



Editor: Kevin Kelleher

BGS

n e w s l e t t e r



2006 Subscriptions reduced (or homeless to propertied in 54 years)

For almost twenty years, the British Geriatrics Society's address was the briefcase of whomever the Honorary Secretary happened to be at the time.

The Medical Society for the Care of the Elderly - as the British Geriatrics Society was called when a handful of geriatricians formed it in 1947 - lived and travelled light.

It took twenty years before the BGS, duly re-branded, graduated from the Honorary Secretary's briefcase to bricks and mortar, as humble tenants of the Institute of Biology. In 1983 it finally bowed to the necessity of orderly paper shuffling when it employed a professional Membership Secretary and bookkeeper.

In less than the two decades which followed, the Society's operations have expanded significantly. Its latest landlord, the

Royal College of Physicians in Regent's Park, was about to review the rental agreement and there were soft signals that the RCP, pressed for space to house its own expanding operations, might be tempted to present the BGS with a financial disincentive to remain at Regent's Park. Thus, led by successive Honorary Treasurers, Dr Jonathan Potter, Dr Ian Sturgess and then Professor

Margot Gosney, the BGS set about finding a home. Marjory Warren House was purchased in 2001.

To acquire affordable and suitable premises in London during the late 1990's was no mean feat. To pay the mortgage in full, less than five years later, is just as remarkable. Where Dr Potter negotiated the first feat, Dr Sturgess and Professor Gosney set and sold to the BGS membership, the stringent financial policy whereby the second could be achieved.

As part of the strategy to pay off the mortgage in 5 years, all UK members had a



President: Dr Jeremy Playfer **President Elect:** Prof Peter Crome

Honorary Secretaries: Dr Kevin Kelleher and Dr David Beaumont **Meetings Secretaries:** Dr Juanita Pascual and Dr Michael Vassallo

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

specialist medical society for health in old age

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premises levy attached to their annual membership subscription; £20 in the case of consultants and £10 for all other grades. This was enormously effective in helping the BGS to become mortgage free so quickly.

A big thank you

Contrary to the frugal natures which made our current Treasurers, Dr Sturgess and Professor Gosney so effective as guardians of the Society's wealth, they have recommended to the United Kingdom Management Committee, that by way of a thank you for the extraordinary generosity of our members, in addition to removing the building premises levy from the 2006 subscriptions (in those categories where the levy was applied), all subscription rates will be frozen at 2005 levels during 2006, as opposed to the usual annual increase in line with inflation. This effectively means a reduction in the UK categories' 2006 subscriptions.

With the Society no longer having to fork out money for rent (or mortgage repayments), it can now concentrate on

applying these savings to projects in pursuance of its objectives. To this end, a second fellowship has been launched, co-funded by RIA. Like the Dhole Fellowship, the new fellowship funds a selected research project with a minimum of £25,000 over each of three years. The other BGS grants funds have also been substantially increased. Further projects will be considered for funding during the course of the next few years.

Not only is Marjory Warren House home to the BGS, it also houses the Secretariat of the European Union Geriatric Medicine (EUGMS), which fortuitous fact, together with the BGS members who serve as office bearers in the EUGMS, places the Society in a good position to influence European policy on elderly care (to the extent that this will be possible!).

In the mean time, in Marjory Warren House, the BGS has an excellent and appreciating asset, thanks to the foresight and financial management of our Treasurers, and the generosity and fortitude of the BGS membership.

The following subscription rates for 2006 will apply

(invoices will be mailed in late October):

Membership Category	2005 Subscription Rate	Discontinued premises levy	2006 Subscription Rate
Category 1: Consultants in the UK	£190	£20	£170
Category 2: Trainees, research fellows, staff grade, clinical assistants, associate specialists, part-time consultants (less than 6 sessions a week)	£112	£10	£102
Category 3: Retired members in the UK, SHOs, GPs, Scientists and associated health professionals receiving Age & Ageing	£97	£10	£87
Category 4: Overseas including the Republic of Ireland	£77	No premises levy applied	£77
Category 5: Allied Health Professionals who do not receive Age & Ageing	£45	No premises levy applied	£45

As always, a discount of £20 applies to members in categories 1, 2, 3 and 5, who pay their membership subscriptions by direct debit. For these members the rates will be £150, £82, £67 and £25 respectively.

Editorial

page

It is not the literal past that rules us, save possibly, in a biological sense. It is images of past. Each new historical era mirrors itself in the picture and active mythology of its past or of a past borrowed from other cultures. It tests its sense of identity, of regress or new achievement against that past. - *George Steiner*

The long lazy days of summer, “the silly season” for the media, usually means not much to report. Hold on, maybe that is a myth this year!

On the 7th July, I was travelling by train to Marjory Warren House for BGS business. The House, profiled on our front-page story, lies in an historic part of London near St John’s Gate. It looks like a building developed post-blitz.

An anxious conversation emanating from a fellow passenger on her mobile phone – impossible not to overhear one side of these conversations – indicated bombs were going off in London, so I quickly exited at the next stop. Her information was correct and the rest is history.

Following these events some older people interviewed by the media invoked the “**blitz spirit**” as an encouragement to citizens to help them cope with the disaster.

However, sober reflections by commentators of an historical or anthropological background indicated that crooks and villains took advantage of the awful disruption caused by the bombings in London during the Second World War. So much for the “blitz spirit”. Once again, the myth shows itself for what it is when scrutinised and explored.

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Exploration came in a different guise, media engendered once again, on “Panorama” on BBC Television on the 20th July 2005.

“Undercover nurse” was a three-month undercover investigation when a nurse secretly recorded the experience of working on an acute medical ward in an NHS hospital.

Indignities were once again portrayed and the skilful editorialisation brought tears to the eyes.

It was familiar ground on television these days.

Do such programmes shatter myths about the quality of care in citizens’ minds? How does one analyse the power of such images against the reporting of areas of “good practice” for older people as covered in our article in this edition of the newsletter called “Rehabilitation in the NHS and social care – BGS response to scoping study”. How does an individual decide about their perception of quality of care? Whose ideas, when portrayed using different modes of communication, win in the invention of the new mythology?

Ian Hastie mentions that a first set of EU wide health data called the European Community Health indicators project is soon to be published. This will aid the tracking and development of health status of the EU population. Similar work will come from North America and Japan. It will

be fascinating to see how the differences and commonalities unmasked by such data will be received and communicated.

Much of the analysis and its communication will depend on the researchers of the future and Phyo Myint gives us an enthusiastic report and

reasons why a trainee should immerse themselves in the methodologies of research.

So I sign off to a new editor and in the words of “The League of Gentlemen” —“Hello Dave”.

Kevin Kelleher

President's column

August is a month with mercifully few meetings to attend so I find myself in reflective mode, particularly as I have a number of important presentations to give in the Autumn.

My reflections were greatly helped by the arrival of the newly retired and sprightly Mahendra Gonsalkorale, armed with his video camera. Mahendra has produced a marvellous DVD, recording John Brocklehurst's historical perspectives on the development of geriatric medicine. He very kindly asked me to preface the DVD, which he hopes to launch at the Autumn meeting of the British Geriatrics Society. John Brocklehurst rather startlingly recognises the origin of our speciality from the time of Henry VIII's divorce! You will have to buy the DVD to discover the full story (a bargain at £10 plus postage and packaging). John of course, was an inspirational leader of the speciality, and I think it is now impossible for anybody to span the spectrum of academic research, scholarship, education and service development that John was able to achieve in his career. It is very evident from the DVD that the development of the speciality arose as a result of the drive and vision of exceptional individuals who radically changed the provision of healthcare for older people. I realised that I knew most of these pioneers personally, but for the up and coming generation, they will only be known as

historical figures. It is very important that the speciality remains in touch with its roots and rich tradition.



Golden age

Following John's narrative, it occurred to me, that the speciality, for all its faults close to, is probably in its golden age. Most of the ambitions of John and the other pioneers, Exton Smith, Ferguson Anderson, Bernard Isaacs and Jimmy Williamson, have really been achieved. The speciality is now the largest branch of general medicine. Acute assessment is routinely and expertly carried out in all NHS acute hospitals. Academic geriatrics is established (although wilting at the moment). We have universal excellent training schemes. In addition, we have the development of specialist care with geriatricians taking the lead in areas such as stroke, Parkinson's disease and falls, etc. Nevertheless the picture is changing. There is a clear reaction against the medical model of caring for older people and politicians by and large do not look to geriatricians for solutions, but to nurses running managed care, privatisation of long stay care and a radical shift from the medical model to the social model.

