



Editor: Chandhi Vellodi

BGS

n e w s l e t t e r

BGS 2002 elections

- *Vox populi vox Dei

Members will be aware from earlier articles, of the significant steps the Officers and Council are taking to render the Society more effective and to match the political devolution taking place in the UK.

Less obvious, but equally significant has been the almost silent revolution in the electoral process introduced this year. For the first time, every UK based member had a direct vote in determining who should fill the officer posts falling vacant this autumn. It was gratifying that 'turnout' reflected a demonstrable interest in the affairs of the Society. Of 1743 papers distributed 627 were returned by post and 80 via the Internet. This represents a substantial

widening of the electoral base, compared to the previous system, when only 40 members of Council determined the outcome. In future the democratic process will be taken a step further with all individual UK members being asked to nominate candidates for office followed by all UK members having the opportunity to express their choice, from amongst those standing for office, through the medium of a postal/electronic ballot.

President Elect

The contenders for the office of President Elect were Dr Doug MacMahon who received 332 of the 703 votes counted. Dr Jeremy Playfer was elected with 371 votes. He will take office in October 2002 and become President of the Society in 2004.



Dr Jeremy Playfer

Jeremy Playfer MD FRCP, is a consultant geriatrician and clinical lecturer, based at the Royal Liverpool

University Hospital since 1977. The BGS has long been central to his professional life. Since 1982, he has continuously held elected positions on all the Society's major committees. He has also held office in the Society before, having served as Honorary Treasurer from 1990-93. He currently sits on the board of *Age & Ageing* and is Chairman of the BGS Parkinson's Disease Section. In broad terms, Dr Playfer sees his future role as President, to support and represent geriatricians, and to maximise the impact of the speciality within the NHS and in the wider medical

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

specialist medical society for health in old age

world.

Deputy Treasurer

Of the 681 votes for the office of Deputy Treasurer, Dr Tom Smith received 152 and Dr Margot Gosney was elected by a majority of 377. She will take office in October this year. Margot Gosney, MD FRCP is a consultant and senior lecturer at Royal Liverpool University Hospital.

As BGS Meetings Secretary (1997-2001), Dr Gosney acquired a permanently determined expression and a reputation for managing to be in many places at once during the biannual scientific meetings. She governed



The Society's Iron Lady

the scientific meetings with an iron hand. Having successfully moved the autumn meeting to the Novotel Hotel, Dr Gosney terrorised the staff of the hotel on matters ranging from the cleanliness of the toilet facilities, to exactly how much "jus" was to be "drizzled" over the fish. Under Dr Gosney's management, the meetings reached new heights in professional polish and financial viability.

Dr Gosney has made it an objective to pay off the mortgage on Marjory Warren House with a view to releasing funds for SpR start-up grants and increasing support to AHPs.

**(the voice of the people is the voice of God)*

Louise Wykes
BGS Office ❖

Editorial column

The Society is again breaking new ground in embracing the benefits offered by new technology. For the first time, this edition is available in print and on-line (both in on-line reading and downloadable .pdf formats) at www.bgsnet.org.uk

The advantages are many, for example, in this edition, the article by Finbarr Martin provides pointers enabling the on-line reader to refer via a hyperlink to the documents cited by Finbarr in his article. In addition, the on-line version includes more pages of notices than could be accommodated in the printed version, where costs and the need to print in multiples of four pages constrain the size of the journal.

Whither away in future? Your opinion counts!

Apart from the advantages mentioned above, the Society could also make savings of £15000 a year

were it to publish the Newsletter **solely** on line. As an experiment this month, members of the BGS Executive Committee will no longer wait for the BGS Newsletter to arrive on their doormats, but will instead receive an e-mail inviting them to download the Newsletter from the BGS web site. This alternative to the mounting pile of newsprint thudding through letterboxes could be extended to all members, **if that is what members want**. The Executive Committee *do not harbour any secret plan to deprive those members who prefer to read the printed version over breakfast, of this pleasure*. Equally we are keen to establish how many would prefer to read the Newsletter on line.

Would you therefore please, if you are that way inclined, access this Newsletter on-line and **let us have any comments**. You might also let the BGS office know whether in future, you would prefer it solely on line. Many thanks for your assistance with this project.

Focusing on the NSF in England

The NSF Focus Group, a subsection of the English Interim Administration has met for the first time. Members of the Group have been identified and tasked with looking at various initiatives. Thus Peter▶

Belfield will look at BGS communication with the new NHS directorates and Ian Hastie will co-ordinate the Society's response to the NSF workforce and training issues. David Black will continue to liaise with the National Older People's Task Force and Finbarr Martin will produce a regular news feature on behalf of the group, which will be published through our Newsletter (see page 13). I will continue to badger you with regular surveys to monitor progress!

And talking of surveys...

Following our successful joint venture with Age Concern on monitoring the progress of the NSF, we plan to continue this project with our next joint Age Concern/BGS Survey on the NSF standard 4 - General Hospital Care. The survey will be coming out to lead clinicians/clinical directors in England in the course of the next month. Please give freely of your valuable time to fill in the questionnaire, which should not take more than five minutes.

Future Director of CME

Professor Mark Castleden, who has been beavering away as CME Director for three years will be retiring at the 2003 AGM. To enable a smooth handover, the BGS is keen to find a suitable replacement to understudy from this year. The appointment to the post will be made by the UKMC. **We would like to invite expressions of interest.**

Congratulations

And finally, hearty congratulations to our newly elected President Elect, Dr Jeremy Playfer and Deputy Treasurer, Dr Margot Gosney. We welcome them to their posts in October 2002. Both Jeremy and Margot hail from Liverpool. Is this a Scouse take-over bid one wonders!

Chandi Vellodi
Editor ❖

President's
column

It would be hard to exaggerate the importance of our specialty working closely with general practice. From the point of view of our patients, everything possible should be done to achieve continuity of service and standards between primary and secondary healthcare.

I am fortunate enough to be married to a general practitioner. This is one possible strategic approach to intra-professional partnership! However we need a more broadly applicable professional and organisational strategy, and I am happy to report on progress being made jointly by the BGS and the Royal College of General Practitioners.

It is self-evident that older people especially (though not, of course, exclusively) bring primary care needs into the secondary care context and equally, carry with them continuing secondary care needs when leaving hospitals. General practice colleagues are only too aware of this, perhaps to an increasing degree.

Our speciality at its best has an excellent record of collaboration with primary care to bridge this transition. When this happens, everyone benefits. The key to success in the past has invariably been the delivery of a responsive service together with well-organised mechanisms to support free inter-communication and agreement between clinicians, on the preferred course of action for each patient. This has not changed, but both disciplines have changed and developed, and there are substantial contemporary opportunities.

This summer I was joined by Drs Chandi Vellodi, Jackie Morris and Paul Knight to meet with representatives of the RCGP at the College. Our discussions were against the background of two recent joint Department of Health-RCGP guideline documents - (1) on General Practitioners with Special Interests (GPSI) and (2) on GPSI Appointment in Intermediate and Continuing Care for Older People^[1]. BGS members not already au fait with these documents should obtain them and become familiar with the innovative GPSI concept the College envisages. Our meeting set out broadly to explore ways (assuming the availability of some funding for posts) in which we could encourage and support GP's to take up or continue GPSI opportunities in this▶

field, as positive personal development and career choices.

The avenues to develop closer working relationships include:

Collaboration in clinical practice and service delivery

Consultants and hospital-based departments should do all they can to encourage the establishment (particularly by teaching Primary Care Trusts or Joint Care Trusts) of GPSI posts reflecting RCGP/DOH guidelines, and in due course to forge links with appointees. Many of us already know outstanding and experienced GP colleagues with particular interest and experience in this field, eminently eligible to take up the challenge (some perhaps at present keeping their heads below the parapet). The current NHS plan incorporates a number of initiatives to promote such appointments.

Collaboration in training and continuing personal development

The RCGP has an extensive programme of accredited CPD. At the time of our meeting the outcome of its negotiations with the Department of Health on the resources for accreditation of GPSI were pending. For the BGS, the analogy of the relationship of specialist societies with the Joint Committees on Higher Medical and General Professional Training of the Royal Colleges of Physicians is a useful one. It is likely that if the resources for accreditation are realised, the RCGP would welcome representative involvement and support from the BGS in its accreditation procedures for this speciality, and in its development of more contemporary training programmes, career-tracks and CPD programmes for GPSI. We should embrace this opportunity with enthusiasm.

Collaboration at national organisational level and in research.

A number of GP's (but too few) are highly valued members of this society. The RCGP has set up its own special interest section on the care of older people. Equally the BGS has a developing SIG in Community and Continuing Care and Health Promotion. The logic of forging relationships between these groupings is inescapable. It is proposed that there should be joint "badging" of a workshop already planned by the RCGP for November this year. This is to be an exploratory workshop (max 60 delegates) focusing on four topics - care home issues, collaboration and organisational interfaces, rehabilitation, and single assessment. The BGS now hopes to support this by fielding a number of delegates (through the SIG) as well as a plenary speaker. There is also the possibility of a jointly badged national conference on ageing and the health care needs of older people.

These and similar interchanges should inevitably uncover the many unanswered research questions about the prevention, early detection and best shared management of the health problems of late life. There is already significant research collaboration within our ranks, but the key to its growth is in organised joint pursuit of both the ideas and the funding.

I very much hope the current initiatives will be highly successful.

^[1]see below for website urls where these documents are available

Cameron Swift
President ❖

Dept of Health/Royal College of GPs - Implementing a scheme for General Practitioners with Special Interests

(published April 2002). Provides information on the issues that need to be considered when commissioning and appointing a GP with a special interest, including how the scheme will operate nationally and locally. The document identifies care of the elderly as a priority area, although it is for

Primary Care Trusts to determine local need for the scheme.

Guidelines for the appointment of GPs with Special Interests in the Delivery of Clinical Services – Intermediate and Continuing Care for Older People (published May 2002). This document provides information on the core activities, competencies and clinical governance of GP specialists in intermediate and continuing care. The

Guidance on General Practitioner (GP) Specialists

document is explicit about integration with departments of geriatric medicine. Reference is made to BGS compendium documents on intermediate care (D4), rehabilitative care (A4) and Clinical Governance (May 2000). Both documents and further information is available at www.doh.gov.uk/pricare/gp-special

[interests/index.htm](http://www.bgs.org.uk/interests/index.htm)
In November 2001, prior to the publication of the DoH and RCGP guidelines, the BGS produced recommendations on the core activities and competencies of GP Specialists for older people. This is available at www.bgs.org.uk/publications/publications.htm ❖

Govt in danger of missing target

- on NHS improvements - Age Concern press release



A major government initiative to improve health and social services in the NHS is in grave danger of falling short of its target.

A Government milestone promised that by June 2001 local arrangements for implementation would be in place.

An Age Concern/British Geriatrics Society report

reveals that one year on, the National Service Framework for Older People (NSF) urgently needs more resources if it is to fulfil its pledge to raise health and social care standards for older people.

