

july 2000



Editor: Rebecca Dunn

B G S

n e w s l e t t e r

Our new home

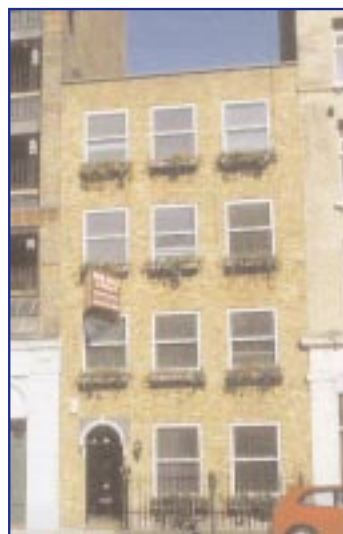


The Society has now moved into its new London home in St John's Square, Clerkenwell.

The four storey building with ample office space and meeting rooms will provide a secure base from which to pursue the Society's aims of supporting some of the most vulnerable people in society.

The Clerkenwell area is steeped in history, St John's Square itself being built round most of the inner precincts of the Priory of the Knights of St John of Jerusalem, founded at the time of the Crusades. A circle of cobblestones, which

mark the round nave of the 1140s Priory Church, can still be seen on the surface of the Square and the 12th century crypt, one of London's few Norman buildings, survives.



31 St John's Square, Clerkenwell

Two doors along from the BGS office is St John's Gate, which was built as the main entrance to the Priory of the Knights of St John in 1504, and now houses the headquarters of the modern British Order of St John, the parent of two famous charities, St John Ambulance and the St John Ophthalmic Hospital, Jerusalem. The St John's Gate museum can be visited free of charge and guided tours of the whole building and priory can be made by prior arrangement.

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specialist medical society for health in old age

FINANCING THE MOVE

The BGS officially became a freehold landowner on 18 June when contracts were exchanged. While there was no difficulty with the principle of securing a mortgage with the Society’s bankers, the process would seem to be inspired by Kafka!

The Society’s fund raising efforts continue, with the Honorary Treasurers determined to pay off the £275,000 mortgage as soon as possible. The good news is that while the response to the corporate fund raising appeal has not been overwhelming, there has been a steady dribble of £300 - £500 from each of several Trusts and Corporations.

The financing of the building has been achieved as follows:

FINANCIAL SUMMARY	
BGS stock market investments redeemed	£279,029
Individual Appeal	£ 8,170 (pledged and banked)
Subscription levies	£ 20,760
Regions	£ 10,234
Corporate Donations	£ 3,000
Total to date	£321,193
Paid out of surplus cash	£103,807
Mortgage	£275,000
Total	£700,000

Our thanks go to those members who have responded to the individual appeal, and a particular word of thanks to the members in the Mersey, Scotland, Wessex, East Anglia, Northern, South East Thames and North Western Branches for undertaking the difficult task of organising the Regional donations.

Please keep the money coming!

NEW CONTACT DETAILS

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Editorial



Whew - we've done it - a place of our own! Buying a house is a major event for the individual and buying a property causes no less stress for an organisation.

But the BGS has done it and more quickly than anticipated. Congratulations to the office staff, Officers and Council members who worked hard and often at short notice to make it happen. The Society now has a permanent home from which to extend its work on behalf of the aged and infirm. I think it should be named 'Marjory Warren House'.

A waiting game

I feel in limbo as we await government action in many areas relevant to the health care of older people. The National Beds Inquiry, Intermediate Care, the funding of long-term care, the spending review, the National Service Framework and the National Plan for the New NHS spring to mind. Will there or won't there be a government white paper on older people? Much is promised for July, so perhaps when you read this the wait will be over and we'll know where we stand on some of these issues.

Innovations

BGS membership is made up of more than consultants and this should be reflected in the Newsletter. This time there is a Trainees' column, which Dr Brian Wood and Dr Steve Parry hope to make the first of many. Sharing good practice is important and starting on page 19 are articles by some of the expert innovators who presented at the conference for SpRs last October (Newsletter Nov 1999 page 22). More are to follow. If you have set up a novel service and feel inspired to write and tell us about it, get typing.

