAMA also try to enhance the services for health-related problems in older people. The last thing that is needed is overlap and unnecessary competition between these players. In the current situation of limited resources, with co-operation, the position of geriatric medicine will strengthen. Competition will be fruitful as long as it stimulates creativity and additional resources.

The first step of co-operation was for the EUGMS to invite the ER-IAG, the GMS and the EAMA, to accept positions within the Society, in order to shape its overall position and to share the activities. The IAG's 'Research Agenda of Ageing for the 21<sup>st</sup> Century' <sup>12</sup> and the 'Valencia Forum' <sup>13</sup> papers show that the IAG gives a high priority to social, economic, behavioural and biological aspects of care. Special attention is given to preventive health measures and health promotion activities. The ER-IAG promotes the development of CME and guidelines for common health problems, although here there may be an overlap with the activities of the EUGMS. The agenda for the congresses and symposia must be carefully drawn up and co-operation is needed in the development of guidelines for medical practice. It is to be welcomed that a representative of the ER-IAG is on the EUGMS board. The training of the teachers is well developed to a high standard by the EAMA, and there is no reason to change this. The EAMA accepted a position on the board of the EUGMS to emphasise the interaction between the two organisations, and the GMS has also become a board

The article is a summary of an article published in *Aging, Clinical and Experimental Research*. The full article may be read in: Hastie I, Duursma S. **Geriatric Medicine in the European Union: Unification of Diversity**. *Aging, Clinical and Experimental Research* 2003; 15,4,4: 347-351

#### Acknowledgements

Thanks go to the members of the GMS of the UEMS, to Prof F. Guillén Llera, Prof. A. Capurso and Prof J.F. Macías Núñez of the IAG and Prof J.P. Michel of the EAMA for providing information on their organisations.

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13. Valencia Forum'. At: [www.sfu.ca/iag](http://www.sfu.ca/iag) or via: [www.eriag.com](http://www.eriag.com).

member. The tasks for the GMS are quality control, and development of guidelines and recommendations for education and training in geriatric medicine. Through this co-operation it is to be expected that there will be acceptance of the GMS guidelines by the EUGMS.

The health care system and the position of geriatric medicine in the United States of America are different from the European Union. Geriatric medicine in the USA has been developed, in the main, as a primary care specialty, with a number of linked nursing home facilities. Within the European Union some countries focus on primary and nursing home care, but in most countries the focus is on hospital services for older people. Research into ageing is well developed in the USA and putting this new research into clinical practice should have a positive effect on the quality of services for older patients around the world.

The IAG allows for exchange between the European and North American regions, but now the American Geriatrics Society (AGS) has a European counterpart in the EUGMS. The '1st Congress of the EUGMS', in 2001, was also the '2nd Transatlantic Meeting' between members of the AGS and the EUGMS.

The ER-IAG, the EUGMS and GMS all have

aspirations to influence the political climate and national governments regarding geriatric medicine and the development of health services for older people. In the structure of the EUMS a link can be made between the GMS, the European Commission and the ministers of health care in the European Union member countries. Influencing the national governments via this route can take a long time, but joint recommendations of the three European Union organisations will have a much quicker and higher impact than advice given by these organisations alone. Geriatric medicine is a growing specialty in the European Union. To meet society's needs, to guarantee the quality of services, and to allow the free movement of specialists between the member states, is a process, that takes time and energy, but is worth doing. The ingredients for a successful future are available now.



Extracted from a paper entitled  
**Geriatric Medicine in the European Union:  
 Unification of Diversity** written by  
**Ian R Hastie and Sijmen A Duursma**  
 on behalf of the Geriatric Medicine Section of the  
 European Union of Medical Specialties (UEMS)

## The BGS Logo

*- who may not use it; who may use it; and under what conditions....*

**The use of a logo conveys credibility and authority to all people who see it. If a product, be it a document, CD, event, flyer or website carries a logo it will be deemed to carry the official approval of the organisation to which the logo belongs. Any logo needs, therefore, to be used with care and respect.**

A considerable degree of autonomy exists within the Society, from the respective national councils down through standing committees, regions and special interest groups/sections. These bodies often collaborate with external organisations in compiling CDs, organising events etc. In this context the BGS logo has been used to lend credibility to a range of products. The request to use the BGS logo can come from a considerable number of sources.

With this in mind, and without attempting to diminish the levels of autonomy currently operated, any group, both

from within and outside the BGS, wishing to incorporate the BGS logo into their work is required by the UK Management Committee to apply for permission to Society's Chief Executive. When making such requests, the applicant should provide full details of the product to carry the logo. These details may take the form of an event programme, a CD, publication or poster. The applicant should also state whether the full logo is to be used, or some proposed variant e.g. the full roundel; full roundel with ribbon, full roundel with strapline etc.

Permission or otherwise, to use the logo will be at the Chief Executive's discretion, although he may refer a request to the appropriate BGS committee for advice.

Once permission has been granted to use the logo, the group is required to submit the final artwork to the Chief Executive for sign-off, prior to production and distribution.

**Alex Mair**  
 Chief Executive

# Trainees' pages



It has been an eye-opening experience becoming Chair of the Trainees Group. My journey home from the Autumn meeting was spent in a state of disbelief.

I wasn't really sure what I'd volunteered for, never mind why I'd done it! I have no real committee experience and, prior to the Autumn meeting, had only been involved with the BGS at a regional level.

