



BGS

n e w s l e t t e r

Aberdeen 2003 BGS Spring Meeting

Four hundred and fifty of us came by plane, train, ferry and car (and all such combinations), to the BGS Scientific Meeting in the Grampian city of Aberdeen - centre of learning since the 15th century.

Those who travelled by car or train enjoyed the rich variety of scenery up the eastern coast of Scotland or along the spectacular A9 motorway. Special arrangements had been made for sunshine during our stay in Aberdeen, according to the Chairman of the Organising Committee, Steve Hamilton, who certainly appeared to have a direct line of influence because Aberdeen opened its grey granite arms and

filled them with swathes of nodding daffodils and basking seals on the Don. We came from the four corners of the United Kingdom, across the sea from Ireland,



Steve Hamilton, Chair of the Aberdeen Meeting Organising Committee, with Bob Stout

colleagues from continental Europe returning after their excellent time at Cork, and travellers from Australia, New Zealand and USA, who had braved the concerns of the SARS epidemic.

Business proper began with a state of the art lecture by Stuart Ralston (Aberdeen), who everyone agreed captivated and stimulated his audience as he made genetics appear simple, and helped us understand why mutations of uncommon bone and collagen diseases could help unlock the mechanisms of osteoporosis. More directly, he reminded us that a family history of fracture, including the famous first citizen family residing on Deeside, was an important predictive factor (nearly 4 fold) for the 50% of us women in the audience likely to be afflicted with osteoporosis.

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President: Prof Robert Stout **President Elect:** Dr Jeremy Playfer
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specialist medical society for health in old age

Never too late

Finbarr Martin (London) introduced the theme of exercise in preventing muscle loss in older ages, and this theme was returned to in the Healthy Ageing Special Interest Group (SIG), by Archie Young (Edinburgh). Both gave us the encouraging information that exercise could limit the age-related decline in muscle bulk. The message here was that 'it is never too late' to stop the 1-2% loss in strength each year, with the possibility of postponing or reducing disability by up to 10 years even in the



Aberdeen, City of Granite

oldest old. An important message by Dr Salota, (Nottingham) that Calcium and Vitamin D supplementation may be as effective as a regime which includes bisphosphonates merits further study, since many older people manifest poor tolerance of bisphosphonates.

Parallel sessions

Parallel sessions in psychiatry and respiratory medicine were welcomed by the specialist registrars who felt that the sortie by Graham Douglas

The Luminaries: Dr Alan Cox (Elizabeth Woodford Williams Prize for best paper read at a Spring Meeting); Dr Roger Smith (President's Medal); and Dr Donald Newnham (Golf guru of the Aberdeen Spring Meeting!)



The 2003 Spring Meeting Aberdeen Organising Committee: Dr Willie Primrose, Prof Gwyn Seymour and Dr John Scott



(Aberdeen) into use of NPPV by CPAP was especially useful in their day to day management of COPD on the acute medical take.

In the psychiatry update, Nitin Purandare (Manchester) reminded us that chronic diseases such as stroke, Parkinson's disease, dementia and cancer are accompanied by serious depression in 15% of people. Salient points were beautifully illustrated by holiday slides. In this session too, Brian McGurn (Edinburgh) demonstrated elegantly, the information which can be gained from longitudinal studies; in this case the IQs from the 1932 Scottish cohort of 11 years olds could be used to estimate and validate the relationship of pre-morbid intelligence to tests for dementia using the National Adult Reading Test. Other information from cohort studies was presented in the Cerebral Ageing and Mental Health SIG under the leadership of John Starr.

US cohort studies presented by William Barker (Oregon) suggests that congestive cardiac failure is increasing exponentially as the population ages. The value of longitudinal studies in ageing as an evidence base in directing and planning policy for the demographic changes expected in the population life expectancy, was further emphasized by Sian Griffiths (Oxford) in the Healthy Ageing SIG.

Holistic vision



Ian Philp

Ian Philp gave us some of the background to the government and his thinking behind the National Service Framework for Older People and how his holistic vision for older people had to be tempered with the government preoccupation with emergency admission and waiting lists. Two years have passed since the publication of the National Service Framework; the main improvements to date relate to combating age discrimination and developing intermediate care services. The next two years will focus on developing integrated services for strokes, falls and mental health, and reforming acute hospital care. Putting older people at the centre of the emergency care reform with geriatricians providing the medical leadership is the key challenge.

Brian Williams (Glasgow) gave a spirited account of integrated care for older people, Scottish style. Incisive questioning to Ian Philp revealed that 'intermediate care' might have been better termed 'integrated care' and that he hoped 'champions for

old age' could be seen as part of the working plan for improving older people's services in England. Geriatricians would provide leadership as clinical champions.

Those who attended Thursday afternoon's drug symposium had a fine overview of stroke risk factors by Ron MacWalter, followed by the cardiologist view by Adrian Brady (Glasgow). A questioner reminded us all that drug sponsored lecturers should carry a conflict of interest warning.

Friday dawned early for those who had taken the message on exercise therapy seriously and had ceilidh'ed till the wee hours. However, a very respectable Friday morning group made it to the breakfast symposium, and then settled into the more intimate choices within the four special interest groups.

With lunch beckoning Gordon Lowe gave an excellent talk on secondary vascular prevention, which was praised by all for its clarity of presentation, useful new information and helpful ABCDEF mnemonic.

Lunchtime on Friday, like Thursday, saw a healthy array of delicious buffet food ranging from Deeside salmon, colorful salads and a range of hot food. The large conference hall with the tables surrounded by the 80+ poster boards and the drug exhibition units made for easy circulation for viewing and discussion during poster sessions. It was also conducive to a chat during meal and coffee breaks. Those of us not familiar with 'coffee and tablet', discovered that our medication was a Grampian style fudge square!

Friday afternoon came, and with feet weary from pounding new carpets and bags becoming increasingly heavy with yet more freebies from the exhibition stands, we recharged the mental batteries and found useful snippets of information in medical ophthalmology, hearing difficulties in consecutive medical admissions and in visualization of gait using an accelerometer in Parkinson's disease.

Revalidation

Those colleagues attending the update in prostatic disease praised the clarity of the presentation but came away with concerned thoughts about 'what to do'. At 4.00 p.m. after further 'coffee and tablet', we settled into Graham Catto's view from the GMC. His delivery and comfortable style is an example of communication ease with an audience as he cantered through GMC in times past and times future, with information about revalidation and license to

practice for us all to digest. We all learnt a lesson in communication skills from the short clip of 'Doctor in the House', followed by his own interview with the 'interviewer from H—'. Full marks to him for using his own discomfiture as a learning experience for us all – and useful too for 'communication' skills training for our medical students and young doctors.

The social evening hosted by the Lord Provost in the Art Centre showed Aberdeen as a city of culture and for those of us unfamiliar with Aberdeen, we saw some of the fineness of its architecture and understood why Victoria loved to visit, and why Albert had to get a tartan of his own! At our dinner at Ardoe house, we sampled more Grampian cuisine, the Balmoral piper and 'a wee dram'. Our president Bob Stout, in his usual effortless style, thanked all the Aberdeen organizing committee for a successful

conference, presented the President's medal to Dr Roger Smith for his long and excellent service to geriatric medicine in Scotland, and reminded us in stories about St Peter that as 'physicians responsible for delayed discharges, we might find ourselves as *trolley waits* outside the Pearly Gates'!

Haste ye back again

Saturday morning saw an interesting multidisciplinary meeting about seating, posture and spasticity followed by community care, for a small but enthusiastic audience. As we packed our bags and headed for the airport, station or road out of Aberdeen, the road signs told us to 'Haste ye back again' - surely an invitation too good to refuse!

Maeve Rea
Ed Hodgkinson

Editorial page

A heartfelt thanks to all the folk who put in such hard work to deliver an excellent BGS Spring Meeting in sunny Aberdeen recently.

As usual the meeting was packed with many excellent presentations and thought provoking issues. It was particularly nice to see so many of the special interest groups being so active and displaying their wares at the national meeting. I personally attended the Ethics SIG and enjoyed being exposed to the concept of value based medicine.

We also carry information in this issue on the Parkinson's disease section of the BGS, in particular its master class series, which is due to begin again later this year.

We pay a visit to the academic dept in Newcastle in this issue, but on a more sombre note, pay tribute to people we have known, who have passed away.

Changes afoot

Alistair Main tells us that further NTN's will come into the service in the near future. His report gives us only a tiny hint of re-engineering and

restructuring in the training of junior medical staff which is about to hit us over the next year or two. A chat with your local Clinical Tutor will give you a flavour of what is to come. Hold on to your hats as phrases such as "foundation course" and "Mini CeX" begins to drift into your consciousness.