Good news for the Health Advisory Service (HAS)

HAS has secured government funding towards administrative and staffing costs for the next three years. Also it has been commissioned by the Commission for Health Improvement to adapt and develop methods for clinical governance reviews in mental health trusts, and the possibility of using its expertise with services for older people to develop methods for similar reviews in community trusts is under discussion. The name HAS 2000 will be obsolete by the end of this year and so it is reverting back to HAS. The HAS staff who work with older people are keen to keep the BGS up-to-date with their work and plans. They will be meeting some of the BGS Officers and writing a series of articles for the Newsletter. They are also willing to talk at BGS Regional Meetings. Email: helenbowers@compuserve.com. To find out what it's like to be at the receiving end of a HAS service review read Dr Robert Luder's article (page 17).

Good practice in continence services

Dr Adrian Wagg, Professor James Malone-Lee and Dr Peter Overstall are familiar names on the lists of those involved in producing this guidance document published by the Department of Health in April. It is available at: www.doh.gov.uk/continenceservices.htm. The accompanying letter from the Chief Medical and Nursing Officers which lists a number of actions that could be taken by Primary Care Groups and Trusts to implement the guidance is at: www.doh.gov.uk/cmoh/cmoh.htm.

Praise for BGS website

The Society's website was commended in the BMJ of April 15. This success is due largely to the work of Recia Atkins, our Finance Manager, and her husband. Thank you both and well done.

Rebecca Dunn

President's column

In the wake of the euthanasia debate, the latest media scare story centres on hospital resuscitation policies and procedures.

A flurry of press reports and a BMJ editorial were stimulated by an Age Concern news release about a 67 year old woman who had found a 'not for resuscitation' entry in her clinical record. Apparently there had been no discussion about this with her or her relatives.

Like the euthanasia issue, this is a very complex area which gains little in clarity when it is the subject of media interest or politicians' soundbites.

At our own Executive meeting in May we discussed a referral from one of the BGS regional branches. Our colleagues had expressed some concern about the implementation of policies relating to cardiopulmonary resuscitation (CPR) in elderly patients. First of all it is important to recognise that CPR is a form of medical treatment which should not be shrouded in mystery. It can be effective but it also has the potential for serious adverse effects in survivors. Studies have shown us that 20% of patients may initially survive CPR, but perhaps 14% of patients of all ages will survive to leave hospital and only 4% of the over 75 year age group.

Recently issued guidelines

The BMA, Resuscitation Council of the UK and the Royal College of Nursing issued a joint statement on decisions relating to CPR in June 1999. This document provides useful guidelines which are not entirely prescriptive and they should assist hospitals in the development of CPR policies. They make it quite clear that it is important to identify patients for whom cardiopulmonary arrest is a terminal event and in whom CPR is inappropriate. It is vital to encourage the involvement of patients, members of the health care team and people close to the patient in decision making and to

ensure the communication of decisions to all relevant health professionals.

Do-not-resuscitate (DNR), not-to-be resuscitated (NTBR) or not-for-resuscitation (NFR) decisions should be considered in the following circumstances:-

- ◆ Where CPR is unlikely to be successful
- ◆ Where CPR is not in accord with the patients' expressed wishes
- ◆ Where CPR is not in accord with a valid advance directive or statement
- ◆ Where successful CPR is likely to be followed by a length and quality of life which would not be in the best interests of the patient to sustain.

Documenting decisions

The overall responsibility for DNR decisions should rest with the Consultant or GP in charge of the patient's care. The entry in the medical case record of the CPR decision should be made by the most senior member of the medical staff available. A similar entry should be made in the nursing notes. DNR decisions should be under constant review depending on the patient's progress. Doctors tend to be reluctant about making and documenting DNR decisions, but a CPR policy based on evidence of likely success and consultation can work well in clinical practice.

For the time being the BGS Executive Committee has endorsed the published 1999 joint statement, but we do recognise the complexity of this issue and we have set up a short-life working group of BGS members, with special expertise in this area, to clarify the practical application and potential pitfalls associated with the guidelines.

Brian Williams

Further reading: 'Decisions Relating to Cardiopulmonary Resuscitation'. A Joint Statement from the BMA, the Resuscitation Council (UK) and the RCN, June 1999. Available from the BMA's Medical Ethics Department in London, tel: 020 7387 4499.

BGS PRESS RELEASE

Further to the Age Concern press release mentioned in the President's Column, the BGS issued the following press release on 13 April 2000.

Patient choice and end of life decision making

The British Geriatrics Society is committed to patients of all ages being actively involved in any decision about their health care and treatment.

It strongly opposes any decisions about access to NHS resources being determined by age. Further, the British Geriatrics Society endorses the application of BMA guidelines to all decisions about the care of patients at the end of life.

Trainees' column



At the last Autumn Meeting, elections took place for the current Trainees' Committee.

