



B G S

n e w s l e t t e r

Queen Elizabeth The Queen Mother - personal reminiscences

The Queen Mother must surely be one of the outstanding examples of 'ageing well'.

Her great determination, together with mental and physical vitality, no doubt sustained and helped her overcome major operations, as well as the recent death of her daughter Princess Margaret. In spite of falls and increasing frailty, she was determined to maintain her mobility and only used a wheel chair towards the end. She has been 'part of the scene' for so long that it is hard to imagine the world without her.



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I never had the privilege of meeting her but was involved in various celebrations in her life. I had the great pleasure of taking part in the Horse Guards parades for her 90th and 100th birthdays. The gods were smiling on each occasion with excellent weather on both days, which helped to create a very carnival-like atmosphere. Those taking part in the parades were representatives of all the organisations of which she was either President or Patron; I was one of those repre-

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President: Prof Cameron Swift, PhD, FRCP **President Elect:** Prof Robert Stout, FRCP
Honorary Secretaries: Dr Chandhi Vellodi and Dr Kevin Kelleher **Meetings Secretaries:** Dr Juanita A Pascual and Dr Janice O'Connell
Honorary Treasurers: Dr Robert J Shepherd and Dr Ian Sturgess **Administrative Director:** Richard Lynham **Sub Editor:** Rawia Habiby

specialist medical society for health in old age

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senting Research into Ageing. There were rehearsals in the mornings, and the particular phalanx of organisations I was with got a well-deserved 'rocket' from Major Parker, the Officer in Charge, for a truly shambolic entry in Horse Guards. We arrived in a narrow arrowhead formation rather than with eight to ten people in line abreast. We did get it right for the real parade.

I remember that, on her 90th birthday parade, the Queen Mother stood without a chair at the saluting base for over an hour, which was the time it took the whole parade to walk past her. She very evidently enjoyed both occasions - as pleased to see us, as we were to see her. The only down side was that we had to stand for a very long period on both occasions in Bird Cage Walk awaiting our entry moment, so we saw nothing of what went before us and, when in Horse Guards, we could hear little of what was said, even by Sir John Mills. However, we did sing with great gusto! After the 100th birthday parade, I went to the reception at St James Palace. All in all, these were really splendid, memorable occasions.

My first 'contact' with the Queen Mother occurred when I approached her, several years ago, for permission to use her photograph in a book I was writing, with others, about health visiting and the elderly. Her Treasurer, Major

Anstruther, wrote back to say she was graciously pleased to agree and he gave me the address of the agency where I could view relevant photographs. I subsequently spent a happy morning looking at hundreds of photographs, ranging from her first days of life to her latter days. Included amongst the collection was that well-known photograph of her with the Queen and Princess Margaret, all of whom were dressed in blue.

Some years ago, ITV co-opted me to be 'on call' to discuss any medical conditions the Queen Mother might develop. About six years ago, on a Sunday morning, I attended a very professional rehearsal of her final illness. By the time I had heard it four times I could almost have believed the fictitious event.

On Saturday 6 April, I queued for three hours outside Westminster Hall to pay my respects, to say thank you and good-bye. The tableau scene in the Hall was one I shall always remember; there was an indefinable 'atmosphere', the absolute stillness of both the guardian soldiers and police, the total quiet after the noise outside, the kaleidoscope of colours, the sparkling crown, and the slow file past of the public. It was truly a piece of British history. I and many others will greatly miss the wonderful Queen Elizabeth The Queen Mother.

Dr M J Denham

EXTRAORDINARY GENERAL MEETING - TELFORD, APRIL 2002

At a meeting of over 100 members, which took place during the Society's annual Spring Meeting in Telford, the resolution was passed, authorising the officers to proceed with the restructuring of the Society, as described in the March Newsletter (see pages 13 to 15).

However the officers agreed to see if, in the process, greater representation of the English Regions could be accommodated.

A fuller report will be published in the July issue of the Newsletter.

Editorial

page

The first anniversary of the NSF is here. Is it really a year on? For our English members it may feel like just another year - but is it?

Joint publication recommended reading

Let me commend to you our first NSF survey report, jointly published with Age Concern's survey of their organisations from a user perspective (**included in this issue of the BGS Newsletter as a separate document**).

From this survey of English clinical directors and lead clinicians, it seems clear that a lot is happening in terms of engagement of our speciality in the processes surrounding the NSF.

Many of us are clinical champions, but perhaps you are unclear as to what this means? What are your roles and responsibilities? Well, you are not alone. The first conference for champions, arranged by the Department of Health (DoH), which I attended, and on which Bev Castleton and Doug MacMahon have kindly produced an article (page 13), made it apparent that the non-executive champions and Social Service members are perhaps even less clear. Networking seems to be the important message - so go forth, all you champions, and spread the word!

Rebadging of beds was a major concern - 20% of respondents to the survey highlighted this as a problem. That this is occurring has been recognised by the DoH. We need to be vigilant, so let us know at the BGS* in order that we can continue to monitor this closely.

More on the NSF jigsaw

Yet more on the National Service Framework in this edition of the Newsletter. David Black's update from the National Older People's Task Force picks up on the concerns regarding the needs of dementia patients as an area that might be falling between stools.

Delayed discharges are also continuing to cause problems. Cameron Swift's paper on page 17 provides a synopsis of the Society's evidence on delayed discharges to the Parliamentary Health Select Committee. Susan LaBrooy's article (page 16) tells us of the Regional Task Force work in the London region.

Workforce Development Confederations (WDCs) are another key to the NSF jigsaw. See Jane Winter's article on page 14. These organisations have the ability to help with our workforce issues - perhaps the development of generic workers or specialist nurses. They have the money and the clout! So, get to know your WDCs - they can be strong allies.

CPD diaries online

Are you struggling with your RCP CPD online diaries? Struggle no more - help is at hand on page 20. Good luck!

Inadequate training in research

Trainers and trainees take heed - inadequate training in research seems to be a likely Achilles heel in our otherwise successful specialist registrar training programmes. Yet, much can be done to get it right. See Nicki Colledges' article on page 5 for more information.

Moving on

Those of you planning retirement DON'T until you read Richard Lynham's call for information on page 28.

And, finally, a great big thanks from me and on behalf of all of you who have enjoyed the Newsletter, to Rawia, our dear 'rottweiler'. Rawia is leaving us for the sunny south of France and a new life. Her work on behalf of the BGS and the Newsletter has been invaluable. We will miss her sorely. Good luck Rawia!

Dr Chandí Vellodi
Honorary Secretary

*Send to BGS main office (address on page 28).

President's column

Hospital medicine and the needs of older people - it is time to regain the initiative ...

There are indications that the health care of older people faces the challenge of an escalating imbalance in health policy, for which physicians need to be prepared.

Ageing for the 21st century

At the beginning of April, I represented the Society at a meeting of the IAG Council and the Valencia Forum, preceding the 2nd World Assembly on Ageing. Council endorsed the IAG Draft Research Agenda on Ageing for the 21st Century, and Dr Gary Andrews is to be congratulated on conceiving and co-ordinating this mechanism of feeding gerontological evidence to the Assembly and on the Forum's scientific programme to support it.

While supporting the initiative, I was, nevertheless, concerned by the absence from the proceedings of consideration in any systematic sense of the special needs of older people for expert medical care in general hospitals. This is in no way an explicit IAG leadership position, but there seems to be an assumption in the ranks that this will now look after itself and that the priorities lie exclusively in social and community care and in health promotion and prevention, whatever the stage of development of the nation concerned. Social science and social policy are unquestionably driving the strategic agenda for health (including the International Plan for Action on Ageing) to the exclusion of the "medical model". I think this new imbalance is profoundly wrong and that those promoting it risk perpetrating a massive disservice to older people.

Training issues

In a session on WHO Training Strategies in Old Age, a fallacious dichotomy was expounded

between: (1) primary and community care (the priority) on the one hand; and (2) "highly specialised geriatric care in tertiary centres" (a strategic irrelevance) on the other. While there is a laudable commitment to train undergraduates in all disciplines, there are no plans to promote the broad training of hospital physicians in gerontology, let alone the recruitment of career specialists.

Britain's strong tradition of general secondary care development for older people may not be immune to this imbalance. Although the pivotal role of general hospital services receives comparatively cursory treatment in the English NSF, it is at least there. It remains to be seen, however, in the NSF progression (and in the corresponding policy initiatives in Scotland, Wales and Northern Ireland) whether there will be excessive deference to the now predominant "social-primary care model" in policy and research. The prescribed clear place for hospital physicians in intermediate care in England has, for example, proved elusive. Signals concerning the academic emphasis and leadership of both the National Forum for Age Research and the NSF-related R&D programme are keenly awaited. If physicians in this field are studiously moved to the wings of the strategic stage, this will, of course, be music to the ears of that subset of politicians who have no genuine wish to absorb the genuine implications of an ageing population for health care in general and hospital services in particular.

Delayed hospital discharges

In similar vein, on 20 March, I gave evidence on behalf of the BGS to a Westminster House of Commons Select Health Committee on Delayed Hospital Discharge, in parallel with witnesses from the Audit Commission, the BMA and the RCN (see page 17 for written evidence). The Committee's report is awaited, but in the three-hour proceedings promoting the crucial importance of skilled practice and specialist services for older people in acute hospitals proved an uphill task. (I was nobly supported by

the Joint RCP/BGS Committee Chair, Dr David Black, whose enforced silence tested him to capacity!) There was much imaginative but unfocused discussion about new (untested) models of community and social care. From my perspective, the closest affinity on this occasion was with the Audit Commission witness whose pragmatic perception of the need for professional leadership, cohesion, continuity and comprehensiveness in a cash-limited health system for older people held much in common with the professional stance of this Society.