In twenty or so years time, a future Mahendra will look on our current era with equal admiration and find much original and pioneering work. However,

We hope to form a special interest group in nursing of the elderly. This will be a major step to our becoming truly multidisciplinary

John Brocklehurst made it quite clear that geriatrics thrived in the United Kingdom because the political framework allowed individual innovation. I believe, in the present climate,

this is going to be increasingly difficult. Many of us are struck by the ineptitude and illiteracy of local commissioning with regard to elderly care. To be successful, geriatricians of the future will need to be part of integrated care networks, of the sort that have been pioneered in Scotland by Ann Hendry. Ann gave a fantastic presentation of this at the Council Study Day in Edinburgh on 14 June. It was a pity so few people were there to hear, but I am sure this is the future of our specialty. Following the meeting that Jackie Morris set up with Dave Black and myself with the Chief Executive of the National Health Service Confederation, on 14 September, the BGS is having a joint conference on vertical integration within the Health Service. The run up to this meeting has not been smooth and is perhaps symptomatic of the blind spot that strategic thinkers in the health service have for our specialty. I do hope that the meeting will open dialogue whereby we can take the responsibility of trying to educate future planners of the Health Service of the importance of retaining a high level of geriatric expertise.

On June 16, I was able to present a view of geriatric medicine to the Medical Specialties Board of the RCP London. I am very encouraged that all three colleges are now recognising the centrality of our specialty. My feeling is that the London College lags behind the Scottish Colleges in the integration of geriatrics within its programme. We will be rethinking our connections with the London College over the next few weeks and will be discussing it at the Joint Geriatrics RCP meeting in September.

Science to Practice

Since the last newsletter, the tragic events of 7 July occurred, on a day in which we were due to hold the UKMC meeting. Out of 23 people due to attend only the intrepid Dr Beaumont and myself arrived, both of us having started our journey in the very early hours. David arrived at Kings Cross

while I came in at Euston within minutes of the outrage, and both of us walked past the bus which blew up outside the BMA House. Alex, our Chief Executive didn't make it into the office because he was on the train immediately behind that which carried one of the bombs. We were extremely well looked after by the staff at Marjory Warren House. Rather ironically I got home from London much earlier than I normally would have, getting the first train to Liverpool out of Euston Station and being the first person on board! I hope that the uncertainty of future attacks will not inhibit people from attending meetings at the BGS Headquarters. I made it back on 11 July so that I could attend the multidisciplinary PD Meeting, Science to Practice. This meeting - a joint venture between the Parkinson's disease section and MEP, organised by Dorothy Robertson, was over subscribed. It was a hugely successful multidisciplinary meeting, which does our Society great credit.

Consultant nurses

The consultant nurses in elderly care group met at the Foresight Centre in Liverpool and I once again had the pleasure of addressing them, on the invitation of David Jones, a valued colleague of mine. There are now over 60 consultant nurses in the group and it is hoped that as many of them will become members of the BGS, and that a special interest group in nursing in the elderly can be formed. This will be a major step to our becoming a truly multidisciplinary society and we look forward to the nurses actively participating in the Society in the future.

Public Relations

Alex and I have been busy pushing the public relations agenda and have forged a link with Onyx Health, who have put together suggestions as to how we might organise and pursue a public relations offensive to raise the profile of geriatric medicine and our Society. I hope to be able to debate this at the UK Management Meeting in September and then disseminate more widely what I hope will be fairly ambitious plans.

I hope everyone has had a jolly good summer holiday with the great weather. Please remember the Autumn meeting in Harrogate in October, which looks like being a very successful event. Judging by last year it would pay to book early.

Jerry Playfer

President Elect's column



House of Lords praises BGS initiative on ageing research

The House of Lords Science and Technology Committee's report on "Ageing: Scientific Aspects", was published in July this year.

The British Geriatrics Society, together with the British Society of Gerontology and the British Society for Research on Ageing were the first witnesses to be heard by the Committee in October last year. The headline conclusions of the report that "little is being invested by the Medical Research Council into ageing-related research, and virtually nothing by the Economic and Social Research Council", will not come as a surprise to academic colleagues although readers will be interested that the MRC states that 27% of its expenditure is on ageing-related research!

The Society (John Potter, Steve Jackson and myself) together with BSG and BSRA representatives met in Birmingham recently to discuss how best to put pressure on Government to implement the report's recommendations and how best the Societies can work together. The Committee praised this initiative. Members of a certain age may recall that 30 years ago Peter Millard and Norman Exton-Smith produced a joint report with the other societies under the auspices of the British Council on Gerontology. Perhaps it is time to resurrect this organisation.

The report is full of useful facts and figures and can be used as a teaching aid. It is available (with the oral and written evidence) on the Parliamentary website: www.parliament.uk/hlscience

Free conference registration for presenters from the developing world

As part of its international strategy encouraging overseas visitors to participate in our scientific meetings it has been decided to waive registration fees for presenters from poorer countries. It has become clear that the high cost of registration has deterred visitors from the developing world from attending. We shall also be holding an informal meeting for our overseas members at the Harrogate meeting to discuss with them how best the Society may meet their needs. One possible avenue to explore will be the establishment of an International Section.

International Association on Gerontology - July 2005

There I was, listening to the new President of the IAG make his inaugural speech when I heard mention of the **Lunar Society!** Afterwards I asked Professor Renato Maia Guimarães how he knew about the Society and he told me that he had trained with Bernard Isaacs in Birmingham. I told him that we had had a talk on this subject at the Birmingham Spring Meeting just a couple of months earlier. I mention this anecdote not only to demonstrate how small the world is, but also remind colleagues that UK Geriatric Medicine is held in high esteem in South America. Ronaldo Kaplan, the President of the Argentinean Geriatrics Society is hoping to organise a meeting marking this link.

The IAG meeting was a veritable *gerifest* with over 4000 delegates, far more than expected. Stars of the geriatric medicine world were talking and perhaps, more important, there is a chance to question and chat to them after the sessions. It was a pity that I saw so few UK geriatricians at the conference - perhaps they were sunning themselves on

the beaches at Copacabana and Ipanema!

Progressive cognitive deficiency syndrome

At the Council meeting it was decided that the 2013 conference will be held in Seoul which beat Hong Kong. (I voted for HK.) The European region is preparing position papers on age discrimination and geriatric facilities. There was also a proposal to abolish the syndrome of dementia and replace this with the phrase "progressive cognitive deficiency syndrome". The BGS will be responding to these proposals. These decisions are of some importance since the IAG is recognised by the UN and WHO as the body representing the scientific community of gerontologists.

Future meetings of the IAG are planned for 2006 (Clinical Section in Ostend) and 2007 in St Petersburg (European region) whilst the next world congress will be in Paris in 2009 under the Presidency of Prof Bruno Vellas, who will be well known to our Euro-travellers.

Staff Grade and Associate Specialists

Autumn meeting programme



Autumn BGS meeting in Harrogate

This year's meeting is taking place on 5 - 7 October in Harrogate at the International Conference Centre. Harrogate is easily accessible by road or rail and the BGS has links with several very comfortable hotels near the main venue. Attending the BGS meeting will enable you to meet your external CPD requirements for the year in order to become

revalidated. There is an excellent programme which includes sessions on Parkinson's disease, epilepsy, polymyalgia and falls.

Staff Grade and Specialist Associates Meeting

All Staff Grade, Associate Specialist, Clinical Assistant or Trust Grade doctors are welcome to attend our meeting. Let me remind you that membership to the SAS group is open to all members of the British Geriatrics Society, but it is also open to non-BGS members by invitation of the Committee. We are a friendly inclusive group who welcome new faces. At this year's meeting, in addition to the very important issues listed in the Agenda opposite, we will be giving **practical advice on Continuing Professional Development, revalidation, appraisal and applying for discretionary points.**

Regional Meetings

Many of you find it difficult to attend the Harrogate meeting, but let me assure you it is well worth the effort. To try and increase SAS involvement in the BGS further, a pilot project within the SW Thames region is being trialled. The aim is to have a regular session at the regional meetings, delivered by an SAS doctor and to enable all SAS doctors to be freed from their clinical duties to attend.

Don Lecamwasam
Secretary
Sue Morgan
Chair

Staff and Associate Specialists Sub-Committee

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Text: 07763 363992 **Phone:** 07763 363992

Snail mail: Joanna Gough, British Geriatrics Society 31 St John's Square London EC1M 4DN

Staff Grade and Specialist Associates Meeting

All staff grade and specialist associate doctors involved in elderly care medicine are invited to a meeting of the BGS SAS Group
(whether a member of the Society or not)

Date: Thursday, 6th October at 1.00pm as one of the BGS Autumn Conference's ancillary meetings

Venue: International Conference Centre, Harrogate

A G E N D A

- Update on BMA negotiations for single spine.
- Progress on PMETB
- Feedback from the further round of questionnaires to SAS doctors
- Report from English Council Meeting
- Recruitment of Regional Leaders and Regional Involvement
- Future Structure of the SAS meetings

Whether you are attending the Autumn meeting or not, please feel free to contact me to discuss any other issues which you would like raised at this meeting.

BGS Trainees pages

Election of the 'Trainees' Committee

As the BGS Autumn Meeting draws near, I would like to invite all current trainees to consider standing for the positions listed on these pages, as the current office bearers come to the end of their time in office.

I can thoroughly recommend getting involved with this committee as we have all really enjoyed our 2 years in post and feel it has been a valuable experience. The consultant members of the BGS standing committees have all been very welcoming and encourage contributions from the trainee representatives.

The only criteria are that you are an SpR with at least 2 years of training to complete. No previous committee

experience is necessary. If you would like further information please contact any one of us via the email addresses below. The elections will be held at the Trainees meeting during the Friday lunchtime at Harrogate. If you would like to stand, but will not be attending, please send a short résumé to me by 30 September and we will put your name forward on the day.