The various members of the Trainees' Committee sit on the majority of the national BGS committees (with two reps on the committees most relevant to trainees) and act as a voice for all of the trainees.

Current postholders

- ◆ Brian Wood – Chairman (sits on the SAC, BGS Council, Training Committee, BMA Medical Specialist Trainees' Committee and the RCP JSC for Geriatrics).
- ◆ Steve Parry – Vice Chairman (sits on the Scientific Committee, BGS Council and the Psychiatric Liaison Committee)
- ◆ Ian Reeves – Rep to Policy Committee
- ◆ Nigel Becket – Rep to Finance Committee
- ◆ Jonathan Trembl - Rep to Training Committee

All of the above are available to answer any queries on issues from trainees regarding the area in which they are involved and can be

contacted via the BGS office staff who will contact the relevant person (Tel: 020 7608 1369 or email: Info@bgs.org.uk).

Trainee meetings

We currently meet as a group twice a year at the BGS meetings (further apologies for the disastrous meeting at Warwick – this should be ironed out in the future). At these meetings all trainees in attendance will be able to bring up matters with the committee and usually one of the senior members of the SAC. At future Spring Meetings we hope to hold the trainees' meeting towards the end of Thursday, followed by an informal social gathering. We also intend to meet up as a group with all of the regional trainee reps on the Thursday of the meetings to highlight any other problems. All trainees should be aware who their own regional rep is.

Tenure of the committee

The national committee currently remains in post for 18 months, but we are keen to extend this tenure to two years at a vote at the next BGS meeting. The reasons for this are twofold. Firstly to give the postholders longer to 'get their teeth into the job' and enact change where needed, as previously people have felt 18 months was too short to do this. The second

reason is that this would mean the elections would take place at the Autumn Meeting, which is generally well attended.

Current issues

The main issues of relevance occurring to trainees at present are changes in progress to the curriculum, and everyone’s favourite bedtime novel – the logbook. Revision of these is required from the JCHMT and matters regarding this are in progress. The new curriculum will include more rigorous assessment procedures, but not at present an exit exam. These changes will not happen overnight, and should not be applied retrospectively to current trainees. Visits from the SAC to the different training rotations will be starting again, and trainees will be

encouraged to play an active part in these visits to ensure training standards are met and are equal throughout the country.

A lot of the current trainees have come through ‘Calmanisation’, and by and large survived to tell the tale. It seems from recent meetings that generally trainees are much happier with their training, their role in the BGS and that improvements have been made. Change (and hopefully improvement) is inevitable and will continue, and the trainees should continue to have representation regarding these changes and to use it effectively. If there are problems, get in touch!!

Brian Wood, Chairman
Steve Parry, Vice Chairman

The BGS, National Beds Inquiry and Intermediate Care

With this newsletter we enclose a supplement containing our response to the Department of Health’s consultation document on the findings of the National Beds Inquiry, ‘*Shaping the Future NHS: long term planning for hospitals and related services*’.*

Recent government statements have strongly indicated that even before the end of the official consultation period on possible future patterns of hospital and community services for older people, they favour an increasing role for ‘intermediate care’. This is encapsulated in the document as Option 3, care closer to home. Although Government thinking is no doubt strongly influenced by the annual winter beds crisis, other considerations are also important.

Rehabilitation outside hospital

Evidence of ‘inappropriately’ long hospital stays emerged during the 1990s, particularly in the Audit Commission reports of 1992 and 1997. Information of variable quality is collated centrally by the NHSE on delayed discharges. The King’s Fund has strongly promoted in conferences and publications the notion that rehabilitation can be effective and efficient if provided out of hospital wards. Despite the dearth of evidence, government publications and statements frequently cite as ‘examples of good practice’ schemes such as residential rehabilitation units, nurse led pre-discharge wards and so on. Geriatricians have been leaders in producing good evidence of effective specialist rehabilitation, e.g. after strokes or falls, and in day hospital and domiciliary settings. Despite this, there is a danger that the specialty is being side-tracked in policy discussions and decisions about intermediate care. Our response to the National Beds Inquiry is part of the BGS’s efforts to redress this. We have also

reviewed the Intermediate Care document in the BGS Compendium. The basic tenets of this document are still very sound, but it must now reflect recent changes such as the introduction of primary care trusts and local authority joint investment plans.