Committed physicians needed

The reality is that the marginalisation of older patients from mainstream medical care (and we are seeing it) is inevitable unless this new imbalance is robustly addressed. Committed physicians are needed at the front line of hospital care (both those with broad, and more focused, training in gerontology), without which the still grossly unsatisfactory plight of sick older people will not improve. The need for such physicians to work across boundaries with social and primary care services is, of course, an equal priority.

The BGS will need to organise to address this at UK, national, regional and local levels, working closely with the Royal Colleges. The structures and mechanisms to do this effectively will continue to occupy the agenda of the office bearers and standing committees. The comparative experience

of BGS members internationally would prove invaluable. Please write to me* with your views. The “model” to which we are committed is the comprehensive one, however unfashionable this may seem. We have rightly fallen over ourselves to embrace the need for further development in new models of social and primary care and, of course, inter-professional working as integral to this. No incomplete “model” is, however, acceptable, and any move to marginalise the importance of achieving change through skilled specialist practice and the work of trained physicians in acute hospitals (including research, recruitment and specialist training) must be swiftly identified and stoutly resisted (!)

The death of Her Majesty, Queen Elizabeth The Queen Mother

I wrote on your behalf to express our condolences to the Society’s Patron, HRH the Prince of Wales, on the Queen Mother’s death. It is self evident that she was an outstanding exponent of the process of growing old well and, in this respect, particularly someone whose example, commitment and strength of character will be missed by very many indeed.

Prof Cameron Swift
President

*Send to the BGS office (for address, see page 28 of this Newsletter).

Research training

for specialist registrars

In the year 2000, the Royal College of Physicians of London surveyed all specialist registrars (SpRs) in the medical specialties in the UK.¹

The survey covered the quality of training and appraisal, time spent in research, attainment of

higher degrees and consultant career plans. Trainees in geriatric medicine were at least as satisfied with the overall quality of training and appraisal as their colleagues in other specialties. However, only 55% had obtained or hoped to obtain a higher degree, compared to an average of 83% in all specialties, and 30% of geriatric medicine trainees did not intend to undertake a period of full-time research, compared to 9% in all specialties.

The curriculum for Higher Specialist Training in Geriatric Medicine specifies that trainees should acquire: *“an understanding of the principles and practice of research, the ability to evaluate medical literature and to promote and supervise research, and the successful completion of a research project or programme”*. Despite this, many trainees do not undertake a period of supervised research, and there is a wide range in the quality and number of publications by trainees at the time of CCST?

This prompted the BGS Training and Trainee Committees to perform a survey of all trainee members of the Society in April 2001 in an effort to explore further the reasons for the apparent lack of enthusiasm for research, and to identify if there were any means of addressing this.

We are grateful to Jonathan Treml for conducting this survey. 203 (67%) out of 300 postal questionnaires were returned, with replies from at least one trainee in each region.

Of those who responded, 45% were planning a period of full-time research during their training, and 61% intended to attain a higher degree such as an MD or MSc. 34% felt that a period in formal research should be compulsory, while 21% stated that they had chosen a career in geriatric medicine as research was less of a priority than in other specialties.

Further findings

The reply that most concerned the Training Committee was that 49% of respondents felt that training in research was inadequate in their region. The reasons for this varied - in some regions, a lack of appropriate consultant supervision or time was reported, while in others, there were no formal training courses in research methodology, or no protected time for research was included in trainees' timetables.

The findings of the survey have now been shared with the Society's Scientific Committee

and the Specialty Advisory Committee (SAC) in Geriatric Medicine.

The Society's response

There is no doubt that there is considerable variation between the standard of research training in different regions. The goal must be to improve all to the standard of the best. Members of the Training Committee were invited to share good practice, and a number of useful examples emerged, such as the Induction Guidance on Research Training given to trainees in South East Scotland (box 1, page 7), the Research Support System in Mersey Deanery (box 2, page 8), and the MSc Course at Keele University (box 3, page 8). Other regions have been invited to use these as templates.

Research surgeries introduced

The Scientific Committee has introduced the initiative of 'research surgeries' to allow SpRs to meet members of the Society who are engaged in research or other academic activities. The idea is to allow those who are interested in starting research to discuss this with an experienced person, including how to obtain funding, where best to undertake research and so on. These "surgeries" will take place at the Society's annual Spring and Autumn Meetings and will be informal, confidential and would put the trainee under no obligation whatsoever. The times and venues will be announced at the Meetings and it is hoped that trainees will make good use of this opportunity. A promising start was made in Telford.

A successful course on Research Methodology in Geriatric Medicine was run jointly by the BGS and Research into Ageing for trainees in Manchester last year. It is hoped that this will be repeated in other regions in due course.

SAC in Geriatric Medicine response

Tim Hendra (Secretary of the SAC) writes: *“All Regional Training Committees have a responsibility to ensure that our specialist registrars are fully trained in accordance with the curriculum for geriatric medicine that requires that they have a sound understanding of the principles of research and personal experience of research activity. The curriculum also refers to the generic requirement for all medical specialties to encourage trainees to undertake a period of full time research, to have good knowledge of research methodology, and active involvement with research projects throughout the training period.*



Dr Nicki Colledge

The questionnaire survey by the BGS Training and Trainees Committees is a very useful study that unfortunately does not give unexpected results. It is a duty of Regional Training Committees and the SAC to enforce the appropriate balance between service and training in SpR job plans, with protection of designated special interest and research sessions. Although SAC visits closely scrutinise SpR job plans for the presence of research sessions, it may, in addition, be appropriate for these sessions to be audited annually at local level.

More MSc courses and research methodology training are available, although, in the end, it is the motivation of trainees and the research track record of their educational supervisors/trainers that often determines how research sessions are used. What is relevant, however, is that twice weekly research sessions over a five-year training period are a significant investment of time that theoretically should yield measurable outcomes in terms of publications or an additional qualification. The studies by Dr Trembl and myself confirm significant regional variation in both the use of research sessions and outcomes in terms of publications. The latter may influence success at consultant

interview for SpRs from different regions, which in turn may affect regional recruitment to training programmes. In the end, this issue comes back to the Training Committees and academic leaders to support SpRs through the ever-increasing maze of bureaucracy associated with performing research. There are Regions with effective research organisation and infrastructure - others may choose to copy their example."

Dr Nicki Colledge

Liberton Hospital
Lothian University Hospitals NHS Trust

References

- 1 Mather H. The Royal College of Physicians Specialist Registrar Survey. Website: http://www.rcplondon.ac.uk/professional/spr_survey2000jun.htm.
- 2 Hendra TJ. Publications by registrars completing higher specialist training in geriatric medicine in the United Kingdom in 1999/2000. *Age and Ageing* 2002;31:81-2.

BOX 1 - SOUTH EAST SCOTLAND INDUCTION GUIDE RESEARCH TRAINING FOR SpRS

Research training aims are to develop the following abilities: (1) critical appraisal of research and own work; (2) understanding of how research findings are disseminated and implemented; and (3) applying the results of clinical research into everyday practice.

The knowledge required includes: (1) research methods; (2) clinical trial design; (3) research ethics and how to apply for ethical approval; (4) statistical analysis and common statistical errors; and (5) how to initiate appropriate clinical studies.

The skills required include: (1) literature review; (2) use of spreadsheets and databases (e.g Excel, Access); (3) statistical analysis including power calculations; (4) protocol writing; (5) presenting a research paper; and (6) writing up.

To achieve this trainees should:
1 attend the research skills course at the Lister Institute in the first year of training;

- 2 attend the Research for Junior Doctors Symposium at the Royal College of Physicians in Edinburgh (usually held in April) in the first year of training;
- 3 attend the seminars organised by Prof Young to provide practical advice from nationally recognised figures in research in older people throughout their training (in the first four months of the year);
- 4 attend the University Department Research meetings, held every two to three months (to help identify local research interests early); and
- 5 be timetabled for one to two research sessions each week during their training; in first year it is suggested that they use this to complete an audit project or a literature based study that can be fitted around clinical commitments

The Cochrane collaboration has a formal system for the performance of systematic reviews and runs a two-day workshop for those involved. Further details can be obtained from the academic staff below.

If trainees have a research idea and need guidance as to how to pursue this, they should seek advice first from the Educational Supervisor, but it may also be helpful to arrange to meet with a member of the academic staff (see below), who will be glad to support them. They may also be able to provide ideas for research if required.

If trainees wish to pursue research more formally with a view to a higher degree, they will require time out of programme from SpR training. Full details of how to negotiate this are given in the Orange Book or via the JCHMT. They should also discuss this at an early stage with Dr Starr. Up to a year of pure research will count toward CCST.

Academic contacts

- ◆ Prof Archie Young, RIE
- ◆ Dr Gill Mead, Senior Lecturer, RIE
- ◆ Dr John Starr, Part-time Senior Lecturer, RVH
- ◆ Dr Richard Lindley, Part-time Senior Lecturer, WGH

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BOX 2 - RESEARCH SUPPORT FOR SpRs IN GERIATRIC MEDICINE IN MERSEY DEANERY

Specialist Registrars (SpRs) in geriatric medicine are often critical of the amount of support they get to help them set up and work on research projects. The research output for SpRs in geriatric medicine is smaller than in other general medical related specialties.

In Mersey we have established a Mersey Regional Academic Board (MRAB) in Geriatric Medicine composed of five senior geriatricians with an interest in research to try to address some of these issues.

Mentorship

MRAB has established a system of mentors so that each SpR on the rotation has an experienced researcher who can oversee their involvement in research and audit, giving advice as necessary. Each SpR will be seen by their research mentor twice yearly and a checklist of progress completed, which will be available as part of the training record.

Research supervisors

In each training hospital there will be research supervisors who may or may not be the educational supervisor and might not even be a geriatrician, but who would supervise directly

the SpR's research in that hospital.

MRAB advice

MRAB collects information about the research interests and publications of consultants and SpRs in the deanery. This information will be available on the deanery specialty website.