'Reasons for Optimism, Reasons for Concern' reveals that geriatricians and Age Concern groups are concerned that the milestones set by the Department of Health are not always being met and that in some cases, beds are being 're-badged' in an attempt to meet targets.

Although there was enthusiasm from medical and voluntary sector staff, as well as some encouraging signs of progress in medical and older people's involvement, this is still patchy and may not be sustainable. In a survey of Age Concern groups and 150 geriatricians all over the country it has been found:

A Government milestone stated that 1,500 more intermediate care beds should be made available by 2001/2, than there had been in the previous year

21% of geriatricians say their hospitals have switched a significant number of beds previously used for acute or rehabilitation care to intermediate care, contrary to the recommendations of the NSF.

40% of local Age Concern groups did not know of any older people who had been involved in the implementation of the NSF in their area.

A Government milestone said that by April 2002 a single assessment process would be introduced, streamlining care and producing collaboration between professionals

90% of respondents to the BGS survey reported new initiatives and funding in intermediate care, but in 64% of schemes there was no geriatrician involvement in daily clinical management, and in 40% of cases no clear operational link between intermediate care and the hospitals.

Gordon Lishman, Age Concern England's Director General, said, "Age Concern is disappointed that the NSF for older people looks in danger of failing in its mission to create equality for older people when accessing treatment and health and social care services. It is important that complacency doesn't set in and rot the good intentions of this framework.

"Resources are needed to encourage greater commitment to making the NSF work, as well as more older people being involved in its implementation."

Cameron Swift, President of the British Geriatrics Society said, "The BGS is worried by the apparent gap between the excellent rhetorical aims of the NSF and the lack of local procedures, safeguards and resources to deliver its standards. It sometimes seems as if any invented scheme – good, bad, indifferent, or just re-labelled - will do for older people. This is not what informed users are telling us, and rightly so. On the contrary, their cry is for the highest clinical skills and for service continuity.

"The Department of Health must now take firmer action to deploy the resource to ensure that for each element of the NSF - the necessary committed consultant involvement, leadership and advice, are invariably in place."

Recommendations to improve its implementation include:

- ◆ Milestones should be identified which clearly illustrate qualitative changes and improvements for older people
- ◆ A national evaluation of the role of Champions
- ◆ An independent evaluation of the involvement of older people and examination of how this can be achieved
- ◆ Financial resources to enable a range of voluntary sector involvement in the NSF implementation
- ◆ Specialist consultants should be consistently involved in the planning process for the NSF
- ◆ Establishment of a clear operational link between hospitals, particularly departments of geriatric medicine and intermediate care provision

Press release provided by **Sophie Howells** and **Cheryl Elliott** of **Age Concern**◆

*In Memoriam**Dr Peter Tweedy MD FRCP (1920-2002)**- by Professor John Brocklehurst*

Peter Tweedy, MD FRCP, born 1920, trained at Newcastle General Hospital and at Gateshead. He was appointed consultant geriatrician to Stockport hospitals in 1959. He died of heart failure on 5 July 2002.

In 1945 Peter landed in Normandy on D-day, eventually reaching Nijmegen whence two events followed governing the rest of his life. He met a young Dutch girl, who became his wife, and he embraced the Catholic faith. His work as a single-handed consultant geriatrician began, as was the custom of the time, with charge of several hundred beds in four different hospitals. He developed a dynamic service with day hospital, stroke unit, acute and rehabilitation wards and encouraged strong community links. He had a team of

Foundation and the Johnny Johnson Trust, raised over £1 million to create a rehabilitation centre - Oakwood, for head injury patients. It was opened by the Queen who was welcomed by Peter from his wheelchair in which he spent his last 15 years. He served St Ann's Hospice in Manchester, both as a member of the management committee (establishing its day hospital) and as honorary medical officer. He also founded a branch of the Catholic Advisory Marriage Council in Stockport.

Peter was a man of great drive and humanity, whose influence for good extended far beyond Stockport. He was also a talented pianist. He leaves his widow Annemarie, one daughter, three sons, one a GP, and 12 grandchildren. ❖

three consultants when he retired. Following retirement Peter led a group that, with the assistance of the Leonard Cheshire

Held on 25 June, and entitled, 'Mental health issues affecting the young and elderly', the summit was organised by the Conservative Party. The 60 delegates attending included representatives from local authorities, voluntary organisations, mental hospitals (Broadmoor), psychiatrists and care providers. Dr Liam Fox, Shadow Secretary of State for Health, opened the summit with a history of treatment of the mentally ill from the past to the present day, and calling for reform of the 1990 NHS and Community Care Act with a view to ensuring the most appropriate treatment and environment for patients, both in a hospital setting and in the community.

The meeting divided into three discussion groups, namely mental health for the young, for adults and for older people. Michaela Willmott,

Policy Officer for Health, Age Concern England, gave a short presentation on mental health issues affecting older people. She cited loneliness, lack of transport and adequate support as key factors affecting mental health. She also pointed out that the NSF for Mental Health and the NSF for Older People do not correspond. Dr Andrew Fairburn, Consultant in Old Age Psychiatry (Newcastle), delivered a short presentation on undiagnosed mental illness and unmet need amongst older people. He stated that mental health does not receive enough attention in primary care where ageist attitudes to treatment abound, and there is a lethargy towards integration.

Participants in the discussion group on mental health for older people were in favour of the same mental health treatment for all, irrespective

Mental Health Summit

of age. They were however, divided on the repeated use of mind-controlling drugs, some arguing these were used excessively while others were of the view that their levels of use were just about right. Participants also stated that much more focus ought to be put on prevention, rather than cure. All were in favour of better integration between social services and health services within the NHS. They considered the biggest challenge the promotion of good mental health.

Annette Guerda-Fischer
BGS Office ❖

Delayed Discharge & Inappropriate Admissions - Select Committee on Health

In March, Prof Cameron Swift, accompanied by Dr David Black, gave evidence to the House of Commons Select Committee on Health.

The report published by the Committee in July is summarised here.

- ◆ The Committee urges the Department of Health (DoH) to reject the use of the term “blocked beds” to refer to patients ready for discharge, but who are occupying hospital beds.
- ◆ The Committee calls for further clarification of the definition of “delayed discharges”, and further guidance on its practical application.
- ◆ The DoH needs to refine its data gathering procedure to achieve a more comprehensive picture of the delayed discharge patient population. There is a need to highlight specific problems in the care and placement of those suffering from mental illness, head injury or other conditions.
- ◆ The Committee welcomes the downward trend in delayed discharges, but it remains to be seen how sustainable this will be. The wide regional and local variations in delayed discharge trends continues.
- ◆ The Committee recognises the crucial role occupied by timely discharge in enabling the attainment of other key NHS objectives, and wholly supports the key objective of ensuring that the right care, in the right place, at the right time, is attained for individual patients and their carers.
- ◆ The Committee is not able to assess the impact of the recently established Change Agent Team. The team’s findings will need to be disseminated at the earliest opportunity if the experience of working in depth with a small number of authorities is to be of wider benefit.
- ◆ The Committee recommends that the DoH identify and publish examples of good practice in

promoting avoidance of inappropriate admission to hospital.

Management of Discharge and Beyond

- ◆ There is merit in having a named person responsible for co-ordinating all stages of the patient journey up to and beyond discharge.
- ◆ Patients should be partners in the discharge process. In circumstances where they lack capacity, they should have access to advocacy services.
- ◆ Arrangements for management of discharge need radical overhaul in many hospitals. In the Committee’s view, best practice involves a multi-agency team, with clear links to all key points in the patient’s journey, actively managing all aspects of the discharge process. The leader of this team should be jointly appointed by the NHS and councils with social services responsibilities. The discharge management process should be proactive rather than reactive.
- ◆ Even if good systems are instituted, there is a danger that they will stagnate. The committee recommends that discharge procedures should be a focused element of clinical governance, and of every CHI review in the NHS. It is also vital that these matters be addressed in inspection procedures, both through the proposed new independent healthcare regulator and through the equivalent body for social services.
- ◆ The Hospital Discharge Workbook should be updated. The Committee recommends that new statutory guidance on health and social care responsibilities for hospital discharge should be issued as a matter of urgency.
- ◆ The Committee is concerned that the focus on tackling delayed discharges, entirely laudable in itself, could lead to an intensification of pressures to discharge patients too quickly, and with inadequate preparation.

Optimising Resources

- ◆ The Committee believes that community hospitals are an important provision and▶

should be a resource centre. This approach requires a new mind-set so that the community hospital is used appropriately, and staff with the right skills provide the support required.

◆ Building capacity, whether in the acute sector, in community hospitals or in residential/nursing homes, risks feeding the problem of delayed discharges. Breaking the cycle demands the simultaneous development of alternative facilities in the community, to ensure that inappropriate admissions can be avoided and timely discharges supported. Current targets are structured to encourage a preoccupation with short-term objectives.

◆ The Committee is concerned that “re-badging” NHS services as intermediate care might lead to a misuse of resources identified for the development of intermediate care, and it represents a failure to utilise the skills and wider experience of statutory and independent sector partners for maximum benefit.

◆ The Committee recognises the value of additional resources being invested in under-performing health authorities, but worries that this appears to reward poor practice. It recommends that, in line with the Government’s emphasis on ‘earned autonomy’, there should be a corresponding development of support to authorities that are performing well.

◆ If the Government is committed to using the independent sector, which provides the majority of intermediate care, it must ensure that the sector is involved in developing care and support services in which the care home is only one of a range of service options, tailored to meet the diversity of need of individuals.

◆ The Committee is not convinced that the requirement for homes to clarify the breakdown of their fees for residents will do anything to redress the situation of nursing homes raising fees to absorb the value of NHS funded nursing care payments. The Government is urged to ensure that the full value of the registered nursing care contribution is passed on to residents as intended.

Innovative care models

◆ Hospitals are not the appropriate place for people awaiting care home placements. The Committee believes that there should be a presumption that those unable to access their first choice home should wait in interim

placement settings unless there are genuine clinical reasons to suggest this would be unwise. However, careful monitoring would be needed to ensure that local authorities did not exploit this artificially, to limit access to good quality homes.

◆ Registered care homes, including those providing nursing care, are an important element in considering options for care; but that provision should not be regarded as the easy option simply because in a given area the capacity is there. To this extent, closure of care home places can act as a further spur to the development of care at home.

◆ The Committee recommends that the DoH conducts a cost-benefit analysis of facilities such as those on offer at Hartrigg Oaks and Berryhill, with the emphasis placed on active community and independent living. The costs of such schemes should be compared with the costs to the state of both additional hospital admissions and stays, and the costs of other forms of care.

◆ The Committee agrees with the Audit Commission that further work is needed to provide guidance on the effective commissioning of equipment services to social services, primary care trusts and strategic health authorities.

