



# BGS

n e w s l e t t e r

## Autumn Meeting 2002

- conference report

One of the good things about going on holiday to the same place is that one can settle in quickly. It is somewhat similar with the Novotel Hotel.

We know our way around, we know there is a good conference hall and we know where to go for food... or a drink. It works well. It is not a holiday, of course, but one looks forward to meeting friends and acquaintances. The programme looked varied and gratifyingly wide ranging.

Wednesday was given to a joint project with the

Society for Research in Rehabilitation and focused entirely on rehabilitation. The packed hall included an audience of geriatricians, nurses, physiotherapists, occupational therapists and others.

### *Rehabilitation*

The first speaker was Prof Ann Chamberlain from Leeds who gave a thought-provoking lecture covering the history of rehabilitation in the community and providing an overview of the services which have been developed, passing through day hospitals, young disabled units, early discharge teams, outreach teams, post hospital discharge rehabilitation, specialist community teams and use of volunteers. Stroke units have been shown to be beneficial in terms of reducing mortality and morbidity; this focused management should be widened to other categories of disease requiring more functional assessment and care. Debate continues regarding generic and specific rehabilitation. Prof Chamberlain reminded us that community rehabilitation will be PCT led. A comprehensive service should be developed which is sensitive to the wishes of disabled persons, is accessible and will prevent un-



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President: Prof Robert Stout President Elect: Dr Jeremy Playfer

Honorary Secretaries: Dr Chandhi Vellodi and Dr Kevin Kelleher Meetings Secretaries: Dr Juanita A Pascual and Dr Janice O'Connell  
Honorary Treasurers: Dr Ian Sturgess and Dr Margot Gosney Administrative Director: Richard Lynham Sub Editor: Recia Atkins

specialist medical society for health in old age

necessary use of hospitals. Evidence for rehabilitation is not easy to obtain. Prof Chamberlain described straightforward trials showing that some patients do better with home physiotherapy rather than attending the hospital from home regularly.

The cost of community rehabilitation is much the same as in hospital, and it is important to realise some patients do better with home rehabilitation than others. There is a concern with staff burnout; there needs to be a united vision, nurturing of ideas, away days and CPD. Community rehabilitation can not be done successfully in isolation. It takes place in many places and in different ways. However it is done, one should strive to make sure it is done well.

This set the scene for further interesting contributions on early supported discharge, care home rehabilitation, intermediate care, generic/specific rehabilitation and the culture of teams. The day went well, but one had the feeling that with greater future collaboration such events will be even better.

### *Stroke*

On Thursday, early birds caught the breakfast symposium on **“Waking up to the risk of stroke”**. Unfortunately, I didn’t wake up early enough to have the breakfast, so the day started with hunger pangs. They were soon forgotten though with the enthusiastic talks by Prof Donnelly (Nottingham), Prof Steve Jackson

## *Prize winners’ gallery*



Left: Prof Cameron Swift presents **Dr Marion Hildick-Smith** with the **President’s Medal**



Right : On behalf of **Dr Shannaz Awan**, Dr Cassidy accepts the **2002 Ferguson Anderson Prize**



Left: **Prof Ray Tallis** receives the **2002 Dhole Eddleston Memorial Prize**



Right: **Dr Vivienne Tut** accepts the **2002 Elizabeth Brown Prize**

(KCH) and Dr Martin James (Exeter). Interesting points discussed included diurnal variation in the time of onset of cardiovascular events, cognitive decline post stroke, and the fact that we have a long way to go before stroke services can adequately respond to demand.

Prof Cameron Swift gave the Presidential welcome address to open the main conference. There followed parallel sessions on Rheumatology and Health Services Research. Prof Paul Dieppe (Bristol) had been asked to update us on “Therapeutic advances in the management of osteoarthritis”. He announced this would be a simple task as, in his opinion, there have not been any! He stayed on the podium long enough to demolish Cox II inhibitors as well as complementary/alternative medicine, believing these have added nothing to OA treatment. Sometimes Prof Dieppe has his tongue in his cheek, but he is always good value.

Prof Allan Stirrat (Sunderland) was originally appointed as a general orthopaedic surgeon, then he progressed to being an upper limb surgeon, and is now an upper, upper limb surgeon...hence his talk on the painful shoulder! He outlined the causes of pain in this ball and saucer joint and emphasised the importance of making a correct diagnosis, warning us particularly against missing posterior dislocations. The place of ultrasound and MRI were clarified, while the need for surgery in rotator cuff injuries requires careful consideration as surgery can make matters worse. Joint replacement works especially well for OA pain.

Prof Sturrock (Glasgow) completed the session with an excellent overview of recent advances in the management of rheumatoid arthritis. Use of ultrasound and MRI for showing joint changes which are not visible on X-rays was discussed and we learnt more about use of anti-cytokine and TNF alpha monoclonal antibodies/ receptor blocker therapy.

In the next session Prof Betteridge (London) summarised cholesterol metabolism and reviewed cholesterol lowering trials, emphasising that statins are beneficial in older patients. In the parallel session, SpRs presented interesting studies on stroke. Dr Wright (Glasgow) found

that hypertension and adverse physiological features predicted stroke in progression; Dr Smith (Wycombe Hospital) improved acute stroke care with minor intervention based on the NSF; and Dr Coull (Oxford) reported that although daily emergency stroke clinics reduced referral delays from 19 to 5 days, this was still suboptimal.

## Posters

There were 69 posters on display at the conference. As usual they were in the same room as the 24 pharmaceutical exhibitions, which worked well as each stand had many visits from members.

The prize for the best oral presentation was awarded to Dr Cox (Dundee) who reported on visual impairment in fractured neck of femur patients. The poster prize went to Dr Johns (Newcastle upon Tyne) who looked into the diurnal rhythm of TFF2, a cytoprotective peptide which contributes to mucosal protection in the upper GI tract.

Parallel sessions followed in therapeutics, falls and bone disease, Care Home medicine/Health Promotion, and Parkinson's disease.

The second afternoon parallel session was again a difficult choice between Issues in Caring for Older People and Special Senses. Prof Chakravarthy (Belfast) updated us on macular degeneration, discussing aetiological/ environmental factors such as cardiovascular disease, cigarettes, oxidative stress and serum carotinoids; treatment with different forms of photocoagulation, antioxidants, zinc and statins was discussed. Due to visual compensation, patients may not present until their second eye develops the condition; they should then be fast tracked to an ophthalmologist.

## Marjorie Warren lecture

The Marjorie Warren lecture was delivered by Prof Michael Lye. He described physiological and structural changes that occur in the heart with age, before concentrating on diastolic function/ failure and CCF, pointing out areas requiring further research. He believes it is

important to recognise when cardiac failure is terminal and to treat accordingly. Above all, Professor Lye communicated his great enthusiasm for our specialty.



Prof Michael Lye

### *Blood pressure and cold coffee*

Friday started with continental breakfast, which was true to form in that the coffee was only just off cold. The following symposium on treating high blood pressure to prevent strokes in elderly patients turned out to be a presentation of the LIFE trial results by Prof Coats (London), Dr Brady (Glasgow) and Dr McIntyre (Hastings). The results indicate that prevention of vascular events depends not only on lowering blood pressure, but also on what agent is used for treatment. Patients received Losartan or atenolol. Despite the blood pressure being lowered equally in the two groups, there was a significantly greater reduction in strokes and total mortality in the treatment group. Patients up to 80 were entered into the trial. When questioned from the floor about treatment of the very elderly, the panel commented that there was no evidence beyond 80, although some patients would have been older than this when the trial finished. This seemed to be a missed opportunity. There is plenty of evidence from vascular disease trials showing that treatments which are beneficial for younger adults are as, or more beneficial in the elderly. Lack of specific evidence beyond a certain age should not equate with there being evidence not to treat.

### *Parallel Sessions*

The main meeting continued with two parallel sessions, a vascular update and palliative care/clinical practice, the latter being ably chaired by two SpRs, Cathy Church (Northumberland) and Jugdeep Dhesi (SE Thames). The speakers at the vascular session were three non-geriatrician professors. Prof Mendelow (Newcastle) confirmed that across Europe the neurosurgical treatment of intracerebral haemorrhage varies enormously; in Lithuania over 90% of patients receive operations compared to only 2% in

Hungary. He described the STICH trial for intracerebral haemorrhage which involves elderly patients up to 90 years of age and will soon be completed. So far, at six months post operation only 16% have had a favourable outcome; conscious patients with focal deficits on admission to hospital have had the best outcome, while comatosed patients on admission have done poorly. We await the detailed results with interest. Prof Mendelow also mentioned the ISAT trial in which endovascular coiling was superior to clipping aneurysms in patients with subarachnoid haemorrhage. Octogenarians who were confused on admission following a SAH had a poor prognosis.

Prof McCollum (Manchester) discussed advances in management of aortic aneurysms. Main messages here were that painful or tender aneurysms need referral as 20% rupture in the next year, while with asymptomatic aneurysms it depends on the patient's general condition and age, as well as the aneurysm size, with surgery being beneficial at 6cms or more. He emphasised the importance of cardiological assessment and use of autologous blood transfusions. Advances in endovascular repair were described. In the third presentation Prof O'Brien (Newcastle upon Tyne) gave an overview of vascular dementia, covering the history, diagnostic criteria and drug treatment.

### *Continuing professional development (CPD)*

Prof Castleden brought us up-to-date on the BGS CPD programme and the present meeting forms part of a five year rolling programme. The syllabus address is: [www.geriatricssyllabus.com](http://www.geriatricssyllabus.com) He commented that there is a definite USA bias and if anybody feels they have the expertise to improve any part of it, then please contact him: [c.castleden@clara.co.uk](mailto:c.castleden@clara.co.uk). Professor Castleden will be standing down as Director of CPD for the BGS, so he is looking for expressions of interest from potential successors.