On the service side **David Black**, the new Chair of English Council, gives us an update on the National Older Peoples Task Force and for the second time in this newsletter mentions the Department of Health sponsored initiative within an American company called "Evercare". It will be very interesting to see the results of this particular initiative over the next 12 to 24 months.

Our report on CHI gives us a flavour of the ever-changing nature of acronyms. **Jonathan Potter** gives us an interesting insight into how this commission operates but also explains how CHI is evolving into CHAI. Ian Philp mentioned in Aberdeen that CHI or CHAI will shortly be looking at the implementation of the Older People's NSF around England. Jonathan also tells us about the Clinical Practice Evaluation Group.

Cath Church mentions a revised constitution for the Trainees' Group. The BGS has been awash with constitutional issues in the last year and it is a credit to their authors that they appear to be adopted

without much rancour by the members.

Many I remind members to think about applying for the post of Spring Meetings Secretary. Details of these very interesting posts can be had from central BGS and the March newsletter.

Scottish piping and BPH

During a comfort break after the main course at the BGS dinner in Aberdeen, I found myself joined in the sanctuary of the gents loo by our splendid Scottish piper for the evening. As he began to attend to his biological functions to my amazement he began to squeeze one bladder, i.e. his bag pipes, and played for a good 25 to 30 seconds. The question

came to mind: is it possible, in the folklore of Scottish piping that if one begins to suffer the effects of BPH in middle to late middle age, emptying a bagpipe bladder enhances one's ability to evacuate the other bladder? It may make physiological sense. Are any of our readers north of the border able to shed some light on my musing?

Finally, on behalf of the members of the BGS, I wish a speedy recovery to full health to both Chandu Vellodi and Richard Lynham.

Kevin Kelleher
Editor

President's column



We had an excellent Spring Meeting in Aberdeen. Steve Hamilton and his colleagues organised a most interesting programme which varied from molecular genetics to a discussion on the differences in the health service in England and Scotland.



Added to this was a splendid social programme, finishing with a magnificent dinner complete with piper and magicians, one of whom doubled as master of ceremonies. The granite city, with its millions of daffodils, was resplendent in the spring sunshine. Some even got a little pleasure from the knowledge that snow had fallen near London. We are very grateful to all who contributed to such a successful occasion.

Location, location, location

Our Society is becoming a victim of its own success. The attendance at our Spring and Autumn Meetings is now around 500 members. Some older members will remember when the Autumn meeting could be accommodated comfortably in the lecture theatre of the Royal

College of Physicians and the Spring Meeting used a university lecture theatre with student residences for accommodation. We now have difficulty in finding suitable venues for our meetings as we not only need to have a lecture room which will accommodate all the delegates, but we also must have rooms for smaller sessions, an area for the exhibition and posters, and of course catering facilities. There are only a few sites around the country, usually in purpose built conference centres, in which it is now possible to hold our meetings. Not only is the availability of venues becoming more restrictive, they are also becoming more expensive. This is particularly the case with the Novotel in London. The UK Management Committee is considering a variety of options, including the possibility of the Autumn Meeting not being held in London, but perhaps in some other conference centre such as Harrogate. I would welcome members' views on this.

UK Management Committee

At the Spring Meeting in Aberdeen we held an Extraordinary General Meeting at which the new articles and memorandum of association of the Society was passed with only one abstention and no votes against. This means that we now have a unitary management structure for the Society, with the UK Management Committee being the

overall management body. We also have four National Councils and I am delighted to report that David Black has been elected the Chair of the England Council with James Barrett as the deputy chair. The constitutions of the four National Councils were approved by the Executive at its last meeting and all the pieces are in place for the Society's new structure. The England Council will have a major task in establishing itself and its way of working. The UK Officers and the BGS Office will be very willing to help. We have held Extraordinary General Meetings at both the Telford and Aberdeen meetings and they were very well attended, very much better than the Annual General Meetings which we hold at our Autumn Meeting. As an experiment we are moving the Annual General Meeting to earlier in the day in the hope that more people will attend. Clearly to have it at the end of the meeting on late Friday afternoon means that many members will already have left for home. The General Meetings are the occasions when members can express their views and, indeed, implement their wishes by their votes and it is important that members should attend and participate in the affairs of the Society.

Gerry Bennett

We are greatly saddened by the death of Gerry Bennett. Gerry was Professor of Healthcare of the Elderly at Queen Mary London. He is probably best known to most people as co-author, with Shah Ebrahim, of an excellent short

text book, *Healthcare in Old Age*. He did distinguished work in very important but rather unfashionable areas of medicine, elder abuse and wound healing. In 1995 he spent several weeks as Visiting Professor in Queen's University Belfast. At that time the medical school was undergoing a major change in its curriculum and Gerry became heavily involved in this and designing new study guides for the course on Ageing and Health. He continued his interest in educational methods and has further developed the study guides so that they are now ready for publication in both paper and CD form. Gerry was part of a tradition, stretching back to some of the distinguished pioneers of Geriatric Medicine, of doctors who took an interest in areas which were outside the mainstream of medicine and yet of great importance to our patients. If Geriatric Medicine ever becomes respectable and part of the medical establishment, then either medicine will have changed for the better or our specialty will have changed for the worse. He will be sadly missed.

Trendy talk

Lastly, for those who like to keep up with the latest jargon, I have heard that breakout sessions in conferences are now known as 'mind harvesting sessions', and in its latest reorganisation the new slimmer Department of Health will be 'steering not rowing' the NHS.

Bob Stout
President

In Memoriam

Fritz Spiegl

1926 -2003 by Margot Gosney

Fritz Spiegl, born in Austria on 27th January 1926, died in Liverpool on 23rd March 2003.

Many of you who attended the dinner at the Autumn 2000 BGS meeting, will remember Fritz Spiegl giving the after dinner address. An immensely versatile man, not only did he write widely, contributing to *The Guardian*, *The*

Independent, *The Oldie* and *Private Eye* but over the years was a busy broadcaster in a range of spheres. One thing that the older members – including me – will remember him for, is the theme tune from *Z Cars*, an early 1960's police drama. This record was to sell more than 200,000 copies within a week of its release. Many doctors and allied health professionals will also have bought a copy of his highly informative and entertaining book *Sick Notes*. He will be missed in Liverpool and I am sure by many people whose lives he touched.

Professor Gerry Bennett

- the world a safer place for many older people

Death takes us by surprise and stays our scurrying feet. Longfellow's words sprung to mind when I heard that Gerry was dying.

Fortunately, I saw him on the morning that he died and was able to thank him for all that he did to make the world a better, and safer, place for older people to live in.

In the early 80's, as lecturer, Gerry made an outstanding contribution to the development of clinical services in St James's Hospital and to the teaching of ageing at St George's. His drive and

enthusiasm led to Ward 14, with its seventeen beds, ten place day hospital for recovering inpatients and ward follow-ups, and an attached small occupational and physiotherapy department being featured on a BBC TV programme. Thereafter I followed his career with interest and was delighted when he became a Professor.

Now his life has been cut short, his personal crusade has ended; the melanoma treated in 1983 came back in virulent form. After a roller coaster ride of hopes for successful treatment, Gerry died on April 13th 2003. Our sympathies go to his mother and to Hywel, his life long partner. Together they made a great team.

Prof Peter Millard

Prof Gerry Bennett

1951-2003 by Ian R Hastie

Gerry Bennett qualified at the Welsh National School of Medicine in July 1976, having been awarded the Clive Rees prize in Social Medicine.

Having gained a taste for geriatric medicine during his SHO rotations he joined us at St George's as registrar in geriatric medicine in 1980. A year later he was promoted to lecturer. At this time we were formally writing the medical student curriculum for training in geriatric medicine and Gerry took an active part in putting the curriculum together, and also in producing training handouts. Later this would

form the basis for his collaboration with Shah Ebrahim and the publication of the **Essentials of Health Care in Old Age**, a book we still recommend to our students at St George's as it closely resembles our teaching programme.

In 1984 he was appointed as consultant and lecturer at the Royal London Hospital, taking the lead in developing its geriatric medicine service. Gerry has many claims to fame but he will probably be best remembered by members of the Society as the person who put the issue of elder abuse on the map. However, I believe that his work on tissue viability, an interest he first developed at St George's, also made an extremely valuable contribution to this area. His work in both of these fields,



and in education were marked by his appointment as Professor 2 years ago.

The recurrence after 20 years of his melanoma was a great shock to everybody yet he continued to work tirelessly up until his final illness. A lot of us will remember him as a valued friend and colleague and our thoughts are with his family and Hywel, his long-term partner. He will be sorely missed.

Special Interest Groups



Updates

Cerebral Ageing and Mental Health Special Interest Group 2003 Aberdeen Spring Meeting

There was a local flavour to the Cerebral Ageing SIG session at the BGS Spring Meeting in Aberdeen.