Change from more of the same

◆ Telecare solutions have a major contribution to make as part of the strategy for developing alternatives to hospitalisation. The Department should establish a national strategy to promote the systematic development of telecare solutions as part of care at home, perhaps beginning with some properly audited pilots. Telecare has the potential not only to achieve cost savings, but also to allow people the choice of staying longer in their homes, with the attendant benefits of such an option.

◆ The fact that almost 30% of discharge delays can be attributed to waits for care home placement might suggest that the obvious solution would be rapid development of further residential and nursing home capacity. The Committee does not support this conclusion on the grounds that it would constitute developing “more of the same”, instead of developing alternative service models.

◆ The use of ‘Cash for Change’ resources appears to have been successful, but may not be sustainable. The increase of 6% per annum in social services funding offers an opportunity▶

for longer term planning.

◆ The experience of medical insurers in the USA has demonstrated that financial penalty incentives can deliver rapid change in delayed discharge, albeit in a very different health culture, but the Committee cautions that there are risks that a system of cross-charging to deal with delayed discharges might undermine partnerships which have taken considerable time to develop.

◆ Evidence from a survey by District Audit, indicates that much creative intermediate care service development is taking place, involving a diverse range of schemes. Ensuring that this diversity becomes part of the mainstream and takes place within the context of the whole health and care system will be a challenging task.

◆ Workforce development needs to be tackled creatively. The Committee recommends the

development of a joint workforce plan and training strategy that brings together the NHS Training Confederation and the new sector skills councils.

◆ The Committee calls for a full and widespread debate on the case for the integration of health and social care, and their linkages with related services such as housing. Pilots should be established to test ways of integrating health and social services, perhaps based on the leader commissioner model.

The full report is available from
<http://www.parliament.the-stationery-office.co.uk/pa/cm/cmhealth.htm> ❖

BGS specialist registrar start up grants (SRSUG)

At the request of the Scientific Committee, applicants applying for the BGS SRSUG during the period 1998 to 2000 were surveyed. Of the 31 applicants, 26 responded to the survey, 23 of whom had been successful in securing the award.

It was found that most applicants had been in their 2nd, 3rd or 4th SpR year when applying for the grant. Only 1 had been in each of year 1 and year 5.

Of the 26 respondents, 7 are now consultants and 14 are senior geriatricians.

Having secured the grant, 15 respondents presented their research at a BGS meeting and 14 had their research published. Of the 3 respondents who had not been successful in their application for the start up grant, 2 secured alternative funding.

The BGS Specialist Registrar Start-up Grant is intended to provide immediate financial assistance to support research projects which may not yet be developed sufficiently to warrant support from research councils.

A limited number of grants of up to £2,500 are available (although the majority of awards will be in the region of £500 - £800). The scheme enables geriatricians to follow through ideas at relatively short notice and to provide short-term assistance to speculative and innovative research that may be at an early stage. The scheme is not intended to provide funding for undergraduate or post-graduate teaching, to provide rescue funding for the continuation of established projects, to supplement existing grants, or to support any activity not directly related to research.

The grants, which are available only to members of the British Geriatrics Society or to non-members who are sponsored by members of the Society, are administered by the Society's

Scientific Committee and are intended for doctors holding substantive posts at Specialist Registrar or equivalent grade in the United Kingdom.

There are no fixed categories of grant, but the following examples provide some indication of the kinds of support that will be considered:

- grants for equipment or consumables; and
- grants for honoraria to secretaries or research assistants.

Grants will not be made for the organisation of conferences, for attendance at conferences or courses, for postgraduate students, for computer equipment, for the costs of publications or printing, for field trips or for principal investigators' salaries.

How to Apply

The applications protocol is available from the BGS office or website. Applications are considered at any time of the year and decisions are usually made within five to six weeks. Enquiries should be directed to **Ms Annette Guerda-Fischer** at the BGS. ❖

National Older People's Taskforce

- Update



Jackie Smith, Minister of State for Health attended the National Older People's Task Force meeting in April to discuss the implementation of the National Service Framework (NSF) and improving older people's services.

She was clearly of the view that good progress was being made on implementation, including the single assessment process, audits of age discrimination and intermediate care. The members of the Task Force were keen to tackle her on funding, in particular, the lack of hypothecated funding for Older People's NSF, and also issues around monitoring and the priority Government gave to older people as opposed to waiting list targets.

The minister's view on milestones seemed to be that the Government needed to know that the milestones were generally being met, but local monitoring processes were much more important for the detail, particularly as the Government was trying to cut back on the central command and control of the Health Service. The view on hypothecated funding appeared to be that the NSF for Older People was simply too large and so much embedded within all other aspects of delivering the National Plan, that it made little sense to have specifically earmarked funds. Members of the Task Force made clear their view that the real funding challenges; providing for stroke, falls and dementia services, were yet to happen. These services would need dedicated extra funding and the NSF might well stand or fall from the progress made in these areas.

Workforce group

The workforce group, where the interests of geriatric medicine are persuasively represented by Alistair Main, have made their bids, including a bid to increase NTN's for geriatric medicine against an expected increase in NTN's across all specialities. Alistair's report appears on page 14-17.

Nurse Consultants and Champions

Many people will be meeting Ian Philp over the next 6 months as he tours all the Strategic Health

Authorities with Dr Colin Thome. This is part of a campaign to raise the profile of the Older People's NSF with the new Strategic Health Authorities and PCT's whilst at the same time, supporting the work of champions by celebrating best practice. In parallel there is a national push for leadership development for all those involved in leading the implementation of the NSF, including the Champions and nurse consultants.

Following the previous discussions with the Minister of Health, some monitoring of milestones on a national basis will become part of this year's SAFF (Service and Financial Framework) process, and this should provide information that can be compared with other monitoring processes such as the work being done annually by the BGS and Age Concern. Although this data will appear quite "high level", it is actually quite an achievement for the Older People's Task Force to have managed to get this concession against a background of considerable pressure to ask for no more data to reported centrally.

Health and Social Services partnership

Real detailed monitoring of the NSF will eventually be carried out at local level by the Commission for Health Improvement and the Social Services Inspectorate. Although this is not yet formalised, some early work is beginning to suggest there is real change happening, in particular partnership working between Health and Social Services. There is also evidence that delayed discharges have fallen nationally and there is a specific team (The Change Agents Team) currently working in 10 parts of the country where there appear to be the most resistant problems.

For many geriatricians, a key part of the NSF was chapter 4 on General Hospital Care. This has probably received less attention so far, and the National Older People's Task Force will be looking to see evidence for action and improvement in this area in forthcoming meetings.

Dr David Black

Clinical Director, Queen Mary's Hospital, Sidcup ❖



BGS SPECIAL INTEREST GROUP IN BLADDER AND BOWEL PROBLEMS - INAUGURAL MEETING

The inaugural session of the Bladder and Bowel problems SIG took place at the spring meeting of the BGS in Telford. The aims of the group are:

- ◆ to provide a focus for those clinicians involved in care of older people who have a special interest in the problems of urinary and faecal continence;
- ◆ to facilitate and encourage collaborative research and development within the field;
- ◆ to promote interest and participation in the care of older patients with bladder and bowel problems.

Objectives

More specifically the group hopes to:

- ◆ produce meaningful audit of care for presentation at national meetings of the Society.

- ◆ encourage original research for presentation at national meetings of the Society.
- ◆ provide continuing professional development in the form of educational updates on bladder and bowel treatment for members of the Society.

MRC Continence Programme

Approximately 60 delegates took advantage of the wisdom accumulated from the MRC continence programme in Leicester, professionally and expertly led by Dr Kate Williams. Data showing the efficacy of a nurse led continence service were presented and discussed in detail, with plenty of audience participation. This session is particularly pertinent given the requirement for integrated continence services for older people as mandated

by the National Service Framework. The aims and objectives of the SIG were introduced to the audience and the case made for the importance of integrated continence services within the National Service Framework for Older People.

SIG Membership

Any member interested in participating in the activities of the SIG should send their contact details to Dr. James Barrett, Secretary for the SIG, at Clatterbridge Hospital, or e-mail him at: jabarrett@clatterbridgesru.freeserve.co.uk

The group is planning a one-day conference to take place in the Autumn. The meeting will cover the essentials of assessment of bladder and bowel problems and service development. Membership of this multidisciplinary SIG is free.

WORLD HEALTH ORGANISATION - first report on Violence and Health

On 3 October, the World Health Organisation intends to spotlight the issue of elder abuse when it launches the first World Report on Violence and Health, in Brussels.

The report examines a broad spectrum of violence, including a chapter on elder abuse, authored by Dr Gerry Bennett, Rosalie Wolf and Lia Daichman.

For further information, contact: Dept of Injuries and Violence Prevention
World Health Organisation, 20 Avenue Appia
1211 Geneva 27, Switzerland

The website can be found on:
www.who.int/violence_injury_prevention

INCONTINENCE

Integrated Continence Services : Good, Better and Best Practice

16 October 2002

London

Cost: £80.00

Inviting: Consultants, GPs and Senior PAMs with a special interest in continence

Contact: Dr Judith Wardle, The Continence Foundation, 307 Hatton Gardens, 16 Baldwins Gardens, London EC1N 7RJ. Tel: 020 7404 6875. Email: continence.foundation@dial.pipex.com



BGS SPECIAL INTEREST GROUP IN GASTROENTEROLOGY AND CLINICAL NUTRITION

The Annual Scientific Meeting of the Special Interest Group in Gastroenterology and Clinical Nutrition was held on Friday, 7 June 2002 in Chepstow, South Wales. It was regarded as a great success and the meeting was attended by over 50 delegates. The presentations covered:

- ◆ **Fatty Liver** - Professor O James (Newcastle)
- ◆ **Chronic Pancreatitis** - Dr E Boyd (Abergavenny)
- ◆ **GI Tumour Markers** - Dr A Brewster (Cardiff)
- ◆ **Re-Feeding Syndrome** - Miss S Jones (Newport)
- ◆ **Endoscopic Mucosal Resection** - Dr D R Davies (Caerphilly)
- ◆ **Treatment of IBD - An Update** - Dr A B Hawthorne

(Cardiff)

- ◆ **Intestinal Pseudo Obstruction** - Dr N Y Haboubi (Abergavenny)
- ◆ **The balance between destructive & protective mechanisms in the older stomach** - Dr J Newton (Newcastle)
- ◆ **PEG Clinic** - Mrs S Lane (Abergavenny)
- ◆ **An unusual case of hepatomegaly** - Dr S Tuladhar (Pontefract)
- ◆ **30-day Morbidity after Colonoscopy in the Elderly** - Dr S Bruce (St Leonards-On-Sea)

The AGM of the group will be held during the Autumn meeting of the BGS at the Novotel Hotel, London on Friday, 18 October 2002, during the lunch time. The Special Interest Group

hopes to increase its membership and invites doctors, specialist nurses, dietitians and therapists to join the group. In particular, it would encourage membership amongst specialist registrars.