### *Longevity and ageism*

The Trevor Howell Lecture "Ageism in the era of longevity", was given by the distinguished Professor of Geriatric Medicine from New York, Prof Robert Butler. A person of wide interests, it

is not surprising his talk started with a short history of the emergence of geriatric medicine and covered the need to improve eating habits and physical activity in children, changes in the retirement age, and gene medicine. He lamented the lack of academic departments of geriatric medicine in the USA, and the fact that it often takes illness of high profile people such as Ronald Regan, before changes are initiated to improve care of older people. He believes old age should be a time of vigour, vitality and economic asset.



Prof Robert Butler

Professor Butler enjoyed recounting what happened when Jeanne Calment, America's oldest woman, had her most recent birthday. One of the journalists present tentatively asked if he would be seeing her next year, to which she replied without hesitation, "I don't see why not, you look to be in pretty good shape"!

### *Car mobility*

The afternoon started with an absorbing clinical update session on the fitness to drive. Expert talks were given by a geriatrician (Prof Marottoli, Yale), psychologist (Catarina Lundberg, Stockholm), occupational therapist (Kate Cranwell, Dublin) and specialist driving assessor (Brian Ellison, MAVIS, UK). The emphasis was on enabling the elderly to drive rather than stopping them. We learnt how patients should be assessed, what could be done to help older people remain car mobile, and how to approach informing patients who should stop driving. Assessment requires a multidisciplinary approach.

The final session before the AGM was a debate, the motion being, **"This house believes that acute hospital care for older people should be delivered by an age-related geriatric medicine service"**. Andy Davies (Sunderland) and Jim George (Carlisle) spoke for the motion, with Sarah Smith and Adam Darowski (both from Oxford) opposing it. This is, of course, an old chestnut and it was good to hear the

arguments eloquently stated by very committed younger geriatricians. Particular mention should be made of Sarah Smith who, as an SpR made her points with great confidence and clarity. That was not enough though to persuade all the audience, for there are some intransigent views out there! Needless to say, when it came to comments from the floor, people were not slow in stepping forward to state their preference. The proceedings were firmly chaired by Prof Stout who had to call a halt to the barrage of opinions from the audience. On putting the motion to a vote, he immediately declared a draw (most present were mesmerised by the speed with which he counted the votes!).

We mustn't forget all the other meetings in the conference which needed to be arranged, such as for the SpR research surgery, SIG Committees, poster assessors and the Chairmen's briefings.

### *Bi-annual dinner and entertainment*

As always, the dinner was a jolly affair, with superb food and an



Dr Colin Currie

atmosphere of increasing conviviality (the excellent wine had nothing to do with it!). **Dr Marion Hildick-Smith** was presented with the Founder's Medal and **Dr Colin Currie** gave a lively after-dinner speech which prepared us nicely

for **Cantabile**, a group of four unaccompanied male singers. An imitation of instrumentalists playing a Duke Ellington theme and a further imitation of a very old, cracked Frank Sinatra record were the highlights ...a skilled and brilliant performance.

Our thanks must go to the Meetings Secretary, **Dr Janice O'Connell**, for masterminding such a successful and enjoyable conference. What an enormous task. She in turn, I am sure, would like to thank everybody at the BGS central office for their hard work behind the scenes, all accomplished in good spirit.

**Roger Lewis**

England Representative on the Executive Cme

# Editorial

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Those of you who were not at the AGM at the Novotel in London would, I'm sure, like to join me in thanking Prof Cameron Swift for his excellent stewardship of the Society during his tenure as President.

Cameron represented us through a crucial time for the Society and for Older People's services, with his tireless work, especially around the NSF. The links that he has strengthened with other organisations such as the Royal College of Nursing and the Royal College of General Practitioners, to name just two, will continue to bear fruit for many years to come. His strategic review gave us a new impetus in reorganizing the Society. We are all most grateful for all his hard work and I, for one, will miss him.



Join me also to welcome on board our new President, Prof Bob Stout. Bob will no doubt stamp his personal style on the running of our Society. I look forward very much to working with him. He will be ably supported by Dr Jeremy Playfer, our President-Elect and Dr Margot Gosney, our new Deputy Treasurer.

## *Autumn meeting*

Once again we have a packed Newsletter. Much is happening within the Society and in the UK generally, regarding older people's services. The Autumn meeting was a great success, thanks to our Autumn Meetings Secretary, Janice O'Connell and her various partners in crime! I am indebted to Roger Lewis for being so prompt with his report of the meeting.

## *BGS Standards of Care*

You will also see in this issue, a brief résumé provided by Gill Turner on behalf of the Policy

committee of the Society's 'Standards of Care for Older People'. It is an excellent document and I would commend it to you, suggesting that you disseminate it locally to your managers and PCT. It may well help you with your local negotiations and service development.

## *National Service Framework*

We also have two excellent articles from the NSF focus group. Ian Hastie's article on workforce issues and Finnbarr Martin's on the work of the group, both containing much useful information, not just for our England colleagues but also for those of you north and west of the borders.

## *On-line BGS newsletter*

Our attempt at on-line publication of the Newsletter was a measured success. There have been 612 visits, at the date of writing. While these visitors may be outside the Society's membership, the BGS website in its various forms continues to raise the profile of the Society and has been responsible for attracting new overseas members over the years. Our thanks to those of you who visited the site. You will note that most of the notices on meetings etc will be published on the site only. So let me encourage you to visit the site, and of course do feed back to us any views you may have.

## *2003 Spring Meeting - Aberdeen*

And finally a date for your diary. It is never too early to plan to be at the BGS Spring meeting to be held at Aberdeen, April 10 – 12 2003. The venue is delightful and the programme promising. So be there or be square!

**Chandi Vellodi**  
Editor

# President's column

**T**raditionally, the President uses this column to report on his activities on behalf of the Society. I am writing one week after taking office, so it could be a short column.

Being so new to this office does however, give me the opportunity to write about some other topics. The first is to thank the Society for giving me the honour of being its President. It is a great responsibility and I will need the assistance of many of you to carry out the duties of the office.

Cameron Swift has been an outstanding President. We tend to think of the innovations that have occurred during a presidency, for example, the opening of Marjory Warren House, the changes to the Society's constitution, and his contribution to the National Service Framework. We must not forget the considerable amount of work that is required to provide day to day leadership to the Society, to which Cameron has put an enormous amount of time and attention. On behalf of the Society, I congratulate Cameron on a very successful term of office and thank him for all he has done for the Society.

We had a most successful Autumn Scientific Meeting at Hammersmith, with over 600 members attending. Organising meetings of this size and complexity is an onerous task and the Society owes a huge debt to its Meetings Secretaries. The breadth of interest of members is shown by the number and variety of the specialty meetings, but I wonder if we lose something by not meeting more often as a Society and hearing the best presentations by its own members on a range of clinical topics. I do not underestimate the task of organising this but it might be something to consider. We look forward to the Spring Meeting in Aberdeen.

I have had the privilege of holding office in a number of organisations of different types and I have noticed a common feature – only the few who hold the senior positions have any idea of the amount of work that is undertaken by the 'office' of the organisation. This is true of the BGS. Richard



Lynham and his colleagues work long and hard for the Society – specially long and hard around the time of the Scientific Meetings. It is only because of their dedication and attention to detail that the meetings are so successful and that the Society's affairs are in such good order. The Society owes a huge debt to Richard and his colleagues for their dedication to the Society and to the interests of its members.

I am the second person from Northern Ireland to be elected President of the BGS. The first was Professor George Adams, who was the Society's second President. I was delighted to receive George's good wishes just before the Autumn meeting, sent from his home near Oxford. George was one of the founders of both the Society and the specialty, and made a major contribution to our knowledge of strokes. His work on barriers to recovery from stroke, with the late Louis Hurwitz, a Belfast neurologist (eg BMJ 1972; 1: 94-98) can scarcely be bettered today. George was a friend of Marjory Warren and was greatly influenced by her work. When taking up the Presidency of the Society, George delivered a presidential address, so far as I know, the only such address in the Society's history. It was published in two parts in *Age and Ageing* (1974; 4: 1-3) and the *BMJ* (1974; 2: 789-791). The title was 'Eld Health'. He had been advised by the Professor of English at Queen's University Belfast that 'eld' was an early English word used to denote an older person, in an analogous way to the word 'child' is used for a young person. He suggested that geriatrics might be renamed 'eld health' just as paediatrics is known as child health. (It has struck me on a number of occasions that in many ways our specialty has more in common with paediatrics than it has with general medicine). We now know that his suggestion was not taken up. Over a quarter of a century later, however, the question of the best name for our specialty, and for the Society, has still not been answered to everybody's satisfaction.

I look forward to meeting many members of the Society in the next two years and hearing your views on matters of mutual interest.

**Bob Stout**  
President

# Falls and Bone Health

3rd National Falls and Postural Stability Conference

Two years ago, Tash Masud ran the first Falls and Postural Stability conference in Nottingham. Little did he know at the time, what a successful venture it would be.

The 3<sup>rd</sup> National Falls and Postural Stability Conference was held in Kensington Town Hall, London in September 2002. The day was an overwhelming success with over 400 delegates and a series of high quality presentations delivered by a range of professionals from various disciplines.

Professor Val Pomeroy opened the day with a fascinating talk on rehabilitative techniques and technologies and this was followed by a masterly presentation by our very own Dr Peter Overstall on the subject of falls and Parkinson's Disease. Later in the morning, the conference moved on to a new topic and Prof Chris Todd gave a thought provoking insight into the psychological aspects of falls, discussing the need to consider patterns of behaviour when designing falls prevention strategies. This area is clearly in its infancy and a lot more good work is likely to be forthcoming in the next few years.

Another first was the presentation by a husband and wife team - Bill and Leslie Gillespie - both of whom are involved in the **Cochrane review of Falls Prevention Strategies**. Marital harmony prevailed and we all got an inside view of the methodologies of the Cochrane review process.