Thankfully I have not had cause to regret my decision...yet! I sit on the UK Management Committee, Specialist Advisory Committee at the College, and the Education and Training Committee. It has to be said that the "great and good" in geriatrics that sit on these committees have been very friendly and welcoming. I have been pleasantly surprised by their interest in trainees' issues and experiences. They really do want to make our training as good as possible!

Hence the following plea.

## Making our voices heard

There are 448 trainees currently, and I need to hear from as many of you as possible, from all the regions, so that I can report back to the "powers that be" any problems, however large or small, that

you may be experiencing. Any feedback would be a real help, so that I'm not just giving my own opinion on current issues such as stroke training, shift patterns and recruitment.



In return, I will keep you all updated via this newsletter, and through your regional representatives. The trainees section of the BGS website will start to evolve over the next few months, and I hope it will become a further useful channel of communication.

## Promoting good research

Under the auspices of the Academic and Research Committee, we are hoping to feature the experiences of trainees who are active in research. We want to hear about what motivated people to go into research, their highs (and lows), so if you feel that you could contribute in this area, please contact either Steve Jackson or myself.

Most of the committee will be at the Spring meeting in Derry and it would be great to meet as many of you as possible, either at the Trainees meeting on Friday lunchtime, or in the bar!

**Sally Briggs**  
Chairman : Trainees Group

## Embarking on research

*- a journey of luck and hard work -* by Jugdeep Dhese

**O**ne of the best ways of getting involved with research is being in the right place at the right time.

The tricky part is, of course, to make sure you are in the right place at the right time. As with

hitchhiking all you can do is to set off early and have at least a vague idea of your destination. As a first year SpR I had decided I would like to do some research, although I was not sure what in, where or how. What I did do was make sure that my educational supervisor was aware of my interest. I think that is often the place to start –

ensuring that people who are likely to know about projects in the region, know that you are enthusiastic and interested. In this way somebody may just give you a ride. This is what happened to me: at one of our monthly meetings my supervisor mentioned a project, which had recently been funded to investigate the role of vitamin D in neuromuscular function in older people. This project was due to start the following year but the research fellow's post was unfilled. As soon as I showed an interest, things started moving. An initial discussion with the lead clinician led to my being interviewed, followed by relocation from the sunny south coast and to south London. Nearly five years on (and one baby later) I am 'looking forward' to a PhD viva this summer.

### The lie of the land

So, where should you start? As any hitchhiker will tell you a good place to start is where you are right now. Unless you have a burning interest, which is unlikely if you are in the first few years of being an SpR, the good step is to investigate the research interests of your local academic or NHS research active departments. Talk to research active SpRs and consultants, get a feel for the kind of projects that may be available, or brainstorm about your ideas. If you are not sure where to find these people the BGS Academic and Research committee will be able to help. If you are starting your own project, one of the most difficult steps is ethics application and funding. For this, you certainly need good guidance about where to go for money, and it helps to have someone in an appropriate position to support your application.

What do you need to bring along? I think that a vital piece of luggage is enthusiasm, but good mentoring, throughout the project, is crucial. Someone to sit with in a pub and moan to (as well as celebrate with) is also helpful.

And why stick out your thumb for this long and often uncomfortable trip? There are many useful skills that you will develop along the way. These include learning how to design a study, develop

methodology, drink lots of coffee, and recruit patients.

### The job of research

The next step is collecting, processing and analysing the data. This involves learning new computing skills and 'refreshing' your statistical knowledge. It feels like quite an achievement – being able to converse in *t tests*, analysis of variance and logistic regression. In order to make sense of your findings, you will learn how to review and critically appraise both your own and others' work. Eventually you reach the point where you sit down (for hours) trying to shape your findings into a coherent and concise piece of writing. And then, at last, that feeling of having arrived - the thrill of knowing that you have found something new (even if it is a negative finding), having an abstract or article published, or presenting it at a conference (more exciting if it is somewhere sunny and exotic)!

Although it has been hard work, I really enjoyed my two years in full time research, enough to make sure I continued with research on returning to a clinical post. It has allowed me to acquire some of the skills I mentioned before. These are proving most useful, both in clinical work and in considering future research work. I have been able to publish our work, present it at national and international meetings, and write a thesis. It has opened up my career path and allowed me to consider new and different directions. Besides all that I believe good research, focussing on the older population, is essential to raising the status, profile and awareness of care of older patients.



Jugdeep Dhesi

**..going it alone, one of the most difficult steps is ethics application and funding. For this you need good guidance about where to go for money, and it helps to have someone in the right position support your application**

**Jugdeep Dhesi**  
Senior Clinical Fellow  
Guy's Hospital

# Care services for older people

## - King's Fund announces inquiry

Concerns are growing that London could soon be faced with a crisis in care services for older people in the capital, the King's Fund says, as it launched a major inquiry into the capital's care market.

A call for evidence is going out to professionals and practitioners in the field, as well as older people and carers directly affected by these services.

King's Fund chief executive Niall Dickson said: "There are serious concerns in London about both residential and home care services. Our inquiry will aim to see whether or not the capital is delivering sufficient care services of the right quality to meet the needs of London's diverse older population. We anticipate that much of our work will also have relevance for care services in other parts of the country."