Research training

The half-day release specialty training programme three times a year will have a research training session on topics such as research method, statistics, use of IT in research, applications to ethics committees, presentation techniques and writing up skills. At each of these sessions SpRs will present their own work or ideas for research. SpRs are encouraged to attend deanery IT and research skills courses and the BGS/RIA research skills course.

Higher degrees

The University of Liverpool runs a modular postgraduate programme in medical science which can lead to an MSc. Modules include research methods, laboratory skills, ethics and gerontology, as well as other clinical areas, e.g. diabetes, palliative care, oncology and rheumatology relevant to geriatric medicine. In addition, SpRs can take time out for full-time

research, especially at the Royal Liverpool Hospital, to study cardiology or influenza vaccination, Aintree for stroke, and Wirral for incontinence. This work can lead to an MD. However, getting funding for research can be difficult and MRAB would like to see more hospitals offering research fellowships funded out of R&D or other sources of finance.

A period of time in research can develop an enquiring mind and help to answer some of the many difficult questions that each of us experience in our everyday clinical practice in the medicine of older people. Research experience not only enhances the career of the individual SpR but that experience may later be used to help other SpRs and other disciplines working in field of the care of older people.

Members of the MRAB

- ◆ Dr Margot Gosney (Senior Lecturer, Royal Liverpool, Chair of MRAB)
- ◆ Dr Anil Sharma (Aintree)
- ◆ Dr Jeremy Playfer (Royal Liverpool)
- ◆ Dr James Barrett (Wirral) and
- ◆ Dr Christopher Turnbull (Wirral, Chair of STBC Geriatric Medicine)

BOX 3 - KEELE UNIVERSITY MASTER OF SCIENCE AND POSTGRADUATE DIPLOMA IN GERIATRIC MEDICINE

This course was designed specifically for SpRs in geriatric medicine who do not have Research Fellowship training. Although primarily intended for medical graduates, it is also open to other health professionals.

The course has a modular design, with each module being taught over a four or five day period. A total of 120 M level credits are required for the Diploma. The dissertation carries a further 60 M level credits and is required for the MSc.

Research methodology is taught within one of the modules, which is organised by the Keele Centre for Medical Statistics. There are both

lectures and computing practicals. Students are given an SPSS licence as part of the course materials. Aspects of research methodology included in the course are study design, statistics, power calculations, grant applications, research ethics and research governance.

Students may mix and match modules from other courses. For example at Keele, we also run M level courses in clinical effectiveness, reflective practice and epidemiology that will also enhance research awareness.

Course structure

- ◆ Research Methods (30 M level credits, taught largely by Medical

Statistics)**

- ◆ Organisation of Care (20 M level credits)*
- ◆ Clinical Geriatric Medicine I and II (20 M level credits each) ***
- ◆ Dissertation (60 M level credits)*

*Compulsory for MSc in Geriatric Medicine

**May be substituted by other research methodology modules totalling at least 30 M level credits

***May be substituted by other modules

Peter Crome
Head of Postgraduate Medicine
and Professor of Geriatric Medicine
University of Keele

Department of Geriatric Medicine University of Wales*

This article, the next in our series on UK departments of academic geriatric medicine, discusses developments in the University of Wales College of Medicine.

**Datblygiadau Ymchwil Yn Yr Adran Meddygaeth Geriatrig: Coleg Meddygaeth Prifysgol Cymru*

Introduction

The University of Wales College of Medicine (UWCM) - known until the granting of a new Royal Charter in 1984 as the Welsh National School of Medicine - is today a broadly based healthcare institution covering medicine, dentistry, nursing, and a number of the professions allied to medicine, notably physiotherapy, occupational therapy and radiography. Its interdisciplinary make-up is an ideal setting for teaching, research and practice of geriatric medicine and the cause is helped by the recent appointment of Ken Woodhouse, Professor of Geriatric Medicine, as Dean of the Medical School. He is overseeing a major expansion in medical student numbers (which, by September next year, will have almost doubled from 190 to 360 students per year), an innovative graduate entry scheme and the development of a Clinical School based in Swansea.

The all-Wales role of UWCM is considered to be all-important and plans are underway for expansion of medical training elsewhere in Wales, based on the hub and spoke model centred on UWCM, with developing plans in North Wales and at the Royal Gwent Hospital in Newport. In Cardiff there are provisional plans for a new multi-million pound medical school building and,



based on the considerable success in the recent Research Assessment Exercise, for a closer alliance and possible merger with Cardiff University.

The University Department

The University Department of Geriatric Medicine at UWCM was established in 1979 with the endowment of the first (and still only) Chair of Geriatric Medicine in Wales and the appointment of John Pathy, now Emeritus Professor. His authoritative textbook on the 'Principles and Practice of Geriatric Medicine', now in its third edition, occupies the shelves of most geriatric units around the world and reflects the department's

strong academic foundations. Prof Ken Woodhouse has ensured that the interests of the department become even broader, with innovative research ranging from molecules, through clinical geriatrics to social gerontology, and

with an especial interest in developing undergraduate and postgraduate education and developing collaborations with academic and NHS colleagues throughout the Principality and beyond.

There have been quite substantial changes in personnel over the years, with a series of Senior Lecturers successfully moving into Chairs of Geriatric Medicine outside Wales (e.g. Professors Swift, Seymour, Finucane and Sinclair). The current staffing of the department includes four Senior Lecturers - Sinead O'Mahony, Taj Hasan, Jolyon Meara and Tony Bayer (who is also currently Acting Head of Department) and a Clinical Lecturer, Ruth Hubbard, together with a range of research and administrative staff. Most are based in the Academic Centre at Llandough Hospital, one of the two major teaching hospitals in Cardiff, with Jolyon Meara heading the North

Wales sub-department based at Ysbyty Glan Clwyd, Bodelwyddan.

The department enjoys close co-operation with NHS geriatricians in Cardiff and throughout Wales, with key contributions made by NHS staff to undergraduate and postgraduate education and a collaborative approach in undertaking a wide range of clinical research. The NHS service commitment of the University Department also continues to be a major

priority, with important contributions to the acute and out patient medical service, responsibility for the Memory Team for diagnosis and management of cognitive disorders, and involvement in the implementation of clinical governance.

Together with NHS colleagues, the department successfully hosted the Society's Spring Meeting in Cardiff in 2001.



Research activities

The research activities of the department include basic science laboratory investigations, pioneering clinical trials, large epidemiological studies and coordination of novel qualitative research in collaboration with centres from across Europe. The department is fortunate in having its own comprehensively equipped laboratory facilities, with a wide variety of analytical equipment and technical support, as well as specialists in epidemiology, clinical trials and qualitative research methodology.

Biological gerontology and pharmacology have been major interests of Ken Woodhouse and Sinead O'Mahony, and laboratory-based research continues to be undertaken into the inter-relationship between the effects of age, frailty, the environment and disease on drug metabolism and response. There is a well established 'Ageing Brain' research programme, lead by Tony Bayer,

into assessment of cognitive impairment and therapeutic approaches to dementia, including preliminary clinical trials of beta-amyloid vaccination for treatment of Alzheimer's disease and studies of cholinergic drugs in non-Alzheimer's dementias. There is also collaboration with colleagues from the University of Bristol on the Caerphilly Study of Stroke and Cognitive Decline and with the European OPDAL Programme to improve the diagnosis of dementia. Interest in quality of life measures has led to the development of the Community Dementia Quality of Life Profile, which has recently completed extensive reliability and validation studies and a carer-generated index to measure non-professional carers' quality of life. Preliminary studies of delirium and the possible role of inflammatory markers are being undertaken by Susan White, supported by grants from the BGS and the Glyn Penrhyn Jones Award.

In the past two years, Win Tadd and Tony Bayer have been successful in being awarded research grants totalling £1.25 million under the Fifth Framework Quality of Life Programme of the European Commission. These concern the information needs of older disabled people with Parkinson's disease, their family carers and professionals, a study of the meaning and significance of dignity and older people and a comparative study of professional codes of ethics. Collaborative centres come from a dozen European countries and involve patient organisations and a range of health professionals and academics, as well as several other geriatric centres.

Continuing research into cognitive function

The department in North Wales under the direction of Jolyon Meara continues to develop its research into cognitive function in older people, particularly in the context of stroke, dementia and Parkinson's disease, into the role of drug treatment and rehabilitation in management of autonomic dysfunction and bladder problems in Parkinson's disease, and into the burden of stroke in residents of nursing homes.

Other major research activities of the department have included a large epidemiological and clinical study of breathlessness in older people living at home, involvement in the recently

completed MRC trial of assessment and management of older people in the community and an ongoing trial of Vitamin D supplementation of nursing home residents throughout Wales.

Teaching activities

Teaching activities remain an important part of the department's work, with a major contribution in all years of the undergraduate medical curriculum, including the special studies modules. Geriatric medicine has a high profile within the curriculum, not least in the two month block in the final year entitled 'Multidisciplinary medicine in the community', which is jointly delivered on an all-Wales basis by geriatricians, general practitioners, community paediatricians and psychiatrists. Taj Hasan has a particular interest and responsibility for medical education, including the development of laboratory-based skills teaching.

Ageing, illness and health course

The most recent innovation by the department is a new postgraduate course leading to a Diploma or MSc in 'Ageing, Illness and Health' (see March Newsletter, page 27). This has been validated by

the University of Wales, with the first student intake in September 2002. The course will enable medical and non-medical practitioners with an interest in care of older people to learn together, bringing a multidisciplinary perspective to the study of healthy and pathological ageing. Specialist modules, each of which may also be studied independently as a Certificate Course, include neurodegenerative disease and dementia, stroke and neuro-disability, bone health and falls, social policy and age, therapeutic care and drug treatment and organisation and delivery of care for older people. There are also more general modules on research methodology, ageing and society, physical health/mental health and age.