We hope we have inspired some of you to stand in October and look forward to seeing you in Harrogate.

Sally Briggs

BGS Trainees' Committee Chairman

Chair

The Chair sits on the UK Management Committee, Specialist Advisory Committee at the Royal College of Physicians and the Education and Training Committee, a total of 10 meetings per year. Extra duties include writing a short annual report and occasional articles for the newsletter. The Chair liaises with the rest of the committee.

Sally Briggs
sally.briggs@fsmail.net

Vice Chair

The Vice-chair represents trainees on the BGS Academic and Research Committee and Joint BGS/RCP Committee. Both committees have regular meetings with a total of 6 meetings a year. One has the opportunity to assess the scientific abstracts submitted to the bi-annual scientific meetings, after undergoing a supervised review process. This happens on a voluntary basis. Other duties include providing updates and new material for the research guidance section of the trainees' website and commissioning, "Why I went into research" articles for the newsletter.

Phyo Myint
Pkyawmyint@aol.com

CPEC rep

Of the 2 representatives on the England Council one sits on CPEC (Clinical Practice Evaluation Committee), a subcommittee of the Academic and Research Committee. CPEC ensures that the BGS is active in promoting active geriatric medicine through clinical effectiveness - via guidelines and national audits. This committee also reviews all abstracts that are sent in under the clinical effectiveness category for the national conferences.

As trainee representative on CPEC, one attends 4 meetings a year (in addition to the England Council meetings). The trainee will be encouraged to act as adjudicator for the clinical effectiveness abstracts.

Jessica Beavan
jessy@clara.co.uk

Finance

This involves 3 meetings a year where trainees can have a say in where some of our subscriptions go...and help keep the subscriptions low!

Andy Evans
bexandy@ukonline.co.uk

Education & Training

The Trainees' representative on the Education and Training Committee attends 4 meetings a year in London where the representative's opinion is sought as to national and regional SpR training issues. Opportunities exist for E & T associated "projects" (on a voluntary basis).

David Hargroves
davidhargroves@mail.com

England Council

The two England Council representatives attend meetings - four a year - in London (reasonable travel expenses paid!). I try, with the other trainee rep, Jessica, to offer a trainees' opinion. I have learnt a lot about what is going on in the world of geriatrics, and in the BGS itself. I also try to communicate with half of the trainees in England via email.

Emily Feilding
emilyf@talk21.com

Policy Cme Rep

The main brief is to represent the prevailing attitude of trainees on those subjects being considered by the committee.

The Policy Committee produces policy statements on issues relating to all facets of healthcare of older adults and replies to requests for information from other organisations. The content and upkeep of the compendium is also under the remit of this committee. The committee meets on average 5 to 6 times a year.

Sandy Thomson
sandythomson@doctors.org.uk

Why I went into research

by  Phyto Myint

The thought of doing research never occurred to me until I had passed my membership examination. Then what! I was encouraged by my educational supervisor to get involved in a small research project.

I did it, not because I was particularly enthused by notion of research, but because I knew that he was right (after all I need to put something a little extra on my CV to be competitive for SpR interviews). I managed to survive the painfully boring business of data collection over the next three months and the results of the study was

published a year later as an abstract (1/4 size of A4 page, with my name as third author). Only then, did I realise how much effort and dedication a researcher has to put into his/her work. To my surprise, I lost count of how many times I read my first (little) abstract. Whenever I read it, the sense of accomplishment I experience is indescribable.

This project was followed by a more enthusiastic approach towards thinking about and finding something to work on. I found the process mentally stimulating. My new found enthusiasm was well received and supported by my consultants at that time. During my early years as an SpR, I was landed with a project on primary brain tumours, awaiting analysis and writing up. By the time the paper was published 2 years later, I had made my mind up that I wished to contribute to medical literature throughout my career. At the



same time, I realised the importance of being able to supervise a project in addition to being at the coalface of the research process. This was brought home to me by the realisation that I would not have managed to get the paper published without my consultant's supervision. She herself had undergone a period of research training had

published papers in peer reviewed journals. I believe the ability to supervise on a research project is one of the essential requirements of "a consultant to be", although this conviction may not be shared by everyone.

Preparing myself

Realising that I wished to get proper research training, I explored means of improving my understanding of research methodologies and statistical methods. I read books on the subject, attended statistics courses locally, and research workshops organised by the BGS Academic and Research Committee (meet

the researcher, getting started with research workshop etc), and needless to say, I emailed and travelled throughout the country in an attempt to find a research project and a supervisor (with some unsuccessful interviews to show for my efforts!).

Opportunity strikes

I won the professional lottery when I was offered my current job to work with the research team of the European Prospective Investigation into Cancer - Norfolk (EPIC-Norfolk) population based study. Although the funding was initially for a year, I was fortunate enough to be supported for a further 6 months, allowing me to obtain an MD degree.

The personal and professional benefits

I am thoroughly enjoying my out of programme experience. I am getting used to, and even quite like, the lifestyle of cogitating over a first sentence to the introduction of my research paper while sitting in a café watching the world go by. I can now appreciate how academics have to work hard. I had the opportunity to get out of the box (hospital medicine), and enter into a completely different world of primordial and primary prevention in public health and the concept behind it. This has certainly made me a more balanced and thoughtful clinician. I am certain that the experience will help me better understand all aspects of health, not only at individual level but also from a global perspective. I now have the

For those who are determined to have some research experience

- ◆ Go for it, you will never regret it
- ◆ It is a combination of effort, luck and knowledge (who to approach, how and when)
- ◆ Have a clear idea which is more important to you between the training you will receive and being able to do your own (pet) project, before applying for a research job
- ◆ Don't be discouraged by the lack of idea – it will come to you when you are in the right learning environment with the support of a good supervisor

For those who are not sure

- ◆ Think twice - How would you deal with your trainee when s/he approaches you to supervise a project?
- ◆ It is never late- make a start today
- ◆ Try it first, before saying never – like me you may become "a total convert!"

For those who are definitely not interested

- ◆ Try to appreciate and support what academics are doing
- ◆ There are a lot of opportunities to get involved in clinical research in collaboration with clinical academics

confidence to supervise my junior colleagues in the future. I have gained a considerable amount of new knowledge and scientific thinking, both of which provide a good foundation on which I can build on throughout my future career. I am determined to carry on doing research projects as a clinician. I would think every researcher dreams of a day when s/he can make a real difference to the way we practice medicine. Whether I achieve so lofty an ideal or not, I share the dream of fellow researchers. At the same time, I am happy as long as I am able to contribute to the best of

my ability, to the scientific body of medical knowledge. After all, it is the collective body of wisdom and knowledge, contributed by many academics, clinicians and scientists, which has led the practice of medicine to where it is today.

Phyo K Myint
Clinical Research Associate,
University of Cambridge
Honorary Lecturer, School of Medicine, Health
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Trainees research guidance



We sent out a questionnaire with the January 2004 issue of the Newsletter, asking trainees regarding their research experience and perceived obstacles to doing research.

guidance website (www.bgs.org.uk/Trainees/research_guidance.htm)

◆ “Why I went into research” series by research active SpRs published in the BGS Newsletter and on the trainees research guidance website starting from March 2004 (the series can be accessed from www.bgs.org.uk/Trainees/research_guidance.htm) as part of the BGS Academic and Research strategy.

◆ A research forum among trainees (informal group of trainees who provide a peer support group). Please contact Miles Witham (m.witham@dundee.ac.uk) if you would like to join us.

◆ Information on UK Geriatric Academic Centres on the BGS website for prospective researchers published in August 2005 ([www.bgs.org.uk/ Research/centres_good_practice.htm](http://www.bgs.org.uk/Research/centres_good_practice.htm))

Please do have a look at these sections and web pages. We would value your feedback and we would be grateful if you can send your comments to editor@bgsnet.org.uk

The results of the survey were published in the September 2004 issue (www.bgsnet.org.uk/Sept04NL/14_trainee_research.htm).

Summary of the results

We had 122 respondents (25% response rate). Among those who responded, there are many trainees who are interested in doing research, but many do not know how to get from ‘I want to do some research’ to ‘I am doing a research project’. Specifically, respondents commonly stated that they do not know how to get funding or to develop research ideas.

A source of assistance

With the support of the BGS Academic and Research Committee, we have developed the following tools to help those interested in pursuing research move from concept to practice.

◆ “How to” series published in the BGS Newsletter and on the trainees research

Phyo K Myint,
Miles D Witham
Alasdair M J MacLulich

Marjory Warren House

from the CEO's desk

External Activities

“Active Ageing” coalition launches in Parliament – June

The Society is a founding member of the **National Coalition for Active Ageing**, alongside such other organisations as Help the Aged and the British Heart Foundation. June saw many months of preliminary work come to fruition with a formal launch in the Commons. Present were a good cross-section of MP's and key members from the Coalition. To coincide with the launch an Early Day Motion was tabled (subsequently supported by 63 MP's), stressing the need for greater government recognition and involvement in promoting an active lifestyle for the older person. Over the coming months we will be establishing a business plan and timetable of activities which will see this broad based group engaging with the Dept of Health (DoH) and Parliament with a view to putting the government's **Opportunity Age (Meeting the Challenges of Ageing in the 21st Century)** into positive action.