For details on gaining membership of the group, contact:

Dr Nadim Y Haboubi
Secretary of the British Geriatrics Society Gastroenterology and Clinical Nutrition SIG
Adult Medicine Department
Nevill Hall Hospital
Brecon Road
Abergavenny NP7 7EG

Email:
becky.jones@gwent.wales.nhs.uk

A conference which aims to review the scientific basis for artificial nutrition and hydration in acute and chronic disease; explore the legal frameworks and moral arguments which surround initiation and withdrawal of ANH; and stimulate interprofessional discussion about the responsible utilisation of ANH.

Contact: Conference Office
Royal College of Physicians
11 St Andrew's Place
Regent's Park
London NW1 4LE.

Tel: 020 7935 1174
Email:
conference@rcplondon.ac.uk

**Artificial
Nutrition
and
Hydration:
Science,
Ethics and
Law**

11 Dec-2002

RCP (London)

**ON LINE
PUBLIC
CONSULTATION**

The **Hansard
Society**,

working with **Age Concern**, has launched an online consultation to gather the views of older people, their families, carers and health professionals, on long term care and related issues. The debate building up is fed into the work of Parliament's All-Party Group on Ageing and Edinburgh's parallel cross-party Group on Older People, providing them with an unusual insight into how care is considered by those who use it.

The consultation and moderated debate may be found on: www.seniorspeak.org

National Service Framework



BGS establishes NSF focus group

The Interim Administration for England has established a focus group to deal with issues relating to the National Service Framework for older people (NSF).

The group's aims

The group aims to influence national policy, support implementation of the NSF and address the concerns of BGS members.

Members of the Society have already been significantly involved in the drafting of the NSF and subsequent reports, and many are also leading on implementation at a local and regional level. It is hoped that an NSF News feature in the BGS Newsletter will be a useful communication tool. The feature will include an update on recent developments in older people's policy and links for members to access useful resources.

Members of the NSF Focus Group

The group is comprised of Dr Ian Hastie, Dr Peter Belfield, Dr Finbarr Martin, Prof. Cameron Swift and Dr David Black

Interim Report on Age Discrimination

Published in April 2002, this report gives the results of the initial audits of age-related policies carried as part of standard one of the NSF. Audits have been completed across three quarters of the NHS. The report concludes that the audit has raised awareness of age discrimination and gained considerable support within the NHS and social care. However there is a lack of common definition or wider understanding of age discrimination. The results show that only a very small number of policies are explicitly age discriminatory, the main

problem is around implicit or unintentional discrimination. In total, 41 specific health service areas

have age-related policies and further work is recommended to ensure that these services are of the same quality as those for working-age adults.

www.doh.gov.uk/nsf/olderpeople.htm

Intermediate Care: Moving Forward

Published in June 2002 this report summarises the key points from the review of progress in intermediate care. The review examines research evidence on the effectiveness of intermediate care, looks at success factors and raises key issues for further development. Examples of good practice are included, along with reports on existing research and details of research projects currently in progress. In particular the review recognises that assessment should include medical input and access to specialist diagnostic and treatment services.

www.doh.gov.uk/nsf/olderpeople.htm

Single Assessment Process: Review reports to be submitted by 30 September

One of the NSF milestones is to undertake a review of the single assessment process during April to June 2002, and submit a report to DOH by 30 September. The requirements of the report are set out in Annexe C of the guidance available at www.doh.gov.uk/nsf/olderpeople.htm. There is no plan for a national proforma for the report, but some regional offices may have developed their own guidelines; the London Older People's Programme have posted a proforma at

www.london.nhs.uk/olderpeople

SAP and Care Approach Programme

Guidance on the relationship between the **single assessment process** for older people and the **care programme approach** has been published. The Care Programme Approach should be applied to older people with severe mental illness due to schizophrenia or other psychoses. The assessment of their needs should be based on the single assessment process for older people. Members may wish to bring the document to the attention of colleagues in local mental health services and managers and other professionals involved in the single assessment process.

www.doh.gov.uk/scg/sap

General Hospital Care

The Department of Health has announced progress in achieving the commitments in standard 4 regarding modernisation of Nightingale Wards and the appointment of Modern Matrons.

£120 million has been promised over a 3-year period for the modernisation of Nightingale wards, an initial allocation was made in 2001. Of the 289 wards being modernised, 211 cater for older people. Modernisation includes re-equipping and refurbishing rehabilitation rooms, converting dormitory-style wards into a combination of smaller bays and single rooms with en-suite facilities and providing additional refurbished bathrooms and toilet facilities.

In April 2001 the Government announced a target of 2,000 Matrons working on NHS wards by 2004. In June 2002 the Department of Health stated that 1,895 appointments have been made.

The next BGS and Age Concern survey will focus on general hospital care including the multidisciplinary team, ▶

discharge arrangements and the ward environment. The survey will be sent to lead clinicians later in Autumn 2002.

Toolkit for Champions

A Champions toolkit was produced for the Champions Conference, Meeting the Milestones, in March. The original document is available on the NSF champion's notice board www.doh.gov.uk/nsf/olderpeople.htm and is now being updated. A new version, which will

continue to be added to and improved, should be available by the end of July.

Social Services for Older People

On 23 July 2002 Alan Milburn announced a programme of investment and reform for older people's social services. <http://tap.ukwebhost.eds.com/doh/intpress.nsf/page/2002-0324?OpenDocument>

Finbarr Martin ❖

Consultant Recruitment Survey



- May 2002

A recruitment crisis? Perhaps - but some of the answers are in our own hands.

In the July Issue of the newsletter about Workforce (p9), I mentioned an up to date survey of consultant recruitment in our specialty. This was carried out to inform the Council debate reported in July and was basically a 'point prevalence' snapshot on the 1st May 2002. Twenty BGS regional representatives including 4 from Scotland, 1 from Northern Ireland, 1 from Wales and 14 from England, were asked to count consultant posts in their region and to note vacancies, (empty posts + locums), and new posts (filled and unfilled) in the last 12 months. They were also asked to comment on recruitment difficulties. All but 4 regional representatives replied, so the results (see table) are based on 16 regions and 703 WTE posts.

What were the headlines?

Overall, the vacancy rate was 8.5% but 6 regions (see table) had 10% or more vacancies. Fourteen posts (6 in the West Midlands) had failed to appoint at least once. The reasons cited were:

- ◆ geographical remoteness
- ◆ poor quality and number of applicants
- ◆ jobs too busy
- ◆ poor medical and administrative support
- ◆ lack of SpRs in the service

In the last 12 months, 47 new consultant posts have been created of which half are unfilled. There are 2 main reasons:

- ◆ the European Working Time Directive is resulting in an increase in consultants in acute specialties (and geriatric medicine – for better or worse is the largest

specialty contributing to acute medicine)

◆ the NSF for Older People, the creation of new Intermediate Care services, a shortage of GPs and the new found power of Primary Care Trusts is pushing for more community based posts which to date, have proved unpopular with our trainees.

What did we learn from the survey?

If not a crisis, we certainly have a problem. The strictures of SpR training (and slow output into the consultant grade), coupled with expansion in consultant posts can only widen the gap. Some ways of tackling this issue and making jobs more attractive are about recognising the reality of the market. They are described in the previous workforce article, yet some regions (or should I say nations - Scotland) seem to have got it right and the rest of us need to learn from them!

A mismatch between trainees' aspirations and job content is evident from this survey. Jobs in which the general medicine component is too dominant are unpopular, as are the innovations in intermediate care. This training 'crisis' has been recognised by the BGS Training Committee. Hopefully as geriatricians become actively involved in these schemes, and indeed in other community based work, the training opportunities will increase, and with them the trainees' confidence to tackle this new area of work – but only if the acute medicine demands on their time allow it. Rather than offering these new posts to SpRs, existing consultants should perhaps be prepared to develop these and to offer 'safer' posts to new consultants.

There is undoubtedly a patchy problem in recruiting good quality motivated doctors into our specialty (it was ever thus!). What is new and poses a particular problem is the opportunity for our SHOs to move into other specialties, also expanding as a result of ▶

the European Directive on Working Hours. We need to attract the best. For me the last word goes to Cath Church, the current SpR Chair who, describing what attracted her into the specialty said (if I can paraphrase her views set out in the July issue of the BGS newsletter), the influence of enthusiastic consultant role models and their approach to patients, the

opportunity to develop a sub-specialty interest, and the recognition that the geriatrician's skills are useful in all settings

Alistair Main
Chair, BGS Workforce Committee

CONSULTANT RECRUITMENT SURVEY - 1st MAY 2002												
Regions	No. consultants (WTE)	Vacancies Empty + Locum	Empty posts	Locum in post	Vacancies next 12/12	Out to advert	Appointed not started	Failure to appoint at least once	New posts since last 12/12	New posts filled	New posts unfilled	
Greater Glasgow	25.5	0 0	0	0	2	0	0	0	1	1	0	
Mersey	45	5 11	2	3	0.5	1	0	1	7	4	3	
N. Ireland	27	2 7	0	2	1	0	0	0	2	2	0	
NE Thames	68.6	6 9	3.5	2.5	0.6	2	0	0	3.5	0	3.5	
Trent	39	6 15	1	5	2	1	1	2	3	2	1	
Yorkshire	59.8	2 3	0	2	2	0	0	0	0	0	0	
Northern	65.6	9.5 14	6.5	3	0	0	0	0	3	2	1	
Oxford	25	4 16	1	3	1	3	0	1	0	0	0	
SE Thames	62.4	4 6	1	3	2	0	1	1	5.6	4.6	1	
SE Scotland	28.8	1 3	0	1	2	0	0	0	1	0	1	
SW Thames	47.5	3 6	0	3	0	2	2	1	4	2	2	
NE Scotland	25	1 4	0	1	0	0	0	0	2	2	0	
NW Thames	50	2 4	1	1	3	1	0	0	3	1	2	
East Anglia	51	6 12	2	4	1.7	3	1	1	4	3	2	
Wales	15.5	2 13	1	1	0	1	0	1	1	0	1	
West Midlands	68	6.5 9	1.5	5	1	4	2	6	7	2	6	
Total (excl Northern)	703.7	60 8.5%	20.5	39.5	18.8	18	7	14	47.1	25.6	23.5	

No response from: 1 region in Scotland, North West, South West and Wessex❖

Workforce



more SpRs for the specialty?

In the July Newsletter (p9), I mentioned your Workforce Committee's efforts to increase the numbers of trainees for our specialty.

In our representations to the Workforce Numbers Advisory Board (WNAB) we emphasised our concern that no new posts had been offered last year despite our estimate that we would need an increase of 125 trainees a year to meet projected consultant numbers. We highlighted the extra demands as a result of the European Working Time Directive, a higher proportion of SpR time spent performing general medical duties, and new services arising from the NSF for Older People

The headline results of the consultant recruitment survey (pages 14-15), confirm that these pressures are already being felt and are resulting in substantial consultant recruitment difficulties in parts of the country.

Can we increase the numbers of trainees?