The theme was the effect of early life cognitive ability on outcomes in old age and drew on the unique data available from the Scottish Mental Survey of 1932 in which nearly all of the 87,500 children born in 1921 were given a validated intelligence test. The presenters reflected the multi-disciplinary membership of the SIG. Ian Deary, professor of psychology in Edinburgh, focussed on cognitive change and told us that 50% of cognitive ability in old age is explained by childhood ability. He outlined the likely factors that might contribute to the 50% that varies over the lifetime and focussed on the role of genes, especially for Apolipoprotein E. Lawrence Whalley, Professor of Mental Health at

Aberdeen, took up this theme, looking at the role of homocysteine, folic acid and other micronutrients, as well as the influence of childhood mental ability on depression score and quality of life in old age.

Finally Alison Murray, senior lecturer in radiology in Aberdeen and an Aberdonian by birth, presented white matter and volumetric neuro-imaging data relating psychometric, socio-demographic and nutritional variables to underlying biological substrates identifiable on MRI.

The scientific programme was followed by a brief AGM in which the current SIG officers were re-elected and Dr Alasdair MacLulich, Lecturer in Geriatric Medicine at Edinburgh University, was elected as trainee representative.

Anybody interested in joining the group, please contact John Starr at John.Starr@ed.ac.uk

John M Starr

Cerebral Ageing and Mental Health SIG Secretary

New Technology in Older People Special Interest Group 3rd Annual Conference

The SIG hosted a very successful 3rd annual conference in October 2002.

Chaired by Professor Chris Bulpitt the meeting included among the presentations, a fascinating insight into the American perspective on **Assistive Technology** from Professor Emily Agree of Harvard University. The threat of litigation explains the widespread use of electronic aids and devices within their Health Care system. If an inpatient falls or sustains an accident where a bed or chair monitor was not in use, the home is open to a compensation claim. Food for thought!

Electronic Tagging. The SIG is currently involved in some controversial but potentially very rewarding research into electronic tagging in older people with dementia and wandering (featured as an editorial in the BMJ

(2002);325:847). Electronic tagging uses similar equipment to prisoner tagging systems and avoids the need for physical or chemical restraints with minimal side effects, but it has substantial ethical implications. Preliminary results should be ready for the BGS Autumn Conference in London later this year.

The SIG will be presenting at a **parallel session of the BGS at the Annual Autumn meeting in London 2003**. The provisional agenda includes: a) Smart Homes and older people in the community; b) Electronic Tagging for people with dementia and wandering; c) Machine Vision for the detection and prevention of falls d) A colleague from Hong Kong will present findings from his research on Telemedicine in Nursing Homes.

Machine Vision is the hot topic in the SIG at the moment. Do come along!

Frank Miskelly
Chairman

New Technology in Older People SIG

Medical Ethics Special Interest Group 2003 Aberdeen Spring Meeting

Held as a parallel session at the main BGS Spring Meeting in Aberdeen,

the meeting of the BGS Medical Ethics

Special Interest Group (SIG) began with a thought provoking presentation by Prof Fulford (Consultant Psychiatrist, University of Oxford and Professor of Philosophy at Warwick University, on value based medicine. He explained that it is his view that all people involved in healthcare, including the patient and their carers, bring to the situation very different sets of values. Increasingly in medicine, we are having our roles defined by the government or managerial objectives, and our ethics coded by law. Prof Fulford outlined two types of values:

Outcome values which are shared values and targets against which one measures one's decision making; and

Process values which are the differing values which do legitimately influence the situation, but may result in conflict.

Prof Fulford went further to examine how these values can influence decision making, saying that there are 10 principles of value based medicine¹, namely:

- 1 All decisions stand on their own 2 feet, values and facts.
- 2 We notice values when they conflict whereas shared values disappear.
- 3 Scientific progress has opened up choices which brings a greater diversity of values into health care

- 4 Information regarding the patient's perspective on the situation is the 'first call' on the decision making process
- 5 Conflicts are resolved by supporting a balance of different perspectives rather than a rule prescribing the 'right' outcome.
- 6 Raise awareness of different values using careful language.
- 7 Use resources available to improve knowledge of everyone's values
- 8 Use ethical reasoning to explore different values.
- 9 Take on board others views and interactions.
- 10 Decisions ultimately should be made by the users and providers at the coal face.

¹(Abbreviated from Fulford: The principles of value-based medicine published in Radden J, Ed, Companion to the Philosophy of Psychiatry, OUP).

The audience were then invited to use these principles in exploring the ethical dilemmas raised in a clinical case presented by Steven Louw, Consultant Geriatrician, Freeman Hospital, Newcastle upon Tyne. The case described complex issues involving a PVS patient and their future needs.

There followed a fruitful, interesting and at times, heated discussion as the issues were debated. An interesting observation was how practical we are as geriatricians, immediately focusing on the practicalities of future care provision and further rehabilitation potential, rather than the ethically challenging decisions. The audience were extremely engaged and numerous hands were still raised at the end of the session.

Anybody interested in joining the group please e.mail kleball@hotmail.com or b.j.liddle@sheffield.ac.uk

Jane Liddle
Medical Ethics SIG Secretary

GASTROENTEROLOGY & CLINICAL NUTRITION SIG

13 June 2003

**Marriott St Pierre Hotel & Country Club
Chepstow, South Wales**

Includes session on 'The Effects of NSAIDS on the Gut', a guest lecture and a free paper session presented by members of the group.

Contact: Send cheque for £50 drawn to "British Geriatrics Society" to: Dr Nadim Y Haboubi, Nevill Hall Hospital, Brecon Road, Abergavenny NP7 7EG. A programme will be sent to you. Registration is limited to 30 places allocated on a first come first served basis.

PARKINSON'S DISEASE SECTION

Conference

15 July 2003

RCP (London)

Examines the four phases of management in PD - diagnosis, maintenance, complex and palliative.

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

FALLS AND BONE HEALTH SIG

4th National Conference on Falls and Postural Stability

**9th September 2003,
Kensington Town Hall, London**

'Practical management of dizziness'; Preventing falls preventing fractures - the relationship between falling and osteoporosis'; 'Risk factors for falls and hip fractures'; 'Prevention of falls in institutional care'.

Contact: Secretariat (Falls)
Hampton Medical Conferences Ltd.
Email: hmc@hamptonmedical.com
Tel: 020 8977 0011

Healthy Ageing, Primary and Continuing Care Special Interest Group Aberdeen Spring Meeting

Beverley Castleden, in the Chair welcomed a great breadth of expert speakers to bring health promotion to the centre of the geriatrics stage.

Chris Drinkwater, Professor of Primary Care, dosed up the geriatricians amongst us with a stern reality check courtesy of the Wanless Report. He warned that unless we proactively engage with the prevention agenda, the unchecked expansion of the older population will lead to uncomfortable congestion of our hospitals by 2022 and further debt. Useful advice was given about how

to turn guidance and policy through both thin and rich networks into contracts and other outputs.

Sian Griffiths, Public Health Consultant at Oxford advocated translation of our skills as geriatricians, currently focussed on individual patients to community, national and even global arenas. The Public Health consultant's job is to take the "long view", perhaps difficult for us when much of our current energies are directed at trolley waits. However such an approach is offered as a useful addition to the armamentarium of policy targeting trolley waits. If the public health message is seized upon now, the trolley waits of the future will be eased. Although she claimed public health was not a glamorous speciality, she showed some rather glamorous slides of healthy ageing.

Archie Young promulgated some

frightening statistics about the loss of muscle strength and, more importantly, "explosive power" as we get older. However he offered the soothing reflection that exercise can afford 10 –20 years rejuvenation.

His colleague, **Susie Dinan** explained the practicalities of prescribing an exercise programme for older people. **Jackie Morris**, Chair of the SIG, rounded up by pointing out how the theme of healthy ageing is linked to what many of the group feel is the role closest to the heart: treating people in nursing homes and preventing older people from getting there. Points raised in the discussion included the immediate need to promote the healthy ageing of the over 65's as this population will be 85 in 20 years time. The lack of data on the effects of exercise in the over 80s was noted.

Yvonne Challiner

Parkinson's Disease

Academy - Presentation Dinner

The presentation dinner for the Parkinson's Disease Academy's (PDA) inaugural masterclass was held at the RCP in February.

The PD Academy is a series of masterclasses run under the auspices of the PD Section of the British Geriatrics Society with the support of the Parkinson's Disease Society and an unrestricted educational grant from Pharmacia (see details in box).

Multidisciplinary Approach

With the increasing complexity of treatment for PD and the growing emphasis on providing an integrated, multidisciplinary approach to management, there was a need for further education and training for senior medical staff. The first course

began in Cornwall in September 2002 with a further module held in the Royal Society of Medicine in January 2003. In addition to the two residential modules, the participants received mentorship and support from geriatricians and neurologists experienced in the management of PD. Most of the delegates have been consultant geriatricians who are hoping to start, or have recently started a PD service. Smaller numbers of senior specialist registrars and staff grade physicians have also taken part.