International Longevity Centre – the Future of Geriatric Medicine Training

Led by Dr Oliver Corrado (Education and Training Committee) and Dr Jackie Morris (Policy Committee), we have had an exploratory meeting with the ILC with a view to preparing a joint submission to Government and the General Medical Council for a new unit on the health of older people for Foundation Year training.

European Union Geriatric Medicine Society (EUGMS)

The Society has started its work providing a secretariat service for EUGMS. The first meeting under the new arrangement took place at Marjory Warren House recently, when the Executive Board of the EUGMS met. The Board consists of ten members drawn from countries right across the EU, whose broad remit is to enhance the practice and standing of geriatric

medicine in member countries and to act as an effective lobbyist in Brussels.

Falls Guidelines and the AGS

The Society has been invited to collaborate with the American Geriatrics Society in updating work on Falls. Dr Finbarr Martin and Professor Roseanne Kenny lead the work on behalf of the Society.

NHS Confederation – Vertical Integration Workshop – Older People's Services

On 14 September we shall be collaborating with the NHS Confederation when they hold another in their ongoing series of Vertical Integration Workshops, this one focussing on older people. Speakers will include Professor Graham Mulley, Dr Duncan Forsyth and Dr John Gladman.

Internal Activities

Succession Planning

2005 is proving to be a year of “goodbye, and thanks for all your help” along with “hello, and welcome on board”, with many members standing down from office and many Councils and Committees being faced with the task of seeking fresh volunteers to serve. The challenge of balancing democracy with continuity is something I shall be paying closer attention to over the coming months, as certain aspects of Society activity may well experience a lull as new members come on board and take up the reins from others. This is a natural result arising from the Society's re-structuring which took place mainly during 2002, with many members coming to the natural end of their three year term of office. Perhaps a system which sees more phased handovers, whilst retaining the inherent core of democracy is something worthy of serious consideration.....?

Strategic Review/Business Plan/External Affairs

With a review and plan under our belt, we have

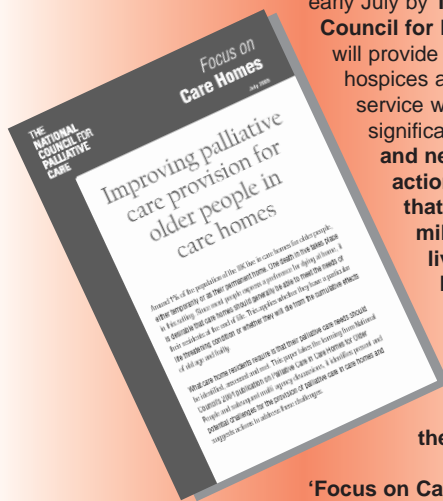
been paying specific attention to the topic of public relations, or “external affairs” as it is perhaps better titled for the Society. Quite a bit has already happened, not least with our profile raising responses to Parliament during the last session and activities highlighted above. Whilst this demonstrates our commitment to engage with others, we are studying ways which will help the Society expand its sphere of influence further. Not surprisingly, some methods come with a large “L” sign attached, and we will have to find the right balance between the messages we wish to impart, the internal resources available within the membership to create such messages and the right methods of delivering them. Initial discussions with outside sources indicate that we may still have a little work to do in establishing what areas of activity we can realistically involve ourselves with in “stand-alone” mode and which others are best achieved through collaboration with others.

Getting out of the Ivory Tower

Whilst our Spring and Autumn scientific conferences present me with the opportunity to meet many of you in the classic “conference” environment, I am conscious that there are many members I have not had the opportunity to meet. Your President Jerry Playfer has made it a feature of his first year of Presidency to visit a good number of regions and Councils, and I should be doing likewise. The regional meeting structure (certainly within England) would seem to be the ideal format, so if any regional chairs or secretaries would like the CEO to come along and explain exactly what it is that happens at Marjory Warren House as part of a forthcoming regional meeting, I would be very happy to do so. I am really very cheap to run and will travel considerable distances for a cup of tea and a biscuit.

Alex Mair

Focus on Care Homes



A new publication launched in early July by **The National Council for Palliative Care** will provide care homes, hospices and the health service with the significant **guidelines and necessary actions to ensure that the half a million people living in care homes across the UK receive the essential palliative care services they require.**

‘Focus on Care Homes’ examines the learning from the 2004 NCPC discussion document ‘Palliative Care in Care Homes for Older People’ and the subsequent conference and multi-agency discussions which followed. It identifies present and potential challenges for the provision of palliative care in care homes and suggests actions to address these challenges. **To order this publication at £7 per copy, email: publications@ncpc.org.uk or call NCPC HQ on 020 7697 1520.**

Charging for the privilege of being ill

Long term care for older people is an area of recurrent and unresolved difficulty. Recent debate has been characterised by **disputes over who should pay for care** and whether some people have been unfairly (and illegally) charged for care which should have been provided free of charge by the NHS. These are important questions. There are also equally vital issues about the nature and quality of long term care - and that debate has scarcely begun.

The Royal College of Nursing (RCN) commissioned independent consultants Melanie Henwood and Eileen Waddington to undertake a short term research project to explore the perceptions and experiences of RCN members about continuing health care for older people. The report of that research provides insight to the informed and expert views of nurses on these issues, and should better enable the Royal College of Nursing (RCN) to contribute to the emerging national debate.

The report (pdf version) may be found on the BGS website www.bgs.org.uk (Select Publications/Reference Material)

Future Housing

and care for older people - BGS response

In recent years, the profile of a range of housing and care issues has arisen. This is also the case with older people's housing and care, where links between good housing and health, independence, dignity and well-being cannot be emphasised enough.

To examine the future of older people's housing and care, a number of national older people's housing stakeholders joined forces to launch the 20/20 Project. These included the Association of Social Alarms Providers, Centre for Sheltered Housing Studies, Emerging Role of Sheltered Housing (ERoSH) - the national consortium for sheltered and retirement housing, National Housing Federation, Association of Retirement Housing Managers, Chartered Institute of Housing, Counsel and Care, Elderly Accommodation Counsel and Federation of Black Housing Organisations.

The 20/20 Project aims to work through a vision for older people's housing and care by the year 2020, when the number of older people will start to peak as a proportion of the general population. It will do this through a number of activities throughout 2005, including conferences and seminars, research and receiving the views of a

range of individuals and organisations involved in this area.

Responding to the consultation process, the BGS has issued the following statement.

The BGS believes that in broad terms housing should be suitable for people with a variety of needs in anticipation of changed circumstances. This should minimise the need for rehousing or relocation if functional abilities change. This will include as standard:

- ◆ walk in showers
- ◆ adjustable height work surfaces and equipment
- ◆ accessible local facilities including shops, pharmacy, health and social care facilities
- ◆ cable television and internet access
- ◆ economical heating and cooling systems with energy conservation schemes
- ◆ secure entry systems
- ◆ easy to use waste disposal facilities

The BGS supports the development of extra-care housing schemes as an alternative to traditional residential care or sheltered housing, to allow support to be increased (or reduced) as needs change, without relocation. It is important to ensure support staff receive appropriate training in health related issues including dementia, Parkinson's disease, stroke, continence promotion, arthritis and in ethical issues of respect and autonomy.

TRAINING TO RESPECT THEIR ELDERS

Nurses need training to treat older people with more respect

On 2 August, the **Times** feature article argued for the needs of older people being met by tailored nursing care and suggested that newly qualified nurses need to be trained to provide the best possible care for the two thirds of patients who are aged over 65.

The article also highlights posters and videos produced by King's College Hospital in south London to illustrate the absurdity of patronising the elderly.

BETTER CARE FOR PATIENTS

From 2006, a new bowel cancer screening programme will also be phased in for men and women aged 60-69 years old.

By 2007, there will be 3000 community matrons.

Two snippets from the DoH press release of 24 August

www.dh.gov.uk/NewsHome/NewsArticle/fs/en?CONTENT_ID=4117962&chk=jVfrNC

NATIONAL SYMPOSIUM ON CARE HOME DIABETES

organised by the University of Salford, University of Warwick and the BGS Diabetes in Later Life Group

**22 September 2005 in
Manchester**

Chairs: Professor Alan Sinclair and Dr Paul Baker

This meeting is designed for General Practitioners, Hospital Specialists in Diabetes or Geriatric Medicine, Residential Care Home Staff, Nursing Staff and Care Home Managers.

Contact: Mrs Julia Hyde, Section of Geriatrics and Gerontology, University of Warwick Medical School, Clinical Sciences Research Institute, Clinical Sciences Building, Walsgrave Hospital, Clifford Bridge Road, COVENTRY CV2 2DX
Email: Julia.hyde@warwick.ac.uk

BGS SCIENTIFIC MEETINGS

**Autumn 2005
5 - 7 October in Harrogate,
Yorkshire**

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

Email: bgs@hamptonmedical.com, Register at: www.bgs.org.uk

Registration free for **presenters** from developing countries.