The King's Fund wants to hear what people living

and working in London think about care services in the capital. King's Fund senior associate Julia Unwin will chair an independent inquiry committee to consider the evidence that will be presented by a broad range of stakeholders, including:

- ◆ older people and their relatives
- ◆ agencies running care homes, home care, day services and very sheltered housing
- ◆ care staff, their trade unions and professional associations
- ◆ social services, housing and health authorities responsible for commissioning care services.

The inquiry will examine how local authorities and their health and housing partners are working with independent care providers to shape and manage local care markets. It will also look at the extent to which inequalities in care services are being addressed, focussing on services for older people with dementia and for older people from minority ethnic communities. As well as gathering and analysing evidence from stakeholders, the Inquiry will commission new research.

King's Fund senior health and social care adviser Janice Robinson, who is leading the inquiry, added: "The future for older Londoners needing care and support remains uncertain. Our inquiry will highlight the challenges to providing a high standard of responsive services that will give the capital's older people the services they need and the quality of life they want."

### Report

The King's Fund will produce a full report of the findings with recommendations for action in spring 2005. Interim findings will also be produced during the 18-month inquiry.

### What is the care market?

In the 'care market', individuals, and local councils and the NHS, who act on their behalf

- ◆ choose and buy different types of residential and home-care services at a price they can afford
- ◆ pay for care services run by different businesses and charities, often in competition with each other for customers or clients.

#### 1 Call for evidence

People are being asked to give their views in writing or online, responding to *all or some of a set of questions*, by 2 April 2004. Oral hearings will be held in summer 2004. The committee of inquiry will also invite some older people and their carers to discuss issues that concern them in small group discussions during the summer of 2004. The call for evidence paper is available from Sarah Robinson on 020 7307 2539 or srobinson@kehf.org.uk

#### 2 Inquiry committee members

**Julia Unwin**, Chair of the Enquiry; **Ratna Dutt**, Director, REU; **Peter Fletcher**, Director, Peter Fletcher Associates; **Howard Glennerster**, Professor Emeritus, London School of Economics; **Tessa Harding**, Head of Policy, Help the Aged; **William Laing**, Director, Laing and Buisson; **Leslie Marks**, Chair, Bromley Council on Ageing; **Lorraine Martins**, Director of Diversity, Audit Commission; **Jo Moriarty**, Research Fellow, Social Care Workforce Research Unit, King's College London; **Peter Smallridge**, Chair, Ashford Primary Care Trust; **Peter Westland**, Commissioner, Commission for Social Care Inspection; **Peter Williams**, Deputy Director, Council of Mortgage Lenders.

#### 3 Fact sheet

The King's Fund Care Services Inquiry fact sheet is free to download at [www.kingsfund.org.uk/summaries](http://www.kingsfund.org.uk/summaries), or by calling King's Fund publications on 020 7307 2591.

Local authorities and the NHS also run care services. But this has declined markedly over the last ten years, and independent agencies now supply the majority of services. Older people with long-term illness and disability are the single biggest group using the care market.

contact Daniel Reynolds in the King's Fund media and public relations office on 020 7307 2581 or 07831 554927, or Michael Moruzzi on 020 7307 2585.

**Sian Evans**  
King's Fund Press Office

For further information and interviews, please

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# Cerebral Ageing and Mental Health

## - Annual Report

**T**he Cerebral Ageing and Mental Health Special Interest Group has continued to be active, despite the fact that it has not secured sponsorship or other funding.

In March 2003, in collaboration with the BGS Primary Care and Care Home Special Interest Group (now called the Primary and Continuing Care SIG), the Cerebral Ageing and Mental Health SIG participated in the Faculty's residential meeting in London, facilitating a workshop on Geriatrician and old age psychiatrist involvement in care homes. Noeleen Devaney, with help from colleagues in both SIGs, then redrafted the Royal College of Psychiatrists' **Position Statement on Specialist Medical Input to Residential and Nursing Home Residents**. This document is currently with the Policy Committee of the BGS and with the Executive Committee of the Royal College of Psychiatrists for ratification. A similar workshop is planned for the residential meeting in Liverpool, March 2004. The importance of this work, in terms of developing policy in collaboration with outside organisations (RCPsychiatrists, RCGP, RCN), led to our SIG being established as one of two that have a direct role in formulating BGS policy, reporting to the UKMC through the Policy Committee of the BGS.

### Parallel Sessions

In April 2003, we provided a parallel session at the BGS Scientific meeting in Aberdeen. This focused on the 1921 and 1936 Scottish dementia cohort studies. Unfortunately an attempt to provide a third stand alone meeting on Mental and Physical Health

Problems in Prisons failed due to inadequate delegate numbers.

In April 2004, we are providing a parallel session at the BGS Scientific meeting in Londonderry, on Old Age Liaison Psychiatry. We shall be bidding for an opportunity to provide a parallel session at a future BGS scientific meeting in collaboration with the BGS Medical Ethics SIG.

Members of the SIG committee have provided and continue to provide guidance to the BGS on responding to NICE guideline developments, e.g. Anxiety and Panic Attacks; Self Harm; Obsessive Compulsive Disorder; Bipolar Disorder; Post-Traumatic Stress Disorder and Cholinesterase Inhibitors in Moderate and Severe Dementia.

I represent the BGS on the RCPsychiatrists Faculty of Old Age Psychiatry Working Group on Old Age Liaison Psychiatry. Members of the SIG are also working with the BGS to develop guidelines on delirium.