The dinner was attended by an number of graduates of the first course as well the next group of delegates who were beginning the second course. Honoured guests included Linda Kelly (Chief Executive of the Parkinson's Disease Society), Mr Keith Krzywicki (President of Pharmacia UK Ltd), and Dr Jeremy Playfer, President Elect of the British Geriatrics Society. Master of ceremonies was Dr Doug MacMahon who, along with Dr Peter Fletcher and Sue Thomas, is the main course organiser.



Keith Krzywicki, Callum Davidson, Linda Kelly and Doug MacMahon enjoy the pre-dinner reception

Linda Kelly said, "Developing access to and quality of services for people with Parkinsons locally and nationally is one of the key aims for the Parkinsons Disease Society. The Academy is an excellent initiative in partnership. It fosters best practice, clinical mentoring and the development of clinical networks and 'champions' for Parkinsons Disease

and related disorders both at a local and national level. We welcome this initiative and are delighted to be associated with it."

Following the after dinner speeches, graduates were presented with their diplomas by Dr David Stewart, Chairman of the BGS PD Section. Members of the Academy's faculty and those who had provided mentorship were also presented with a memento of the occasion.

The PD Academy has been a great success. Feedback from the first group of participants has been universally positive. We believe that this is an important initiative which, by supporting and encouraging the development of PD services, will help improve management and deliver the quality of service patients and carers desire. Demand has been such that, in addition to the second course now underway, a third is planned starting in Cornwall in September 2003, concluding March 2004.

Doug MacMahon
James Parkinson Centre



PARKINSON'S DISEASE ACADEMY - Master class series

The PD Academy is a series of Master Classes in the management of Parkinson's disease.

It was developed when the Parkinson's Disease Section of the BGS, responded to a need for a course for senior medical staff who wish to receive further education and training in Parkinson's disease and its management. We believe this to be an innovative approach, and it is proving very popular. In addition to clinical skills enhancement, it offers mentorship and support, and aims to promote best practice and fulfil the clinical governance agenda in this disease area.

The aims of the programme are to: -

- ◆ enable geriatricians and general practitioners to further develop effective clinical management skills and to provide access to opportunities for personal development and learning in the management of Parkinson's Disease;
- ◆ enable participants to develop skills in the application of a disease management model in Parkinson's Disease;
- ◆ provide opportunities for participants to develop clinical skills across organisational boundaries;
- ◆ enable participants to critically evaluate the relationship between clinical management, the National Service Framework (NSF) for Older People and the forthcoming NSF for long term medical conditions and neurology (scheduled 2004);

- ◆ enable participants to relate theory in PD management to practice as leaders of service development and delivery in their own local areas;

- ◆ to understand and fulfil the clinical governance agenda in Parkinson's disease

The next masterclass will take place in Cornwall in September 2003 and will conclude in London in January 2004. The course is run in two modules, Module 1 in September 2003 will look at initial diagnosis and maintenance issues in Parkinson's Disease. Module 2 in January 2004 will take participants onto Complex management of Parkinson's Disease and will also focus on palliative care issues.

The faculty is comprised of experienced geriatricians, neurologists and clinicians from other relevant disciplines. Between modules participants will be mentored and undertake further learning through experiential visits with their mentor and through regional master class workshops. We are grateful for the assistance of Pharmacia through the provision of an unrestricted educational grant to establish this project.

Enquiries to:

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RESEARCH FELLOWSHIP

NEUROLOGICAL IMPAIRMENT IN OLDER PEOPLE

Research into Ageing is delighted to announce the availability of a research fellowship in neurological impairment in older people fully sponsored by the Barnwood House Trust. Outline applications are invited from individuals with a medical qualification, from a profession allied to medicine or from post doctoral researchers ready to embark on an independent research career. Funding is available for three years and the total cost should not exceed £150,000 or £175,000 for applicants with a medical qualification. The deadline for outline applications is **30 May 2003**; the decision will be made end of Nov 2003 for start any time in the following calendar year.

OTHER FUNDING OPPORTUNITIES

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

Research into Ageing



Help the Aged

Examples of topics we support are cellular ageing processes, dementia, vision, hearing, falls, mobility, osteoporosis, stroke, incontinence, wound-healing, depression and diet. We do not normally fund cancer research. Applicants may be any nationality, but the project must be carried out in the UK. In 2003 Research into Ageing will fund in excess of £3 million worth of bio-medical research and we anticipate further growth in 2004. The following awards are currently available:

PhD studentship

Incontinence research funding scheme

Research fellowships

Programme grants

HOW TO APPLY

Please find further information about the research funded by Research into Ageing and outline application forms for the Fellowship in Neurological Impairment and for the other funding schemes available to download at our website www.ageing.org Telephone enquiries to Ian Jarrold, Project Administration Officer on 020 7843 1572.

**Research into Ageing
is a special trust within
Help the Aged**

Research into Ageing, 207-221
Pentonville Road, London N1 9UZ

MULTIDISCIPLINARY MSC/DIPLOMA COURSE IN AGEING, HEALTH AND DISEASE (TWO YEARS PART-TIME)

The Department of Geriatric Medicine at the University of Wales College of Medicine

is offering an advanced course of study suitable for graduates in medicine, nursing, the professions allied to medicine, social care practitioners, other professionals and managers who work with older people. Applicants without a degree, but with vocational qualifications and related work experience, may also be considered.

The course is offered on a multidisciplinary, multi-agency basis providing the opportunity for health and social care professionals, together with people working for voluntary agencies to study and learn

together. Assessment of student progress will be by continuous assessment, and for the award of the MSc, successful completion of a dissertation will be necessary.

**The course will commence in
October 2003**

**Course fee 2003/2004:
£1,750.**

Information available from:

Mrs Shirley Green
Course Administrator
Department of Geriatric
Medicine
3rd Floor, Academic Centre
Llandough Hospital
Penarth CF64 2XX
Tel: 029 2071 6986 Email:
MSC-AGEING@cf.ac.uk

BLADDER AND BOWELS SIG

Leicester Continence Residential
Training Course

Leicester General Hospital

9-11 June 2003

Course fee: £300

**For programme and further details,
contact:** Dr Tony Vallance, Leicester General
Hospital, Gwendolen Road, Leicester LE5
4PW Tel: 0116 258 4041 Email:
Dr.Vallance@uhl0tr.nhs.uk

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Download full versions of some of the
articles featured in this newsletter and
make your views known in the on-line
discussion forum

Lessons from America

adapting UHG Evercare model for the NHS

A number of PCTs are aiming to improve services for older patients through collaboration with UnitedHealth Group (UHG), an American Healthcare Maintenance Organisation

The intention is to pilot the adaptation and implementation of their 'Evercare' model for managing care for a vulnerable older population.

Back in November 2002, 10 PCTs began working with UHG to scope how the 'Evercare' model could be tailored and adapted.

Following this initial work PCTs have been discussing their requirements for more hands on support from UHG in implementing an adapted Evercare model over the next 18 months with UHG.

Pre-emptive monitoring

In the US patients in the Evercare programme are monitored intensively to catch illness early. The intention is to keep older people healthy and when they do become ill, to avoid unnecessary hospital admissions by offering a greater range of services in the community and by treating them in the least intensive setting.

A primary care team is used to deliver this model. Nurses are at the centre of the model and they work closely with hospital geriatricians, and with the patient's doctor and family to develop care plans for patients.

The starting point for implementing an adapted Evercare model in the 10 PCTs is to identify the high-risk population. The approach then will be to develop a model of care where, the role of the GP is extended through a collaborative partnership with nurses and social care staff, and where consultants are engaged as part of a community based team to enable more proactive management of the high-risk caseload. Professor John Young, Consultant Geriatrician in Bradford, sees the potential for care

modelled in this way, saying, "This is a big opportunity to support some of our most vulnerable older people, both at home and in care homes - to provide them with enhanced and timely care." Prof Young added, "At the heart of the Evercare project is a tried and tested training programme for nurses embedded in partnership working between GPs and geriatricians."

As well as improving the way that care is provided this project can also help PCTs in their efforts to deliver success against National Service Framework

for Older People standards such as: assuring standards of care; extending access to services; and developing services which promote the independence of older people. This approach will also build on the integration of health and social care services for older people.

"At the heart of the Evercare project is a tried and tested training programme for nurses embedded in partnership working between GPs and geriatricians."

Lyn Wilkinson, Director of Community and Nursing Services in Airedale PCT, sees clear benefits in participating in the project. Ms Wilkinson said, "We are delighted to have the chance to pilot this new programme of care in the PCT. This will improve quality of care for the most frail older people, and their carers, by reducing levels of polypharmacy, avoidable hospital admissions and offering more patient/carer involvement in care".