Coffee and lunch gave delegates the opportunity to peruse the posters submitted. With each year passing, the number of posters submitted has increased and there was a lot of good work presented, giving people the opportunity to share research and service development successes (perhaps we should also be more open about sharing failures). The prize for the best poster presentation went to Dr Fade from Southampton

General Hospital, for her study entitled: **'Study to assess the validity of a modified 'stratify' score to predict fallers in a residential setting'**.

The selected platform presentations were of outstanding quality this year and this was acknowledged in the feedback from delegates. The prize for the best platform presentation was presented jointly to Dr V S Stel, from EMGO Institute, the Netherlands, for her talk: **'Treatable risk factors for falls in the elderly: from risk profile to intervention strategy'** and Dr

Jugdeep Dhesi, King's College Hospital, London for her study: **'Vitamin D supplementation improves neuromuscular function in older people who fall'**.



## Fracture Prevention

In keeping with the overall aim of the conference and the Special Interest Group, the latter half of the afternoon moved away from falls prevention and focussed on bone health and fracture prevention. Dr Terrence O'Neill gave a splendid review of the epidemiology of osteoporosis and fractures and this was followed by Dr Richard Keen who delivered an excellent synopsis of treatment strategies for osteoporosis and fracture prevention.

With just 5 minutes to spare, Prof Angus Wallace strolled into the conference centre - much to the relief of the session's chairs - Finbarr Martin and Roger Francis. In his truly inimitable style, Angus closed the afternoon with a talk on the management of hip fracture, which was deliberately contentious and at times quite political. His take-home message was that there are orthopaedic surgeons who care about the management of patients with a fractured neck of femur.

The afternoon drew to a close and the delegates dutifully completed the evaluation forms before heading back home to all four corners of the UK and Europe - with some stopping off to take advantage of local retail opportunities and hostels (myself included).

### *Quo Vadis*

With the increasing popularity of the conference, there is little doubt we will continue to run this forum annually. The challenge will be to ensure that we continue to attract a multidisciplinary audience and explore new areas not previously presented. Topics yet to be covered in any depth include falls in institutional care, cognitive impairment and falls, cardiovascular investigation of falls and the more practical issues of how to set up a falls service, and

the role of hip protectors in clinical practice.

Thanks to all those who continue to support this conference and we look forward to seeing you again next year along with new faces who have been bitten by the “falling” bug!

**Jacqueline C T Close**  
Secretary – Falls and Bone Health SIG

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# Aberdeen Spring Meeting

## Conferences, castles and whisky

**A**berdeen the venue for the 2003 Spring Scientific Meeting, is the furthest north the Society has ventured in the UK.

### *Aberdeen on your doorstep*

Nevertheless Aberdeen is easily accessible from across the UK and several cities in continental Europe. It is Europe's bustling oil capital, a thriving and beautiful city, known as the 'Flower of Scotland', surrounded by the splendour of the Grampian Highlands. The meeting itself will be held just outside the city in the modern Aberdeen Exhibition and Conference Centre in Bridge of Don, just 30 minutes from the airport. It is estimated that 90% of UK geriatricians live within driving distance of an airport with a direct flight to Aberdeen, and several low cost airlines serve the city. Our colleagues in the Netherlands also have direct flights from Amsterdam. The Society will contract with a travel agency to ensure that all delegates have access to favourable, discounted fares. Some delegates may prefer to fly to Edinburgh or Glasgow and hire a car to reach the meeting and explore the Highlands.

### *Something for all tastes*

Aberdeen offers a wide range of accommodation to suit all tastes and budgets. The Society's meetings organisers, Hampton Medical will co-ordinate reservations and have negotiated favourable rates. Transport arrangements within the city are generally easy, and courtesy buses will provide a link between the city hotels and the conference centre. There is

ample parking space for cars at the Conference Centre.

### **Exploring Aberdeen, the granite city**

The City itself has much to offer with the **Aberdeen Art Gallery, the Provost Skene's House** (a 16<sup>th</sup> century house providing a glimpse of the grandeur of that period), the Aberdeen **Maritime Museum** with stunning views over the harbour, reflecting the city's long association with the sea, the hands-on **Science Centre, the Botanic and Winter Gardens**, not to mention the scope for an invigorating walk along the **sandy beach**.

### *Gateway to the Highlands...*

**Gateway to the Highlands, Royal Deeside and the only Malt Whisky trail in the world!**

**Drum Castle** lies close to Aberdeen in the picturesque **Dee Valley**, or driving on through Ballater one can visit **Balmoral Castle**. Follow the **Malt Whisky Trail** with a wide range of distilleries which welcome visits, such as Strathisla at Keith or Glenfiddich. If you feel like adding on a day's sightseeing after (or before the meeting) **Urquhart Castle** at the eastern end of Loch Ness is well worth a visit

### *To business*

**And there is the Scientific Meeting itself, a feast of medical information!**

In addition to the presentations by



members of the Society and an extensive programme provided by the Special Interest Groups, the programme offers an unrivalled opportunity for members to add to their continuing education on subjects less frequently covered, – with **updates on psychiatry** ( Professor Alistair Burns, Professor of Old Age Psychiatry, Withington Hospital), on **respiratory issues** (Dr Graham Douglas, Physician in Chese Medicine, Aberdeen Royal Infirmary), on **Medical Ophthalmology** (Dr John Olsen, Ophthalmologist, Aberdeen Royal Infirmary) and **Carcinoma of the Prostate**, (Professor Freddie Hamdy, Professor of Urology, University of Sheffield) in addition to key note lectures, the **Genetics of Osteoporosis** by Professor Stuart Ralston, Professor of Medicine, University of Aberdeen, and on **Secondary Vascular Prevention** by Professor Gordon Lowe, Professor of Vascular Medicine, University of Glasgow.

### *Quality all the way*

It is hoped to arrange a satellite symposium on the Wednesday evening; details in the January Newsletter. The Saturday morning multidisciplinary session is well worth staying for, the Masterclass on Seating, Posture and Spasticity, and the review of community care as perceived from the perspective of primary and secondary care respectively (the interface between the two is an area in which Scotland is pre-eminent).

### *A sparkling social programme...*

complements the scientific programme, with a civic reception

on Thursday evening in the **Aberdeen Art Gallery**. This will be followed by a traditional Scottish Ceilidh, complete with Caller at the Ramada Jarvis Hotel in Aberdeen. Dinner on Friday evening will be held in Ardoe House (modelled on Balmoral).

### *Golf for the intrepid*

The traditional seaside links course at Newburgh provides the setting for the annual BGS tournament on the Wednesday. The course was founded in 1888. Details on their website [www.newburgh-on-ythan.co.uk](http://www.newburgh-on-ythan.co.uk); membership is still available!

### *The weather - generally dry and mild*

In keeping with the British Spring the weather can be variable, but is generally dry and mild, although the occasional snow is not completely unknown, but this is more than offset by the warm hospitality of the Highlands and there is always the whisky to offset any outer dampness!

**Steve Hamilton**

Chair, Organising Committee

**Richard Lynham**

Administrative Director

*The Spring Meeting in the Highlands  
people pay to go on holiday in! Can you  
afford to miss it? Surely not!*

## *In Memorium*

*Cyril Shanahan*

*1922 - 2002*

- by Chris Turnbull

The Mersey branch of the BGS announces with regret, **the death of Dr Cyril Valentine Shanahan** who died in July, 2002 just short of his 80<sup>th</sup> birthday.

After qualifying in Ireland, Cyril came to England where after various posts and two years service in the RAMC as a Captain, based mostly in Egypt, he settled in Liverpool working between Park Hospital and Newsham General Hospital from which he retired as a consultant in 1987.

Cyril thrived as a geriatrician. Undaunted by a punishing

workload and less than ideal facilities, he along with his colleagues worked tirelessly in the interests of their patients. Behind the scenes this charming gentleman used his not inconsiderable diplomatic skills both on the Committee of the H.C.S.A. and locally to advance the cause of geriatric medicine. His vision and efforts bore fruit with the transfer of services to newly built accommodation at Broadgreen Hospital in 1988.

After retirement, Cyril continued to be active in medicine part time and was a regular attender at the Mersey BGS meetings where his wisdom and experience were much appreciated.

Outside medicine he continued to play hockey at senior level until his mid forties. More latterly and up until his final illness, he enjoyed walking and in particular sailing whilst on holiday in Cornwall.

Cyril is survived by his wife, three sons and a daughter.

# National Service Framework

## Training and Workforce Issues

**A**s you read in the September issue of the Newsletter, the BGS has established an NSF Focus Group as part of the Interim Administration for England.

With my background of postgraduate deanery, membership of the BGS Training Committee, and dealing with training across Europe, I was asked if I would hold a watching brief on the training and workforce issues that came up as a consequence of the National Service Framework. I see this as covering all aspects of training, not just of specialists, but of primary care nurses and other health professionals as well. I want to make it very clear however, that I have no intention of stepping on the toes of the BGS Training Committee, nor of Alistair Main in his role as BGS Workforce Committee chairman.

At the present time I believe there to be three areas for consideration:

### *More training slots with NTN's*

Alistair's article in the September Newsletter very succinctly explains the issues around increasing NTN numbers. By the time this article is published we should know whether the postgraduate deaneries have been successful, firstly in gaining the extra ceiling NTNs, and secondly whether they have managed to get any numbers additional to these. In this round of bidding I am sure that the number of NTNs that we receive, whatever that may be, will be less than the number of bids that have come in from the individual Trusts who have been able to find the finance for these potential extra posts. The postgraduate deaneries, along with the Workforce Development Confederations, will therefore be looking very carefully at which posts will be able to provide the best training, whilst taking into account geographical divisions. It is hoped that another bidding round will occur next year.

### *Intermediate care*

This is probably the most talked about aspect of the NSF. Those consultants who trained ten or more years ago followed, in general, a training programme containing those aspects of geriatric medicine that would now encompass intermediate care. With a shift over the last decade to geriatric services becoming more involved with acute medicine, some of these aspects have not been so well covered within our training programmes. The BGS Training Committee has identified this and, under the chairmanship of Steve Allen, is producing a curriculum appropriate to a consultant taking an interest in intermediate care. It is hoped that the SAC will take this on board.