If you are from a developing country (as defined by the UN), and are presenting either a poster or platform paper, please apply to Mrs Joanna Gough (abstracts@bgs.org.uk) to be allowed to register for the Autumn Meeting free of charge. See www.bgs.org.uk/Notices/bgsconf_autumn.htm for more detail.

Scientific Meeting Abstracts

The deadline for receipt of abstracts for the Spring meeting in April 2006 is 1 December. The online submissions facility goes live on 1 November. See www.bgs.org.uk/Research/abstract_submission.htm

PSYCHIATRY MEDICAL UPDATE

Psychiatrists working with Older People

Thursday 6th October 2005

Chilworth Manor, Southampton

Learning Objectives: by the end of the meeting participants will be familiar with the recent advances in our understanding of common medical conditions affecting the elderly, new treatment guidelines for common medical conditions affecting the elderly and the pitfalls in the management of common medical conditions affecting the elderly.

Register by contacting the Centre for Professional Development in Mental Health (CPDMH) 023 80 825704 or visit www.cpdmh.swhants.nhs.uk

ADVANCED MEDICINE FOR CONSULTANT PHYSICIANS

Discover the latest advances in the management of acute emergencies.

London and South East

10 – 13 October 2005
Radisson Edwardian Marlborough Hotel, Central London

Ireland

24 – 27 October 2005
Ramada Belfast Hotel, Shaw's Bridge, Belfast

North West

21 – 24 November 2005
Manchester Airport Moat House Hotel, Wilmslow, Cheshire

24 RCP CPD credits applied for

See www.bgs.org.uk for registration information

MENTAL HEALTH

**'A Patient's Journey'
14 October 2005
Jury's Inn, Birmingham**

£175 medical staff, £100 non-medical staff.

The patient's pathway and the interface between the older people's services and the psychiatric services provided.

Contact: Andrew Sims Centre at Leeds Mental Health Teaching NHS Trust Email: Louise.Gardham@leedsmh.nhs.uk

www.leedsmentalhealth.nhs.uk/andrew-sims/

FOR MORE EVENTS

We regret that owing to a lack of space we are unable to publish all events which we have been asked to publicise. Please visit the Notices section of www.bgs.org.uk for details of more events, for downloadable programmes and registration material

EUGMS SYMPOSIUM GERIATRIC CARDIOLOGY

21 - 22 Oct 2005

Madrid, Spain

Email: gc2005@biotour.es
www.eugms.org
www.biotour.es/gc2005

MOVEMENT DISORDERS

Second meeting of RLS: UK with the EKBOM Support Group and the Sleep Section of the Royal Society of Medicine

**RSM, London
14 October 2005**

Covering all aspects of the commonest movement disorder known. Includes genetics, epidemiology, ethnic variations, treatment update and patient perspectives. The guest lecture will be delivered by Dr Richard Allen, Johns Hopkins University, USA. Other speakers include K Ray Chaudhuri (Chairman RLS:UK), D MacMahon, D J Burn, A Williams, M King and E Gill (President RLS:UK and Coordinator Ekbom Support Group).

CME accreditation 8 hours

Entry and registration is free and lunch and coffee will be provided.

Email RLS:UK coordinator: susanne.tluk@uhl.nhs.uk or call 0208 333 3030 ext 8060 and leave a message. The programme has been made possible by an unrestricted educational grant from GSK pharmaceuticals.

LAW

**The expert witness system:
Yesterday, Today, Tomorrow**

London SW1P 3NZ

14 October 2005

Contact: The Expert Witness Institute, Africa House, 64 - 78 Kingsway, London WC2B 6BD
Email: info@ewi.org.uk

Download programme from the BGS Website (Notices/Non-BGS Meetings)

THE NSF FOR OLDER PEOPLE

The National Service Framework for Older People three years on - how will we know if it is working?'

18 October 2005, 5.30 p.m.

The meeting will report on the process of evaluation of the National Service Framework for Older People, and the implications of the evaluation for geriatric medicine, general practice, nursing care in the community and social care.

For further information or to book on-line you can visit the Section of Geriatrics & Gerontology website www.rsm.ac.uk/geriatrics

CENTRES OF GOOD PRACTICE

Research centres are invited to have a look at the centres of good practice pages on the BGS website and to re-classify the areas of interest assigned to their centre. Please visit www.bgs.org.uk/Research/centres_good_practice.htm and contact editor@bgsnet.org.uk with your comments/ corrections/ additions.

NEW ZEALAND VACANCY

Health Professionals International

Clinical Director ATR & Older Persons Service

Health Professionals International is a retained search company specialising in the placement of medical professionals across all specialties throughout New Zealand, Australia and the United Kingdom.

We are currently on assignment with one of the largest District Health Boards in New Zealand, searching for the following professionals to join their Rehabilitation / Older Persons Service department:

- Clinical Director / ATR & Older Persons Service
- Geriatricians
- Clinical Nurse Specialist Rehab
- Registered Nurses Rehab & Geriatric Medicine

Assistance will be given with relocation, registration & immigration procedures.

For further information, please contact

Darryl Cooksley
Phone: +1 917 577 4877
Email: darryl@nyheadhunter.com

Or visit our website at www.healthprofessionalsinternational.com

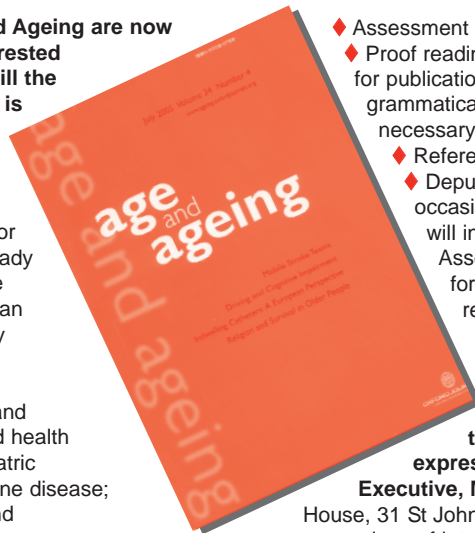
AGE & AGEING ASSISTANT EDITOR SOUGHT

The Editorial Board of Age and Ageing are now inviting applications from interested members of the Society to fulfill the role of Assistant Editor, which is a voluntary position.

It would be helpful, but not essential, if the Assistant Editor were also to take responsibility for a particular subject area not already covered by the current Associate Editors, unless they are already an Associate Editor. Areas presently covered include:

Respiratory diseases; diabetes and endocrinology; epidemiology and health services research; sleep; psychiatric problems; falls and metabolic bone disease; stroke and related conditions; and cardiovascular disease.

The key elements of the role are:



- ◆ Assessment of revised papers
- ◆ Proof reading a proportion of the papers approved for publication in Age and Ageing, to include the grammatical correction of material where necessary
- ◆ Refereeing of submissions
- ◆ Deputising for the Editor as and when the occasion arises, e.g. leave cover. Deputising will include appointing some manuscripts to Associate Editors and taking responsibility for other manuscripts if there isn't a relevant Associate Editor

Interested applicants should, in the first instance, submit their expression of interest via the Chief

Executive, Mr Alex Mair, at Marjory Warren

House, 31 St John's Square, London, EC1M 4DN. All expressions of interest will be passed on to the Chair of the Editorial Board and the Editor, and will be treated in the strictest confidence.

INAUGURAL BGS PARKINSON'S DISEASE SECTION AWARD

Applications are invited for two awards inaugurated by the British Geriatrics Society Parkinson's Disease Section

Two awards available:

One for medical students and one for nurses and allied health professional students.

Word count :

1500 (four sides of A4)

References : No more than 10

Subject area :

Multidisciplinary working in Parkinson's disease

Prize : £500 and the opportunity to present at a national Parkinson's disease meeting

How to apply : Submissions should be submitted to the following British Geriatrics Society at grants@bgs.org.uk

Closing Date : 1 April 2006

The winning entrants will have the opportunity (optional) to present at a national Parkinson's Disease Society meeting. The essays will also be considered for publication in the BGS newsletter and on the BGS website

ENGLISH COMMUNITY CARE ASSOCIATION (ECCA)

"Making ends meet"

23 November 2005

Birmingham

Care sector conference & exhibition

Download programme from the BGS website:
www.bgs.org.uk (select Notices/non-bgs meetings)

VASCULAR DEMENTIA

Fourth International Congress on Vascular Dementia

Porto, Portugal

20 - 23 October 2005

Contact: Fourth International Congress on Vascular Dementia
Kenes International, 17, rue du Cendrier, PO Box 1726
CH-1211 Geneva 1, Switzerland
Tel: +41 22 908 0488, Fax: +41 22 732 2850
E-mail: vascular@kenes.com
Website: www.kenes.com/vascular

NEUROLOGY

**The National Hospital for Neurology and Neurosurgery, Queen Square ,
London**

**Dizziness
A Multi-Disciplinary Approach
Diagnosis, Therapy and Management**

11 - 14 October 2005

*Download programme and registration from
www.bgs.org.uk/Notices/non_bgs_meetings.htm*

Following the success of the previous Dizziness Courses, the Department of Neurootology has expanded its course to four full days, which will include:

- Mechanisms of dizziness
- Evidence based vestibular testing
- Opportunity for "hands-on" experience with the department's equipment
- Developments in genetics and radiology
- The range of medical diagnoses
- Diagnostic strategy
- BPPV and Particle Repositioning Manoeuvres
- Role of physiotherapy
- Psychological aspects including the role of cognitive behavioural therapy
- The future of pharmacological therapy
- Failed management and role of surgery
- Theoretical basis of vestibular compensation

The course will include three full days on the diagnosis and management of balance disorders with case histories, videos and quizzes and an optional fourth practical day. There will be a dinner on the Wednesday evening.