The Government's plan to increase the number of doctors by 15,000 over the next few years is widely known. WNAB has recognised the increased pressures on doctors in the NHS. In July 2002, its chairman wrote to Postgraduate Deans, announcing that in addition to the 300 SpRs currently being distributed (none to geriatrics), there would be new funding for an additional 400 SpRs and 200 GP Registrars for 2003-4. However beyond 2004, no new funding is planned and the share for our specialty of the new posts for 2003/4 is likely to be small (10-20 nationally). Furthermore, new central funding is likely to be focused (as this year) on shortage specialties likely to embarrass the Government by pushing up waiting lists (pathology), or stacking up people in A&E Departments (radiology). So the impact of new funding on our specialty is likely to be small, and numbers of new NTN's allocated to our specialty is also likely to be

small despite the impetus and pressure resulting from the NSF for Older People.

WNAB has developed the notion of 'floors and ceilings' for new posts. The **floor** for the specialty is the minimum number of newly funded SpRs in a particular year (2002/3) – none for geriatrics. The **ceiling** is the number which can be funded by 2004 (funded and unfunded) - 10 for geriatrics nationally, distributed by discussion between the lead dean for the specialty (in our case Professor Cochran in Glasgow), and advised by the SAC. So far, rather disappointing.

However new 'flexibilities' in the ways in which new NTN's can be created are being introduced, provided that local funding can be found, and these may be used to increase the floor target and hence the total numbers.

So how can we increase our numbers of trainees and their conversion into consultants ?

Make the cake bigger

The Workforce Committee has been and is arguing, not just for a larger share of the 'cake' but for a larger cake! The arguments most likely to hold sway are to do with the 'acute access' agenda – around the way that new posts would contribute to the smoother working of acute hospitals, e.g. specialist input into A&E Departments to assess frail patients or support for admission avoidance schemes in Intermediate Care.

Use the new "flexibility"

Under the new 'flexibility' arrangements, unfunded NTN's can be developed by converting current educationally approved posts into SpRs. Money used for Trust grade doctors could go to fund new SpRs and recognised SHO posts could be converted to SpR posts.

Increase the "flow" out of SpR schemes

We could encourage Visiting Trainees to stay (as ►

many in our specialty wish). We could also minimise the training period by critical review of the need for 'out of programme' training. Finally, we could convert 'LATs' into accreditable potential consultants.

Using what we have got

We need to capitalise on the welcome focus on older people in the wake of the NSF, but in the short term, demand for consultant time is likely to outstrip supply. Nice for the trainees, not so good for the rest of us!

In the longer term it is emphasised (as highlighted in our last Study Day) that an increase in trainees is not the only measure to be taken to reduce the pressure on doctors. We can adopt changes in skills

mix and more imaginative cross-cover arrangements. To inform the process of using the new 'flexibilities', WNAB is undertaking a scoping exercise via the Postgraduate Deaneries to assess the feasibility of offering new SpR posts to Trusts in all specialties. The timetable is tight, and if you haven't heard about it by now it is probably too late for this year. However the exercise is to be repeated periodically.

In a subsequent article I will report to you the early experiences of establishing a new weapon in the armoury – the GP with a Special Interest (GPSI) in Older People (for now, see President's column and page 3) .

Alistair Main

Chair: BGS Workforce Committee❖

BGS Interim Administration for England

The proposed new structure (detailed in the March 2002 issue of the BGS Newsletter) is based on devolution to four national councils.

Northern Ireland, Scotland and Wales effectively already have national management structures in place, but a Council for England will need to be created to serve as a forum for the 14 existing English regions.

At its meeting on 23 May, BGS Council agreed that the President should convene an "interim administration" for England. In consultation with the English regional branches the Interim Administration will develop proposals for a permanent English Council, to take office by no later than October 2004. During the transition period the Interim Administration will deal with key issues in the health service and the Society relating to England.

It is the intention of the Interim Administration to maintain a good two-way communication with the English regional branches. Therefore the existing English members of the current UK Council will continue to act as their regions' national representatives.

The first meeting of the Interim Administration will be held in September. Subsequent meetings will be at two monthly intervals.

For further information on the Interim Administration please contact Louise-Wykes@bgs.org.uk

Stop Press - Legal delays

While the process of devolution is proceeding smoothly, it will take longer than anticipated to effect the legal revision of the BGS Constitution. It is now expected that this will be available for approval by the membership at an extraordinary meeting to coincide with the Spring Meeting in April 2003.

Louise Wykes
BGS Office❖

Members of the Interim Administration

Chair: Prof Cameron Swift	Dr Ian Hastie
Dr Peter Belfield	Dr Roger Lewis
Dr David Black	Dr David Maisey
Dr Beverley Castleton	Dr Finbarr Martin
Dr Ian Donald	Prof Graham Mulley
Dr Margot Gosney	Dr Chris Turnbull
	Dr Doug MacMahon

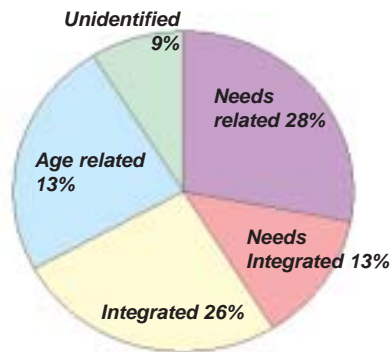
Service Models

- Results of a BGS Survey

In July, the BGS office received a request from a member whose Trust was reviewing the organisation of older people's services.

A quick email survey of service models was conducted to help provide data for the review meeting. Sixty lead clinicians were asked whether their service is age-related. Responses were received from 54 Trusts, and sorted into one of three models; needs related, integrated and age related. In trying to categorise the services, a degree of ambiguity was found in some cases, in respect of the needs related and integrated models.

The results are charted here.



A number of members provided comments on the service models operating in their hospital, some of which are summarised below:

◆ The move from an age-related to an integrated service was partly driven by the reduction in

junior hours and introduction of a shift system in one Trust.

◆ Some respondents referred to the significant increases in workload and resources required to move from an age-related service to an integrated service.

- ◆ Some respondents referred to the relationship between admission policies and NSF Standard 4
- ◆ Within integrated services (shared acute take) the existence of needs related rehabilitation facilities under the care of geriatrician are mentioned.
- ◆ There is increasing reference to a needs related stroke facility within hospitals, in some cases linked to the geriatrician led rehabilitation ward.

Overall there appears to have been a shift to, or there is existing pressure to convert to an integrated model, held back in some cases by a lack of resources. Others, on the other hand reported pressure to go to a needs related basis.

In Grimsby 'there is a dedicated Day Hospital where there is rapid assessment and management of older patients with subacute crises to avoid inappropriate admissions. Outpatient services and some rehabilitation for older people with unstable complex medical problems also take place in the Day Hospital'.

There is one quote which is explicit in lauding the merits of an age related service - 'a lower hospital admission rate per population, shorter length of stay and lower readmission rate, which I think is a reflection of better care for older people in Age Related Service'.

Others take the opposite view 'we do not take ALL patients over a certain age, as this would in our opinion, deprive patients of the best care from another specialist if appropriate. We also take any patient <65, whose needs would be better met on our unit, e.g. stroke or patients needing rehabilitation'.

For a copy of the results in detail please contact

Louise-Wykes@bgs.org.uk

Louise Wykes

BGS Office ❖

The John Brocklehurst Fellowship prize, worth £200, is funded and administered by the North West (NW) region of the British Geriatrics Society. It is awarded to a specialist registrar on the north west region rotation following a presentation and poster

of a research or audit project at the BGS NW branch's autumn meeting. The judging panel consists of members of the north west BGS and usually includes John Brocklehurst.

JOHN BROCKLEHURST FELLOWSHIP PRIZE

If you are an SpR on the NW region rotation, and wish to have more details, email **Dr M Cheshire** at: **jamike38@cheshirec.freereserve.co.uk**

The Health Advisory Service

- the Society's position



Several members have written to the Society, expressing concern that the Society should be withdrawing as a partner in the Health Advisory Service (HAS).

It is therefore appropriate that the reasons for this are explained more fully.

From the outset it should be understood that the Society will continue to give the HAS every help and advice that it can, in its capacity as an independent professional society and charity. What the BGS felt it could not do, was to remain as a corporate partner of the HAS when it had doubts over the financial governance of the HAS.

The HAS is no longer funded by the DoH and has to generate its own income from the services it provides. In 2001, the Older People's Services of the HAS was losing money, and it was only their Mental Health Services which still provided a positive cash flow. At the time the BGS withdrew, the HAS were forecasting a loss of £100,000 for 2002. A plan to reverse the declining trend had been put forward, but under the present conditions in the NHS, the BGS perceived this as a high risk strategy, involving as it did, an initial outlay of up to £60,000.

The BGS was represented on the Board of the HAS by two directors and trustees. Trustees under Section

1(1) of the Trustee Act 2000 have a duty of care. The Charity Commission guidelines state that they 'are required to act reasonably and prudently in all matters related to the charity'. It is difficult to see how the BGS's representatives on the HAS Board could have been deemed to be acting prudently, had they supported a financial plan that was, rightly or wrongly, in their opinion and in the opinion of the BGS Executive, an imprudent plan. It would also have created a difficult and uncomfortable situation for the Board of the HAS, in managing the organisation, when two directors were fundamentally opposed to future policy. In consequence the Society felt that it had no alternative but to withdraw from the HAS as a corporate member.

In looking at the duty of the BGS trustees, one also needs to bear in mind that they were trustees both of the HAS and of the BGS; they therefore had a double duty of care. Whilst the BGS's financial exposure to any loss by the HAS was limited, it nevertheless seemed to the BGS Executive, undesirable that it should support a policy that it considered financially unwise.

It is a matter of great regret that this difference of opinion on financial management should have occurred. The BGS is in every other respect, fully supportive of the aims of the HAS and will continue to give every support it can to assist the HAS in its work to improve the provision of older people's services.

R G Lynham
Company Secretary

<p>The Society and Research into Ageing (RIA) are delighted to announce the availability of a research training fellowship to members of the Society with an NTN. The Fellowship is funded jointly by the Society and RIA, but will be administered by RIA.</p> <p>Outline applications are invited from prospective applicants for a project start after July 2003. The funding is for a period of two years and should not exceed £90,000.</p> <p>The research remits applied by RIA cover the biology of ageing and, diseases and disabilities associated with older people. Cancer research is</p>	<p>not normally funded. Applicants may be any nationality, but the project must be carried out in the UK.</p> <p>To apply: Further information and application forms are available on the RIA website:- www.ageing.org</p> <p>Telephone enquiries to lan Jarrold at RIA, on 020 7843 1572.</p>	<p>THE DHOLE RESEARCH TRAINING FELLOWSHIP</p> <p>jointly funded by</p> <p>Research into Ageing and the British Geriatrics Society</p> <p>Deadline for applications: 8 Nov</p>
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Poole Intermediate Care Services



win first National Queen Mother Award for Intermediate Care

HRH Prince Charles announced the winners of the award at the Queen Elizabeth Conference Centre on 30 July - with Intermediate Care Services in Poole winning the first National Queen Mother Award for Intermediate Care.