High satisfaction

Independent evaluation of the programme in the US by the University of Minnesota has shown high physician and family satisfaction - 97% of families appreciated the extra care and attention received through the Evercare programme.

As a condition of taking part in this programme PCTs are participating in Action Learning Sets as part of the transformational change programme being run by the National Primary and Care Trust Development Programme. This will ensure that learning opportunities can be captured during the roll out of the project and spread more widely.

Patrick Harrison
Policy Development Manager, DOH

2003 Who's who

in the British Geriatrics Society

Officers of the British Geriatrics Society



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President Elect:
Secretary:
Treasurer:
Deputy Treasurer:
Deputy Secretary:
Autumn Meetings Secretary:
Spring Meetings Secretary:

Prof Robert Stout
 Dr Jeremy Playfer
 Dr Chandi Vellodi
 Dr Ian Sturgess
 Prof Margot Gosney
 Dr Kevin Kelleher
 Dr Janice O'Connell
 Dr Juanita Pascual



Jerry Playfer

Chandi Vellodi

Ian Sturgess

Margot Gosney



Wales Council

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South East Wales: Dr Dwarak Sastry

2 Trainees: TBC

Northern Ireland Council

Chair: Dr Joe McElroy
Chair Elect and Secretary: Dr Maeve Rea

Treasurer: Dr Peter Flanagan

Regional Rep: TBC

Trainee Rep: TBC

2003 Who's who

in the British Geriatrics Society



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Deputy Chair:	Dr James Barrett
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NE Thames:	Dr Sara Lightowlers
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SE Thames:	Dr Jonathan Potter
South West:	Dr Harbans Bhakri
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Oxford:	Dr Adam Darowski
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2 Trainees:	TBC



David Black



Rose Anne Kenny



Jonathan Potter



Ray Tallis

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Marion McMurdo

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Argyll and Clyde, Ayrshire and Arran, Dumfries, Galloway and Borders:	TBC
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Forth Valley and Lanarkshire:	Dr Alan McKenzie
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Trainees:	Dr Vera Cvoro Dr Adam Bowman
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SPRING MEETINGS SECRETARY

- Deadline for nominations: Friday, 6 June 2003

editor@bgsnet.org.uk by Friday 6 June 2003.

The office of the Spring Meetings Secretary becomes vacant in October.

Nominations for the post should consist of a brief CV and a supporting citation from the relevant regional or national branch, sent to

The UKMC will vote on the nominations received at its meeting on 17 July 2003.

New NTN^s in Geriatric Medicine

The lid comes off the ceiling!

In a letter to College presidents, specialty representatives, postgraduate deans and chief executives of the Workforce Confederations, the 'allowance' of 400 new centrally funded and 1516 new locally funded NTN^s was confirmed.

This effectively removes the severe 'ceiling' restrictions on new posts. The major arguments for this change of heart are:

- ◆ The dawning reality of the impact of the European Working Time Directive (EWT^D) on acute specialties.
- ◆ The need to bolster cancer and surgical services and their supporting specialties.

Funding the new posts

Central funding or a mixture of central and local funding was reserved for a number of shortage specialties, including general and old age psychiatry, histopathology and radiology (as widely anticipated) but did not include geriatrics or any other clinical medical specialties

Locally funded new posts are more numerous with the largest numbers going to general surgery (200), anaesthetics (160), paediatrics (100), respiratory medicine (150), and T&O (90). Local Workforce Confederations are expected to find the funding within trusts from reallocation (e.g. SHO or Trust grade posts) or from new internal money.

Good news for our specialty

At least 2 months ago, we were given strong hints that our manpower arguments in the specialty (well rehearsed in BGS Newsletter articles and greatly strengthened by our internal workforce surveys) had been favourably received. Geriatrics has been awarded 80 NTN^s (10 of which have already been allocated). Our

allocation, amongst acute medical medicine, runs ahead of endocrinology & diabetes (70), gastroenterology (50), and cardiology (40). The distribution for geriatrics by Workforce Confederation is indicated in the table.

Implementation of the proposals is now being entrusted to the recently established Workforce Development Confederations (WDC^s) and local postgraduate deans with advice from the specialty lead deans, in our case Professor Cochran from Glasgow. He has the responsibility of distributing the posts in geriatrics fairly, especially to places offering good training but hitherto denied adequate SpR allocation. It is also expected that there may be some 'horse-trading' between WDC^s (those who can and can't support trainee posts): and we also have to grapple with the changed 'workforce boundaries' from the old Regional Health Authorities and related deaneries to the WDC^s!

Fishing in a shallow pond

This change of heart by the Government gives us significant challenges, not least competing with other medical specialties for good trainees. It will be several years before the expansion of medical schools feeds through to SpR level. To 'feed' the SpR grade in the more immediate future, there is a proposal, supported by the Medical Workforce Review Team, to convert up to 1300 SHO posts (all specialties) to SpRs. Distribution of these posts and implementation of scheme is still being finalised. We will continue to rely on overseas graduates and must do all we can to encourage the conversion of non-training grades into trainees. We also need to create new rotations between teaching and non-teaching hospitals.

The nature of the job

The EWT^D has already radically altered the nature of the work in acute medical specialties, some would say 'dumbing down' of all grades. Already many registrars involved in acute

medicine are doing what would hitherto have been regarded as SHO or HP work (on take or covering wards when others are on take) and in national surveys have expressed their dismay at being pushed into shift systems. If large numbers of SHO posts are converted to SpRs, this situation can only worsen. Already training in geriatric medicine has been severely eroded by

the dominance of acute medicine and it will be increasingly difficult to put together attractive new training programmes which will fulfil the requirements of the new SpR training programme. So, we still have a few problems to solve!

Alistair Main
Chair, BGS Workforce Committee

NEW LOCALLY FUNDED NTN_s IN GERIATRIC MEDICINE		
Workforce Confederation	Current stock of NTN_s	Additional NTN_s
Avon, Gloucs, & Wiltshire	25	0
Birmingham & Black Country	19	2
Bedfordshire & Hertfordshire	15	0
County Durham & Tees Valley	11	0
Cornwall & Devon	8	5
Coventry & Warwickshire	8	3
Cumbria & Lancashire	5	12
Dorset & Somerset	6	3
Essex	7	5
Greater Manchester	32	0
Hampshire & Isle of Wight	10	4
Kent and Medway	5	7
Leicestershire, Northants & Rutland	15	0
Merseyside and Cheshire	18	4
N&E Yorkshire & N. Lincolnshire	8	5
North of England	32	0
North Central London	22	0
North East London	13	2
Norfolk, Suffolk & Cambridgeshire	17	0
North West London	18	0
South East London	19	0
Staffordshire & Shropshire	9	2
South Yorkshire	8	5
South West London	12	0
Surrey and Sussex	17	5
Thames Valley	15	1
Trent	8	15
West Yorkshire	27	0
TOTALS	407	80

National Older People's Taskforce

Update

The National Older People's Taskforce continues to meet on a quarterly basis to act as a source of advice, encouragement and, of course, constructive criticism to the National Director of Older People's Services in delivering the NSF.

The taskforce brings a multi-disciplinary reality check to Ian Philp and the Department of Health officials. This is an important role because although the National Director has just about completed his twenty six visits to all the Strategic Health Authorities in England, he is of course being shown the best of all schemes.

At the moment the reality, across the country, is that there is enormous pressure on chief executives to deliver financial targets and A&E access targets. The financial problems have made the development of local delivery plans (LDP's the successor to SAFF's) very difficult, and there was a widespread view that delivering the milestones in the National Service Framework for Older People (NSF) had been pushed down the priority list. On the other hand, delivering access targets will greatly benefit many older people, and all of us individually have a challenge to persuade our health community that getting services right for older people in hospital means getting it right for the rest of the Health Service. Another area of some disappointment has been the new GP contract where the specialist clinical targets for older people unfortunately did not make the final contract.

On the Workforce Front

On a more positive note, the eighty new NTN's for geriatric medicine will be widely welcomed and Alistair Main, who represents the BGS on the Workforce Group, reminds us how important it is to develop attractive training

programmes which will pull trainees into geriatric medicine. There also appear to be leadership funds available for training the first cohort of GP's with a special interest in older people. It is hoped that up to 300 of these could be trained in the first cohort. There is agreement that they will interface very closely with local geriatric services and where GP's do take on this role, it must help to deliver better services in the community.

Champions

A key part of the delivery of the National Service Framework, has been to identify and enthuse enough champions at a local level to keep progress moving forward on the National Service Framework, even if it does not make highest political priority. There is now a national database and up to 2000 people are registered on it. The DOH has appointed a National Development Manager, whose job will be to work with these champions, to develop them and encourage them in influencing local policy.