The course will be suitable for clinicians, scientists, audiologists and therapists involved in the care of the dizzy patient and will be run by Professor Linda Luxon, Dr Rosalyn Davies, Mr Albert Coelho and Mrs Karen Cox.

CME accreditation will apply and CPD points will be awarded.

For details contact: Dr Rosalyn Davies / Mr Albert Coelho / Mrs Karen Cox,
Department of Neurootology, The National Hospital for Neurology and
Neurosurgery, Queen Square, London WC1N 3BG
Tel: 020 7837 3611 ext. 3386 or 3274

MEDICAL EDUCATION

**Training in Geriatric Medicine:
Present and Future**

30 November 2005

RCP, Glasgow

Organised by Specialty Advisory
Committee in Geriatric Medicine
and
BGS Education and Training Cme
Joint meeting

Download programme from the
BGS website: www.bgs.org.uk
(select Notices/non-bgs meetings)

ISTANBUL, TURKEY

**Geriatrics 2006
International Congress of
Elderly Health
2 - 6 April 2006**

*Abstract submission deadline: 6
January 2006
Early registration: 5 January 2006*

Download programme from
[www.bgs.org.uk/Notices/non_bgs_](http://www.bgs.org.uk/Notices/non_bgs_meetings.htm)
[meetings.htm](http://www.bgs.org.uk/Notices/non_bgs_meetings.htm)

Social programme may include
visits to ancient Ephesus,
Pergamum, Cappadocia,
Pammukkale and Kusadasi, as
well as visits to Gallipoli and the
War Memorials

<http://www.geriatrics2006.org>

MOVEMENT DISORDERS

**15 - 17 March 2006
Birmingham**

Aimed at specialist registrars and consultants in neurology and geriatrics. The first half deals with hypokinetic movement disorders, in particular Parkinson's disease. The second half concerns hyperkinetic movement disorders.

Application form can be downloaded from
www.bgs.org.uk

OSTEOPOROSIS

**National Osteoporosis Society 11th Conference on
Osteoporosis**

25 - 28 June 2006

Harrogate, North Yorkshire, United Kingdom

Contact: National Osteoporosis Society, UK:
Email: s.phillips@nos.org.uk
Telephone: +44 (0)1761 473106
or refer to the conference website at
www.nos.org.uk/conference

Prof Sinclair on the move again but with new direction



Congratulations to Prof Sinclair who has been appointed to the key position of Associate Dean at the new Bedfordshire and Hertfordshire Postgraduate Medical School.

The School is a joint venture between the Strategic Health Authority and the Universities of Luton, Hertfordshire, and Cranfield. This is a welcome extension of his postgraduate medical education career – Alan chaired the West Midlands regional training committee during the transition to Calman, and was also SAC Chair at the Royal College of Physicians. He has also been influential in driving forward European initiatives in education through his role as Academic Director of the European Union Geriatric Medicine Society (EUGMS). Alan was formerly the second Charles Hayward Professor of Geriatric Medicine in Birmingham (1995-2001) having succeeded the late and eminent Bernard Isaacs.

Alan will have a strategic NHS role in Luton where

his extensive medical and geriatric experience will help to support the modernisation of services to improve the health of older people. He will be working closely with his colleagues in both the Acute sector at the large Luton and Dunstable hospital and in the Primary Care Trust.

His research interests in Diabetes, nutrition and cognitive disorders will continue in his new post. Alan's academic career has recently been boosted by his Visiting Professorship at Oxford Brookes University, and more importantly by the conferment of his Professor of Medicine title at the University of Luton when his new post starts.

Prof Sinclair commented: "My time in Coventry and Warwick has been very rewarding and challenging, but the balance between academic time and NHS work was not right. This situation is not unique to many clinical academics. This new position will allow me more time to spend in postgraduate medical education and research, and at the same time, give me an opportunity to influence change in the NHS locally. I also intend to offer my direct support to the BGS locally and nationally, having spent the last 6 years working very much at the European level".

COUGHLAN AND CARE FUNDING UPDATE

From www.nhscare.info

Simple advice for solicitors ...

"The judgment in Coughlan clearly establishes that where a person's primary need is for health care, and that is why they are placed in nursing home accommodation, the NHS is responsible for the full cost of the package." - summary of the Law Society's Evidence to the House of Commons Health Committee Inquiry into NHS Continuing Care available on the NHS Care website.

Simple advice for NHS and Social Services staff ...

Make sure you are not breaking the law. Ignorance of the law, and the fact that many others share this ignorance, is no defence in a Law Court. NHS Doctors and Consultants may wish to read extracts from Derek's recent letter to the BMA

[on the website]. NHS Care welcomes contact - including from "whistle blowers"

Simple advice for families ...

- ◆ consult the website including the overview of the judgement to confirm that you have a case: discuss with close friends and relatives.
- ◆ do what you feel is right for the patient. This may include going along with unlawful advice from Social Services. make sure you have written at least one letter, mentioning Coughlan.
- ◆ keep a paper file of all information such as printouts from www.nhscare.info, all letters and medical history.
- ◆ find a close friend or relative able to write and respond to letters over what may be many years.
- ◆ consider refusal to pay for care. If you do so, first consult the website for more information.
- ◆ otherwise, write a complaint letter to the Primary Care Trust (PCT)
- ◆ complain to the Ombudsman?

Euro Geriatrics



Update

As President of the Geriatric Medicine Section of the European Union Medical Specialties (GMS-UEMS) I am pleased to update members on Geriatrics matters within Europe.

Although many individuals and groups lobby the European Union the UEMS is the only official body inputting to the European Union on medical matters. Each specialty has a section with two members from each country. I am the BGS nominee and Ronnie Barber from Bristol is the JCHMT nominee.

French Membership

Many of us in the UK have cooperated over the years with our French colleagues. Unfortunately in France, unlike the UK, there is still some disagreement on recognition of the specialty with their official national bodies. This culminated this year in France almost being thrown out of UEMS but I am pleased to say that a compromise was achieved at the eleventh hour. On the Geriatric Medicine section we still have to achieve representation from French geriatricians rather than from General Practitioners who deal with older people as part of their work. (This is perhaps a warning of the need for close relationships between BGS members and GPs with a special interest in elderly care.)

Draft Directive and the Recognition of Professional Qualification

The EU is trying to consolidate its existing directives, but as a consequence this could have

meant that very few medical specialties were recognised across Europe. This has led to a great deal of heated debate across Europe especially involving the BMA. Although it has not finally been agreed, it now seems that if any specialty is recognised in two fifths of the member states, that specialty's professional qualification will be recognised across Europe. I am pleased to say that Geriatric Medicine is in this group and therefore qualifications in Geriatric Medicine are transferable within the EU. This makes it even more important that one of the aims of the Geriatric Medicine Section is to encourage training to comparable levels across all member states. With this in mind a pan-European

curriculum and an accreditation system has been established (not dissimilar from that already existing in the UK).

Emergency Medicine

A joint multidisciplinary speciality committee has been established to try to develop emergency medicine as a new speciality. BGS members will, I am sure, be pleased that the Geriatric Medicine Section is taking an active part in these

discussions.

Geriatric Medicine in member states

At each of our meetings one or two member states give a presentation on Geriatric Medicine within their country. These will be available on the Geriatric Medicine section website at www.uemsgeriatricmedicine.org and there will be a link from the BGS website.

European Union Geriatric Medicine Society

We are forging very close links between the EUGMS and the Geriatric Medicine section of

The first set of EU Wide Health Data from the European Community Health Indicators Project is soon to be published. The aim is to provide better and more comparable data to track development in health status of the EU population.

the UEMS as although we are different organisations with different responsibilities our general aims are closely aligned. As reported in a previous newsletter, we were very pleased that the BGS took over the secretariat of the EUGMS.

New Health Data

The first set of EU Wide Health Data from the European Community Health Indicators Project is soon to be published. The aim is provide

better and more comparable data to track development in health status of the EU population. There will also be comparable data for North America and Japan. The website is being developed over the next couple of months and the information can be found on http://europa.eu.int/comm/health/ph_information/dissemination/echi/echi_en.htm

Ian R Hastie
Consultant and Senior Lecturer

Rehabilitation in the NHS

and Social Care - BGS response to scoping study



The BGS has responded to the DoH Scoping Study on rehabilitation in the NHS and Social Care.

The BGS welcomes the opportunity to comment on the scoping study relating to rehabilitation in the NHS and social care.