The department has a long tradition of receiving overseas visitors for training and for the exchange of ideas about all aspects of geriatric medicine. It is hoped that the international activities will develop further in coming years, with greater opportunities for postgraduate study and more collaborative research.

Dr Tony Bayer

University of Wales College of Medicine

Update on the National Older People's Task Force

Most geriatricians will now have heard through their Regional Task Force and BGS meetings of Prof Ian Philp's series of national visits to promote intermediate care involving both geriatricians and local primary care physicians.

His meetings are also being linked to the development of leadership at a local level, to promote the National Service Framework (NSF). At the

most recent meeting of the National Older People's Task Force, Ian again emphasised his four key messages for the coming year:

- 1 person-centred care (the importance of dignity, autonomy, routing out age discrimination);
- 2 promoting whole system working (trying to encourage co-ordination of programmes of work and preventing fragmentation);
- 3 timely access to services (in particular, timely access to best specialist care, such as falls services and stroke services); and
- 4 promotion of health and active life.

Health service reorganisation

With the latest health service reorganisation,

there were concerns about the future of the regional task forces. It appears that they will now usually be sponsored by individual strategic health authorities, although, in some areas (for example London) they will still work across a number of strategic health authorities, but certainly they are to continue. The new chief executives of the 28 strategic health authorities have already been brought up to speed regarding the NSF at one of their first 'Away Days' and one of their directors should have responsibility for delivering on the Older People's National Service Framework.

The formal guidance on the Single Assessment Process was published earlier in the year. Any realistic chance in delivering this depending on the delivery of an Electronic Patient Record. It is hoped that, over this year, we will start to see large amounts of dedicated investment going into IT to start making these changes real.

Needs of dementia patients

It has become increasingly apparent that the needs of older people with dementia are not yet being best met by the NSF. For example, dedicated funds were made available this year for the Mental Health NSF but not for older people covered by the Older People's NSF. It has become apparent that many patients with dementia are being actively excluded from intermediate care schemes. The Alzheimer's Disease Society also notes that the uptake of the new dementia drugs has not been nearly as dramatic as the prescription of lipid lowering drugs, suggested in the NSF for heart disease. It also believes that many of the tools for the Single Assessment Process are not patient centred and the free nursing care assessments fail to capture the problems of patients with dementia adequately. To address this, there will be a special focus over the next year on patients with dementia,

including improvement to the Mental Health Standard, a development programme for a number of primary care pilot sites, arranging a workforce pilot in Croydon for dementia sufferers, and work on medicine management in the long-term care setting.

Delayed discharges

The matter of delayed discharges is obviously a hot political issue once again (see page 17 of this Newsletter). The Health Select Committee is enquiring into delayed discharges and at least two of the zero star hospitals that lost their chief executives had large problems with trolley waits in casualty, which they claimed were due to delayed discharges. The Department of

Health has now taken on six full-time experienced NHS managers, as part of "the change agent team" who can be invited into your hospital to help trusts develop realistic plans in con-

junction with primary care and social services to resolve problems. Unless the issue of delayed discharges can be satisfactorily addressed, particularly, in the big conurbations and across the South of England, it is very difficult to see how the Government's other plans for improving emergency and elective access can possibly succeed.

Realistic appraisal

Finally, it is important to state that the task force do not view the progress of the NSF through rose tinted glasses. A very realistic appraisal has been made of the achievements and the difficulties so far; this will be fed directly back to ministers. All agree that there is still a lot more the Secretary of State could do to publicly and privately reinforce the importance of delivering improved services through the NSF; unless the politicians are saying it is a priority, it will not be a priority for purchasing bodies such as PCT's.



Dr David Black

Member of the
National Older Peoples' Task Force

Who are the champions, my friends?



As we approach the first birthday of the National Service Framework, one rather overlooked aspect has been the establishment of 'older people's champions' in each health and social care organisation.

The term has not met with universal approval, even though the aim of their appointment is altruistic enough. There are meant to be both clinical champions and non-clinical ones. Are you one? Do you know who the others are in your area? Have you met them?

A recent meeting held at the Commonwealth Institute in London suggested that more could be done to support the rapidly growing network of people appointed to these roles - both as clinicians and as non-professionals alike.

What can they do?

They are charged with being ambassadors, advocates and representatives, and are also asked to gain empowerment for older people in their organisation. Ultimately, they should be powerful allies, and it would clearly be advantageous to keep them abreast of local issues.

Who are they?

It is difficult to generalise, but many of the non-clinical champions are non-executives, and some have had little prior experience of, or contact with, health or social services. They may be unaware of elderly care specialist services, and have been appointed with little idea of the job description, let alone local contacts.

The message to geriatricians can be simply stated - **befriend your champions** - go out and seek them in each health and social care organisation as soon as practicable. Why?

Judging from the workshop participants, some

are feeling quite isolated, needing encouragement and support and, vitally also, some information.

Website shares information

Their networks are only just beginning to form, and they are working very much in isolation. A website has just been created at the national level to help provide some opportunity to share experiences and information (<http://www.doh.gov.uk/nsf/olderpeople.htm#discussion>). The electronic forum is a means of sharing experience, solutions, and examples of good practice with others who are facing similar challenges in improving health and social care services for older people. However, local personal contact must surely be the first approach, and colleagues in London have already started meeting on a regional basis.

They will clearly need friends, and there must be benefits from early contact, and hopefully an on-going relationship. Indeed, the concept of 'champions' from both clinical and non-clinical board members of new trusts and service users getting together in a synergistic way is exciting, and may add a certain dynamism to the rate of NSF delivery that may currently be lacking pace.

Find your champion!

So get on out there! At the very least ask your managers who the champion is in your organisation and those others (Trusts, PCTs, SSDs, SHAs) linked with your own department. Then perhaps you could host a meeting with them. At the very least, you may find that the answers are interesting! At best, a whole new relationship may bloom.

Dr Doug MacMahon

Consultant Physican Care of the Elderly
Royal Cornwall Hospitals Trust

Dr Bev Castleton

Consultant Physican Care of the Elderly
Medical Director for Specialist Services North
Surrey PCT

What are the Workforce Development Confederations?

And how can they improve services for older people?

On 1 April 2002, 27 Workforce Development Confederations (WDCs) were created, with boundaries aligned to the Strategic Health Authorities (STAs). The STAs will support the WDCs to modernise the healthcare workforce and will 'performance manage' them in this task. Confederations are member organisations with formal constitutions. The role of the chief executive and their core team is to deliver the agreed objectives of the confederation's members in the context of the NHS Plan targets.

Creating an effective structure

Each confederation will create a structure to reflect the needs of NHS and non-NHS organisations involved in the delivery of health care locally - including health and social care employers and commissioners, higher and further education, voluntary and independent sector and other organisations with an interest in the wider workforce and local employment issues, such as the Learning and Skills Council, Regional Development Agencies, Employment Services and Training Organisations such as the Training Organisation for Personal Social Services (TOPSS).

WDCs therefore bring together local NHS and non-NHS employers to plan the whole healthcare workforce. This new approach to planning recognises that the NHS is not the only employer of healthcare staff, and that local authorities, private and voluntary sector providers, the Prison Service and others need to work together if workforce planning and development is to be effective. The WDCs are clearly a key forum for consolidating information and making plans to fill gaps in knowledge and practice.

A strength is the local collaboration of its member organisations and their networks. Local people are increasingly seen as the solution to developing culturally sensitive service delivery. The importance of securing a well-trained and flexible workforce that reflects the nature of the communities being served is a driver for the confederation, as is the development of imaginative partnerships with higher and further education and voluntary sector training organisations to ensure flexible career routes for both clinical and non-clinical staff.



Jane Winter

Key partnerships

A further strength is the new key partnerships, mentioned above, with the Learning and Skills Councils and the Lifelong Learning Partnerships that bring local agencies together to plan workforce development for the whole economy.

As one of the largest industries in every locality, health and social care can now be represented through the WDCs to share those agencies' targets on raising achievement and extending participation in learning. Among a whole range of the initiatives for employee development and small business support that form their agendas ours converge on, for example, basic skills strategies, review of NVQs, adult and community provision, further education and Lifelong Learning, development of flexible routes to higher education, IT and e-learning, Investors in People and modern apprenticeships.

The LSCs have a Skills and Workforce Development Strategy that "consists of activities which increase the capacity of individuals to participate effectively in the workplace, thereby improving their productivity and employability". The five London

LSCs have identified six key sectors to be given priority, of which 'health and social care is one'.

Assisting the implementation of the NSF

Working closely with SHAs and PCTs, confederations will make links to Health Improvement and Modernisation Plans and Service, Workforce and Financial Frameworks to ensure that they address workforce issues, including those in social care. The approach taken by confederations to this work will reflect local service plans, National Service Frameworks and specialist commissioning needs.

Major priority areas

A national review of local plans has identified three major priority areas of which the need to improve the quality of service and outcomes in the clinical priority areas of cancer, heart disease, mental health and services for older people is one.

The Government is supporting progress with the NSFs by earmarking money in the NHS for cancer, coronary heart disease and mental health. In addition, social services are receiving earmarked resources to reduce delayed discharges and expand capacity in services for older people. The WDCs are another link in local networks to ensure the workforce issues within these earmarked funds can be addressed.

The NHS Plan actions for 2002/03 include the implementation of NSF milestones, including the information strategy for older people, recently published on the DoH website, and the single assessment process; fair access to care services; the audit of age discrimination; and work towards the conversion of the majority of Nightingale wards. It would be the expectation of the WDCs to see the training needed to support

outcome. Staff can be supported to learn in the workplace through Learning Sets, Mentoring, Practice Facilitation, for example, and through clinical placements across the whole economy, not just within health agencies. The WDC can take every opportunity to bid for funds within the European Community, and work with other funding agencies to combine budgets to achieve common targets e.g. Employment Services 'New Deal' monies, LSC workforce development monies, Regeneration and Neighbourhood Renewal funding.