### *Workforce Development Confederations*

These have been fully operational since April 2002. They have a responsibility for making sure that the local workforce is fit for the purpose for which it is required. This includes not only nurses and therapists, as was previously the case with the old educational consortia, but now in association with the postgraduate deans, also the medical workforce. Your Workforce Development Confederation will be looking at the NSF and local HImPs in order to decide the training requirements for the local workforce. It is important that local groups, including geriatricians, looking at the NSF for Older People, be in close contact with the Workforce Development Confederations in order to make sure that we have a properly trained workforce for the future of older people.

Many people have said that we live in interesting times; that is true. Others say we live in a time of change; that is also true. With both of these running concurrently, it is imperative that as geriatricians we do not take our eye off the ball, because if we do we will suddenly find that we have been left out in the cold, not doing what we have been trained for. Also it would not be fun, and we should be enjoying ourselves!

**Ian Hastie**  
Interim Administration Member

# National Service Framework



## *Single Assessment Process*

### **Homegrown tools now acceptable**

The **Tools and Scales Guidance** on the DOH website was updated on 26 September to include a worked example of the single assessment summary, plus introductory notes. The worked example explicitly demonstrates the minimum contents of the single assessment summary. The guidance points out that localities do not have to adopt an assessment tool, developed for national use, for overview assessment. A homegrown approach that uses a local tool or a checklist approach can be equally appropriate as long as professional judgment is supported and the SAP guidance is followed. [www.doh.gov.uk/scg/sap/index.htm](http://www.doh.gov.uk/scg/sap/index.htm)

### **EASY-Care and MDS to collaborate on research and development**

The development teams for MDS (University of Kent and University of Manchester) and EASY-Care (University of Sheffield) have decided it would be in the interest of local services and older people to collaborate on R&D on single assessment. Each will continue to develop their assessment instruments; MDS for assessments in complex and long term care and EASY-Care for contact and overview assessment. Work will be undertaken to ensure electronic linkages between EASY-Care and MDS assessments are possible in local services. EASY-Care [www.shef.ac.uk/sisa/easycare](http://www.shef.ac.uk/sisa/easycare) Inter RAI UK: [www.interrai-uk.org/interrai/index.htm](http://www.interrai-uk.org/interrai/index.htm)

The Development Centre for Older People's Services at Sheffield will undertake its role in organisational and professional development in support of local implementation for single assessment, including support for EASY-Care and MDS. A request has been made to the National Network for Geriatric Assessment (NNGA) to act as a focus for collaboration.

## *General Hospital Care*

The Department of Health has published **General Hospital Care – Recent and Ongoing Work in Key Areas** [www.doh.gov.uk/nsf/olderpeople.htm](http://www.doh.gov.uk/nsf/olderpeople.htm)

**#discussion.** The document signposts work that may be of interest to members, namely:

### **Emergency response (4.6)**

**Reforming Emergency Care** published by the DOH Emergency Care Strategy Team 2001 [www.doh.gov.uk/capacityplanning/reforming](http://www.doh.gov.uk/capacityplanning/reforming)

### **Ongoing care on general medical and surgical wards (4.12)**

**Services for NHS patients with acute and chronic pain** published by the Clinical Standards Advisory Group (CSAG) in March 2000 <http://www.doh.gov.uk/publications>

## *Wounds and Pressure Sores*

**NICE Guidance on Pressure Ulcers Risk Assessment and Prevention** published in 2001. Guidelines on treatment are due in 2004 and the use of pressure relieving devices in August 2003. [www.nice.org.uk](http://www.nice.org.uk)

**The prevention, Management and Treatment of Wounds** commissioned by NICE, the timetable for completion is to be confirmed.

## *Continence*

**Good practice in continence services** published by the DOH in April 2000 [www.doh.gov.uk/continenceservices.htm](http://www.doh.gov.uk/continenceservices.htm)

**Audit of Urinary And Faecal Continence Care in Older People** by NICE, the scope was posted on the NICE website July 2002

## *Palliative Care*

**Palliative Care beacons** [www.nhs.uk/beacons](http://www.nhs.uk/beacons) **Integrated care pathways for dying.** Acute sector pathways are now being developed for use in the community. [www.mariecurie.org.uk](http://www.mariecurie.org.uk)

**Supportive and Palliative Care** clinical guidelines commissioned by NICE part A is due for publication in December 2002

**Essence of Care**, patient focused benchmarking for health care professionals [www.doh.gov.uk/essenceofcare](http://www.doh.gov.uk/essenceofcare)

**The hospital environment** (4.19 et seq.)  
Revision of the **Building Notes for Health Care Facilities for Older People** due to be published September 2003.

**Nightingale wards** - 289 Nightingale ward refurbishment schemes approved to date

**Mixed sex wards** - Specialist Support Teams are working with Trusts

### *Nursing issues (4.26)*

**Caring For Older People: A Nursing Priority**  
Standing Nursing and Midwifery Advisory Committee guidance published April 2001  
<http://www.doh.gov.uk/snmac/publications.htm>

**Improving the Experience of Acute Hospital Care for Older People with Dementia or Confusion: A pocket Guide for Hospital Staff**  
[www.helptheaged.org.uk](http://www.helptheaged.org.uk)

**Nursing educational implication for the NSF Older People** published by the Nursing Midwifery Council [www.nmc-uk.org/cms/content/home/home.asp](http://www.nmc-uk.org/cms/content/home/home.asp)

**Nurse Specialists RCN & BGS joint statement**  
[www.bgs.org.uk](http://www.bgs.org.uk)

**Progress report on Modern Matrons**  
[www.doh.gov.uk/modernmatrons/index.htm](http://www.doh.gov.uk/modernmatrons/index.htm)

### *Discharge planning (4.28)*

Change Agent Team visits (see below for details of the new work programme)  
Revision of the Discharge workbook (1994) due for publication in Autumn 2002

### *Stroke Care*

The Changing Workforce Programme (CWP) published **New Ways of Working in Stroke Care** in August 2002. The CWP is developing a radical approach to job redesign, this publication gives examples of new or extended roles for those involved with the care of stroke victims and their carers. [www.doh.gov.uk/nsf/olderpeople.htm#discussion](http://www.doh.gov.uk/nsf/olderpeople.htm#discussion)

### *Care homes*

**The Residential Care and Nursing Home sector for Older People: an analysis of past trends, current and future demand**  
[www.doh.gov.uk/careanalysis/index.htm](http://www.doh.gov.uk/careanalysis/index.htm)  
The report concludes that **Building Capacity Partnership in Care**  
[www.doh.gov.uk/buildingcapacity](http://www.doh.gov.uk/buildingcapacity); the

agreement between the statutory and independent social care, health care and housing sectors is encouraging a more strategic, inclusive and consistent approach to capacity planning at a local level.

### **Building Care Capacity Grant: Allocations for 2002/03 and conditions**

[www.doh.gov.uk/jointunit/delayeddischarge/determination.htm](http://www.doh.gov.uk/jointunit/delayeddischarge/determination.htm) Published on 8 August 2002 this gives details of the grants to be paid to local authorities and the welfare services that the grants are to be used to support.

### *Delayed discharges programme*

The Health and Social Care Change Agent Team have published information on their forthcoming work programme at [www.doh.gov.uk/jointunit/workprogleteraug02.htm](http://www.doh.gov.uk/jointunit/workprogleteraug02.htm). **Two Learning and Service Improvement Networks** are being formed for care pathways/integrated discharge planning and intermediate care. Each network will enable participating organisations to share information about what works (and what does not), and carry out development work. The organisations will be assisted to develop a local action/performance improvement plan. A list of those organisations invited to sign up in the first instance has also been published. A third network will be developed to stimulate local developments in housing-based models of care, including alternatives to hospital care. A series of seminars will be held in the autumn to share good practice from the Team's work. Details of dates and venues will be publicised shortly.

### *Launch of the integrated care network*

To promote service improvement through integration of local authority and NHS services, a new integrated care network will be launched on 24 October. The network is a joint initiative of the Department of Health and the Office of the Deputy Prime Minister, with non-government partners. It will create a central information resource, develop action learning sets, provide consultancy, spread good practice and arrange national information meetings. Contact Roy Harry, Tel: 020 7210 5005

**Dr Finbarr Martin**

Chairman : NSF Focus Group

**Louise Wykes**

BGS Office

## Implementing reimbursement around delayed discharge – BGS/RCP (London) response to consultations

**A** joint response from the BGS and Royal College of Physicians (London) in response to consultations on proposals for reimbursement around delayed discharge from hospital

### *Introduction*

The BGS and RCP (London) applaud the Department of Health for recognising the problem of patients occupying acute hospital beds who no longer need acute care and whose recovery and rehabilitation is adversely affected by the delay, and for setting out to identify an innovative solution.

We agree that that it is essential to bring this issue to the forefront of social services planning. So far, the perverse incentive to leave older people inappropriately in health care facilities has meant that changes in social services departments' (SSD) working practice, (including assessments and care management continuing over weekends and holidays), have failed to occur. In addition, process delays, such as time waiting for care manager allocation and time to assessment, urgently need to be tackled.

### *Issues for implementation*

In registering the response above we wish, however, to highlight **four** key concerns:

**It will be essential in safeguarding the interests of patients to ensure that the assessment, care planning and decision making for each patient in hospital are at all times driven by best clinical and multidisciplinary practice, underpinned by sound clinical governance.**

This is implicit, but insufficiently explicit in the document. It presupposes a central and mandatory

role for physicians and their allied professional colleagues (including social workers) in this speciality.