Evercare

The group were also updated on a Department of Health initiative with an American company called 'Evercare' that provides enhanced medical care and co-ordination of services to older Americans on behalf of the Federal Government. Evercare work principally by using specialist nurse practitioners and care staff to work with frail elderly people in both the community and institutional care with a view a proactive improvement in the quality of care and to prevent unnecessary hospital admissions. Independent evaluation has been by Professor Robert Kane from Minnesota, who is well known to many members of the BGS. The Department of Health through its primary care arm have invited Evercare to look at 12 PCT's around the UK to see if they could develop (not deliver) local services in a cost effective fashion along the lines of the model provided in the USA. A number of geriatricians have been involved in this and the BGS and the National Older

People's Taskforce will be very keen to receive feedback from the geriatricians involved in local sites, if their PCT's decide to fund one of these programmes.

Intermediate Care

Finally, the Taskforce spent a considerable period of time reviewing Intermediate Care. Ministers see Intermediate Care as a success for the NSF. The feedback was that nationally, progress has been patchy. There is no doubt that there are extremely well run and effective schemes, but unfortunately there are still a significant numbers of ineffective or poorly run schemes. The message coming up time and again is the need for clear leadership and management back up;

proper partnerships between health and social care required; a single point of access; adequate medical input needed to be achieved; and the schemes need to be visible, pro-active and prepared to take on and solve problems.

“Cherry Picking” schemes are rarely seen as successful. An issue that also continues to come up is that of “professional silos” and a reluctance to work in a genuinely multi-disciplinary environment. Clearly, a lot of work continues to be required to get the most out of the funds that have been invested in Intermediate Care.

David Black



We are seeking geriatricians for the Illawarra Area Health Service, one of the largest health services in NSW and, in turn, Australia.

The specific focus of the job role is flexible, depending upon the clinical and research interests of the successful applicant. An opportunity also exists for a conjoint academic appointment with the University of New South Wales.

You would be joining a dedicated team of health care professionals with a commitment to quality patient care and ongoing education. There are three geriatricians in Illawarra, and all inpatient units have accredited registrar positions.

Shoalhaven Hospital is a 150 bed hospital in picturesque Nowra which has recently undergone a major

upgrade to complement the recently completed rehabilitation ward. In partnership with the University of NWS, the Area Health Service is developing a new Clinical Teaching Program in the area. The Aged Care Service is already actively involved in undergraduate and postgraduate medical student teaching.

The Illawarra is a beautiful coastal region offering a great lifestyle. Wollongong is just over one hour from Sydney with Shoalhaven two hours by car. For families, the region is well serviced educationally by public and private schools, and the University of Wollongong. Geographically, the region offers an outstanding mixture of beaches, mountains and coastal plains, along with many lakes, rivers and the magnificent Jervis Bay. Wollongong also offers a range of leisure, cultural, and sporting facilities,

and teams in major national and state sporting codes.

Specific job details are negotiable with the successful applicant, depending upon their clinical and research interests.

You will:

- ◆ Be eligible for registration as a medical practitioner in the state of NSW
- ◆ Have either FRACP (Geriatric Medicine), or equivalent.
- ◆ Be eligible to obtain a driver's licence in NSW
- ◆ Enjoy working within and leading multidisciplinary clinical teams
- ◆ Have a commitment to maintaining professional education and clinical quality
- ◆ Ideally have some research and/or teaching experience in geriatric medicine, although not essential.

Enquiries or applications can be made, in confidence, to:

Wayne Bruce by phone on +61 2 9232 8148 or by email: wayneb@trakrecruit.com



Commission for Health Improvement (CHI)

Many members of the Society will be familiar with CHI and its rigorous methods of working. For those who wish to know more, a read of any report on the CHI website will give an insight into the comprehensive nature of their visits.

CHI is currently evolving into the **Commission for Healthcare Audit and Information (CHAI)**.

Members may be forgiven for suspecting that the new arrangements mean more tea and less action, and may wonder where we go from here - maybe CHAIN (we once had cogwheel), CHAIR (more committee and less action) or even a euro version CHAIS. Some details of CHI/CHAI and the importance for clinicians are outlined below.

Introduction

CHI was established to improve the quality of patient care in the NHS. It does this by reviewing the care provided by the NHS in England and Wales (Scotland has its own regulatory body, the Clinical Standards Board). CHI aims to address unacceptable variations in NHS patient care by identifying both notable practice, and areas where care could be improved. It has six operating principles that underpin all of its work, namely:

- ◆ The patient's experience is at the heart of CHI's work
- ◆ CHI will be independent, rigorous and fair
- ◆ CHI's approach is developmental and will support the NHS to continuously improve
- ◆ CHI's work will be based on the best available evidence and focus on improvement
- ◆ CHI will be open and accessible
- ◆ CHI will apply the same standards of continuous improvement itself, that it expects of others

Statutory functions of CHI

CHI currently has four statutory functions:

- ◆ **Clinical governance reviews** (see the CHI website for more details: www.chi.nhs.uk)

◆ Studies

The first CHI national study report into Cancer Care in England and Wales was published in December 2001. The next study, which will look at implementation of the NSF for coronary heart disease, will be published in 2004.

◆ Investigations

CHI investigates serious service failures in the NHS. It will only investigate issues if there are lessons to be learned across the NHS.

◆ Leadership

CHI leads, reviews and assists NHS healthcare improvement and aims to collect and share notable practice in the NHS.

How is CHI's work changing?

At the request of the Secretary of State for Health, CHI has been asked to set up an Office of Information on Healthcare Performance. CHI will become **CHAI (Commission for Healthcare Audit and Information)**. This will become a leading source of information regarding the performance of NHS organisations, both at local and national level. This specialised department will be responsible for publishing NHS performance ratings and carrying out national surveys of patients and staff. It will also conduct national clinical audits. This will mean that CHI will review all aspects of patient care and will publish a wide range of information about the NHS.

These new arrangements are being presented to Parliament with a view to coming into force in April 2004. **Professor Sir Ian Kennedy has been appointed as the Shadow Chairman of the Commission** until he takes up the substantive role. He chaired the Bristol enquiry. His appointment indicates the determination of the Government to implement the lessons learnt from Bristol and in particular their determination to obtain information



Prof Sir Ian Kennedy

on which performance can be judged.

NICE

Although arrangements are not yet confirmed, changes may well include taking over the currently proposed NICE portfolio of audit – including the **National Stroke Audit, the Myocardial Infarction National Audit Project (MINAP)** and the proposed **National Continence Audit**. CHAI may well also subsume the **National Health Service Information Agency (NHSIA)** and the **National Clinical Audit Support Programme (NCASP)**.

Such changes are important for clinicians, as there will be growing pressures to obtain data on performance which will be open to public scrutiny. It is essential, therefore, that the profession contributes to these developments to ensure that the data generated reasonably reflects practice.

How independent is CHI?

“CHI works closely with the Department of Health

(DoH), but operates independently from it.” CHI commissioners, appointed by the Secretary of State for Health in England and NAW, ensure that CHI operates independently. The National Audit Office is CHI’s external auditor.

BGS members can draw their own conclusions as to the likely independence of a body of commissioners appointed by the Secretary of State for Health. Recent newspaper reports have highlighted that the Government is concerned about its ability to control potentially damaging reports regarding the state of the NHS. There appear to be moves to reduce the guarantees of independence for the newly emerging Commission for Healthcare Audit and Inspection.

JM Potter

Chairman

Clinical Practice Evaluation Group

Geriatricians as Trainers



The training of junior doctors (HPs, SHOs and SpRs) is undergoing mammoth change, as is our specialty, geriatric medicine.

With the appointment of more consultant physicians in sub-specialties, geriatricians are doing and are expected to do more on-call emergency duties.

The future geriatrician is expected to do a variety of tasks besides emergency on-call duties, ward duties and rehabilitation. Many geriatricians are also developing sub-specialty interests e.g. stroke care, movement disorders, intermediate care, etc.

How will this impact on future consultants? How should we train our specialist registrars?

“Geriatricians as Trainers” - the first meeting of its kind, will be held at Warwick University in Coventry (not Warwick Hospital) on Friday, 28th November 2003. It is being co-ordinated in collaboration with the Training Committee of the BGS. It will help to bring together consultant physicians who have a

training responsibility for specialist registrars. Sir Liam Donaldson, our Chief Medical Officer, and Prof Bob Stout, President of the BGS, will be attending and we will gather a panel of experts to deliver an excellent programme which will cover various aspects of the training of specialist registrars.

A provisional programme will be ready by the end of the summer.

Scarman House at the University of Warwick has excellent facilities for the conference and there is room for only 120 delegates. Our intention is to allow 20 senior specialist registrars (the trainers of the future!) to attend. SpRs who have a particular interest in medical education will be given preference. CME accreditation will be available.