### Ongoing Liaison

On behalf of the SIG, I and committee members continue to seek ways of bringing Old Age Psychiatrists and Geriatricians together in educational and research fora and would welcome any suggestions of ways to achieve this.

All committee members were re-elected in 2003 for a second and final term of office. Nominations are being sought for future committee membership, as we will need a new committee in 2006. A new post of trainee representative was elected to the committee.

**Duncan Forsyth**  
Chairman  
Cerebral Ageing and Mental Health SIG

## RCP (LONDON) - EMERGENCY CARE

### Emergency Care and Older People: The Forgotten Millions

25 March 2004

Royal College of Physicians, London

Despite major improvements through the NHS plan, Reforming Emergency Care and the 4-hour target for Emergency Departments, certain groups still do not receive appropriate or adequate care. These include older people who often have the most complex needs.

At this half-day conference high profile speakers will discuss whole systems care for the acutely ill elderly, and admission prevention. They will also review the evidence base for different aspects of care and examine multidisciplinary working.

This conference will be of interest to: Specialists in Care of the Elderly Medicine, GPs, Emergency physicians, Nurses, Rehabilitation professionals.

#### For a programme and booking form please contact:


Conference Office, Royal College of Physicians  
Tel: 020 7935 1174 Ext. 300/436/252 Fax: 020 7224 0719  
Email: conferences@rcplondon.ac.uk

## BGS 2004 SPRING MEETING

22-24 April 2004

Millenium Forum and St Columb's Theatre, Derry/Londonderry, Northern Ireland

Register online at:  
[www.bgs.org.uk/meetings/meetdate.htm](http://www.bgs.org.uk/meetings/meetdate.htm)



Hampton Medical Conferences has moved to: 113-119 High Street, Hampton Hill, Middlesex TW12 1NJ  
Tel: +44 (0)20 8979 8300

## OSTEOPOROSIS AND OTHER METABOLIC BONE DISEASES

31 March - 2 April 2004

Supported by the British Geriatrics Society, the National Osteoporosis Society, Bone and Tooth Society and the Society for Endocrinology

Balliol College, Oxford

CPD approval applied for

#### Contact:

BioScientifica Ltd, Euro House, 22 Apex Court, Woodlands, Bradley Stoke, Bristol BS32 4JT. Tel: +44 1454 642240 Email: conferences@endocrinology.org

## MOVEMENT DISORDERS

### Birmingham Movement Disorders Course

2-4 April 2004

University of Birmingham

Focussing on hypokinetic movement disorders (primarily Parkinson's disease)

Contact: Susan Pope, City Hospital, Dudley Road, Birmingham B18 7QH  
Tel: 0121 507 4076 Email: susan.pope@swbh.nhs.uk

## BGS RETIRED MEMBERS

7- 9 May 2004

The 2004 meeting of the BGS Retired Members Group will take place in the historic market town of **Beverley, East Yorkshire**

All members of the Society now in retirement are welcome to take part. Meetings are essentially agreeable occasions with opportunities for conversation and reminiscence based in interesting locations.

Further details are available from Peter Horrocks, 3 Langholm Close, Beverley, HU17 7DH. Tel 01482 882390 or e-mail peter03@doctors.org.uk

### ORTHOPAEDICS

#### Modernising Orthopaedic Services

17 May 2004

The English Heritage Centre,  
London

**Contact:** The Bookings Dept, IBC  
UK Conferences Ltd., Informa  
House, 30-32 Mortimer Street,  
London W1W 7RE

Email: [cust.serv@informa.com](mailto:cust.serv@informa.com)  
Register: [www.healthcare-info.co.uk/LH1232](http://www.healthcare-info.co.uk/LH1232)

### EMERGENCY CARE

#### Managing and Improving Emergency Care Services

18 May 2004

The English Heritage Centre,  
London

**Contact:** The Bookings Dept,  
Informa UK Ltd., P O Box 406,  
West Byfleet KT14 6NN

Email: [cust.serv@informa.com](mailto:cust.serv@informa.com)  
Register: [www.healthcare-info.co.uk/LH1233](http://www.healthcare-info.co.uk/LH1233)

### MEDICINE FOR THE ELDERLY

#### 10th Leicester Medical Conference

9 June 2004

Oadby, Leicester

Early discharge, osteoporosis,  
psychiatry etc.

**Contact:** Dept of Cardiovascular  
Sciences, Ageing and Stroke  
Medicine Group, The Glenfield  
Hospital, Groby Road, Leicester,  
LE3 9QP  
Email: [stroke@le.ac.uk](mailto:stroke@le.ac.uk)

### BGS SPECIAL INTEREST GROUP GASTROENTEROLOGY & CLINICAL NUTRITION

#### Annual Scientific Meeting

11 June 2004

The Marriott St Pierre Hotel and Country Club, Chepstow, Gwent

**Contact:** Dr Nadim Haboubi  
Consultant Physician/SIG Secretary, Nevill Hall Hospital, Brecon Road,  
Abergavenny NP7 7EG Email: [nadim.haboubi@gwent.wales.nhs.uk](mailto:nadim.haboubi@gwent.wales.nhs.uk)

### HIPFEST SIX

#### Hip Fracture Care; the changing picture

11 June 2004

RCP, Edinburgh

Casemix trends, Surgical  
techniques, Good practice

Registration: £60 (lunch included)

**Contact:** Mrs Margaret Farquhar  
Education and Standards Dept  
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### PARKINSON'S DISEASE

#### British Geriatrics Society SIG on Parkinson's disease

15 July 2004

#### 9th conference on the "From Science to Practice" series

Royal College of Physicians, London

The morning session will review the current research on why people with Parkinson's disease fall and what can we do about it. Visuospatial function is also affected in Parkinson's disease; the significance of this in practice and right- and left-sided differences will be examined. The afternoon sessions will concentrate on palliative care in Parkinson's disease. This is an important area with very little science and, unfortunately, a lot of dubious practice. This year we return to this topic in more depth, starting with the ethical and legal framework for end-of-life decisions.