**If the detail is not right, this proposal may not necessarily achieve effective change, whilst coincidentally undermining the developing relationships between health and social services departments, particularly in the community.**

This would stifle the innovative thinking, which has led to some examples of excellent joint working. There are well recognised cases where the delays in discharge are not related to any factor which is necessarily under the control of social services (such as the recruitment crisis in home care in some parts of the southeast England, and the closure of many care homes).

**We are concerned that this proposal will increase bureaucracy and thus divert money from direct care.**

This will have adverse consequences for patients, will be self-defeating for the whole system and will not succeed. Rather, this initiative must be seen to drive health and social services professionals into meaningful collaboration within a single cause - the hallmark (where it happens) of successful service delivery in this field.

**We would strongly wish the effects of these changes to be monitored and indeed would suggest a research program be commissioned to analyse the full effects.**

### *Responses to questions*

We have attempted below to answer specifically some of your consultation questions.

**Q: Are there issues for patients delayed in other settings (such as mental health or non-acute NHS services) which would mean that a system of reimbursement would need to operate differently for these patients?**

In non-acute NHS settings there is proportionately a greater problem with patients whose discharge is delayed. This has an obvious knock on effect for patients in acute settings, which often means that patients may be inappropriately placed as they have not had the opportunity for rehabilitation. Tackling the problem in acute beds is not a whole systems approach, as SSD will simply concentrate all their efforts on the acute beds. This will also give the acute sector the perverse incentive to bypass possible rehabilitation.

Were the system to be introduced for non acute NHS (e.g. rehabilitation settings), our expectation is that the culture of multidisciplinary goal setting would enable discharge dates to be predicted well in advance (1 - 2 weeks) and it would be much easier to penalize for systematic delays due to inefficiency.

**Q. A number of delays are associated with housing services, which may be handled by a different tier of local government. How can we ensure that housing partners are effectively brought into this system?**

Commissioning of the care of older people must utilise all the partners who may be involved in the process, and primary care trusts should be encouraged to enter into discussion with all relevant parties.

**Q. Are there other key steps which need to be in place to avoid conflict over the decision that a patient is ready to move from the acute setting and to ensure a robust plan is in place for the patient, which means that they get the right care at the next stage in their care and change processes and practice to enable a discharge plan to be put together within 3 days for every patient?**

◆ In addition to ensuring the necessary up-front involvement of medical and multidisciplinary staff in this speciality, require trusts to have local resolution procedures in place which require and rely on their expertise.

◆ Require trusts to define with SSD and Community Services in advance what does constitute a requirement for acute care; (e.g. patient must have a diagnosis or plans to make one, patient does not need to see a doctor in the next week, patient does not need intravenous drug use - with the obvious exception of schemes specifically designed to deliver IV drugs).

◆ Ensure all patients get a comprehensive assessment

on admission, which includes social details. This may mean acute hospitals changing the expectation that other members of a multi-disciplinary team other than physicians and nurses (i.e. other allied professions i.e. the Allied Health Professions) do not routinely undertake such work at weekends.

◆ Acute health teams should make themselves available to discuss cases with SSD.

◆ Invest in the IT support needed for the Single Assessment process so that teams in the acute setting know what the background information is - and this can be shared without delay with the local SSD.

◆ Use care managers who work seven days a week in acute settings, who have real knowledge of the local care systems (although they could still be locality based operating an “inreach” service).

◆ Accept that in the same way acute beds need to operate at approximately 85 – 90 % occupancy to be efficient, community based social care needs to operate with spare capacity in order to be flexible, which will increase costs.

**Q. In general, would such a scale of payment provide the incentives described in paragraph 41?**

The arguments on which the scale is based appear to be sound and therefore the incentive would be there. However, we do not believe that the threat of loss of income through readmission is a sufficient disincentive to acute trusts to stop them identifying patients as ready for discharge too early. Many patients will not be readmitted (because they refuse or the care home tries to cope) or will be readmitted to another Trust or care facility.

Trusts should be required to audit a percentage of their reimbursements and discharges to follow up the eventual outcomes for their patients.

We would wish guidance to clarify the reimbursement situation where the patient is defined for NHS continuing care. Since the responsibility for this lies with the PCT, is there an expectation that a system of reimbursement will apply to them also?

Finally, we would wish you to consider rephrasing paragraphs 26 and 27 to be clear about choice. Current Continuing Care Guidance (HSC 95(8)) still leaves the choice about discharge to a Care Home to the patient.

Cameron Swift

# The private sector

Notes from BUPA's Care Services Medical Director

**A**fter 15 years as a consultant in the West Country, I was appointed Medical Director to BUPA's Care Services in 2000 - a unique role in the UK .

It has been quite a journey from the Monday morning ward round in Weston-Super-Mare to the office in Leeds! Here, I will try to provide some insight on the sometime new, sometime familiar ground I now tread.

Firstly, many will not be familiar with BUPA's range of activities identifying it principally with health insurance and hospitals. BUPA is much larger than that! It comprises Wellness, a healthcare screening service and a diverse and growing international portfolio including Sanitas, a major health and care company in Spain, businesses in Asia, and most recently a major insurance company in Australia. The Care Services division principally concerns the management of over 17,000 care home beds across the UK, BUPA Healthcare professionals a major staffing agency, Goldsbrough estates (retirement/sheltered accommodation) and Surgichem a company that supplies the NOMAD medication measured dosing system. The scale of our provision and commitment to public service should not be underestimated; about 70% of our beds are state funded, principally by social services departments. BUPA is currently the largest single operator of care beds in the UK and further development is planned.

Remarkably, it seems widely accepted that care in one's own home will be possible for all older people and that coupled with a "compression of morbidity", institutional care will become largely redundant. Evidence in the form of vignettes of inappropriately placed people in care homes are quite simply irrelevant to the increasing

dependency and medical complexity more generally observed. There is an inescapable reality that a cure for neurodegenerative disease, particularly the dementias, remains beyond the horizon and that for any reasonable planning, proper institutional provision will be necessary.



Clive Bowman, Medical Director, BUPA Care Services

As Medical Director I have responsibilities for the standards of services and contribute to strategic development. My team currently comprises, a head of quality, a head of performance, hotel services manager, leisure services adviser, an analyst, a coordinator - additionally a mental health consultant and a tutor. Our regional business teams have Quality and Development managers that with the operational managers and home managers and their staff, all contribute to an information flow on performance. The experience and commitment of colleagues is matched by their ability to laugh at me as well as with me! My accountability is to the Managing Director of Care Services and professionally, to BUPA's Group Medical Director. Accountability takes several guises; formal board reporting complemented by regular one to one sessions with a variety of colleagues both in Care Services and the BUPA group. For those wary of accreditation, validation or indeed valediction, this corporate commitment combined with a 360-degree personal feedback and an annual service organisational profiling may appear excessive, even intimidating. After an initial acclimatisation I commend them as enormously constructive and no, I am not, nor never will be just a number!

Policies, procedures, clinical governance,

complaints, adverse event and critical incident management form a large part of the team's day to day work. Developing effective systems of CPD support for the 5000 plus registered nurses is another important matter. The development and provision of new intermediate and specialist care services is something of a passion, shared with many potential partners for whom the common difficulty remains commitment. One size does not fit all and understanding and developing differentiation and diversity is a recurring theme.

BUPA's vision statement "taking care of the lives in our hands" strongly influences our services. Irrespective of funding our residents are customers and are valued as such. The new found discipline of budgeting for and working to an annual plan after years of discarded strategic documents and nefarious efficiency savings, vacancy factors and un-funded service expectations, has been welcome. The transparency and accountability is a new discipline!

Perhaps the principle triumph of geriatric medicine has been the prevention of inappropriate admission to long-term care through access to modern medicine, rehabilitation, planned care and community support. The specialty's birthplace in long-term care, though a matter of great debate and opinion remains remarkably poorly characterised and developed. I have long sought a greater understanding and development of care. It is

clear that the appetite for research and development investment in care is a poor runner up to the genome and allied phenomenon. For the foreseeable future, innovative commissioning, provision and evaluation are the most likely means of progressing care from anecdote and iterative development to a solid evidence base. BUPA will seek to be at the forefront of those providers, offering a more complete solution than merely a serviced bed. The RCP report, "The health and care of older people in care homes: A comprehensive interdisciplinary approach: A report of a joint working party", published in June 2000 offers insight into how that may shape up.

The greatest constraint now and for the foreseeable future remains the serious shortage of staff. Improving and developing NVQ training that will allow care staff enhanced roles, responsibilities and opportunities, in turn allowing nurses take on a greater role in planning care will allow a restructuring of the roles of doctors in both primary and secondary care. The care and support worker inquiry commissioned and reported by the King's Fund makes many useful observations and recommendations that would help the kick-start this chain of events and another area of our activity.

There is much more. The unknown is how far we will really be able to make a difference. No major obstructions have been encountered – watch with interest!

**Clive Bowman**

## *BGS new research literature database*

**The Scientific Committee is very interested in finding out about the research produced by BGS members since 1999.**

For this purpose the BGS is setting up a new database listing published research. If you have had your research published, we would like to hear from you.

Please submit the following details:  
Name, research title, name of the publication in which the study was published (including volume,

page number and date of publication).

You may send this to the BGS office, either by email ([info@bgs.org.uk](mailto:info@bgs.org.uk)), or by mail to:

**British Geriatrics Society  
Freepost NW6074  
Marjory Warren House  
31 St John's Square  
London EC1B 1DT**

**Annette Guerda-Fischer**  
BGS Office

## BGS NEWSLETTER ON LINE

We would like to thank all those readers who piloted the first **on-line version of the BGS newsletter** in September, as well as those readers who took the trouble to visit the site.

The content of the newsletter continues to outstrip the 28 pages to which we are restricted by printing costs. For the moment, the on-line content will mirror the printed version with the exception of notices of meetings, courses and overseas posts vacant, more details of which will appear on the on-line version of the newsletter only.