Marianne Lambourne from Poole Primary Care Trust and representatives of all the Poole Intermediate Care Services were present at the award ceremony.

In Poole, Intermediate Care comprises

- ◆ The Woodlands Elderly Resource Team
- ◆ Rapid Response Home Care Service
- ◆ Home from Hospital Home Care Service
- ◆ Rehabilitation Home Care Service

These services all work very closely together to provide care that is focussed on patients' individual needs.

The 'extras' that impressed the judges for this award are

- ◆ Collaborative learning sets
- ◆ Carer involvement▶



Woodlands Elderly Resource Team

This is a team of health and social care professionals who provide specialist advice, support and intervention to older people in their own homes. The team includes Physiotherapists, Occupational Therapists, Social Workers, Rehabilitation Assistants, Dietician, Speech and Language Therapist, Pharmacist, Patient Advocacy and Specialist Nursing.

The team offers crisis intervention to prevent admission to hospital, community rehabilitation,

enhanced discharge to help older people move out of hospital and back home more quickly, falls clinic and falls management programme, specialist rehabilitation and carer support.

The team was developed from a community rehabilitation team based at Alderney Community Hospital, funded by Dorset Healthcare NHS Trust. The PCT have built on the work that was started by Dorset Healthcare NHS Trust four years ago to develop the Elderly Resource Team.

Home from Hospital Home Care Service

A specialist home care service provided by the Borough of Poole Adult Social Services (commissioning). It is used by hospital staff to allow older people to leave hospital quickly with the help that they need to regain their independence at home.

Rapid Response Home Care Service

A specialist home care service provided by the Borough of Poole Adult Social Services (commissioning). It is available for two weeks to support an older person or their carer at home, and prevent their admission to hospital or residential care. It can be accessed by primary care teams, staff in A&E, the Woodlands Elderly Resource Team, or any social services staff.

Rehabilitation Home Care Service

This is a specialist home care service provided in partnership between the Poole Primary Care Trust and Borough of Poole Adult Social Services.

The service is based within the Elderly Resource Team and it provides intensive rehabilitative home care to older people in their homes.



- ◆ Multi-agency working parties
- ◆ Patient advocacy
- ◆ Use of a Single Assessment

Marianne Lambourne, Intermediate Care Manager, said “We are extremely proud to win this prestigious award. The front line staff who work so tirelessly to provide these services need to be recognised for their dedication and commitment. If it wasn’t for the staff from this wide range of different services working so well together for older people, they wouldn’t be nearly so successful. The staff based at the Woodlands Elderly Resource Team have worked particularly hard together, to make sure older people in Poole receive tailor-made therapy and care that recognises their individual needs. I am very proud of the work they have undertaken and wish to thank them for their effort in giving people much more independence than could have previously been expected.”

Dr Matt Thomas, Consultant Physician in Medicine for the Elderly at Poole Hospital said: “We are proud

to have helped Poole PCT to develop their Intermediate Care services. With their help we are able to offer the most appropriate care for older people locally. Before the Woodlands Elderly Resource Team was developed, patients were sometimes admitted to hospital unnecessarily, or kept longer in hospital because there were fewer alternatives. Now older people in Poole can receive the most appropriate care for their needs and can often return to their homes more quickly.”

Angie Smith, Principal Officer from Poole Social Services said, “We have been developing these services over the last few years and are proud to be leading the way nationally, particularly with the Rehabilitation Home Care Service which allows older

people to receive intensive rehabilitation in their own homes, and has produced some quite remarkable results. The Rapid Response Home Care Service and Home from

Hospital Home Care Service were both available in Poole before many other areas in the country. We are very grateful for the hard work of the staff that provide these services on our behalf from SCA Community Care Services and Care UK, and very proud of what they have achieved.”

For further information contact Julia Lawrence - Tel. 01202 710100.

Press release provided by **Dr Matt Thomas**
Consultant Physician, Poole Hospital NHS Trust❖

Intermediate Care was described in the National Service Framework for Older People as “integrated services that promote faster recovery from illness, prevent unnecessary acute hospital admissions, support timely discharge and maximise independent living”.

Department of Health Publications

Free Access to Care Services guidance: Free Access to Care Services guidance is now available at www.doh.gov.uk/scg/facs . This guidance provides councils with a framework for setting their eligibility criteria for adult social care, and should be implemented by April 2003.

Reimbursement for Delayed Discharges: Published July 2002, this consultation paper sets out proposals to introduce a system of

reimbursement, at the point at when responsibility for a patient’s care transfers from NHS to social services. Subject to legislation, the

Government intend to introduce the reforms by April 2004. A similar system introduced in Scandinavia is claimed to have had a major impact on reducing the extent of delayed discharge for older people. The consultation is open until 18 September and the BGS Policy Committee will be preparing a response. www.doh.gov.uk/jointunit

Fully Equipped 2002: In June the Audit Commission published a report on action taken following publication of

the original ‘Fully Equipped’ report in 2000. The 2000 study was critical of the failure of commissioners to use additional funding for the purpose for which it was intended. The 2002 report found some areas of excellence and innovation, but the general consensus is that so far the recommendations within ‘Fully Equipped’ have yet to be fully implemented. The report sets out a further range of recommendations for commissioners, highlighting the financial benefits of good equipment services for health and social care economies. It can be accessed at www.audit-commission.gov.uk/publications/upequipped02.shtml

Sheffield Institute

for Studies on Ageing

The Sheffield Institute for Studies on Ageing (SISA) is a multi-disciplinary research and undergraduate and postgraduate training centre concerned with the health and social care of older people and their health and well-being.

It was established in 1993 in the Faculty of Medicine of the University of Sheffield. SISA is both a core group of specialists in gerontological research and training, who form a section of the School of Clinical Sciences in the Faculty of Medicine, and a cross-faculty network of academics in the University of Sheffield with

Sheffield University - Firth Court



active interests in gerontology. The wider network has an executive drawn from the biological, engineering, social science, nursing and medical school departments, and a faculty

membership of over 50 researchers. In addition to its research activities, the Institute plays a role in influencing policy on ageing and in training the next generation of researchers on ageing. The Institute has links to service and advocacy groups in South Yorkshire, where it has a direct impact on improving the quality of life of older people in the region.

SISA core group

Research

We are an inter-disciplinary group of 10 full-time staff and associated research assistants. The core group's expertise extends from clinical medicine to ethnographic research; and includes particular interests in geriatric assessment, intermediate care, stroke rehabilitation, palliative care, dementia care, housing choice, the organisation and effectiveness of community health and personal social services, and the development and appraisal of homeless services. SISA researchers are presently conducting projects

funded by, among others, the European Union, European Science Foundation, and the Department of Health.

Current active research grants in the core group are in excess of £5 million, and during 2000/01 we authored over 50 refereed articles and authored or edited 8 books. Details of current grants and publications can be found on our web site.

During 2000/01, SISA saw major developments in its staffing and research programmes.

Highlights of 2000-01

National Director for Older People's Services

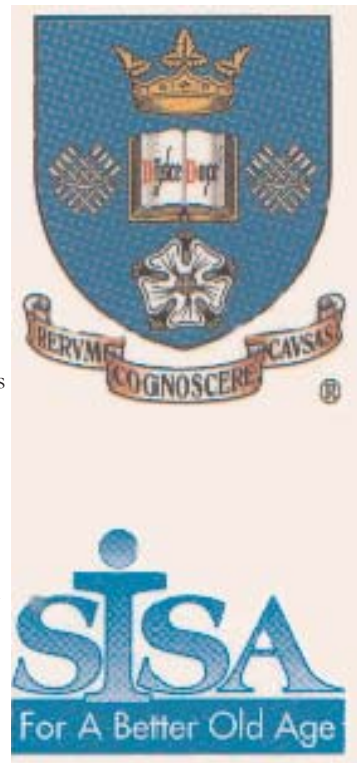
In November 2000, Professor Ian Philp began a three-year secondment to the Department of Health as National Director for Older People's Services, chiefly to finalise and implement the *National Service Framework for Older People's Services*, published in March 2001. Professor Tony Warnes took over as Director of SISA.

Barnsley Chair

In the summer of 2000, Professor Stuart Parker joined from the University of Leicester as Professor of Health Care for Older People. He has been appointed to the inaugural Chair in Geriatric Medicine at Barnsley District General Hospital NHS Trust, ▶

Core Academic Staff

Professor Tony Warnes (*Director*)
 Professor Stuart Parker (*Clinical Director*)
 Professor Ian Philp (*Professor of Health Care of Elderly People*)
 Professor Associate John Young (*Bradford*)
 Dr Salah Gariballa (*Clinical Senior Lecturer*)
 Dr Mike Jennings (*Clinical Senior Lecturer*)
 Dr Kevin McKee (*Lecturer*)
 Dr Merryn Gott (*Lecturer*)
 Dr Maureen Crane (*Leverhulme Research Fellow*)
 Dr R Ullegaddi (*Clinical Research Fellow*)



where he joins Dr Salah Gariballa, Clinical Senior Lecturer, appointed the previous year. Together they are developing both the health district's older people's services and a foundation research programme.

New Lecturer

In May 2001, Christine Parker was appointed to a lectureship in gerontology. A medical statistician and psychologist, she has worked on multi-centre studies of dementia and of rehabilitation after stroke. She had been a research fellow on a joint EPSRC-funded project with the School of Architectural Studies that is studying associations between design features of nursing homes and the quality of life of the residents. She will continue with the analysis of this and follow-on studies, and be engaged with the *EASY-Care* and *COPE* research programmes.

Intermediate care research theme

A significant development has been the award to teams, including SISA members, of two of the three projects in the *National Evaluation of Intermediate Care R&D Programme* and *Intermediate Care: A National Evaluation* programme. This is a multi-centre project to be conducted by a consortium drawn from the Universities of Sheffield (Professor Stuart Parker), Leicester and Birmingham and led by Professor Gillian Parker, Director, Nuffield Community Care Studies Unit, University of Leicester. The second award is to Associate Professor John Young, based at St Luke's Hospital, Bradford, for the project which he leads on a *Multi-centre Evaluation of Community Hospital Care for Older People*.

Research grants

Other highlights have been the good progress of the

ESRC and EPSRC projects directed by Dr Kevin McKee, and the rapid expansion and early national media impacts of Dr Merryn Gott's research on sexual health among older people, which is supported by Pfizer. Dr Salah Gariballa has raised grants with Dr Hilary Powers of the Centre for Human Nutrition from the PPP Health Care Trust to support a prospective study of nutritional supplements among older people. Dr Maureen Crane has been awarded a Leverhulme Special Research Fellowship to complete her longitudinal study of the resettlement of older homeless people, and to develop a comparative three-nation project on the causes of homelessness. An ESRC award has been granted to Tony Warnes and Maureen Crane for the British component. Tony Warnes has also been awarded a grant by the European Science Foundation to support a Scientific Network on access to health and social care services among older migrants and expatriates in Europe, while Dr Jane Seymour and Dr Merryn Gott led a successful bid under the joint ESRC/MRC Innovative Health Technologies Programme to explore the role of health technologies during the end of life care of older people.