**Contact:** MEP Ltd on Tel: + 44 (0)20 7561 5400 or Fax: + 44 (0)20 7561 5401  
or Email on [info@mepltd.co.uk](mailto:info@mepltd.co.uk).

### FALLS SYMPOSIUM

#### East Midlands and Trent Falls Symposium

11 June 2004

Post Graduate Education Centre,  
Nottingham City Centre

**Contact:** Gill Costello, PGEC,  
Nottingham City Hospital, Hucknall  
Road, Nottingham NG5 1PB  
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# BGS Strategy

- promoting academic medicine and research

**A** thriving research culture in ageing and clinical geriatric medicine is of key importance to the future strength and influence of the Society, and to the future care of older patients.

Academic medicine in general, and academic geriatric medicine in particular, are experiencing difficult times for a variety of reasons, not least the squeeze in higher education funding and the rush to try to enhance research assessment ratings for the next research assessment exercise. The focus of the NHS on short term targets and continuing under funding of research by the NHS (<1% total expenditure) has also contributed to increased difficulties in maintaining active research programmes in geriatric medicine in many universities. It is only necessary to look at the evidence base underlying those medical specialties without significant academic activity to understand the likely long term detrimental effects of a loss of research activity within the specialty. In keeping with many other specialties, there are vacant chairs and senior lectureship posts in geriatric medicine.

Of equally great concern is the trend to disestablishing academic departments. Whilst loss of departments in itself is not a problem, loss of posts in academic geriatric medicine will have far reaching negative effects on both teaching and research. These factors have been well reviewed by Professor Stout ([www.bgs.org.uk/publications/acadmedicine.htm](http://www.bgs.org.uk/publications/acadmedicine.htm)). If the specialty is to survive in the university sector, the BGS must actively promote its profile and nurture its trainees with independent research potential and its newly independent researchers. There are examples of successful geriatric research groups in the UK, where groups of clinical, basic and social scientists have flourished in the current academic environment. The single most powerful argument in favour of academic geriatric medicine is that population ageing is here to stay and future challenges, although not funded, are now recognised by the NHS. It is essential that the BGS

and its members are seen to be united in both their conviction and their arguments in support of the continuation of academic geriatric medicine.

## Identification and support of potential independent researchers

It is crucial that the “supply” of young researchers is increased and that they are supported. Research experience within SpR training should be seen as the ‘norm’ and not the exception. Without being directly exposed to a research environment it is impossible to identify, with any certainty, those that will flourish and become the future leaders of academic geriatric medicine. Nevertheless, it is possible to identify those more likely to become productive researchers. The Society can contribute towards this process in a number of ways:

### Research methodology training

Working with the charity Research Into Ageing (RIA) (now part of Help the Aged), a series of research methodology workshops have been started. These workshops have been based around local experts and priority given to local SpRs. It is hoped that local contacts will result in relevant collaborations in subsequent research proposals. The first of these workshops was held in Manchester in 2001 and subsequently in Bristol in May 2003 and in Glasgow in November 2003. Whilst it continues to meet a need, this will continue as an annual event.

### “Meet the Researchers”

Starting in April 2002, a lunchtime session has been organised by the former Scientific Committee and held at the national BGS meeting. The objective of the meeting is for SpRs interested in research to meet active researchers (both NHS and University employed) and to talk about how to get started. The attendance and feedback from SpRs has been excellent for the three sessions that have been held to date. These sessions will continue, initially on a bi-annual basis.

### Raising the Profile of Research Active Trainees

The scientific meetings continue to provide an opportunity for research active SpRs to present their work and compete with others for the oral

presentation and poster prizes. In addition, the Society's Newsletter will become a vehicle for raising the profile of research active SpRs.

### Travel Grants

At present the only research grants available to SpRs from the Society (other than the Dhole Training Fellowship), are the Start-up Grants designed to pump prime own-account research to enable external grants to be obtained subsequently. A potentially important expansion in the categories of grants available from the Society will be to include the funding of proposals to visit centres of excellence in order to learn new techniques or methods. In addition to learning methodology, it will enable aspiring researchers to experience first hand, the way large successful research groups work. This will be linked to research proposals and follow up information about successful applicants will be recorded.

### Training Fellowships

Training fellowships offered by the MRC, Wellcome Trust and the recently introduced National Clinician Scientist Scheme are highly competitive and strongly favour applications associated with major research groups. Application for these will be encouraged. Substantially funded by income from the Dhole bequest left to the BGS by the late Dr Dhole, a Dhole Fellowship will be awarded every three years. The first fellowship is expected to start this year. This fellowship is jointly funded by Research into Ageing and the Society (£25K per annum for three years). The Academic and Research Committee is of the opinion that a training fellowship would have a far greater impact on the research profile of the Society than the previous use of the money to fund small individual research projects. It must be the strategy of the Society to expand this programme, initially to an annual fellowship.