Definition of Rehabilitation

Our preferred definition of rehabilitation is that it is: "An active process by which those disabled by injury/disease achieve a full recovery, or if full recovery is not possible, realise their optimal physical, mental and social potential and are integrated into their most appropriate environment", attributed to the World Health Organisation, because the definition describes the process in a pragmatic manner. It is concise, easy to follow and motivating.

Direction of travel for rehabilitation

Our view is that rehabilitation services have probably declined in capacity, but more importantly have changed in character. That is, they are taking place in a greater variety of settings, for example community based rehabilitation suffered from a drive towards acute care in hospital settings, from declining medical

involvement due to pressure on geriatricians to take part in general medical emergency work., the shift of rehabilitation into Intermediate Care settings and reduction in specialist inpatient rehabilitation beds. We believe this to be disadvantageous due to the relationship between disease and disability, and the need to optimise medical treatment to support rehabilitation.

Funding Mechanisms

Our view is that rehabilitation services probably suffer from a shortage of funding, but there is a question as to whether current resources are spent wisely to achieve maximum effect. We believe that there has been a shift of resources from rehabilitation to acute care.

Prioritising Rehabilitation

Our view will be that the priority given to rehabilitation in hospital will decline over the next 5 years, with greater emphasis on community based rehabilitation which is inadequately evaluated and lacks the evidence based multidisciplinary approach of comprehensive geriatric assessment. Pressure on budgets and to achieve 4 hour waiting targets in Accident and Emergency are likely to reduce resources available.

Current Difficulties

We believe that current barriers to effective rehabilitation include:

- ◆ the lack of comprehensive geriatric assessment processes in the community
- ◆ lack of training for colleagues in primary care in health needs of older people
- ◆ pressure to discharge from the acute sector
- ◆ lack of will on the part of primary care organisations to develop rehabilitation services in hospital
- ◆ divided responsibilities between primary care, secondary care and community based services
- ◆ divided managerial leadership for therapists in multidisciplinary teams

Good Practice Schemes

We would highlight:

- ◆ Orthogeriatric services in Peterborough and Norfolk and Norwich hospitals
- ◆ Community stroke services in Bradford (Prof. J Young)
- ◆ Community services in Gloucester (Dr I Donald)
- ◆ Community services in Leeds and Nottingham (Professor G Mulley and Dr J Gladman)

Good Practice Schemes

Our view would be that rehabilitation should be given higher priority nationally and locally within acute trusts: In particular, we would urge that

- ◆ a comprehensive assessment approach should be adopted for older frail people (this the BGS defines as a multidimensional interdisciplinary

diagnostic process focused on determining a frail older person's medical, psychological and functional capability in order to develop a co-ordinated and integrated plan for treatment and long term follow up. Comprehensive assessment has demonstrated an improvement in physical function at 6 months. Reduction in hospital readmissions and placement in care homes as well as improvement in quality of life and in cognition is shown at 12 months. *Ellis. G and Langborne P Comprehensive geriatric assessment for older hospital patients. British Medical Bulletin 2005 71(1):45-59*

- ◆ rehabilitation is a process which should start at admission and continue beyond discharge
- ◆ rehabilitation is necessary to restore daily living skills and mobility in older people recovering from acute illness
- ◆ rehabilitation is essential to aid recovery from planned or emergency surgery
- ◆ rehabilitation is an important component of Chronic Disease Management
- ◆ rehabilitation must include a medical contribution to ensure treatable illness is not missed
- ◆ rehabilitation needs to be multidisciplinary and evidence based

Dr D M Beaumont

Dr J Morris

BGS Policy Committee

Assisted dying for the terminally ill

National Council for Palliative Care responds

The National Council for Palliative Care has published its response to the House of Lords Select Committee report on the Assisted Dying for the Terminally Ill Bill.

The National Council for Palliative Care (formerly The National Council for Hospice and Specialist Palliative Care Services) is the umbrella organisation for all those who are involved in providing, commissioning and using hospice and palliative care services in England, Wales and Northern Ireland. It promotes the extension and improvement of palliative care services regardless of diagnosis in all health and social care settings

and across all sectors to government, national and local policy makers.

The National Council has produced this response in advance of the forthcoming House of Lords debate on the Select Committee's report, due to be held on 10 October. It is hoped that the response will assist and inform this debate. At the same time, the response is intended to contribute to the broader and continuing debate within society on the issues of voluntary euthanasia and assisted dying.

The National Council for Palliative Care (NCPC) welcomes the balanced nature of the Select Committee's report, and particularly the way in which it identified the significant issues and gaps in the evidence that need to be addressed before a decision whether or not to legalise assisted suicide or voluntary euthanasia can safely be made by Parliament.

According to the NCPC these issues include:

- ◆ The ethical and practical implementation questions created by the proposed legislation.
- ◆ The difficulty in drafting satisfactory legal definitions of when a patient is "terminally ill" or experiencing suffering, that also match clinical realities.
- ◆ The extent to which palliative care can address the wider aspects of suffering, through

psychological, spiritual and social care, as well as providing physical and symptom relief.

- ◆ The impact on the relationships between patients and their professional carers in the context of current British medical practice and within our current healthcare systems.

The National Council believes that unless and until these issues can be resolved, it would not be right to change the law. The NCPC welcomes the emphasis placed by the Select Committee on the need to develop palliative care for all those who need it. This follows similar recommendations made by the House of Commons Health Committee in its report on palliative care in 2004.

The National Council's Chairman, Francis Plowden, said:

"It should be emphasised that palliative care is vitally important in its own right, and should not be portrayed simply as an alternative to assisted suicide or voluntary euthanasia."

A copy of the Executive Summary may be found in PDF format, on the BGS newsletter site: www.bgsnet.org.uk. The full publication is available at £20 per copy and may be ordered from the NCPC website: www.ncpc.org.uk

Vicky Kington
Communications Co-ordinator
NCPC

Department of Health Liaison Group meets with BGS England representatives

At a meeting with the DoH Liaison Group, attended by Prof Ian Philp and Mr John Holden the England Council discussed a range of topical issues. We present a summary of these here.

Health outside hospitals

The Secretary of State has announced a new consultation process, due to commence in September 2005, leading to an expected White Paper on "**Health outside Hospitals**" due to be published in early 2006.

“Coding” is the key whereby PBR is delivered, but it is a difficult system to apply to patients with multiple conditions

The Department of Health (DoH) strongly recommends that the BGS meet with Mr Liam Byrne MP, before the consultation process on the "Health outside Hospitals" White Paper commences, to demonstrate how geriatric medicine can provide a positive contribution.

Assessment and reducing bed days

The DoH proposes to promote Integrated Care Networks, which will incorporate Chronic Disease Management, the immediate aim being to reduce the number of emergency bed days - a key DoH policy.

The BGS and DoH agree that speedier social care assessment, in parallel with clinical assessment, would go some way to reducing the number of emergency bed days. It was noted that an Australian model had produced successful results. However, simply reducing bed days can be dangerous, if insufficient diagnosis is being carried out. It was agreed that comprehensive geriatric assessment is a key part of success. CGA can be carried out by multi-disciplinary teams, away from acute settings.

Closure of rehabilitation beds

The BGS expressed concern at the rate of closure of rehabilitation beds, and the "warehousing" of patients

Diverting geriatricians to acute intake

On the topic of geriatricians being diverted into greater levels of acute work, the DoH suggested that focussing on the following issues would be useful:

- Reducing bed days - CGA can play a lead role in this
- Improving the patient experience, by reducing the number of people the patient encounters

- Proactive alignment with SAP terminology would be useful; adds weight to the workforce case, leading to greater PCT investment in geriatrician posts

There was general agreement that better quality assessment, particularly with patients displaying signs of dementia, would reduce hospital admissions. Involvement of care homes, GP's, community matrons and others would be required.

The DoH agenda

The DoH outlined the following topics which are at the top of the current political agenda for health:

- Health promotion
- Social care reforms
- Development of Integrated Care Networks - to include long-term conditions strategy
- IT and the Single Assessment Process
- Fully funded falls services
- Stroke - in the context of a medical emergency
- A new vision for mental health
- Reform of emergency procedures for older people suffering with stroke or from falls
- Dignity of the older person in hospital
- Dignity of the older person at the end of life stage

Payment by Results (PBR)

The BGS delegation expressed concern that PBR was leading to closure of beds in many cases. The DoH stressed that PBR was quality driven, not results driven. Payment flow should follow the patient, not lead the patient.

It was noted that PBR is still being rolled out - dependant on service being provided.

“Coding” - the mechanism whereby presenting conditions are coded (in the same way that police assign codes to criminal offences and perpetrators) - remains an issue. It is the key whereby PBR is delivered but it is a difficult system to apply to patients with multiple conditions. "Upcoding" is inevitable in any system, although plenty of checks and balances

are being built in.

The question of coding pure rehabilitation services was discussed. The DoH uses length of average stay, together with number of different identifiable interventions as the basis for coding. It is recognised that specialty situations need to

be better recognised and coded, so that PBR can be seen to be transparent and effective. It was agreed that a presentation on PBR might be useful and this will possibly be done at the next meeting of England Council.