To register interest please contact:

Pamela Bayne
Dept of Medicine, Warwick Hospital
Lakin Rd
Warwick CV34 5BW
Tel: 01926 495321 ext 4341
Email: pamela.bayne@swh.nhs.uk

Clinical Practice Evaluation Group

- Putting the D into “R&D”

The Society has a long tradition of promoting and carrying out research. Now the BGS is developing its commitment to clinical effectiveness through the CPEG

The Clinical Practice Evaluation Group (CPEG) is a sub-committee of the Academic and Research Standing Committee of the Society. The role of CPEG is to promote the conversion of evidence based research knowledge into best practice – promoting the “development” part of “research and development”.

Many other specialist medical societies have well established traditions for developing guidelines and carrying out audit that have informed practice nation wide. The CPEG will endeavour to move the BGS in a similar direction.

Recent years have seen an increasing emphasis on the need to implement change and service development and to evaluate services in an objective way. National bodies such as the National Institute of Clinical Excellence (NICE), the Commission for Health Improvement (CHI), the National Health Service Information Authority (NHSIA), the Modernisation Agency and the Audit Commission are examples of these changes.

Equally new methods have developed for the acquisition, aggregation and interpretation of research findings. Information scientists and systematic reviewers have become highly sought after professionals. There are now rigorous methods for the development of guidelines, the carrying out of audit and the implementation of change.

Current Activity

The CPEG is developing on various fronts, namely:

1. Contributing to national bodies

The CPEG receives requests from NICE for representation on guideline development groups and for stakeholder input into guidelines under development. Many members of the Society have already contributed. This is invaluable work, as the guidelines will inevitably form the basis for a national approach to the management of conditions. It is essential that the needs and requirements of older people are recognised and incorporated. Examples of NICE guidelines underway include:

- ◆ Cardiac Failure
- ◆ Chronic Obstructive Pulmonary Disease
- ◆ Pressure Sores
- ◆ Epilepsy

The CPEG contributes suggestions to national bodies for Health Technology Appraisal and for further guidelines.

2. Carrying out Society based audit

The CPEG has established a database of departments interested in contributing to multicentre BGS audit. The first exercise is currently underway with departments contributing to an audit of appropriate prescribing of bisphosphonates to prevent steroid induced osteoporosis. It is hoped to present the results of the audit at the Autumn Meeting of the BGS in the “PRACTICE” section.

3. Contributing to the Royal College of Physicians (London) Clinical Effectiveness Forum

The Royal College of Physicians (London) has an established forum of specialist societies which meets to promote clinical effectiveness. To date the Forum has established a database of clinical guidelines developed by member societies and these are being “kite marked” on the basis of the methodological soundness. Details of guidelines on the database on the RCP (London) website:

www.rcplondon.ac.uk

The Forum is currently seeking information on multicentre audits carried out by member societies. These will also be entered onto a database with the view that departments interested in similar audits can use the same methodology and compare results with other departments around the country.

4. CPEG sections within the BGS Spring and Autumn Meetings

CPEG has initiated a new section within the Spring and Autumn Meetings of the BGS to highlight and promote best practice.

CPEG at Aberdeen

The inaugural session of the Clinical Effectiveness section of the poster presentations was held at the Aberdeen meeting. 10 posters had been accepted covering aspects of practice development including:

audit
resuscitation
guideline production
best practice
care pathways

pressure sores,
hospital infection
bowel care
falls service
stroke

These poster presentations had been adjudicated by members of the CPEG committee and had been judged to be based on sound scientific method. Dr John Pounsford and Dr Martin Connelly – both recognised nationally for their work in clinical effectiveness – reviewed the posters and discussed issues of clinical relevance and scientific rigour. While these presentations will not be published in **Age & Ageing**, they

attracted great interest and stimulated much discussion. It is hoped that similar sessions at future meetings will provide a useful forum for members of the Society to discuss methods of service improvement.

Members are invited to submit abstracts for the BGS Autumn Meeting using the abstract submission guidelines in the usual way. **The deadline for submission is 1 June.** In addition to the areas of service development above, other aspects might include: benchmarking of services, innovations in service development. The Committee would emphasise that submissions must be directed towards the **“PRACTICE”** section for abstracts. The submissions are adjudicated separately from those submitted to the research component of the BGS meeting. In view of time constraints and the need to give an unbiased review of all abstracts submitted, abstracts cannot be referred from the research sections to the clinical effectiveness **“PRACTICE”** section once the deadline has passed.

Conclusion

The work of CPEG has got off to a good start. I am extremely grateful to the members of the CPEG Committee for their interest and enthusiasm. I hope members of the Society will find this new development of interest and will seek to support the initiative through encouraging their departments to contribute to the activities of CPEG.

JM Potter

CPEG Chairman

jonathan.potter@ekht.nhs.uk

VIENNA CONGRESS

6th Vienna International Congress in Geriatrics

22-24 May 2003

Vienna, Austria

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

GETTING STARTED WITH RESEARCH

A free conference for SpRs in geriatric medicine

30 May 2003

Southmead Centre for Medical Education, Bristol BS10 5NB

Contact: Dr Susanne Sorenson, Research into Ageing. Email: Ssorensen@ageing.org

SCOTLAND - RCP(E) SYMPOSIUM ON GERIATRIC MEDICINE

28 May 2002

Queen Mother Conference Centre, Edinburgh

Contact: Ms Eileen Strawn, Education & Standards Dept, RCP Edinburgh, 9 Queen St, Edinburgh EH2 1JQ. Tel: 0131 225 7324. Website: www.rcpe.ac.uk Email: e.strawn@rcpe.ac.uk

Trainees' Column



The Trainee Group of the BGS met on 11th April during the BGS Spring Meeting in Aberdeen. It was a lively meeting with lots of discussion.

BGS Structure

The BGS National Council has devolved and a new English Council has been set up. The English Council will have 2 trainee representatives. There already exists Scottish, Welsh and Irish Councils, all of which have trainee representation. These Councils report to the BGS UK Management Committee (formerly the BGS Executive).

Trainees Group Constitution

A revised constitution (circulated to trainees by post prior to the meeting) was proposed. The essential changes were to allow more flexibility within the Trainees' Committee itself, and also to recommend that Council representatives (2 English, 2 Scottish, 1 Welsh and 1 Irish) be voted for at national meetings by their peers. The proposal that this revised constitution should be approved and adopted with immediate effect was passed by a majority vote indicated by a show of hands.

The revised constitution is on the trainees' website (www.bgstraining.org.uk).

The next election for the 5 posts on the Trainees' Committee will be at the BGS Autumn Meeting in October 2003. The Council representatives will be elected at this stage (members of the current Trainees' Committee will provide representation to the English Council until then).

SpR Assessment/New Curriculum

All SpRs taking up posts from 1st Jan 2003 will be trained according to the New Curriculum.

Assessment methods are still to be piloted. It is unlikely that these will be applied retrospectively but this has yet to be confirmed.

Stroke Training

Jo Kwan, Honorary Chair of the Trainees Group of the British Association of Stroke Physicians (BASP), gave a short presentation.



Cath Church

There has yet to be agreement on the duration of training (although it is likely to be an extra year), and whether/how much of previous training in stroke medicine will count towards this. For the new Stroke Curriculum, look at www.basp.ac.uk/baspexcdocs. If you are interested in stroke training,

contact Jo on jk@1to1.org.

EWTD/Shifts

I would be grateful if you could all return the EWTD/Shifts questionnaire (if you haven't received one, please contact the BGS office or me at c.j.church@newcastle.ac.uk

Research Training

RIA grants, Start-up Grants and travel bursaries are available. A research register is currently being set up.

The Research Surgeries were badly attended this year – it is unclear whether this was due to bad publicity or a general lack of interest from trainees.

A large proportion of abstracts were rejected this year for a variety of reasons e.g. lack of ethical approval; lack of data. Feedback is always given to those whose abstracts are rejected.

General

Dr Roger Harris (rogerh@adhb.govt.nz
www.adhb.govt.nz) and Dr Shankar Sankaran
(www.sah.co.nz) are Elderly Care Physicians
based in Auckland, New Zealand. They can offer
placements for UK trainees and would be keen
to be contacted directly. Trainees should enquire
locally as to whether this training would count
towards their CCST. There was concern that
many regions are discouraging trainees from
taking time out abroad in order to push them
through to CCST – it was stressed that this
shouldn't be the case if the time out is to be
counted towards training.

Date of next meeting

This will be held during the Autumn BGS
meeting in October 2003.

Cath Church

Chairman : Trainees Group

PROMOTING A CAREER IN GERIATRIC MEDICINE

Doctors C Church and C Turnbull have
updated the information concerning a career
in geriatric medicine.

Two versions are available on the Society's
website. The first version is aimed at people
who prefer reading on screen. The second
(‘smart’) version is for career fairs.

The .rtf version can be downloaded, printed,
photocopied and handed out to medical
students. We hope it will be a valuable tool for
careers' fairs. The on-screen and
downloadable versions are available at:
www.bgs.org.uk/training/train.htm

Attention all Geriatric SpRs!!