### Role of SIGs/Sections in research/research management

When the SIG and Section framework was set up a high priority was placed on the development of research related activities. Most of the SIGs and all the Sections include the presentation of research in their meetings, indeed this is one of the requirements for a SIG to acquire Section status. Over the last three years SIGs and Sections have sent representatives to a meeting, held within the Society's meetings, to share information and feed back to the Academic and Research Committee.

### Identification of evidence gaps

The identification of gaps in the evidence base must

be the way to drive the research agenda rather than having the agenda capacity driven by groups with expertise. The process of drawing up a coherent list of such topics should be undertaken by the SIGs/Sections as they are the experts in their fields. This fits well with the new Health Technology Assessment process of seeking suggestions for research questions.

### Management of the research process

Having identified important gaps in the evidence, several SIGs/Sections have put together research grants that have been funded. These have involved multicentre studies and the process of protocol development leads to a natural management committee that meets on a regular basis. This model is one that fits well with the structure of the Society and the research interests of its members.

### Involvement with outside bodies

Working with SIGs/Sections, the A&R Committee will interact with outside bodies to identify ways in which the Society can impact on the climate for research in ageing and the process by which research priorities are set. To date the BGS has had such interactions with the Health Technology Assessment agency and has submitted research questions. In the future, interactions with other Dept of Health agencies, the Medical Research Council, the Wellcome Trust and the US National Institute of Aging should be sought. In the last case this interaction might identify, possibly in collaboration with the American Geriatrics Society, collaborative research, funding or exchange facilities. A major funder of ageing research is Research Into Ageing. Close links between the BGS A&R committee and RIA Research Advisory Committee (RAC) exist with two rBGS representatives on the RIA RAC: usually the Chairman and one other member.

### Developing the research capability of individual departments

Departments of Geriatric Medicine/academic geriatricians should critically evaluate their current strengths and weaknesses. They must be encouraged to participate fully in the research strategies of their universities and medical schools, and seek alliances with relevant disciplines in particular areas. Academic geriatricians should play a lead role in facilitating and supporting age-related research by other researchers and encourage collaboration between clinical academic geriatricians and other clinical academic specialties and non-clinical scientists in order to build a critical mass of

researchers.

### **Role of the UK Association of Professors of Geriatric Medicine**

The Association of Professors of Geriatric Medicine has traditionally met for one hour only once a year although this has recently increased to twice a year, at the national BGS meetings. The range of interests of this group covers the whole spectrum of traditional academic activities including teaching and training as well as research. During the preparation of this strategy paper, the Association has given support to expanding its activities to include areas not previously covered.

### **Review of job plans and job descriptions for clinical academics**

This process might help to establish viable clinical academic posts by ensuring that fixed clinical sessions do not exceed half the full time NHS consultant maximum of 6, i.e. 3 fixed clinical sessions. This advice will be modified in the light of the new consultant contract.

### **Peer support for senior lecturers**

The establishment of support mechanisms including a mentoring scheme for senior lecturers is an important step in helping senior lecturers to remain focussed on their agreed objectives, and to achieve promotion to professor within 10 years. A senior lecturers group will be part of this initiative.

### **Provision of support for academic geriatricians under threat**

Support for Departments or individuals faced with pressure for closure/loss of academic status from their university is unlikely to have any influence. Of potentially greater value will be to recognise those at risk much earlier, and have discussions with the academic members about their strategy.

### **Review of Grant Applications**

Particularly for training fellowship applications and probably other grant applications, the A&R Committee, together with the Association of Professors, could promote an internal review process. This will enable applicants to enhance the quality of their applications prior to submission. The process will be undertaken with a sub group composed of members of both committees charged with the responsibility for undertaking this task. The review of proposals could all be done electronically.

### **BGS Scientific Meetings**

The BGS has the opportunity to demonstrate the quality and relevance of its members' research at the Scientific meetings and this must be continued together with the rigorous peer review process already in place. These meetings provide an important opportunity for researchers to interact and in particular, for trainees to experience the excitement of research and see good research presented.

### **Lobbying**

At the most senior level, the BGS must use its influence to persuade decision makers of the importance of the contribution our speciality can make to the health of the population. Further, the message must include the clear statement that without a healthy academic base, this contribution will be severely weakened. It may be productive to concentrate on the Department of Health and Department for Education and Skills. Involvement with Universities UK would seem much less likely to be productive. This role is likely to be most effective if taken on by those most likely to be heard. This will include not only some senior members of the Society, but also some of those recently retired.

### **Undergraduate Teaching**

The recent white paper, "The Future of Higher Education", from the Department for Education and Skills gives the impression that teaching will be given far more priority than in the past. Teaching currently continues to be sacrificed in favour of the much more lucrative 5-star research assessment rating. Without a strong academic base, undergraduate teaching quality will suffer and the best students will not be attracted into the speciality. The Society is strongly opposed to the delivery of specialist geriatric medicine teaching by those not trained in the speciality. This is a distinct risk if numbers of academic geriatricians/Departments are reduced, as multidisciplinary research groups cannot take on this role. NHS consultants not in academic posts increasingly play a major role in the delivery of teaching. Ways to provide support for and recognition of this activity will be considered by the Society's Training Committee. The Society has recently held a symposium on teaching and training within the main meeting.