What can the BGS do?

- ◆ Brief Dr Main who has joined the Older People Care Group Workforce Team, chaired by Prof Ian Philp. The workforce priorities for Years 1 and 2 of this Team are the single assessment process, intermediate care, general hospital care, dementia services and long-term care (care assistants).
- ◆ Include workforce issues on every topic sub group agenda.
- ◆ Look for common issues raised in the annual reports of the non-executive 'champions' to their boards.
- ◆ Support the emerging networks of 'older people's champions' (see page 13) within and across localities.

What can you do?

- ◆ If you are not a local champion, establish contact with the person who is and ensure your ideas are shared with them.
- ◆ Encourage a workforce development plan to be written for the service you work in, and ensure the link person leading on older people at your confederation is included in the action plan.
- ◆ Use every opportunity for reflective practice, e.g. complaints, audit, and research to identify workforce issues.
- ◆ Contribute to the annual report on the implementation of the NSF for Older People to the board.
- ◆ Ensure the non-executive director who is the nominated champion at board level has contact with your department and is well briefed on its day-to-day activities.

North East London 
Workforce Development Confederation

these targets feature in the plans for each agency in the health and social care economies.

Promoting skills in the workforce

The WDCs can encourage new ways of learning that promote skills in the workforce which will have an effect on standards of care as an

Jane Winter
Assistant Director
Workforce Strategy Older People
North East London WDC

The London Task Force

and being a 'regional champion'

Chandi Vellodi's BGS survey¹ indicates that most of us are involved locally in some way in implementing the NSF for Older People.

The National Task Force and the new Strategic Health Authorities will be monitoring performance and the Society will have input at many levels in the modernisation agenda. This leaves Regional Task Forces with the rather ambiguous remit of being 'champions' with no more specific portfolio and, more importantly, no funds to distribute.

So when David Black, a South Londoner (compared to my North) and on the National Task Force, called to say: "*Shouldn't we try to get the London geriatricians together to see if there was a role for a London group*", it seemed like a sensible move.

We asked for one representative from each hospital and, at our first meeting, both David and Prof Cameron Swift shared their perspectives of the NSF and its implementation. About 30 geriatricians attended and the feedback was that, though they were involved in local implementation, many were not leading initiatives like intermediate care. Many were also not aware of regional funding.

Prof Ian Philp addressed our next meeting with a valuable update on issues like single assessment and, in our discussions, we agreed that if people emailed me² I would reply to those interested with news of regional meetings, funding and anything else that might be relevant. We also agreed to have future meetings around single issues pertinent to NSF targets that were coming up. Our next meeting will be on auditing ageism. If we can agree a set of indicators pan-London, it will enable some very useful comparisons. Janice Robinson of the King's Fund will share some research they are doing on auditing the less objective measures of ageism.

Sector workshops

Prof Philp will also be holding some sector workshops in London with geriatricians, old-age psychiatrists and GPs and, hopefully, we will be able to share issues raised at a pan-London meeting.

Regional Task Forces have been set up to help with NSF implementation; this is how we've explored doing it in London.

Dr Susan La Brooy
Hillingdon Hospital

- 1 See March 2002 BGS Newsletter, page 11.
- 2 Email: susanlabrooy@180.hillingh-tr.nthames.nhs.uk

AGE AND AGEING ONLINE: <http://www.ageing.oupjournals.org>

As a member of the BGS in 2002, you can access all articles published in *Age and Ageing* since 1999, and search through tables of contents and abstracts going back as far as 1974. As well as searchability, you can also join the email table of contents alerting service, to be sent the very latest table of contents of each issue, in advance of publication.

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Delayed discharges

- the Society's evidence

In March, the Society gave evidence to the Parliamentary Health Select Committee on delayed discharges.

The oral evidence was given at the House of Commons along with that of representatives from the Royal College of Nursing, the British Medical Association and the Audit Commission.

1 The British Geriatrics Society (BGS)

1.1 The Society is the professional organisation of British physicians with specialist expertise and career commitment to the health care of older people. Its membership numbers 2,500 and also comprises some psychiatrists, general practitioners and members of professions allied to medicine.

1.2 The Society shares the view of the Royal College of Physicians that there is an urgent shortage of consultant and trainee workforce numbers in the field (which is mirrored in the allied professions). It endorses the College's estimate of a required increase of 70% in England, Wales and Northern Ireland - i.e. 540 whole-time equivalent posts.

2 Summary

2.1 The track-record of speciality-based integrated, comprehensive services for older people in resolving inappropriate hospital bed occupancy is impressive.

2.2 Such services are characterised by:

- ◆ a clear identity and structure;
- ◆ skilled interdisciplinary practice;
- ◆ successful partnership working between primary and secondary care; and
- ◆ successful partnership working between health and social services.

2.3 The causes of delayed discharge from hospital reflect service deficiencies in these four

criteria before and during admission and at the time of appropriate discharge.

2.4 Delayed discharge is a symptom of overall system failure that escalates in a self-perpetuating manner and results in progressively substandard patient care. Furthermore, where delayed discharges are significant, this is not making best use of front line staff. Its reversal will only be achieved by firm and clear strategies covering each of the four aspects in 2.2.

2.5 The required basis for action can be found within the broader recommendations of the National Service Framework, but focused planning and strategic targeting of resources are urgently required to deliver on the priorities of hospital bed occupancy. Specific recommendations for each aspect are incorporated into this evidence.

3 Basis of evidence

3.1 Evidence from the BGS is based on:

- ◆ published and unpublished historical data on the efficiency of speciality-led whole services for older people;
- ◆ three national BGS surveys of consultant staff in specialist departments throughout the UK with respect to delayed discharges;
- ◆ experience of BGS members involved in the External Reference Group and specific task groups of the National Service Framework and in the National Task Force;
- ◆ anecdotal day-to-day experience of physicians working in frontline NHS hospitals; and
- ◆ findings of a joint Department of Health/Royal College of Physicians Workshop on Delayed Discharges, held in December 2001.

4 Track-record of integrated speciality-based whole services for older people

4.1 Historical data published over the last three decades show clearly the positive impact of such services on hospital bed usage [1-5]. This has been mirrored subsequently in numerous comparable studies and more recently in randomised

control trials using optimal models of specialist interdisciplinary organised care (e.g. stroke rehabilitation units with non-selective operational policies).

4.2 Such services have been characterised by clear organisational identity (both in terms of clinical practice, management and resource) by sustainable recruitment of skilled multidisciplinary professional staff, by the building of close collaboration between the primary and secondary care components of such services and by clear partnership building between health and social services. Most published models predate the *1990 Community Care Act*.

5 Causes of delay in the discharge of older patients from hospitals

5.1 Pre-admission causes

There are indications that under the current system, growing numbers of older people with complex health problems present to acute hospitals via casualty at a late and sometimes irretrievable stage in their progression. This reflects:

- ◆ delayed identification of complex need;
- ◆ delayed or absent pre-crisis intervention;
- ◆ lack of alternative crisis intervention tracks (other than hospitalisation).

5.2 In-hospital causes

These comprise a range of barriers to efficient and expert interdisciplinary assessment. They include the following.

5.2.1 Over-occupancy of hospital beds (greater than 85%) resulting in patients becoming spread all over hospitals into any available beds. As a result, integrated interdisciplinary teamwork becomes incredibly difficult and frustrating, with patients placed in inappropriate wards.

5.2.2 Defensive approaches to risk management arising from: (a) fragmented and/or mutually unresponsive interdisciplinary practice; and perhaps also (b) as a perverse consequence of performance targets related to readmission.

5.2.3 The impact of directives related to junior doctors' hours. Shift patterns that require greater time off leave much less time available to see patients and relatives. This is leading to inefficient communication and interaction with patients and relatives with respect to discharge planning. The problem is now likely to be exacerbated with the impact of further directives in 2004.

5.2.4 There is a universally accepted national lack of therapists to resource timely assessment.

5.3 Discharge-related causes

5.3.1 Erosion of decision-making responsibility. Department of Health regulations still allow patients or their relatives to refuse a discharge except to the residential or nursing home of their choice. There is the right to choose an institution with a long waiting list and to remain in hospital for the interim. There are currently no legal mechanisms to insist on an interim placement. In addition, rising expectations driven by the Patient Charter have led to conflicts in determining discharge plans and timing according to need rather than the demands of individuals.

5.3.2 A lack of clearly linked specialist services (e.g. some forms of non-resident intermediate care) to support timely discharge. Guidance on intermediate care in the National Service Framework has been poorly interpreted in some areas, particularly with respect to joint primary and secondary care clinical responsibility and to integration and accountability within a whole system. Much of the money identified by the Government cannot be traced through to new beds or services. Where these have been set in place, there is little evidence of accompanying workforce increase, either of consultant staff or therapists. As a result, such services do not perform effectively.

5.3.3 Independent, duplicated and sometimes protracted assessments by health and social services in parallel or in series.

5.3.4 Perverse financial incentives. Local authorities currently consider themselves under greater financial pressure than health authorities and there is a significant financial disincentive for local authorities to support early discharge, whether to their own home or to nursing homes.

5.3.5 There has been a significant reduction in the number of nursing home placements within the last 18 months, due to economic conditions, particularly in the South of England.

6 Effective strategies to resolve delayed discharge

6.1 General

The following initiatives are required.

6.1.1 Re-establishment of the identity and organisation of speciality-based comprehensive services.

6.1.2 Reorganisation of professional practice to

mandate interdisciplinary teamwork and partnerships between primary, secondary and social care. Ways should be found to re-establish and re-integrate professional social work within comprehensive speciality-based services for older people.