[www.bgsnet.org.uk](http://www.bgsnet.org.uk)

## VACANCY : SPECIALIST PHYSICIAN IN GERIATRIC MEDICINE - GEELONG, AUSTRALIA

**Barwon Health - The Geelong Hospital and Grace McKellar Centre - invites applications for appointment as a full-time Staff Specialist Physician in Geriatric Medicine.**

This new position has been created to be the **third member of a team of geriatricians** providing high-quality evidence-based medical consultancy services in geriatric medicine to patients in the Geelong Hospital's 20-bed Acute Care of the Elderly (ACE) unit, 26 interim care (NHT) beds at two off-site facilities and at the Grace McKellar Centre (300 residential care beds). Responsibilities include leading the ACE Unit (and elder care philosophy), Emergency Medicine Department early triage team for elderly patients and care co-ordination for the elderly as part of the ACE Unit.

The State Government has already committed \$22 million funding for Stage 1 of the \$96 million Grace McKellar Centre redevelopment program. It will provide a 90-bed assessment and rehabilitation facility as part of a six-year redevelopment of aged-care services. Construction (Stage 1-100 sub-acute beds) began earlier this year.

Geelong is Victoria's second largest city and port. Barwon Health serves a population catchment area of 450,000. With 380 acute beds,

44,000 inpatients and 40,000



Emergency Department attendances each year, Barwon Health has a wide range of specialty medical and surgical services, and specialty clinics (mobility, falls, dementia). Its stand-alone Department of Clinical and Biomedical Sciences is the umbrella for three professorial departments in medicine, surgery and psychiatry. It also has a joint undergraduate clinical school with St Vincent's Hospital in Melbourne through the University of Melbourne and an independent voice on the Board of the University of Melbourne's Faculty of Medicine.

Comprehensive Pathology and Medical Imaging services, including CT and MRI, support the clinical services.



**Applications and requests for additional information should be sent in the first instance to:**

**Les McBride**, the recruitment consultant assisting Barwon Health, at:

**Mail:** Level 35, 101 Collins Street, Melbourne, Vic. 3000, Australia

**Phone:** +61 3 9663 0944  
**Fax:** +61 3 9663 2088

**E-mail:** [lmcbride@ihug.com.au](mailto:lmcbride@ihug.com.au)

## VACANCY : NEW POST EUGMS JOURNAL EDITOR

**The European Union Society of Geriatric Medicine (EUGMS), plans to create its own journal in 2003.**

This will take the form of an additional section to an existing European journal *Nutrition and Neurosciences*, which is being expanded to encompass two other new sections as well as that on Geriatrics and Gerontology.

**Expressions of interest are invited for the post of editor of the Geriatrics and Gerontology section.**

Please submit an emailed CV to Professor Alan Sinclair, as soon as possible, at [Sinclair.5@btinternet.com](mailto:Sinclair.5@btinternet.com)

A short list of names will then be prepared and reviewed by the Academic Board and Executive of the EUGMS and recommendations will be made to the Chief Editor of *Nutrition and Neurosciences*, Prof Bruno Vellas, who will reach a decision on the appointment.

## GERIATRIC ASSESSMENT WIZARD SOFTWARE

The **first free available software** (shareware-version) for geriatric assessment is now available at

[www.healthandage.com/html/too/geriatric\\_assess.htm](http://www.healthandage.com/html/too/geriatric_assess.htm)

Development was supported by the Novartis Foundation for Gerontology and the European Academy for Medicine of Ageing.

## IGNATIUS NASCHER PRIZES OF THE CITY OF VIENNA IN GERIATRICS

The **Ignatius Nascher Prizes in Geriatrics** will be awarded by the City of Vienna during next year's 6<sup>th</sup> Viennese International Geriatrics Conference.

The Lifetime Achievement Award in Geriatrics (7270 €) will be dedicated to an enthusiastic teacher, outstanding researcher and compassionate medical doctor who has influenced the geriatric community through his/her work on social projects and with successful implementation strategies.

The Sponsorship Prize (3630 €) will be awarded to applicants who have shown an important scientific contribution to the field of geriatrics, with a special emphasis on the areas of health promotion, prevention, diagnostics, therapeutics, rehabilitation or continued geriatric long-term care.

**Closing date:** 15 January 2003

**Address:** Prim. Dr. Katharina Pils  
Ludwig Boltzmann Institute for Interdisciplinary  
Rehabilitation in Geriatrics SMZ-Sophienspital,  
Apollogasse 19, A-1070 Vienna, Austria

**Submission for the Sponsorship Prize should include in triplicate :**

- ◆ a completed study including the project evaluation or the publication in a reknown scientific journal
- ◆ an application letter
- ◆ a CV

The application may be presented by a person, a team or an institution. Former prize-awarded publications or theses submitted for the certificate of habilitation are excluded. The publications have to be presented in english **or** german, the studies in english **and** german, according to the general publication rules, i.e. aim of the study; patients, material and methods; results; discussion; references; abstract.

The applicant is required to provide a written statement, that all scientific participants were mentioned as co-authors or acknowledged.

The winner of the Sponsorship Prize will be informed by the end of April 2003, the prize-winning study should be presented during the 6<sup>th</sup> Viennese International Geriatrics Conference in May 2003.

## IAG WEBSITE

The **International Association of Gerontology (IAG)** aims to make the IAG website a major resource for researchers, educators, practitioners and students. Features include:

- ◆ complete listing of English language scientific and practice-oriented journals on ageing;
- ◆ links to key international and intergovernmental organisations concerned with older people;
- ◆ calendar of national and international ageing-related conferences
- ◆ full text copies of IAG speeches at UN 2nd World Assembly in Madrid and European Economic Commission Ministerial Conference in Berlin
- ◆ full text of UN Programme on Ageing's research agenda on Ageing for the 21st Century and Valencia Forum report.
- ◆ up to the minute listing of IAG contacts worldwide (Presidents, Council members, head offices)
- ◆ searchable database of over 3000 abstracts from the 2001 world congress.
- ◆ new student's section.

[www.sfu.ca/iag](http://www.sfu.ca/iag)

## RCP (LONDON) THE GRAHAM BULL PRIZE IN CLINICAL SCIENCE

This **award** was established in 1988 in honour of the **late Sir Graham Bull, the first Director of Clinical Research at Northwick Park**. A Trust for the Graham Bull Prize was set up to provide money for young research workers under the age of 45 years who feel that they have made a major contribution to clinical

science. The prize as designed by the Trust is specifically for an application and not for nomination of individuals. The work can cover a wide range of expertise. It is open to both clinical and basic scientists who must apply for their work to be considered. The sum of £1,000 is offered on a competitive basis each year.

**Closing date for applications:** 31 March 2003.

**Application forms available from:**

Academic Registrar, Royal College of Physicians, 11 St Andrew's Place, London NW1 4LE  
Email:

[conferences@rcplondon.ac.uk](mailto:conferences@rcplondon.ac.uk)



# Standards of care for older people

The NSF, CHI and NICE reports, together with the HAS standards in Scotland, are all attempts to define standards of care for older people receiving health care.

The BGS Policy Committee was concerned that there has not been a definitive statement of how geriatricians should contribute towards improved services for older people especially, but not exclusively, when they are ill.

Over the past year the Policy Committee with the support of the Executive Committee, has worked to compile such a document, not to revisit old debates about styles of service delivery, but rather to define the expectations the BGS has for geriatricians and those who work with them in specialist departments. The standards have also been reviewed by Age Concern in order to ensure the proposals are in keeping with the expectations of older people themselves.

### *Standards of Care for Specialist Departments in Geriatric Medicine*

The document is available to download on the website at [www.bgs.org.uk](http://www.bgs.org.uk). It is subdivided into sections which will link with the NSF, but is a statement of policy which applies to the whole United Kingdom, and is equally relevant in countries where the NSF does not apply. In many cases there is ample evidence to underpin the contents but for simplicity the references have been omitted. It is a statement of expectation which will help to set and develop standards and services locally, often in an incremental fashion.

In conjunction with any guidelines for care, there is a need to undertake local review of services to monitor quality. This is necessary as part of the clinical governance programme of any Trust and also as part of the clinical evidence needed by consultants as part of their appraisal. Aware of the shortcomings in older people's services of the English National Performance Assessment Framework, the Policy Committee in this document has provided ideas to enable the

development of local clinical performance indicators which, if supported by appropriate clinical information, could be used by BGS members to review local services. It is important to note however, that some of the suggested performance indicators are not absolute values, but rather allow continuous local review in order to signpost areas which may benefit from more detailed investigation and audit.

Copies of the document summary, together with the web site details for downloading will be sent to PCT's and NHS Trusts for their information and in the hope that it will facilitate discussions about investment decisions and development of services, both now and in the future.

In line with all other compendium documents, 'Standards of Care' will be reviewed regularly by the Policy Committee - generally in a 3 year rolling cycle. Comments about this document, either concerning style or content, would be most welcome. Comments about the audit/performance indicators and their local utility would also be particularly useful in order to plan the structure of future compendium documents.

Gill Turner  
Chair, Policy Committee

### *Decisions about cardiopulmonary resuscitation* - model leaflet published by the BMA

The BMA have published this leaflet which has been **endorsed by Age Concern, the Resuscitation Council and the Royal College of Nursing.**

The text is available from the BMA website at [www.bma.org.uk/cpr](http://www.bma.org.uk/cpr), in MS Word and .pdf formats. The BMA have waived the copyright in the hope that Trusts will download the text. **Feedback** about the use of the leaflet would be welcomed. Please email your views to [ethics@bma.org.uk](mailto:ethics@bma.org.uk)

# Director of Continuing Professional Development Job description

**P**rof Mark Castleden, Director of Continuing Professional Development (DCPD) wishes to retire and the BGS invites expressions of interest in the post.