**Steve Jackson**  
Chair, Academic & Research Committee

# Health care accreditation programme



- update

**T**he Hospital Accreditation Programme (HAP) has a proven record in promoting organisational standards in healthcare organisations.



It was set up in 1990 to monitor, assess and develop organisational standards in healthcare organisations.

HAP seeks to set standards that -

- ◆ Provide hospitals with a supportive management development tool
- ◆ Encourage hospitals to review current practices and procedures to facilitate change
- ◆ Provide supporting mechanisms for hospitals preparing for accreditation
- ◆ Improve the organisational standards in small hospitals
- ◆ Set standards that are credible, achievable, measurable, applicable and agreeable
- ◆ Train surveyors to be professional, objective and consistent in their assessment
- ◆ Establish a national Board of professional advisers to assess reports consistently
- ◆ Direct the future programme to the best interest of hospitals and Trusts in relation to macro environmental changes
- ◆ Provide a mechanism to enable participants to network
- ◆ Provide a competitive cost efficient mechanism for internal development
- ◆ Provide an overall efficient and professional service.

Approximately 300 survey visits have been undertaken in healthcare organisations within the UK, Ireland and even in some organisations abroad. Initially, HAP focussed on hospitals with less than 200 beds, mainly independent and NHS community units. More recently the programme

has expanded to include accreditation in community services including Primary Care Trusts and District Nursing Services.

HAP is owned by CHKS Ltd but managed by CASPE Research. CASPE Research is a 'not for profit' organisation carrying out research aimed at improving the quality of care. It carries out research on behalf of the DoH and it runs the Accreditation and Development of Health Records Programme. HAP offers independent and NHS healthcare organisations an opportunity to participate in voluntary accreditation programmes. The programme aims to ensure that robust systems are in place within the organisation to delivery quality services and to support clinical and corporate governance.

## Updating assessment standards

The healthcare standards used for assessment are continually monitored and reviewed in consultation with the users and with professionals to provide comprehensive up to date guidance. HAP runs a programme of organisational development to ensure participants are continually updated on new standards, changes in national policy and quality issues affecting them at a national and local level. HAP surveyors are recruited from accredited facilities and are seconded to the programme for approximately six days per year. Surveyors offer individuals the chance to visit similar facilities throughout the UK and thereby promote professional development. HAP was in fact the first accreditation programme in the UK and has set up accreditation programmes in Europe and South Africa. It is recognised by the Academy of Medical Royal Colleges, Community Hospitals Association and the Independent Healthcare Association. It also contributes to the International Society for the Quality and Healthcare Initiative to develop international principles for healthcare accreditation standards (ALPHA project).

## Stakeholders

HAP's Board has advisors from fourteen organisations including the BGS but there are members from, among others, the Royal College of

Anaesthetists, RCGPs, Royal College of Midwives, RCN, Royal College of Obstetricians and Gynaecologists.

The role of the Independent Professional Board, of which I am a member, is to decide on the level of accreditation to be awarded. Board members consider all aspects of the surveyors' report and assess whether the organisational practices are conducive to the delivery of good quality, safe care and award accreditation status as appropriate. Accreditation may be awarded for either 1, 2 or 3 years depending on the level of compliance with the standards. Members liaise with nominating organisations to promote and monitor safe practice and continuous quality improvement. I have fed in details of NSF, Essence of Care, recent BGS Bulletin information etc. as well as information I obtain in my roles as Medical Director at Basildon and Thurrock University Hospitals NHST, NSF Lead for Elderly, Manager of the Education and Training Directorate at Basildon and work on the North Thames SpR Training Committee.

### Training the Board

There is formal training for Board members and surveyors at least twice a year (1 or 2 days). At this point an opportunity is taken to update Board members on accreditation processes, review standards etc. I have attended these annually and their quality is excellent. Standards are continuously reviewed and updated to ensure they are relevant and timely, and events in relation to CHI assessments, NCSC, PPU, IHA and Department of Health are taken on board.

### Walk in centres

Recently standards for assessment of treatment centres and walk-in centres are being developed and included. Approximately two years ago I took part in a full review of the standards relating to the older people and these are being reviewed again this year. In addition to a constant review of the standards framework, client feedback is taken on board to improve the accreditation process.

Apart from my input in assessing the outcomes of accreditation visits and input into keeping standards for the elderly updated, I was also involved in a sub-group looking at the scoring mechanism for HAP. This mechanism has now been piloted and introduced to help support the Board in making objective decisions on accreditation with particular reference to the safety of the organisation accredited and separating

“core” and “non-core” standards.

Since my time on the Board, standards applicable to community services have also been added (1999), including health visiting and district nursing services, and manuals for accreditation standards and for surveyors have been split to focus on particular sectors and healthcare structures, e.g. a document focussing on independent healthcare, one on Scottish health services and one on NHS services throughout England and Wales.

### Changing times

The UKMC is of the opinion that, for the moment, the BGS should remain involved in this organisation to ensure that proper standards for care of older patients are maintained within the organisations accredited, and the standards themselves focus on clinical issues, up to date practice and excellence relating to older patients' care.

The increased involvement of CHAI is bringing pressure on organisations involved in accreditation such as HQS and HAP. With the arrival of CHI assessment and new risk management standards including CNST etc, organisations have been less inclined to be involved in accreditation processes. This has been because much work was involved in multiple reviews along with the usual clinical workload. The BGS may need to review involvement with HAP in the future, should HAP change its focus.