6.1.3 High priority, fast tracking of key components of the National Service Framework.

6.1.4 Removal of perverse financial incentives.

6.1.5 Targeting of resources (preferably ring-fenced) directly to the above priorities.

6.1.6 An immediate rise in national training numbers for geriatricians.

6.2 *Specific*

6.2.1 The recommendations on Single Assessment in the National Service Framework should be used to drive early comprehensive assessment and sharing of information between primary, secondary and social care. This should facilitate appropriate intervention in the pre-crisis period.

6.2.2 The priority to develop effective systems of intermediate care conforming to DoH guidelines should be underpinned by immediate increases in medical staff (consultant and GP specialist), therapist and nursing staff time, and in national training numbers for consultants. Furthermore, intermediate care must be co-ordinated on a locality basis by means of a single multidisciplinary management team and a single point of entry to the whole system. ("NHS Direct" resources might have a role.)

6.2.3 NSF recommendations on hospital services, particularly the consolidation of specialist interdisciplinary teams, should be expedited.

6.2.4 If bed occupancy begins to fall as a result of improved efficiency, there should be a requirement that no beds can be closed (e.g. for cost improvement programmes) in any acute or rehabilitation environment until bed occupancy falls below 80% overall.

6.2.5 With respect to junior doctors' hours, if it is too late to influence the legislation, alternative approaches to discharge co-ordination (discharge co-ordinators, physicians' assistants) must be resourced to underpin interdisciplinary clinical decision-making and team integration.

6.2.6 Measures should be taken to remove duplication of assessment of hospitalised patients between health and social services.

6.3.7 The regulations and guidance concerning interim placement should be changed to guarantee interim funded placement if lifelong placement is likely to be delayed.

Prof Cameron G Swift
President

References

- 1 Hodkinson HM, Jeffreys PM. *Making hospital geriatrics work*. Br Med J 1972, 4: 536-539
- 2 Bagnall, WE, Datta SR, Knox J, Horrocks P. *Geriatric medicine in Hull: a comprehensive service*. Br Med J 1977, 2: 102-104
- 3 Evans JG. *Integration of geriatric with general medical services in Newcastle*. Lancet 1983, 1: 1430-1433
- 4 Rai GS, Murphy P, Pluck RA. *Who should provide hospital care of elderly people?* Lancet 1985, 1: 683-685
- 5 Mitchell J, Katetz K, Rossiter B. *Benefits of effective hospital services for elderly people*. Br Med J 1987, 295: 980-983

THE SOCIETY WITHDRAWS AS A MEMBER OF THE HEALTH ADVISORY SERVICE (HAS)

The Society is retiring as a member of HAS in light of the fall in demand for their services in the geriatrics field. In turn, this is as a result of Government agencies taking on more monitoring and accreditation, coupled with the fact that hospitals are overburdened with inspections and short of funds to engage outside services. There may remain a need for peer review but this is something that the BGS may wish to consider providing for on a regional basis.

Richard Lynham

Online CPD diaries

The Federation of Royal Colleges of Physicians (RCP) CPD online system for recording your CPD activities could not be simpler, quicker and more user-friendly.

Yet many geriatricians do not use it, opting instead to use the more time-consuming paper version or failing even to record their activities.

This short article runs through the method of online recording and aims to encourage all those not using the system to have a go. Should you experience any difficulties you can contact the CPD Office Help Desk at the College where you are registered.¹

Method

Accessing your diary: Use your code number and password (issued to you when you register for the online system) to log-in to your diary from the CPD section of the College website.²

Externally approved CPD activities: Click on the

Add and Remove tab from the Main Diary Page, which brings up a search screen. You can narrow the search by selecting from one or more of the drop-down menus. Click on the title of the activity you wish to add to your CPD log, and click on the **Add to Diary** button. The activity will not be added to your credits until you have evaluated it. To do so click on **Evaluate** button, complete the questions and then submit the form.

(Please note that once the **Submit** button has been pressed, only the reflection - which will be noted in your diary for your own reference - can be amended. The activity can also not be deleted after it has been submitted). If you have not evaluated and submitted the activity, you can remove it by clicking on the **Add and Remove** tab and scrolling down the page until you reach the activity and then click on **Remove** button.

Other approved CPD activities: Scroll down the Main Diary Page until you come to the list of Other Approved CPD. If you want to add a new record, click on the **Evaluate** button in the appropriate field. If you want to amend an existing record, click on view and edit details and then edit. Should you wish to delete an existing record, click on view and edit details and then delete.

Credit achieved: Click on the **Credit Achieved** tab at any time to see your current status with respect to meeting the CPD scheme minimum credit requirements.³

In conclusion

The online system provides you with an easy way of producing a record for your annual appraisal of your CPD activity over the past year.

Anne Jordan
CPD Manager, RCP

Mark Castleden
Director of CPD, BGS

REFERENCES

1 Edinburgh - Tel: 0131 225 7324. Email: cpd@rcpe.ac.uk. **Glasgow** - Tel: 0141 227 3245. Email: cpd@rcpsglasg.ac.uk. **London** - Tel: 020 7935 1174, ext 426. Email cpd@rcplondon.ac.uk.

2 Websites: www.rcpe.ac.uk, www.rcpsglasg.ac.uk, www.rcplondon.ac.uk.

3 The minimum credits are 50 clinical educational per year or 250 credits over five years. These include 25 non-clinical (professional) credits over five years. In any one-year period a minimum of 25 credits must be external credits and no more than 10 personal credits can be counted towards meeting the Scheme's annual requirement of 50 credits.

Developing future pharmacy services

This conference took place at the Westminster Central Methodist Hall, London, in January.

Future pharmacy

Dr J Smith (Chief Pharmaceutical Officer, Department of Health (DoH)) spoke on future pharmacy - helping patients get the best from their medicines. Key themes of the four-year pharmacy programme within the NHS Plan (DoH 2000) include: (1) modernisation and new ways of working; (2) patient-centred services; and (3) improved access, equity and service quality.

'Principles of Pharmacy in the Future' (DoH 2001) include: (1) helping patients get the best from their medicines; (2) access to high quality pharmacy services which are designed around patients; (3) using the skills of pharmacists and their staff to best effect to deliver these objectives; and (4) delivery constraints include resources, workload and workforce (15% of pharmacist posts vacant nationally).

'Shifting the Balance of Power' (DoH 2001) specifies that primary care trusts will be key in front-line management of 'Pharmacy in the Future' and the NHS Plan, with direction and performance management by strategic health authorities. The Government will issue fewer targets and directives.

Approximately 770m prescriptions are issued each year, making drug prescription the most frequent clinical intervention. Prescribing is also the biggest single cost pressure on the NHS, running at £6.5bn (>15% NHS revenue). Prescriptions are growing at 10% pa in real terms, largely due to increasing clinical activity. This puts pharmacy and in particular medicine management centre-stage.

Medicine management aims to reduce sub-opti-

mal therapy, adverse reactions and interactions, medication errors, poor concordance, poor clinical outcomes, avoidable ill-health and waste. In hospitals it encompasses drug selection, procurement, delivery, prescription, administration and review (*'A Spoonful of Sugar'*, Audit Commission, December 2001). Hospital pharmacy will require re-engineering to further develop clinical pharmacy services, with more efficient, safe, patient-focussed systems, more work on admission wards, dispensing for discharge using patient packs, use of patients' own drugs, self-administration, better communication with primary care and dependent prescribing by pharmacists.

Medical management in primary care

Michael King (Head, Professional Development for the Pharmaceutical Services Negotiating Committee, PSNC) outlined a pilot of medicine management in primary care. The outcomes of structured intervention to GPs by community pharmacists trained in CHD, will be assessed in a randomised controlled trial.

The National Prescribing Centre in Liverpool manages a second medicine management pilot in primary care. It uses an action learning approach to disseminate good practices via 26 primary care trusts. This will cover all primary care trusts by 2004. Both pilots have been funded by the DoH.

Extended role of pharmacy

Chris Cairns (Chief Pharmacist, University Hospital Lewisham) discussed the extended role for pharmacists and new prescribing initiatives. *'A Spoonful of Sugar'* emphasises that pharmacy services save both lives and money. There are 1000 drug-related deaths annually in the UK; drug-related morbidity, inconvenience and costs are also extensive so there is still much to do. Extended roles explored included pharmacist-lead antiretroviral and lithium clinics and dependent prescribing. Successes in pre-admission clinics, post-take ward rounds, medication histories, must be applied in all trusts.

The primary/secondary care interface is a major area of risk. This risk must be minimised through streamlining discharge, incorporating IT-based communication and inclusion of community pharmacy.

The IT revolution

Andrew Murdoch (Pharmacy Director and Superintendent, Lloyds Pharmacy Ltd) examined the impact of the IT revolution on pharmacy. The NHS Plan highlights the importance given to electronic patient records and electronic prescribing. UK primary care prescriptions are currently keyed in three times by the GP, the community pharmacist and by the prescription pricing authority. Automation linked to electronic prescription transfer could reduce this multiplication of effort, minimise transcription errors and free community pharmacists' time.

E-health has further potential to optimise therapy outcomes, hasten discharge with more accurate information for primary care and provide drug information. Centralised automated processing could improve management of repeat prescriptions (80% of all prescriptions) and cope with the increasing volume.

'Building the Information Core' (DoH 2000) sets a target of 100% implementation of integrated primary and community electronic patient records by 31 March 2005.

Electronic transfer of prescriptions

Ewan Davis (Partner, Woodcote Consulting; Chairman PharMed) considered the electronic transfer of prescriptions. The growth in primary care prescription volume makes the current service delivery and pricing system unsustainable. Current primary care prescribing data is of limited use as it is not linked to indications or by patient. The present system is inconvenient for patients.