## Requirements

The DCPD must be a full member of the Society, of consultant or senior academic status, with a comprehensive understanding of geriatric medicine and the role of the geriatrician, and their needs, coupled with a good knowledge of developments in medicine and in the delivery of care. **A good knowledge of medical education, CPD, and validation are essential; an understanding of IT technology and its potential in education would be desirable.**

## Role of the DCPD

The DCPD will use his/her best endeavours to ensure that the Society, through its scientific meetings, publications and electronic media, provides its members with every opportunity to keep up to date with developments in geriatric medicine and the management of older patients across the United Kingdom. The DCPD **also represents the BGS views at meetings of the Royal Colleges on CPD.**

## Term of office

The DCPD serves for a period of 4 years, but is expected to understudy his/her predecessor for a year prior to taking over.

The DCPD is a member of

- ◆ the BGS UK Management Committee (in an advisory capacity)
- ◆ the BGS Education & Training Committee
- ◆ the RCP London SAC Geriatric Medicine and represents the BGS on the Federation of Royal Colleges CPD meetings, **and the JCHMT and its successor**

## Specific duties

- ◆ keeping the CME curriculum up to date in co-operation with the Meetings Secretaries
- ◆ ensuring that the curriculum is covered through a rolling programme of education, provided by the Society's UK scientific meetings, and by encouraging its inclusion in the national meetings organised in Scotland, N.Ireland and Wales, and regional meetings throughout the UK
- ◆ determining the allocation of CME points for attendance at **meetings of geriatric medicine throughout the United Kingdom** (the DCPD is supported administratively in this by the BGS office)
- ◆ updating the BGS/Novartis Foundation geriatrics syllabus website
- ◆ case finding, reviewing and editing the data to be placed on BGS/Novartis Foundation website, advising on any other educational materials the BGS may produce, such as an educational supplement to Age & Ageing
- ◆ **keeping au fait with developments in medical education and training in Europe**
- ◆ fulfilling any other work related to CPD/CME that the UKMC may require

## Scope

The post is an honorary un-paid appointment, which offers the holder an opportunity to make a substantial contribution to the Society and the specialty of geriatric medicine, and to influence significantly the quality of geriatric medicine.

## Administration

The DCPD is supported administratively by the BGS office. Travel and subsistence expenses are paid related to the work undertaken. By prior agreement with the Administrative Director, there may be scope for establishing an additional budget to cover e.g. the production of publications, or other activity.

**Mark Castleden**

Director of Continuing Professional Development

**Richard Lynham**

Administrative Director

# Regional Specialty Advisers

All things bright & beautiful, the Good Lord made them all

The Royal College of Physicians (London) has long had in place, a network of Regional Specialty Advisers to provide advice to the College on service and training issues within the regions of England, and in Northern Ireland and Wales.

In Scotland there exist Specialty Training Advisers whose names I have listed below and whose function would cover matters similar to those contained under Higher Specialist Training in the RCP London job description quoted below. Likewise in respect of the Republic of Ireland. The purpose of this article however is to provide information, and hopefully clarity over the role of the Specialty Advisers and their mode of appointment south and south-west of the border.

## *Terminology*

At one time the advisory functions were, for geriatric medicine, in each region combined into one single function. Since 1997 the BGS has in half the regions, divided the workload between two separate advisers. Thus were created:

The **Specialty College Adviser** (whom the College call **Regional Specialty Adviser - Service**) to advise on job descriptions for planned consultant appointments, on the suitability of individuals for election to Fellowship and on advisory committees, on service standards and service delivery.

The **Specialty Training Adviser** to handle the many issues appertaining to training, listed in the RCP's job description. Whereas this was once called the **Dean's Adviser** and still includes this element, it is now very much a joint appointment to the College and the Post Graduate Dean.

In addition, the BGS has in 11 regions an

**Academic Adviser** to assist members on research and academic development. Unlike the previous two appointments, the Academic Adviser appointment is independent of the College, being peculiar to the Specialty.

## *The RCP job description and the BGS*

The central RCP job description, quoted in full below, relates to a combined role of Regional Specialty Adviser - Service and Training Adviser, giving a more detailed description of the training role. In the case of the service role, advisers would be sent consultants' job descriptions by the College's main Regional Advisers, and asked to comment on any aspect of the job description which seemed unreasonable or unacceptable on specific grounds. They would also be asked to comment on nominations to Fellowship of the College - this request would come either from the Regional Adviser or from the College's Membership Department.

What the RCP central job description emphasises is that 'it is essential that' the **Regional Specialty Adviser - Service** and Specialty Training Adviser liaise closely together.

## *Appointment; the BGS proposes, the RCP disposes*

It is customary for the regional officers in each BGS region to put forward to the College a candidate to fulfil the role(s) of Specialty Adviser(s). So far the College has always seen fit to accept the recommendations, which is no doubt evidence that the BGS regional officers have put forward appropriate and suitably qualified candidates to fill the post(s).

How the regional officers decide on their recommendation is a regional affair and neither the College nor the BGS centrally has sought to influence this. However, clearly it is in the interests of both the Society and the Specialty that the College be given the best possible advice on both service and training matters, so it is the

quality of the appointee that counts. For this reason it may be more appropriate to select the person(s) generally recognised as leading in service and training, rather than inviting nominations and holding an election, unless it be to decide between two particularly outstanding candidates.

The appointments are for three years, but may, with College approval, be extended.

**Richard Lynham**  
Administrative Director

## *Royal College of Physicians London* *Functions of Regional Specialty Advisers*

### *Introduction*

These appointees have a major role in overseeing Higher Specialty Training in the relevant specialty or specialties. They are also able to advise the Regional Adviser on matters relevant to the specialty such as consultant job descriptions and Advisory Appointment Committees.

### *Higher specialist training*

For Higher Specialist Training Programmes, Specialty Advisers are responsible for the following:-

- a) The development of the new training programmes.
- b) The supervision of higher trainees during their rotation through the programme.
- c) Representation on Appointments Committees for specialist registrars.
- d) Making arrangements for trainee assessment meetings, providing appropriate feedback to trainees and for ensuring relevant documentation is made available to the College.
- e) Ensuring that systems of appraisal are in place and in particular that trainees are aware of a confidential channel through which they can draw attention to anxieties they may have about the programme or its supervision.
- f) Liaising closely with the JCHMT through the SACs.
- g) Facilitating arrangements for SAC inspections of programmes in collaboration with Postgraduate Deans.
- h) Attending regional Specialty Training Committees, as chairman

where possible and, since they are joint appointees with the Postgraduate Deans, acting as a channel of communication between the Postgraduate Deans and the College.

- i) Contributing to the first stage of appeals procedures relating to annual assessment decisions.
- j) They are expected to play an important role for both over-seas doctors and for those in academic and research posts. For the former they should facilitate their placement in suitable, relevant training programmes as well as their supervision, appraisal and assessment. They should support and encourage trainees wishing to enter a period of research and should facilitate entry into such a period and exit back into clinical training programmes. They are involved in assessing the training credit to be recommended in respect of service undertaken during periods of research. With regard to non-training activities, Specialty Advisers are able to provide advice for the Regional Advisers on such matters as consultant job descriptions and Fellowship proposals. The membership of the SACs of the JCHMT includes representatives from the Specialty Advisers.

### *Appointment*

In view of the vital role to be played by Specialty Advisers for specialty training it is clear that close working relationships with the Postgraduate Dean are essential. The College has agreed with the Postgraduate Deans

that Specialty Advisers should be joint appointments and Advisers will then work on behalf

of both the Deans and the College on training matters in their specialty.

The Specialist Societies also have a strong interest in regional specialty matters and it is hoped that in most instances, the Specialty Adviser will be the same person who acts as the Specialist Society's representative. Where this is not possible, or where the workload is heavy, the responsibility for advice on job descriptions and other clinical practice matters could be undertaken by the Specialist Society's representatives where they exist. In this case it will be essential for the appointee for specialty training matters to liaise closely with the representative responsible for other specialty matters.

### *Term of Office*

The term of office of Specialty Advisers should be three years and appointment should be agreed between the Postgraduate Dean and College.

### *Lines of communication and responsibility*

As well as a line of responsibility to the Postgraduate Dean, Specialty Advisers communicate directly with the relevant SAC and JCHMT for all higher training matters. Specialty Advisers communicate with Regional Advisers on matters relating to AACs, Fellowship proposals etc. and through them to the College Registrar.



# Regional Specialty Advisors

Region	Specialty College Advisors - Service	Specialty Training Advisors	Academic Advisor
East Anglia	Dr D Luxton	Dr S Grimmer	Prof K Khaw
Mersey	Dr C Turnbull	Dr C Turnbull	Dr M Gosney
Northern	Dr R Francis	Dr R Curless	Prof R Kenny
Republic of Ireland		Prof D Coakley	
Northern Ireland	Dr I Taylor	Dr I Taylor	Prof R Stout
North West	TBC	Dr P Baker	Prof M Connolly
North East Thames	Dr C Gent	Dr G Rai	
North West Thames	Dr C Vellodi	TBC	Dr J Pace
South East Thames	Dr A Rudd	Prof C Swift	
South West Thames	Dr S Samadian	Dr M Ward	Dr M Cottee
Oxford	Dr N Gunasekera	Dr S Fairweather	Dr H Hillawi
South West	Dr R Barber	Dr R Barber	Prof Gordon Wilcock
Trent North	Dr C Austin	Dr C Austin	
Trent Mid	Dr J Marrant	Dr J Marrant	
Trent South	Dr D Ives	Dr D Ives	
South Wales	Prof K Woodhouse	Prof K Woodhouse	
North Wales	Dr B Bhowmick	Dr B Bhowmick	
Wessex	Dr G Turner	Dr G Turner	Prof R Briggs
West Midlands	Dr P Overstall	Prof A Sinclair	
Yorkshire	Dr A McEvoy	Dr O Corrado	Prof G Mulley
West Scotland		Dr B Martin	
East Scotland		Dr M McMurdo	
South East Scotland		Dr J Starr	
North East Scotland		Dr M MacArthur	

# BGS Scientific Meetings

## New Developments



### The BGS needs poster assessors

Will you be attending the BGS Spring 2003 meeting in Aberdeen? If so, have you thought about being a poster assessor?