Having said this, HAP does work closely with Commission for Health Improvement, the Independent Healthcare Association and the National Care Standards Commission to ensure integration. At a meeting earlier this year, CHI indicated that it was not in the business of standard setting and clearly organisations that were already subject to an accreditation process would be in a strong position. HAP may well therefore benefit from positioning itself to support such accreditation.

A catalyst for change may be the plan for quite a large group of independent hospitals to withdraw from HAP accreditation. HAP may increasingly be involved abroad and the BGS will then review the usefulness of its involvement with organisation.

**Gill Jenner**  
BGS representative on  
HAP Board

# Keele University

launches Institute of Ageing

At a ceremony presided over by Sir David Weatherall, Chancellor of Keele University, the Institute of Ageing was launched on 26 January

The Institute of Ageing brings together one of the largest groups of researchers working in the field of gerontology in the UK. There are already five Professors whose interest in ageing is expressed in their titles (Chris Phillipson, Mim Bernard, Judith Philips, Simon Biggs and Peter Crome). Keele University pioneered studies into the social aspects of ageing populations, and has built on this work with an expansion in research and teaching across a broad range of health, social and bio-medical topics. The main research groupings within the Institute are drawn from the Centre for Social Gerontology, Geriatric Medicine, Nursing, the Centre for Health Planning and Management and Physiotherapy. Many have presented their work at BGS meetings. Research in the field of ageing contributed to the 5-star rating secured by the Social Policy unit of assessment in the 2001 Research Assessment Exercise.



Prof Peter Crome

## Research themes

The work of the Institute is built around three main research themes, namely:

- ◆ The social construction of ageing (e.g. family and intergenerational ties, social exclusion, and social influences on identity and behaviour).
- ◆ Rehabilitation and disability in later life (e.g. stroke, respiratory disease, falls and osteoarthritis) and the development of relevant outcome measures.

- ◆ Service management and development (e.g. evaluating service delivery and policy, intermediate care, the interface between health and social care).

## Research Mission

The Institute is a cross-faculty group that combines clinical and non-clinical interests in ageing across the University. The aim of the Institute is to promote Keele as a leading international centre for the study of old age. A related concern is to stimulate multidisciplinary and interdisciplinary research projects. Key objectives of the Institute include:

- encouragement of collaborative research;
- building research capacity within the University around work on social and health aspects of ageing;
- and working with health, social care and voluntary organisations across the West Midlands region as well as nationally.

## Research Highlights

Members of the Institute have built an extensive track record of funding and collaboration with major national and international organisations, including Research Foundations, NGOs, Government Departments and major charitable foundations. Project funders include the **Economic and Social Research Council**, the **Joseph Rowntree Foundation**, the **Nuffield Foundation**, the European Union, the **Stroke Association**, **Action Medical Research**, **Research into Ageing**, the Community Fund and the **Novartis Foundation**. Publishing collaborations have been developed with **Help the Aged** and **Age Concern** and policy collaborations with government and voluntary bodies concerned with the care of older people. Strong international links have been formed, notably with research centres in Germany,

Holland, Japan, Canada and the USA. Regular invited presentations at key international conferences, for example those organised by the International Association of Gerontology, the Gerontological Society of America, and the Canadian Association of Gerontology. Institute members hold leading positions in the Royal Society of Medicine, British Society of Gerontology and International Association of Gerontology.

### Postgraduate Teaching

Members of the Institute run two highly successful modular Masters courses: the MA in Gerontology and the MSc in Geriatric Medicine. These courses attract both UK and overseas students including many of the Specialist

Registrars on the West Midlands rotation.

### Future Plans

This Institute is one of three linked to the development of the Medical School at Keele. Six new posts in ageing research are planned for the next few years. The first two posts, a clinical Chair in Disability and Rehabilitation and a non-clinical Readership in Health Services Research are due to be advertised later this year. The University has also just appointed Professor Maggie Pearson as Deputy Vice-Chancellor. She will also be joining the Institute.

**Peter Crome**

Professor of Geriatric Medicine  
Keele University

## The Dhole Research Training Fellowship Research into Ageing

**British Geriatrics Society** and **Research into Ageing** are delighted to announce the availability of a research training fellowship to members of BGS with an NTN. This fellowship is jointly funded by the British Geriatrics Society and Research into Ageing. Outline applications are invited from the prospective applicants for project start after November 2004. The funding is for a period of two to three years and should not exceed £150,000. **The deadline for outline applications is 28 May 2004.**



### Research into Ageing funding opportunities

Research into Ageing supports research into the biology of ageing and diseases and disabilities associated with

older people. Examples of topics we support are cellular ageing processes, dementia, vision, hearing, falls, mobility, osteoporosis, stroke, incontinence and wound-healing. We do not normally fund cancer research. Applicants may be any nationality, but the project must be carried out in the UK.

### How to Apply

Please find further information about the research funded by Research into Ageing and application forms for the Dhole fellowship and other funding schemes available to download at our web-site [www.ageing.org](http://www.ageing.org)

Research into Ageing, 207-221 Pentonville Road, London N1 9UZ. Email: [grants@ageing.org](mailto:grants@ageing.org)  
Research into Ageing is a special trust within Help the Aged.

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