The Government has outlined its commitment to electronic transfer of prescriptions in primary care and core criteria have been defined. Pilots of electronic prescriptions transfer started in England at the end of 2001. The three basic models include: (1) a patient-carried machine readable script (smart card, bar code or magnetic strip); (2) point to point (email); and (3) use of a central repository to hold prescriptions ordered

by GPs until it is withdrawn by a community pharmacist. National roll-out is planned for April 2004 with the aim of a complete roll-out by 2006.

In the future, primary care electronic prescription transfer could be linked with secondary care at admission, at discharge or with out-patient prescribing.

Risk management

Mike Cross (Director of pharmacy, Barts and London NHS Trust) spoke on risk management and pharmacy services. Adverse drug events encompass adverse drug reactions, medication administration errors and non-compliance, and result in morbidity, mortality, inconvenience and cost. Inappropriate prescribing may be separate again, as it can be intentional.

Non-compliance is responsible for around 23% of nursing homes admissions and 11% hospital admissions for older people (Col et al 1990). A contraindicated drug was prescribed in 11.5% of hospital admissions (Lindley 1992). Around 40% nursing home residents receive one or more inappropriate drugs.

Direct costs from drug-related morbidity and mortality are greater than costs for diabetes and obesity and are around 67% of costs attributable to cardiovascular disease (Johnson et al 1995). In hospital 5.5% of oral doses given by nurses are erroneous (Barber and Dean), thus an inpatient receiving the mean of 12 daily doses has a 98% risk of being the subject of an error during the mean stay of five days.

Hospital pharmacists frequently contribute to drug therapy: 50,000 major contributions per year in 38 London trusts (Batty and Dhillon 1997). Electronic prescribing, automated dispensing and increased clinical activity are high priorities. Quick wins can be achieved with patients with multiple admissions, drugs that require special monitoring, patients that require special monitoring, decision support for prescribing, drug histories on admission, compliance.

Legal implications

Jon Merrills (Consultant) discussed the legal implications of extended pharmacy roles. There is a recent trend in bringing criminal charges

against doctors and pharmacists, previously only considered as torts in civil court. Claims (and associated costs) are increasing at a dramatic rate.

Legal update

David Reissner (Partner, Charles Russell Solicitors) gave a legal update. Four areas where changes have occurred or are imminent are: (1) data protection/confidentiality: *Data Protection Act 1998*; (2) supervision of pharmacies and drug

sales; (3) control of entry - the OFT is reviewing how the present restrictions affect competition and consumers and whether there are alternative ways of achieving the public interest objectives; and (4) disciplinary procedures.

C Alice Osborne

Clinical Age Research Unit
Kings College Hospital
London

Canadian geriatrics

- from where, to where?

This article is based on an address* given to the Canadian Geriatrics Society, Toronto in October 2001.

Where have we come from?

Looking to the past, I believe there were three reasons for becoming a geriatrician - the intellectual challenge, the emotional reward and collegial satisfaction of working as an effective team. Looking to the future, there are wider issues to be taken into account, so ...

Where are we going in Canadian geriatrics?

It is instructive to look at two jurisdictions, both of which have contributed greatly to Canadian geriatrics but, perhaps now, we should be wary of following where they are going. I refer to the United States and the United Kingdom.

American geriatricians have essentially espoused the primary care route. They have set up in direct competition with family doctors and general internists and have seen themselves in an age-related specialty much as our paediatricians do. Entry into the specialty is both via family medicine or general internal medicine. They have effectively established certification and re-certification and their specialists undertake primary

care with only a small subset left as “trainers in teaching hospitals”.

In the UK, almost the opposite has happened. There has been a major shift towards acute care, as geriatric medicine has filled the vacuum left by the disappearance of general internal medicine as it fractionated into its sub-specialties. The general internist with a special interest in geriatrics has been created.

The effect of this drift towards acute care has been complete withdrawal from long-term care and virtual withdrawal from rehabilitation. This has been particularly marked in England and far less so in Scotland. The comprehensive modern geriatric service, the gift of the British Isles to formal health care delivery for older adults, has come under severe strain and almost disappeared in some places. Some British colleagues have talked of the need for another Marjory Warren!¹

There have been some good effects from this reorientation. The traditional antagonism between general internal medicine and geriatric medicine has greatly diminished. This was rarely a problem here in Canada. Certainly, the English change of emphasis has increasingly resolved the pejorative labelling of second-class beds, containing second-class patients and looked after by second-class doctors and nurses with second-class resources. Nevertheless, my sense is that the

cost of this change in the specialty has been the destruction of the former comprehensive service.

So the question for Canadian Geriatrics is should we follow the American or the British course? I would strongly suggest neither. Canadians cannot go the US route because we just don't have the numbers. In Canada, we have wholeheartedly accepted that geriatricians cannot and should not look after all the over 65s, or indeed all the over 85s. The geriatrician is a catalyst so that after his or her arrival, homehelps should be doing a better job caring for older people and at the other end of the spectrum, the professor of medicine should be doing a better job looking after older people. The geriatrician is a resource, not a substitute for a family doctor (remember the family doctor's role is, on occasion, to protect his/her patients from specialists). We must continue to work hard at what unites us by whatever route we came into geriatrics: whether we are family doctors, psychiatrists, internists, public health doctors, or indeed any of our colleagues.

Reasonable remuneration important

One early objective of Canadian geriatrics must be reasonable remuneration, related to recruitment. Medical students in the hard light of financial realities and those crippling student loans, have been opting for remuneration in this world rather than recompense in the next. The advent of the Wade Report² provides a real opportunity for reasonable remuneration. Every item of the fee tariff is subjected to a weighting reflecting the following characteristics: communication and interpersonal skills, knowledge and judgement, risk and stress, technical skill.

Geriatrics - an academic discipline

The second objective must be the continued affirmation of the academic basis for our discipline. I quote from a recent obituary on Sir William Ferguson Anderson, whose SR I was for two years: "*Fergie was utterly convinced that the only way to promote health care of older people was to make geriatric medicine an academic discipline and ensure*

undergraduate teaching in the subject."³ We still have a long way to go.

Enlist the help of the 'well elderly'

My third objective for the future of Canadian geriatrics is not to forget 'the well elderly'. These are older adults who perhaps are much less likely to become our patients. They can be powerful allies and friends and, indeed, powerful enemies, as the Canadian government discovered when attempting to de-index their pensions; within eight weeks the seniors of this country totally reversed a major government initiative. Our experience in Nova Scotia in effecting an Alternative Payment Scheme for the geriatricians and funding rural geriatric clinics reflects effective intervention by seniors on our behalf.

I commend the 'mobilization' of seniors to help us in both our remuneration-recruitment and in our academic-education endeavours. Seniors can do what we cannot do. They can tell provincial Departments of Health that 'we need geriatricians' (and geriatric specialist nurses and all the rest of our gang). Similarly, they can say to Deans of Medical Schools: "what are you teaching medical students and doctors-in-training about us?"

The need for expertise

Bernard Isaacs once asked me a question: "*In one word, what are you trying to get across to medical students about health care of older adults?*" I replied: "*Enthusiasm*", but one needs more than enthusiasm to be a geriatrician. One needs expertise - and I carefully distinguish that from experience; however, without enthusiasm, without fire in the belly, we won't do the job as well as we could, and our patients will suffer.

Prof Colin Powell

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*A fuller version of this article was first published in '*Geriatrics Today: Journal of the Canadian Geriatrics Society*', 2001, 4(4); 178-181. Parts of it are herewith reprinted by permission.

References

- 1 Matthews DA. Dr Marjory Warren and the origin of British Geriatrics. *JAGS* 1984;32:253-8
- 2 Resource-Based Relative Value Schedule Commission of Ontario: Draft for Comment, September 2001
- 3 Williams B Sir Ferguson Anderson: obituary. *Bull roy coll phycns Glas* 2001;30:5

Elective report



This report is from an Edinburgh University medical student who spent part of her elective working in a district general hospital in Northern Ireland, and the remainder in India.

Background

I chose care of the elderly as my specialty during my time in Northern Ireland, as I intend to pursue a career in this field in the future.

During my elective, I decided not to carry out a specific project. Instead, I worked alongside the junior medical staff on a day-to-day basis, and attended multidisciplinary team meetings and ward rounds with the consultant, in order to get more of a feel for what working in a care of the elderly unit is like.

The hospital I was based in is a small district general, with four consultants in general medicine, one of whom has a particular interest in medicine for the elderly. I was, therefore, attached to her during my time there. There is a forty-bed rehabilitation unit, which is mainly occupied with stroke patients, and patients for whom there are issues with placement. Patients over the age of 65 were also often transferred to this unit for a few days, after an acute admission for convalescence.

Multidisciplinary care

Each week, each of the medical consultants carried out a ward round in the rehabilitation unit, which was attended by all the members of the multidisciplinary team. During these, the progress of each patient in the unit was discussed, and decisions made, in conjunction with the wishes of the patient and their family, on dates for discharge and on placement for the future. Unfortunately, during the time that I was at the hospital, the social work department had no available funds for providing home helps and

carers in the home. Many people were therefore forced to stay in hospital beyond the time they needed to, unless they were willing and able to pay for their own carers, or had families who would shoulder the responsibility. My experience in Edinburgh, during a care of the elderly placement there, was very similar in this respect.

The team

The multidisciplinary team consisted of the consultant, the ward sister, the occupational therapist, the physiotherapist, and the social worker. Previously there had also been a speech and language therapist working as part of the team, but she had resigned her position and had not been replaced. As many of the patients in the unit were being rehabilitated after cerebrovascular accidents (CVAs), she was a great loss to the unit. However, there is a shortage of speech and language therapists in Northern Ireland and, as this is a small district general hospital, she is unlikely to be replaced in the near future.