European Federation of Internal Medicine course

- an opportunity not be missed!

Every September, a week's course in medicine is held for trainees undergoing higher medical training across Europe. It is organised by the European Society of Internal Medicine (ESIM). In the UK all SpRs, regardless of medical specialty are eligible to apply.

The Royal College of Physicians (London) adverts should be posted on notice boards of postgraduate centres. To apply, send a CV plus an application form. Selections are made by the RCP (London).

I was one of the lucky SPRs in medicine during 2002 and the only one from the geriatrics speciality to attend the ESIM-5 course at Alicante, Spain. Tickets, accommodation, meals, entertainment – everything is taken care of so it is just a matter of packing one's bags for this trip of a lifetime.

During the week, trainees who had assembled from all over Europe, presented interesting and rare cases. The main sessions had the theme of 'Medical Emergencies' last year.

All the evenings were packed with pre-arranged entertainment programs / visits followed by sumptuous meals. This was a wonderful opportunity to meet higher medical trainees from across Europe, sing and dance together, get a feel for the different training programs and develop continued e-mail links.



The hospitality of Professor Merino (President of ESIM and from Spain), his constant presence attending to finer details, and the gorgeous weather certainly made it an unforgettable experience. A detailed report can be seen at BGS the website (BGS Wales) and I would strongly urge Geriatric SPRs to be on the lookout for any future ESIM course.

Abhaya Gupta
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West Wales Hospital, Carmarthen
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Newcastle - Clinical Geriatrics and Institute for Ageing and Health

The Faculty of Medicine in the University of Newcastle upon Tyne recognises ageing research as one of its top strategic priorities.

UNIVERSITY OF
NEWCASTLE



This is due, in no small part, to the enormous success of the multidisciplinary research strategy which has evolved within the **Institute for Ageing and Health (IAH)**. The IAH is the largest cross-disciplinary research grouping within Newcastle's Faculty of Medicine, which recently obtained the highest 5 or 5-star rating in all fields evaluated in the UK Research Assessment Exercise 2001.

Professors Oliver James (Head of the School of Clinical Medical Sciences, which includes Geriatrics) and Jim Edwardson (Director of the IAH) were the visionaries responsible for the establishment and development of the IAH: thus securing the future of high quality, high profile age-related research in Newcastle, when so many academic departments of geriatric medicine are falling by the wayside. The IAH was set up in 1994 to bring together clinical, basic and social scientists in partnership with colleagues in the NHS. The IAH has become a model for the development of other cross-disciplinary institutes within the University and in the UK.

The mission

The mission of the IAH is to promote research aimed at:

- ◆ Increasing and improving training in clinical, basic and social sciences
- ◆ Elucidating basic biological mechanisms of ageing
- ◆ Understanding the major causes of ill health and disability in older people
- ◆ Developing effective preventative and

therapeutic measures to combat chronic disability and ill health

- ◆ Assessing the prevalence, incidence and cost of such conditions
- ◆ Determining the most effective use of resources; and
- ◆ Measuring effectiveness and efficiency of care delivery systems

The successes

The IAH was founded in partnership with the NHS and the University so that **clinical investigations** are facilitated and **research advances** can be piloted and assessed in a health care environment. In clinical geriatrics, the IAH has five professors (Oliver James, Rose Anne Kenny, Gary Ford, Chris Grey and David Barer), two readers (Helen Rodgers, Roger Francis), six senior lecturers in geriatric medicine (Julia Newton, Steve Parry, Fiona Shaw, Janice O'Connell, Michelle Davies, Terry Asprey) and there are three professors of old age psychiatry (Ian McKeith, Clive Ballard, John O'Brien).

Thirty-five Clinical Research Fellows in geriatric medicine have been awarded PhDs and MDs in the past five years. Successful, highly competitive clinical training fellowships include MRC (4), Wellcome Trust (3), Alzheimer's Society (2), National and Regional R&D and other awards (10). Members of the Department of Geriatric Medicine have published in excess of **200 original** peer reviewed papers in the past five years (these are on the BGS Publications database).

Across the disciplines

The recent strategic appointment of Professor Tom Kirkwood to the Chair of Medicine in Newcastle has enabled a large **Biogerontology** group within the IAH, providing further foundation for basic sciences in cross-disciplinary work.

In recognition of research achievements and proposals to expand research on brain ageing, a

highly prestigious **MRC Centre Development Grant** has been awarded to the University to develop a Centre in **Clinical Brain Ageing** at the IAH which focuses on four key areas, each supported by an MRC Programme grant:



Prof Rose Anne Kenny

◆ **Vascular risk factors for cognitive impairment and dementia** including mechanisms underpinning dementia in stroke survivors

and in autonomic syndromes such as orthostatic hypotension and carotid sinus syndrome (Raj Kalaria, Rose Anne Kenny, Clive Ballard)

◆ **Dementia with Lewy bodies** and related movement disorders such as Parkinson's Disease (Ian McKeith, Elaine Perry, Robert Perry, David Burn)

◆ How the phenotypic presentations of Alzheimer's Disease, dementia with Lewy bodies, vascular dementia and mixed syndromes are influenced by **candidate genetic risk factors** (Jim Edwardson, Chris Morris, Doug Turnbull)

◆ **Dementia in primary care** including service use during the earliest phase of cognitive decline (Martin Eccles)

This work will feed into the development of the **Healthy Brain Unit**, which will provide a one-site-one-stop clinical assessment facility for the early and comprehensive assessment and intervention of patients deemed 'at risk'.

This novel facility will be driven by four overlapping clinical services - the Memory Service (Ian McKeith), the Falls and Syncope Service (Rose Anne Kenny), the TIA Service (Gary Ford) and the Movement Disorder Service (David Burn).

Future strategies

Some of the future strategies of interest to members of the BGS include:

◆ **The 85 plus Study** - this is an investigation of genetic and non-genetic determinants of successful ageing in a comprehensive cohort study of the 85+ population in the North East (in collaboration with Leiden University).

◆ A new **Genetics Knowledge Park** – on the theme of genome instability (led by Prof Tom Kirkwood) has received substantial awards from the DoH. The Genetics Knowledge Park will create new academic posts and facilities as well as supporting links in patient care, bioethics, public engagement in science, and industry

◆ A longitudinal clinico-pathological study of cognitive impairment and dementia in the well-



Key research fields

Biology of ageing -

Factors which contribute to the vulnerability and loss of homeostasis in aged tissues and the development of bioinformatics models of molecular mechanisms of ageing

Falls and neurocardiovascular instability -

mechanistic and intervention studies for falls and the role of neurocardiovascular instability in falls, in dementia and in depression.

Brain ageing and dementia -

a wide program of established and emerging research in the areas highlighted in the MRC Centre for Clinical Brain Ageing

Stroke and ischaemic brain disease -

spanning epidemiology, prevention, acute interventions, rehabilitation, cognitive decline, dementia and health services research

Depression in later life -

including the role of white matter lesions and microvascular pathology in later life depression

There is also established collaborative research with other strong research groups in Newcastle, such as vision (including a new **Centre for Age-Related Eye Disease**), musculoskeletal disorders (including **osteoporosis** research), **prostate cancer** and **oral health**.

characterised and large Newcastle series of people with **neuro-cardiovascular instability**.



Newcastle's spectacular Millenium Bridge

- ◆ **Driving** ability in dementia and stroke (in collaboration with Trinity College, Dublin).
- ◆ Prevention of **in-hospital falls** (in collaboration with Dundee).
- ◆ Plans are being developed for a **Centre for Assistive Devices** (led by Prof Jim Edwardson) to meet the clinical, biological and functional challenges of ageing and disability.
- ◆ Plans are being developed for a **Centre for Age-Related Eye Disease** to draw together basic sciences and clinical expertise in age-related eye diseases including macular degeneration and cataracts.

There are many **research training opportunities** for young members of the British Geriatrics Society. The established cross-disciplinary collaboration provides an outstanding environment which encourages high quality output in a friendly and thriving atmosphere. We welcome enquiries about research positions and collaborations.

For further information about the Institute, our website address is www.ncl.ac.uk/iah

Prof Rose Anne Kenny
Institute for Ageing and Health
University of Newcastle

.....for the diary

Some **forthcoming meetings** organised by the **IAH** which are of interest to BGS members include:

Third International Workshop on Dementia with Lewy Bodies and Parkinson's Disease Dementia (DLB/PDD)

Date: 17-20 December 2003

Venue: Civic Centre, Newcastle upon Tyne

Visit: www.dlbconference.com

International Syncope Conference

Date: 20-22 November 2003

Venue: Civic Centre, Newcastle upon Tyne

Visit: www.syncope-conference.co.uk

Newcastle will host the **2006 Spring BGS** meeting which we hope will reflect the outstanding achievements in age-related research in this thriving environment.

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