Teaching

Lectures

SISA contributes to teaching in all phases of the undergraduate MBChB curriculum. The broad aims are that at qualification students should: understand the principles of assessment of physical, mental and social functioning in older patients and have developed communication skills with older people; have a knowledge and understanding of the organisation of health services for older people; and have a knowledge of the epidemiology, causes, prevention and management of the common diseases of old age.

The delivery of this teaching is through a series of lectures in phase 1, and teaching in communication skills and clinical examination in phase 2. In phase 3a (Medicine in the Community) students are tasked to: undertake a comprehensive, assessment of the physical, mental and social functioning of a frail older person living at home, and discuss management with members of the primary health care team; take a history from a deaf older person using guidance for communication with someone who is deaf; and discuss with their GP tutors, primary care approaches to the care of older people, including drug prescribing for multiple medical problems. ▶



From left to right back row: Prof Stuart Parker, Dr Kevin McKee, Cos Tingle, Dr Mike Jennings, Dr Merryn Gott, Dr Salah Gariballa, Prof Ian Philp, Prof Tony Warnes and Dr Raj Ullegaddi. From left to right front row: Keung Mi Oh, Chris Parker, Sharon Hinchcliffe, Joy Marriott, Beth Fawcett, and Carrie Taylor.

A lecture on the causes, consequences, prevention and management of falls in older people is followed by small group work and plenary discussion. A final session is devoted to discussing the characteristics of frail older people and how services are organised to respond to their needs.

In level 5 of the course (phase 3b of the revised curriculum), core teaching is provided in the organisation of health care services for older people, and the assessment of patients undergoing rehabilitation. The department also offers a B.Med.Sci. in Social Gerontology and has contributed to the Bsc Paramedical Studies through a two week module on 'Health care for older people'.

New Masters gerontology courses

Early in 2001, the cross-disciplinary planning group for new Masters gerontology courses received the good news that a new module, 'Introduction to gerontology', had been approved. The course will first be offered in the second semester of the 2002/03 session, starting February 2003, in the revised Masters

course pathways of the School of Nursing and Midwifery. The course is also available as a University *Research Training Programme* module. The syllabus of the module 'Elderly people and elderly patients' has been revised with a stronger emphasis on research methods and priorities for delivery in the Spring semester of 2002.

SISA cross faculty and gerontological research clusters

The SISA cross faculty activities include a series of public lectures and research stimulation activities. In addition there are a number of active gerontological research clusters (see boxes below) situated in departments across the University which are active in the clinical and social sciences.

Overseas Development Group

The principal training development during the past year was the launch in July 2001 of an intensive▶

SISA - GERONTOLOGICAL RESEARCH CLUSTERS

Palliative and end-of-life care

Department or section: Sheffield Palliative Care Studies Group (SPCSG), Academic Palliative Medicine Unit, and The Trent Palliative Care Centre

<http://www.sheffield-palliative.org.uk>

Investigators: Professor David Clark; Professor Sam Ahmedzai; Professor Sheila Payne; Dr Jane Seymour

Osteoporosis and ageing

Department: Bone Metabolism group, Section of Medicine, Division of Clinical Sciences (North)

www.shef.ac.uk/~med/index.html

Investigators: Professor Richard Eastell; Dr Aubrey Blumsohn (Senior Lecturer); Dr Nicola Peel (Honorary Senior Lecturer); Postdoctoral Research Assistants: Dr Lynne Ferrar, Dr Rosemary Hannon, Dr Yvette Henry, Dr Bridget Ingle, Dr Helen Lambert, Dr Kim Naylor, Dr Margaret Paggiosi, Dr Angela Rogers, Dr Christine Smith.

Supporting older people and their families

Department or Section:

Community, Ageing, Rehabilitation Education and Research (CARER), School of Nursing and Midwifery

www.snm.shef.ac.uk/departments/car/carer.htm

Investigators: Research leads: Professor Mike Nolan, Dr Sue Davies, supported by several staff (Louise Brereton, Jayne Brown, Dr Elizabeth Hanson, Janet Nolan, Dr Pat Schofield and Josie Tetley)

The Disability and Ageing Research Cluster

Department: Dept of Sociological Studies

Investigators: Professor Tim Booth (co-ordinator), Professor Alan Walker, Dr Ruby Chau, Dr Margaret Lloyd and Dr Lorna Warren, with Professor Richard Jenkins and Dr David Phillips as associated members; 2.7 fte research staff and 16.5 PGRS are attached to the cluster.

Extending quality of life

Department: Dept of Sociological Studies

Investigators: Prof Alan Walker, Dr Catherine Hennessy, Kristina Martimo

Rehabilitation and intermediate care

Department: Institute of General Practice & Primary Care, School of Health and Related Research

Investigators: Prof Pam Enderby, Liz Croot, Dr Alex John, Michelle Marshall, Dr Tony Ryan, Joanne Thompson.

vocational course for health and social care managers from low income countries. Titled *Ageing and Development*, it is a joint initiative of SISA and Dr Peter Lloyd-Sherlock of the Overseas Development Group in the School for Development Studies at the University of East Anglia. The inaugural run attracted nine students from Brazil, Mozambique, Malaysia, Montserrat, South Africa, Trinidad and Zimbabwe and a Japanese national who works for the United Nations Population Fund. Many colleagues in the University helped with the teaching programme, which was unusually stimulating for the tutors and positively evaluated by the students.

Public lectures

The SISA programme of multi-disciplinary public lectures, which began in our inaugural year, continues to provide a diverse programme of excellent speakers and to be well supported. It is organised by Dr Lorna Warren of the Department of Sociological Studies and a member of the SISA Cross-Faculty Executive. During 2000-01, there were lectures on 'Dementia in context', 'Family, kinship and ageing', 'Did people in the past grow old?', 'Developing gerontological nursing', and 'Euthanasia and palliative care', the annual joint lecture with the *Trent Palliative Care Centre*. The *Marjorie Coote Annual Lecture* was delivered by Baroness Sally Greengross, Director General of the *UK International Longevity Centre*, with the title 'Facing the Future: What Does an Ageing Society Mean to Us

All?

Research development workshop on 'Assistive Technologies'

In June 2001 Professor Mark Hawley and Dr Jane Seymour of the SISA Cross-Faculty Executive helped organise a research stimulation workshop on 'Assistive Technologies' for older patients and their formal and informal carers. The overall objective was to bring engineering, social science and health service research expertise in the University together, and to identify 'hot' topics and those which Sheffield teams are exceptionally well placed or enthusiastic to research. An afternoon programme was designed with a 'round table' format, and the structured agenda with short presentations on existing or past work proved stimulating. It led immediately to new inputs into an outline bid led by Professor Peter Tregenza of the School of Architectural Studies to EPSRC to establish a new multi-disciplinary research consortium to research *Sustainable Urban Environments*. The outline bid has been successful and Judith Torrington is now engaged with potential partners in the consortium building process.

Prof Stuart Parker
Clinical Director

Sheffield Institute for Studies on Ageing❖



Prof Ian Philp

LAUNCH OF DEMENTIA SERVICES COLLABORATIVE

Health Secretary Alan Milburn, together with **Ian Philp, National Director for Older People's Services** and **Harry Cayton, Chief Executive of Alzheimer's Society** recently launched a major project to improve the care of people with dementia across the North East, Yorkshire and North Lincolnshire.

Under a new Dementia

Services Collaborative, GPs and staff from community health services, hospitals and social services will join forces with the voluntary and independent sector to make it easier for people with dementia to get help. It will also give people with dementia and their carers a chance to have their say on what services they need.

For further details contact:
0191 215 6110❖

PD MASTER CLASS

Preliminary announcement: Parkinson's Disease Academy

19 to 20 September 2002

St Austell, Cornwall

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

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

Presenting posters at Scientific meetings

a guide to design



The following guidelines for preparing presentation posters was adapted from the work prepared by Dr Rustam Al-Shahi, Prof Charles Warlow and the Medical Illustration Dept of the University of Edinburgh

Content

- ◆ Make your title short and snappy summarising, if possible, the message of the research. “Poor management of urinary incontinence is more expensive than you think” is more inspiring than, “An observational study of the excess NHS costs associated with poor management of urinary incontinence on geriatric medicine wards.”
- ◆ Keep the messages minimal, maybe two points of information at the most (if you have more, then consider more than one poster presentation).
- ◆ The abstract you submitted to get your poster accepted is for the Abstracts Book. Your poster should not reproduce your abstract. Rather, it should illustrate and expand on your abstract.
- ◆ Use the smallest number of words you can get away with. A poster is NOT a paper (which should come later) and you can deal with any questions at the time of the poster session. Aim for a word count between 300 and (an absolute maximum of) 500.
- ◆ Don't feel constrained by the scientific paper format of introduction, methods, results and discussion. The results and methods sections can often be merged, as can the discussion and conclusions.
- ◆ Do not include references unless you are desperate.

Style

Layout (see example opposite)

- ◆ Use a portrait (vertical) rather than landscape (horizontal) format, although conferences may occasionally insist on the latter.
- ◆ Use an A0 single sheet print out (841 x 189mm),

rather than several A4 sheets.

- ◆ Use a white poster background.
- ◆ Surround the poster contents with a thick black line.
- ◆ Consider the photographer's rule of thirds: very often the key bit of a photo is one third from the top or the bottom of the picture, so use 2 columns for text and one for graphs.
- ◆ There should be a dark stripe across the top with your logo at the right hand end, and maybe another research specific logo at the other end. In this stripe goes the title and below that, the authors and institution in smaller, white letters.
- ◆ The reading order of a poster should be down columns, rather than across rows.
- ◆ Panels for graphs should have a light grey/blue background with black letters.
- ◆ Use a maximum of four colours; the dark stripe at the top, the white background, the grey/blue panel background, and one other.
- ◆ Put the conclusions in a prominent panel at the bottom of the poster.
- ◆ Watermarks in the middle of a poster tend to distract. A good picture or cartoon to attract the eye, set by itself in a panel would be much better. After all, people use pictures in platform presentations, so why not on posters?
- ◆ Do not justify the column text if there are few words to a line.
- ◆ Be selective in your use of bullet points, perhaps only in the conclusion.

Font

- ◆ Poster body text must be readable from 2 metres (with the possible exception of references) and the title from 4-5 metres.
- ◆ Use a black *sans serif* font (e.g. Arial or Gill Sans) throughout.
- ◆ Avoid capital letters except at the beginning of sentences and proper nouns.
- ◆ Do not underline anything.
- ◆ Use a bolder, larger typeface for the main titles and headings. It can be effective to use a different typeface for headings and subheadings.
- ◆ To emphasise body text, use a bold or italic font.