Main medical problems

The main medical problems in the elderly population in Northern Ireland are similar to those in Scotland. Like Scotland, diet is very poor, with a lot of foods rich in fats; consequently, the majority of patients are over-weight. This, combined with the high number of smokers in Northern Ireland, made it unsurprising to see that heart disease and cerebrovascular disease were very prevalent in the inpatient population. Many patients also had a degree of chronic obstructive airways disease. Therefore, during my time at the hospital, I learned much about recognising and treating cardiac failure, and about signs that localise CVAs, and their immediate and long-term management.

After leaving the hospital, I spent a further two months in India, where I saw the importance of being able to clinically localise lesions, as CT scans are less available due to their cost. As many of the elderly patients had multiple health problems, there was an opportunity to see how

the doctors balance the treatments they gave. One patient with cardiac failure, and pleural oedema also had renal failure. He needed diuretic therapy to relieve the oedema, which could have further compromised his renal function. To ensure that this did not happen, his renal function had to be monitored daily. Eventually, he was stabilised, and able to be transferred to the rehabilitation ward.

Conclusion

Spending part of my elective in care of the elderly medicine has served to heighten my

resolve to pursue a career in this discipline. I find that here there is much more focus on holistic medicine, where issues like housing and mobility are as important as acute medical problems. Unfortunately, there are not the resources, either financially or in staffing to meet the needs of our aging population at present. As the average age of the population increases, hopefully more money will be made available to more adequately meet their needs and ensure that, as the average length of life increases, so too will quality of lives.

Claire Warnock

In Memoriam

DR NIALL COX - 4 NOVEMBER 1970 TO 21 MARCH 2002

Dr Niall Cox was brought up in Cheddar, Somerset, and educated in Kings of Wessex School and St George's Medical School. He carried out his general professional training in the Princess Margaret Hospital, Swindon, and at the University Hospital of Wales, Cardiff.

In 2000, he entered the North Wales rotation as specialist registrar in general and geriatric medicine and worked for his last 18 months in Ysbyty Gwynedd, Bangor. In his application for this post he described his enjoyment of acute medicine and problem solving, the challenges and satisfaction of work with older people and the rewards of participating as a member of a team. His fondest memory of his professional experience was as a member of the Stroke Team where his personality and professional skills were highly



valued and respected. Here he carried out research on hydrocephalus and produced results with useful clinical application.

Niall was diagnosed with acute lymphoid leukaemia at the age of 15 and eventually received an autologous bone marrow transplant at the time of his A levels when he was 18. He later developed acute myeloid leukaemia leading to a second bone marrow allograft from which he never recovered.

To those who knew Niall as a professional colleague, it seemed that his own experiences had provided a gift of insight and empathy. His attitude was consistently positive, lighthearted and humorous, where appropriate, with an exceptionally clear sense of value. His personal strength was revealed by his attitude to

work in the last months of his life. He took minimal time off and attended to his clinical duties to a consistently high standard and with good nature, even when anaemic and unwell.

Niall was a talented railway photographer, he enjoyed this as a simple pleasure and with good humour. He was amused to have achieved publication of one of his photographs in *'Railway Magazine'* shortly before he died.

Niall's positive engagement with life was epitomised in his choice of partner, Kathy; together they lived life to the full, with a sense of adventure and enjoyment. This attitude was still evident as Niall approached what was to be his last course of treatment with remarkable courage.

In our grief we acknowledge the unfulfilled potential and special qualities of one who died so innocent.

Dr Alan Bates
Consultant Physician
Ysbyty Gwynedd
Bangor

RETIRED MEMBERS GROUP (RMG)

14 to 15 May 2002

Lichfield, Midlands

All members of the Society are welcome to join the RMG, on their retirement. For more information on the meeting in May contact: Nick Coni at: Nickconi@btinternet.com or Peter Wilson on: 01206 734273.

TOWARDS A 48-HOUR WEEK

European Working Time Directive

16 May 2002

Royal College of Obstetricians & Gynaecologists, London

Topics include: legal issues; challenges for existing working patterns; education and training; and delivering the EWTD in practice.

Contact: BMA/BMJ Conference Unit, BMA House, Tavistock Sq, London WC1H 9JP. Tel: 020 7383 6605. Email: confunit@bma.org.uk.

ACTION ON ELDER ABUSE CONFERENCE

A bitter pill to swallow

21 June 2002

London Voluntary Sector Resource Centre, Holloway Road

MP Paul Burstow's report *'Keep Taking the Medicine'* will be discussed at this conference, as well as the perspectives of a GP, a pharmacist and an academic.

Contact: Conference Administrator, Action on Elder Abuse, Astral House, 1268 London Road, London SW16 4ER. Tel: 020 8765 7000. Website: www.elderabuse.org.uk

DELIRIUM IN DARWIN

Australian Society of Geriatric Medicine 2002 Annual Meeting

24 to 26 June 2002

Darwin, Australia

Topics include: research approach to delirium; preventative aspects of hip protectors; and recognition, etiology and management.

Contact: ASGM 2002 Secretariat, PO Box 949, Kent Town, South Australia 5071. Tel: 08 8363 1307. Email: info@fcconventions.com.au

PARKINSON'S DISEASE

Multidisciplinary care in Parkinson's disease/parkinsonism

17 July 2002

RCP London

Abstracts deadline: 14 June 2002

Topics include: dementia; mood disturbances; pain and sensory systems; and botulinum toxin.

Contact: Medical Education Partnership, 30-34 New Bridge St, London EC4V 6BJ. Tel: 020 8993 8570. Email: info@mepuk.com.

FALLS CONFERENCE

Falls & Bone Health SIG "Falls and Postural Stability"

6 September 2002

Kensington Town Hall, London

Deadline for abstracts: 1 July 2002

Topics include: assessment of gait and balance; Parkinson's disease and falls; and epidemiology of fractures.

Contact: HMC Ltd, 127 High Street, Teddington, Middx TW11 8HH. Tel: 020 8977 0011. Email: falls@hamptonmedical.com.

DIABETES

Diabetes Special Interest Group Annual Meeting

13 to 14 September

Derbyshire

For further details contact: Dr Simon Croxson, Bristol General Hospital, Guinea Street, Bristol BS1 6SY. Tel: 0117 928 6101 or email him at: simon.croxson@virgin.net.

PD MASTER CLASS

Preliminary announcement: Parkinson's Disease Academy

19 to 20 September 2002

St Austell, Cornwall

BGS Parkinson's Disease Section and the James Parkinson Centre in Cornwall have announced the first PD Academy - a residential Master Class, designed for consultants, final year SpRs and staff grades currently running or wishing to run PD clinics. Participants will be locally mentored until the second residential 2-day module (dates yet to be agreed) in London. The cost will be £250 per person.

Contact: Dr D MacMahon, James Parkinson Centre, Camborne-Redruth Hospital, Redruth, Cornwall TR15 3ER. Email: events.redpublishing@btopenworld.com.

AUTUMN MEETING 2002

BGS Autumn Meeting 2002

17 to 18 October 2002

Novotel Hotel, London

Abstracts deadline: 1 June 2002

Contact: HMC Ltd, 127 High Street, Teddington, Middx TW11 8HH. Tel: 020 8977 0011. Email: hmc@hamptonmedical.com.

STANDARDS IN HEALTH AND SOCIAL SERVICES

What can I expect? - A guide for older people and carers

This summary of the National Service Framework for Older People was produced by Age Concern. It aims to be jargon free and explains what standards and services older people can expect as a result of the NSF implementation.

The guide covers: same access to services or treatment, whatever the age; being treated as an individual; living as independently as possible; quality of care in quality hospital environments; access of services to prevent people becoming ill and access to services providing the best support if people do become ill; leading a healthy active life; and how to take medication safely,

getting the most benefit from it.

The guide can be downloaded from the website: www.ageconcern.org.uk. Single copies, which can then be photocopied, are available from Age Concern England, Astral House, 1268 London Road, London SW16 4ER. Tel: 020 8765 7200. Email: acc@acc.org.uk.

£10,000 BUPA AWARDS**BUPA Foundation Awards Scheme 2002 - call for entries**

Closing date: 1 July 2002

The BUPA Foundation has launched a new award aimed at improving care for Britain's elderly. It brings the number of annual awards that recognise exceptional achievement in healthcare and research to six, with a total prize money of £60,000.

The Foundation would particularly like to receive applications that address areas raised by the National Health Service Framework for Older People, e.g. intermediate care services for stroke patients, dementia and other specialist care.

Entrants, e.g. clinicians, researchers and allied healthcare professionals, should send in short applications profiling their work. Winners in each category will receive prizes of £10,000 in each category.

Contact: Fiona Reid, Corporate Communications, on 020 7656 2246. Email: reidf@bupa.com. Website: www.bupa.com.

**NOTICE TO RETIRED MEMBERS -
DO NOT GO UN-NOTICED INTO THIS DARK NIGHT!
(WITH APOLOGIES TO DYLAN THOMAS)**

It is the practice of the BGS office to invite members who retire to provide the office with a copy of their CV for the BGS archives.

This provides a means of recording and retaining for posterity details of the valuable work effected by each member and provides an historical record of the practice of geriatric medicine as a whole.

Fortunately, due to the foresight of Dr Irvine in the 1980s, we have on record details of most of the early pioneers and their successors, provided by the members while they were still living; the majority of these are still with us. However, it is disappointing that the office has in recent years had a poor response to its request for information, which risks leaving a significant period in the progress of the specialty, in the latter years of the 20th century, un-represented in the Society's annals. It is also very sad when we receive news of an older member's death and we have no information on which to base an obituary. This has now happened several times, with doctors in their late 80s or 90s, where the successors in their hospitals, who may well be 40 years younger, cannot help us with any personal knowledge.

I would, therefore, urge all members who retired in the last five years to send (BGS office address below) in their CV and a few personal details, so that we can maintain our records and pay proper tribute to you when the time comes, hopefully not for a few decades yet! But now is the time to go on record, while it is all fresh in your mind.

Richard Lynham

Published by the British Geriatrics Society

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