Posters are the primary means of communicating current scientific research to the membership. As the number and categories of posters are increasing at every meeting, we need a large number of assessors. Presently, the categories are:

Bone, muscles & rheumatology	Health Services Research
Biology & social gerontology	Incontinence
Cardiovascular	Law & Ethics
Clinical Practice	Neurology & Neuroscience
Clinical Effectiveness (new)	Parkinsons' Disease
Diabetes	Pharmacology
Eyes, ears and teeth	Respiratory
Epidemiology	Psychology/Psychiatry
Falls, fractures and trauma	Work in progress
Gastroenterology	Stroke

Poster assessors work in pairs and assess a maximum of six posters (usually less) in one category. The poster assessment takes place in the morning coffee break and does not clash with any of the scientific sessions.

**If you are interested (\*), please send an e-mail to [abstracts@bgs.org.uk](mailto:abstracts@bgs.org.uk) stating which category or categories you would be interested in assessing.**

Poster assessor instructions can be obtained from the BGS office - Email: [annette-guerda-fischer@bgs.org.uk](mailto:annette-guerda-fischer@bgs.org.uk)

\* At the moment we do not yet know the number of posters (and categories) needing to be assessed, as the deadline for submissions of abstracts is 1 December 2002.

**Annette Guerda-Fischer**  
BGS Office

### Clinical Effectiveness - A new category of poster

The Scientific Committee has approved the introduction of the new category of "Clinical Effectiveness" posters for BGS meetings. The aim is to enhance standards of care by promulgating work that demonstrates the implementation of research evidence into clinical practice.

The posters might include details of:

- ◆ guidelines
- ◆ audits that have been carried out and changes in practice that have resulted
- ◆ benchmarks of best or innovative practice
- ◆ datasets that have been used to monitor and improve care.

Details for abstract submission are circulated to the full membership twice a year, with the Newsletter, and are also available from the BGS website: [www.bgs.org.uk](http://www.bgs.org.uk).

Abstracts will be selected on the basis of the methodological soundness of the work carried out and the national relevance of the work. Abstracts will not be published in *Age & Ageing*. If however the innovation is successful, methods of wider dissemination of abstracts will be investigated.

**BGS members are encouraged to consider whether they have work of national interest that they would like to submit for the Aberdeen Meeting, April 2003.**

**Jonathan Potter**  
Chairman  
BGS Clinical Practice Evaluation Group

# Future England Council

## Election of Chair and Deputy Chair

The proposals for BGS devolution, which should be ready for approval at an extraordinary general meeting in April 2003, will create a new council for England.

The English members of the existing UK Council are studying a draft constitution for the England Council, which should be approved in January 2003. This constitution envisages a council comprising 14 regional members plus a chair and a deputy chair, both of whom will represent England on the UK Management Committee of the Society. The purpose of this notice is to invite expressions of interest in the two positions of chair and deputy chair. Although the proposals regarding devolution and the English constitution have not yet been approved, we are acting now in order to ensure that the new English Council is in a position to take up its programme of work as soon as possible after the EGM.

### Chair

It is envisaged that the work of the new Council will focus on policy matters appertaining to the provision of medical care for older people in England. The chair will need to be a high profile, experienced person with a comprehensive grasp of the entire spectrum of care for older people in England. The chair will be responsible for liaising with government representatives and will sit on the BGS Department of Health Liaison Group, as well as the BGS UK Management Committee and the BGS & RCP Joint Geriatrics Committee.

### Deputy Chair

Given the potential workload foreseen in the paragraph above, it is thought that the work will need to be divided between the chair and deputy chair.

Both appointments are for a two-year period. There is no provision for the deputy chair to automatically succeed the chair. Where a regional representative is

elected chair or deputy chair the region he/she represents shall appoint a new representative to act for the region.

### Eligibility and how to apply

Every BGS member residing or working in England may nominate a colleague, who is also a BGS member residing or working in England to serve as chair or deputy chair. Nominations should consist of a CV from the candidate and a brief citation signed by the nominator and a seconder, subject to the agreement of the nominee, and sent to the BGS office by post or email. At their first meeting the regional members of the England Council will elect the two officers from the names submitted.

**Nominations should reach the BGS Office by Friday 7 March 2003.**

### Regional Representation

The 14 regional representatives on the England Council will be appointed from each of the 14 English regional branches as UK Council members are at the present time.

**Louise Wykes**

Committee Secretary : BGS Office

Email: Louise-Wykes@bgs.org.uk

### Cowboy Dentistry in the UK - a reader's letter

Sir,

I was recently disturbed to be informed that the NHS is unwilling to undertake dental repair work such as bridges and dentures. On making enquiries, I was shocked to discover that private dentists are charging exorbitant prices and being allowed to charge customers on an *ad-hoc* basis. Surely the time has come for the British Dental Council, the General Dental Council and the Community Dentist Primary Care Agency to intervene against this policy of overcharging.

**Dr S K Das**

# Our Patron calls

## HRH Prince of Wales visits Cambridge

**H**is Royal Highness, the Prince of Wales, and Patron of the BGS, paid a visit to Davison House at Brookfields Hospital, Cambridge.

Davison House accommodates patients receiving rehabilitation and continuing care.

The visit took place on Friday 27<sup>th</sup> September. Fortunately the weather was pleasantly warm and sunny, and several patients and staff greeted the Prince in our excellent gardens. The Prince spent several minutes with each patient, all of whom thoroughly enjoyed the occasion as did staff, the experience was most memorable for all involved and a tremendous boost to morale.



We were fortunate that His Royal Highness had

found time to honour us with a visit during a crowded schedule that took in a visit to the adjacent hospice and then on to the main event of the day - the rededication of the American Air Museum at nearby Duxford with the former President Bush.

I would strongly encourage colleagues in the BGS to consider hosting a visit from our Royal Patron and to liaise with Richard Lynham. Richard was of immense help to me both in making the initial contacts and in providing the accepted mode of address for my thank you letter. If you are due for a visit then expect a preparatory meeting with St James' Palace staff, possibly at short notice. The visit itself will involve a police presence, the Lord Lieutenant of the county, other staff, and a press corps. It is likely that a visit may, as in our case, be combined with some other prominent local event. The happy memories and uplift to spirits do make all the effort worthwhile.

**Tony Luxton**

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# Trainees' Report

## *Trainees' meeting - 17 October*

All of the Trainees Committee was present except for Jonathan Trembl (Training Committee Rep) who sent his apologies. The meeting was well attended by trainees. Suzanne Sorenson (Research into Ageing), Nikki Colledge (Secretary, SAC Geriatric Medicine), and Steve Allen (Chair, BGS Training Committee) attended on the Trainees Committee's invitation.

## *New curriculum for geriatric medicine and SpR assessment*

The New Curriculum is awaiting final SAC approval in December and is expected to be in place for all new SpRs appointed from 1<sup>st</sup> January 2003. It will not be retrospective and will therefore only apply to new SpRs taking up posts from the beginning of 2003. There are ongoing discussions regarding the assessment of SpRs both in terms of competence



Cath Church

and knowledge. As regards assessment of competence, the plans are to include both a 360 degree appraisal and mini CEX (clinical evaluation exercise). The mini CEX is widely used in the USA and comprises repeated clinical assessments (preferably by different consultants) throughout the year e.g. supervised history taking and examination. These will be piloted on current SpRs in due course.

As regards a knowledge-based test, the plan is for a web-based assessment but further details have yet to be decided.

It was stressed that these assessments will not be retrospective and therefore will not apply to SpRs currently holding an NTN.

### *New SHO modernisation plan*

The plan is that doctors will undertake a 2 year foundation programme after qualification. The first year will be as a PRHO and the 2<sup>nd</sup> as an SHO although it isn't entirely clear what this 2<sup>nd</sup> year will comprise. There will then be a basic training programme as an SHO which will probably be 4 years in duration. This will be taken in one of approximately 8 subjects (e.g. general medicine, general surgery). The period will be 'time-capped' and doctors will then move on to a period of higher specialist training. Concerns have been raised that this plan may increase the amount of time in purely service posts, particularly for those who are unable to enter a higher specialist training post of their choice. The plan also discusses obtaining a CCST in GIM only one year after completion of the basic training programme, which raises concerns about a 'junior consultant grade'.

### *Research*

All SpRs should have a research supervisor and ideally should meet with them on an annual basis. They will obtain a report from this supervisor which should be submitted at their RITA assessment. Research will be monitored more

vigorously by means of the RITAs and SAC visits.

### *Intermediate care*

Steve Allen has drafted a document to clarify the components of intermediate care and guidelines for training requirements and assessment in this area. The document has been submitted to the SAC for approval.

### *Stroke training*

The new subspecialty SAC for stroke medicine met for the first time a couple of weeks ago. It is still unclear what the impact of stroke training and a stroke CCST will have on our training (in terms of duration).

### *European Working Directive (EWTD)*

The EWTD is law and the 48 hours duty time limit (including all rest/breaks) comes into force in 2009. Discussions are ongoing between the DOH and BMA Junior Doctors' Committee regarding derogations from the rest rules. Many more SpRs are now working shifts, particularly since the pay for band 3 posts increases substantially in December 2003. There are concerns about the impact of shifts on SpR training and it was agreed that the Trainees' Committee would send out a questionnaire to trainees to try to establish the impact that the shifts are currently having.

### *General*

The BGS Newsletter is now available both on line at [www.bgsnet.org.uk](http://www.bgsnet.org.uk) as well as and in paper form.

BGS subscriptions are to increase slightly next year and SpRs will be expected to pay more than SHOs.

### *Next meeting*

This will be held during the Spring BGS 2003 in Aberdeen.

**Cath Church**

Chair of Trainees' Committee  
c.j.church@ncl.ac.uk

Published by the British Geriatrics Society

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