Alex Mair
Chief Executive

Department of Health Consultation - Code of Conduct for Payment by Results

The stated intention behind the Department of Health's **Payment by Results (PbR) Scheme** was to support the provision of high quality, cost effective healthcare, which is shaped around the needs of patients. The effective implementation of PbR will depend on **constructive relationships between all parties**. This **Code of Conduct** describes principles for best practice. The principles are supported by some more detailed rules.

Comments on any aspect of the Code of Conduct will be welcomed, but the DoH has provided some questions on which it is particularly keen to hear views. It has set out a proposed list of consultees.

The Code of Conduct was developed by a working group with representatives from the Department of Health, Monitor, the Healthcare Commission, the Audit Commission, Strategic Health Authorities, Primary Care Trusts, NHS Foundation Trusts, NHS Trusts, Primary Care Practices and the Independent Sector.

It is proposed to issue the Code of Conduct in late 2005, subject to Ministers' views on the outcome of the consultation. The DoH will make available a summary of responses that it receives, and any changes made as a result. It expects to publish these on the Department of Health website in December 2005.

The BGS will be responding to the consultation - the deadline for responses being 4 November. The consultation code of conduct can be downloaded from the DoH website:
www.dh.gov.uk/Consultations/LiveConsultations/LiveConsultationsArticle/fs/en?CONTENT_ID=4117108&chk=ztUUqR

Wales National Service Framework for Older People

A draft National Service Framework (NSF) for Older People in Wales has been developed with the advice and contribution of many key stakeholders, including older people.

This draft NSF was launched by the Deputy Minister with specific responsibility for older people - John Griffiths AM - for formal consultation on 6 July 2005, and comments are welcomed from all interested parties. The consultation period will close on 14 October 2005, and it is intended to issue the final NSF and implementation framework early in 2006.

On the Wales NHS web site www.wales.nhs.uk/sites/home.cfm?orgid=439 one can now access **pdf versions of the draft NSF**, the Executive Summary and the accompanying Medicines and Older People booklet. (Click on 'Consultation Documents' on the left hand menu). Welsh language versions will also be posted.

DoH website

Expert witnesses in geriatrics and psycho geriatrics required

The BGS periodically receives requests for names of geriatricians and psychogeriatricians who are willing to serve as expert witnesses.

We would be grateful if members who perform medico-legal work of this nature would register this fact with the BGS office.

Joanna Gough
BGS Membership Secretary

Letter from Glasgow

Paul Knight, Secretary of RCPSG

When the editor asked me, at the Spring meeting, if I could write an article for the Newsletter about my activities as Honorary Secretary for the Royal College of Physicians and Surgeons of Glasgow (RCPSG), I wasn't actually sure that I knew what these were.

I was only a few months into the post and had not had the benefit of the 3 year run in period as deputy secretary that normally happens. So before giving you some insights, in an Alistair Cooke style, perhaps some background would be in order.

Founded in 1599, RCPSG is unique amongst the medical royal colleges in that it encompasses amongst its membership, physicians, surgeons and dentists. Currently we have around 8000 members, 40% of whom live in areas of the UK other than Scotland and one third are abroad. Some of its more famous Fellows from the past include Lord Lister, David Livingstone and, of course, Sir Ferguson Anderson who was a past president. Last year we managed some 4000 candidates through various examinations and had 2,300 people attend our educational events. The current President of the College is Graham Teasdale, the originator of the Glasgow Coma Scale. The College is located on St. Vincent Street, perched atop of one of Glasgow's drumlins. The building dates from the 1820's, and was originally a private house. The location is perhaps appropriate as the street is named after the naval battle off Cape St Vincent. This was one of Nelson's early successes and earlier this year the College loaned the surgical instruments of Sir William Beatty, the surgeon and College fellow who attended Horatio Nelson after the battle of Trafalgar, to the bicentennial Trafalgar exhibition at Greenwich.

The job of an Honorary Secretary

So what does the Secretary do? Well, essentially they provide clinical input into the management of the College's affairs, from meeting minutes to staff salaries. For me this has meant a very steep learning curve. For instance, what is basic surgical training? Why do we not examine more often in the MRCS in India? Why is the Senate of Surgery such a disorganised group? And why does it include Ireland? Not to mention a myriad other dental and surgical topics. Equally dizzying, has been a crash course in the management of the MRCP (UK), the possible future format and role of knowledge testing in various medical specialities and the combined interests of the Federation of the Royal Colleges of Physicians in the UK. Conversations with Dame Carol Black are never dull!

These are just routine business meetings where topics such as MMC, revalidation and PMETB are discussed with varying degrees of specialty spin. All of the physician and surgical colleges are trying to work out where their place is in this brave new world, whilst improving services to an increasingly sceptical membership who wish to see far better value for money. To that end, I found myself pitched into an ongoing strategic review within College on my first day. Over the last seven months my main task has been to help create business units within College and subsequently reorganise its staff. As I write this we have appointed a new Chief Executive and are two thirds the way through appointing heads of our business units. Hopefully, this will give us a more robust outlook over the next few years.

As I have alluded to, RCPSG is not just a Scottish College and part of my role is to manage the replies to the 50 or so formal consultation exercises that we get involved in each year. These can come from quite disparate groups including the Scottish Parliament, the House of Lords, the Department of Health in England and the Medicines Commission. I had a



Dr Paul Knight

good grounding for this work when I chaired the BGS Policy Committee.

Although the Medical Royal Colleges are primarily about setting and maintaining standards they also have a role in supporting the profession. In the near future I can see that both the Federation and

Senate will need to think far more constructively about their relationships with the specialty organisations. We should be working together in an equal partnership, not pushing apart.

So, there is never a dull moment. Just a small number of the challenges I can see on the horizon include, the management of post-graduate medical education, entry criteria for specialist medical training, the role of College diplomas, the divergence of the organisation of health care north and south of Hadrian's wall and the emergence of workplace assessments. I am sure that will keep me going for a few months!

Paul Knight
Hon Secretary
RCPSG

Dr Opinder Sahota

honoured for his work with older people

Dr Opinder Sahota from Queen's Medical Centre (QMC), Nottingham has been named Hospital Doctor of the Year in the East of England and the Midlands.

Dr Sahota also led the team which won the Technology Award in the Health and Social Care awards run by the Department of Health.

Asked what attracts him to this area of medicine, Dr Sahota said: "You can make a big difference by doing something very simple."

When Dr Sahota began work at the QMC in 2001, almost none of the 1,500 people seen with fractures and broken hips at the QMC each year were assessed for osteoporosis. Few were

given advice on treatment or how to avoid falls, or referred to the Falls Prevention Services run by local health authorities. However, with the help of colleagues, Dr Sahota has overhauled the hospital's service.

Now 94% of the outpatients aged over 60 who come to the fracture clinic are assessed for falls and osteoporosis. Almost all of those admitted with hip fractures receive detailed assessments. When they are discharged they are referred directly to the falls teams to reduce the risk of taking another tumble when they go home.

The Department of Health says the Doctor of the Year must have made an "outstanding contribution to the development and delivery of services to patients, service users or carers over a number of years".

Dr Sahota said: "I am very proud that we have developed a comprehensive service. It is recognition of delivering patient care. We have tried to develop a service that prevents people



Dr Opinder Sahota

from having another fracture. Although I was nominated for this award, the development of the service has been driven by a number of people throughout the trust and wider health community.”

Dr Sahota and his colleagues have also tackled the problem of older people falling while they

are in hospital. In an innovative scheme, which has won the technology award, beds and chairs on an 18-bed ward, where elderly female patients are cared for as they recover from hip fractures, have been fitted with pressure sensors beneath the cushions and mattresses. When the patient leaves the bed or the chair, the system activates a pager carried by an auxiliary nurse, who can then go and offer assistance and support.

During an eight-month trial, the first of its kind, the number of falls on the ward were cut by half.

At the QMC, up to 3,000 patients fall over each year, leading to people staying an extra ten days on average. Each day in hospital is estimated to cost £350. All the changes implemented by Dr Sahota and his team have been done without extra money.

Asked what attracts him to this area of medicine, Dr Sahota said: “You can make a big difference by doing something very simple.”

Dr Sahota has also championed blanket prescribing of vitamin D and calcium for all elderly patients in nursing homes in the Nottingham area, who do not receive what they need through their diet or exposure to sunlight.

Dr Sahota’s efforts have been appreciated by his patients. Bernice Flowers, secretary of the Nottingham branch of the National Osteoporosis Society, said: “We are delighted. He has been very supportive of people with osteoporosis. He is getting things done. He has got the recognition he deserves.”

Mrs Flower, who is treated by Dr Sahota and has suffered from osteoporosis for 19 years, said: “It is important work. People who have had a fracture should not leave treatment and not realise they have osteoporosis.”

Alice Reynolds, 90, from Stapleford, has had two hip replacements. She said: “I always find him very helpful and patient and prepared to listen. I would rate him above other doctors in his attitude to patients.”

Another patient on ward 50, Ivy Starman, 79, who has been in hospital for five weeks following a hip replacement, said: “I think he is marvellous. He has made me walk when I thought I would never walk again. I can’t praise him enough.”

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