Vacancy

Specialist
Physician
in
Geriatric
MedicineWaikato
Hospital in
Hamilton,
New
Zealand

Waikato District Health Board

Our services for the elderly are based on site at Waikato Hospital Hamilton, New Zealand, is seeking to appoint two Specialist Physicians in Geriatric Medicine to complete a team of six consultant physicians.

The Waikato District Health Board is committed to improving services for older people to meet the increasing demands of this significant population and would provide career opportunity in contributing and making a difference to the development of this service.

Patients are treated at Waikato

hospital as well as in the community and these services will expand with the addition of further specialists. Geriatric medicine services are based at a 600 bed tertiary hospital, in an urban area and is close to many outdoor recreational activities.

Applicants will need to be eligible for Registration with Medical Council of New Zealand, and are expected to have postgraduate qualifications and appropriate training in General and Geriatric Medicine.

Representatives from the Waikato District Health Board will

be visiting the UK towards the end of October and would be available to meet with you to answer any queries you have about this opportunity.

For more information or to register your interest please contact the Recruitment Centre, Waikato District Health Board. Telephone 64-7-839-8949, fax 64-7-839- 8738 or email: recruit@waikatodhb.govt.nz.

For an informal discussion, please contact Dr Sarath Fonseka or Rose Hawkins (64-7-839-8899)

The Flexible Masters Programme
Postgraduate Award
in

Diabetes
and the
Older
Person

18 - 22 Nov 2002

Centre for Health Services Studies,
University of Warwick

Led by:-
Prof A J Sinclair &
Dr R Gadsby

This PGA programme (20 CATS points at level 4) is aimed at healthcare professionals wishing to develop and enhance their knowledge and application of the principles of diabetes and the older person in the workplace.



The course structure involves: -

- Day 1** Ageing, glucose tolerance & metabolism, epidemiology & prevalence in older populations, diagnosis & methods in older people.
- Day 2** Functional assessment of older people, cognitive function assessment, complications & care pathways.
- Day 3** Diabetes treatment issues in the elderly, metabolic & vascular risk assessments.
- Day 4** Models of care, organising local services for older people with diabetes.
- Day 5** Diabetes in care homes, education of staff, care plans & care structure.

Consisting of lectures, seminars, tutorials and home study. Can form the module of the Warwick Masters Programme in Diabetes (MClinSci, MA, MSc).

For an application pack or further information, please contact:

Miss Kerry Drakeley.
PGME.
Avon Building Westwood,
University of Warwick,
Coventry
CV4 7AL

Tel: (024) 7652 3913
Fax: (024) 7652 4311
Email: k.j.drakeley@warwick.ac.uk
Website: www.warwick.ac.uk/fac/sci/Medical

Course Fee: - £600

Vacancy

**SHO/
Registrar
in
Geriatric
Medicine**

**South
Australia**

Looking for a short term opportunity in sunny South Australia? The Repatriation General Hospital (RGH) is an accredited 260 bed acute teaching hospital with close clinical and training links to Flinders Medical Centre and Flinders University of South Australia.

The RGH is seeking to appoint a SHO/Registrar in an accredited position for the Australian Faculty of Rehabilitation Medicine and Australian Society of Geriatrics. This will involve an Occupational Training Visa initially for 12 months, with the possibility of

extending. The position will be a Stroke and Aged Care attachment in a Rehabilitation Unit. There will be the opportunity to learn specialty skills through attendance at the osteoporosis clinic, memory clinic, stroke unit and spasticity clinic.

Salary & Special Conditions: Salary package approximately in the range A\$56K to A\$83K per annum depending on qualifications. Air-fare assistance is available.

Qualifications & Experience: Applicants must be registrable with the Medical Board of South Australia.

Enquires: Further information is available from Dr. Tim Jones, Consultant Rehabilitation & Aged Care, telephone (08) 8276 9666 or email tim.jones@rgh.sa.gov.au.

Applications, including curriculum vitae and the name, address and contact number of 3 referees, should be forwarded to: Mr. Ken Mayes, Manager Medical Administration, Repatriation General Hospital, Daws Road, Daw Park, S.A. 5041.

Applications close Friday, 27 September 2002.

DIABETES

**Diabetes Special Interest Group
Annual Meeting**

13 to 14 September

Derbyshire

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

**REHABILITATION AND
INTERMEDIATE CARE**

**Reforming Intermediate Care
and Rehabilitation Services**

18 September

London

Contact: Mr Jay Stewart, Nexus, Alexander House, Alexandra Terrace, Guildford, Surrey GU1 3DA. Tel: 01483 306912 Email: bookings@nexusgroup.co.uk

**IRISH
GERONTOLOGICAL
SOCIETY**

50th Anniversary Conference

20 to 21 September

University College, Cork

Conference is approved for CME

Contact: Ms L Murray, 10 Beaumont Avenue, Ballintemple, Cork. Tel. 00353 21 4293918. Email: lucette@iol.ie

REHABILITATION

**Effectiveness of Rehabilitation
for Cognitive Defects**

17 to 19 September

Cardiff

Contact: Ms K Giblin, School of Psychology, Cardiff University, P O Box 901, Cardiff, CF10 3YG. Tel: +44 (0)29 2087 5356. Website: www.cf.ac.uk/psych/ercd

PARKINSON'S DISEASE

**PD Master Class
Parkinson's Disease Academy**

19-20 September

St Austen, Cornwall

Residential Master Class, designed for consultants, final year SpRs and staff grades currently running or wishing to run PD clinics. Participants will be locally mentored until the second residential 2 day module (dates to be agreed) in London. Cost £250 per person

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

LONG TERM RESIDENTIAL CARE

Long Term Residential Care for Older People - Policy into Practice

24 September

London

Contact: Harrogate Management Centre, FREEPOST LS6534, Progress House, 87 Skipton Road, Harrogate HG1 4LF, Tel: 01423 531166. Email: info@hmc.co.uk

DEMENTIA

Dementia - Current Developments - National Conference

4 October 2002

York University

Contact: National Conference Secretariat, P O Box B135, Huddersfield HD1 1YG. Tel. 01484 532102. Fax: 01484 425 699. Email: worldforum@aol.com

FAIR ACCESS TO CARE SERVICES

Implementing the Guidance on Eligibility Criteria

17 October 2002

London

Conference is approved for CME

Contact: Harrogate Management Centre, FREEPOST LS6534, Progress House, 87 Skipton Road, Harrogate HG1 4LF. Tel: 01423 506611. Email: info@hmc.co.uk

GERIATRIC ONCOLOGY

7th International Conference - Cancer in the Elderly

27-28 September 2002

Boston, Massachusetts, USA

Contact: Heather Drew, Imedex Inc., 70 Technology Drive, Alpharetta, GA 30005-3969, USA. Tel: +1 770-751-7332. Email: H.Drew@imedex.com. Website: www.imedex.com

MAXIMISING YOUR SINGLE ASSESSMENT PROCESS

14 October 2002

London

Suitable for CME

Chaired by Dr K Kelleher and speakers including Dr I Carpenter

Contact: Ms E Woodward, The Bookings Dept. IBC UK Conferences, Informa House, 30-32 Mortimer Street, London W1W 7RE. Tel: 01932 893852. Url: www.healthcare-info.co.uk/LH1175

NHS ALLIANCE

Vision into Practice - Are we getting better?

17-18 October 2002

Harrogate

Topics to include: Redesigning primary care and service delivery

Contact: Procon Conferences Ltd, Tattersall House, East Parade, Harrogate HG1 5LT. Tel. +44 (0)1423 564488.

NEW TECHNOLOGY IN ELDERLY CARE

New Technology in Elderly Care SIG

8 October 2002

Charing Cross Hospital

Topics include: automatic fall detection and prevention systems and physiological monitoring at home.

Contact: Dr F Miskelly, Postgraduate Medical Centre, Charing Cross Hospital, Fulham Palace Rd, London W6 8RF. Tel: 0208 846 7197. Email: f.miskelly@ic.ac.uk

AUTUMN MEETING 2002

BGS Autumn Meeting 2002

16-18 October 2002

Novotel Hotel, London

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

NUTRITION IN CARE HOMES

Nourishing Older People in Care Homes - a series of one-day courses

Taunton - 23 October 2002

Birmingham - 13 November 2002

Leeds - 27 November 2002

Cost: £125.00

Contact: Ms G Maylin, RIPH, 28 Portland Place, London W1B 1DE. Tel: 020 7291 8362. Email: gmaylin@riph.org.uk

**BGS HEALTH SERVICES RESEARCH
SPECIAL INTEREST GROUP**

HSR SIG Conference

31st October 2002

The British Library, 96 Euston Road, London

Focus on measuring outcomes in chronic disease and the format of the meeting will be a series of focussed presentations followed by a panel discussion based on questions submitted from the floor.

Contact: Beth Fawcett at SISA, Community Sciences Centre, Northern General Hospital, Sheffield S5 7AU
Tel: 0114 2714939. Email: B.Fawcett@sheffield.ac.uk
Website: www.shef.ac.uk/misc/groups/bgshsrsi

**BAP CERTIFICATE IN CLINICAL
PSYCHOPHARMACOLOGY**

1½ Day Module - Drug Treatments in Old Age
Psychiatry

6-7 December 2002

Manchester

Contact: Susan Chandler, BAP Office, 36 Cambridge Place, Hills Rd, Cambridge CB2 1NS. Email: susan@bap.org.uk

**GERIATRICS &
GERONTOLOGY**

International Conference

8 to 10 November 2002

India Habitat Centre, New Delhi

Separate Sessions for Doctors,
Scientists and Nurses

Cost: Doctors/Scientists US\$100

Contact: Dr O P Sharma, K-49,
Green Park Main, New Delhi -
110016, India. Tel: + 91-11-
6865916. Email:
opsharma@geriatricindia.com
Website: www.geriatricindia.com

**OSTEOPOROSIS AND
DEPRESSION**

EUGMS Symposium

6-8 December 2002

Warwick

Deadline for abstracts: 30 Oct 2002

On line registration:
www.mfgroupe.com

Contact: MF Congres, 8 rue
Tronchet, 75008, Paris, France. Tel:
+ 33 (0)1 40 071 121re-
info.co.uk/LH1175

GERIATRICS IN AFRICA

Geriatric Care in Africa -
International Conference

6-8 March 2003

Cape Town, South Africa

Call for papers:
www.uct.ac.za/depts/pgc-
geriatrixafrica.html

Contact: Janet Sirmongpong,
Conference Management Centre,
University of Cape Town, Faculty
of Health Sciences, Observatory
7925, South Africa. Tel: +27 21 406
6330. Fax: +27 21 448 6263. Email:
jsirmong@curie.uct.ac.za

**ARTIFICIAL NUTRITION
& HYDRATION:
SCIENCE, ETHICS AND
LAW**

11 December 2002

See page 12 of this newsletter
for more detail

Publication and Copy Information

The BGS Newsletter is published every second month by:
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