Specialist input is vital

Several meetings have taken place, including with ministers and civil servants in the DoH, at which the key importance of specialist comprehensive geriatric assessment and rehabilitation have been emphasised. The President and others are in close contact with the medical Royal Colleges to advise on the geriatric viewpoint on intermediate care and have been successful in changing their views. There is an urgent need for the messages to be pushed home in the districts and to argue for adequate resources and time to be available for consultant involvement in intermediate care developments, at the stages of planning,

implementation, and monitoring. There may be scope for the development of gerontological nurse practitioners to work in community settings but closely allied with geriatric departments. We have had discussions with the DoH about this.

Not all geriatricians will wish to refocus their work towards the community, but if the speciality does not succeed in preserving the specialist components of rehabilitation of older people, and play a leading role in its implementation across the health and social care divide, we will have failed our successors as well as our patients.

Brian Williams, President

Finbarr Martin, Policy Committee Chairman

**The consultation document is available at www.doh.gov.uk/nationalbeds.htm*

'DEVELOPING INTERMEDIATE CARE SERVICES' - CONFERENCE REPORT

I was pleased to chair this Laing & Buisson conference at the Royal College of Physicians on 19 April 2000. The timing was propitious following the announcement by the Secretary of State for Health of Intermediate Care Service (ICS) development in February. Much uncertainty exists regarding ICS and this conference explored the subject with an interesting audience mix of Primary Care Groups, Health Authorities, Social Services, Trusts and a wide spectrum of providers.

Prof Judith Lathlean reported the varying approaches to measure effectiveness and Gareth Jones, a recent DoH recruit, reminded us of the working definition of ICS: 'A whole system approach to a range of multidisciplinary, multi-agency services designed to maximise independence by

- ◆ Maintaining people in their own homes or homely settings wherever

possible;

- ◆ Reducing avoidable hospital admission;
- ◆ Facilitating timely discharge and promoting effective rehabilitation;
- ◆ Minimising premature or avoidable dependence on long-term care in institutional settings.'

Whole systems approach

Doug MacMahon championed the need for integrated care within a whole system, highlighting his international experience from the Winston Churchill fellowship he held in 1998. Comprehensive geriatric assessment, chronic disease management and the BGS policy all promoted with just one final rogue slide, or was that a slide of a rogue! Bob Lewis, an ex director of Social Services and presently a non-exec of Stockport Acute Services NHS Trust, took a broad view to make clear that both local government and the Health Services were changing

inevitably and stressed partnership action. Andrew Dearden, a GP from Cardiff, constructively cited Winnie the Pooh, 'It's best to know what you are looking for before you look for it', and broadened the discussion beyond beds to health and care generally. Graham Smith, Managing Director of BUPA Care Services, made clear that proper funding would be key to successful ICS projects and offered an open book approach to contracting; a useful base cost projection of £625, rising to perhaps £775 in the South East. Examples of ICS projects that had been successful were given, for which sustained funding had proved difficult with commissioners seemingly reluctant to make a long-term commitment.

Prof Nick Bosanquet advanced the opportunities for palliative care across the diagnostic spectrum and Richard Bailey demonstrated the real

opportunities for ICS to assist orthopaedic surgery.

Common themes

The presentations made it clear to me at least that early ICS projects may be Health Authority or even Trust driven as components of secondary care services; as Primary Care develops it is possible to see partnerships with Social Services for forms of sub-acute care. The perspective of presentations varied, there was lively discussion and common themes emerged:

- ◆ ICS may be difficult to evaluate but

the outcomes of the whole system of care should be measured and critically reviewed. ICS should be an integrated part of the infrastructure of health and care services.

- ◆ Professional time is currently stretched for both primary and secondary care, and whilst even small IC projects may only require small inputs, this will need investment (as indeed all the professions allied to medicine).
- ◆ The unprecedented investment in long-term care over the last few decades by the private sector could be replicated for ICS, providing long-term contracting was financially viable for

partners.

- ◆ Need and improved outcomes rather than age should drive programmes.

In summary, the drive to manage old physiology in a high technology health service needs careful planning and responsible leadership; Geriatric Medicine is going to get a whole lot more interesting!

Clive Bowman
 Physician & Geratologist
 International Institute on
 Health & Ageing
 University of Bristol

Clinical governance



President Elect, Prof Cameron Swift, reports on the joint BGS/RCP committee paper on implementation of clinical governance.

The Clinical Governance working group (Dr D Black, Prof C M Castleden, Dr P Knight, Prof M Severs and Prof C Swift [Chair]) and the Executive were extremely grateful to the large number of members who responded under tight pressures of time to the request for comments on the circulated penultimate draft of the above paper. The feedback was amongst the most helpful and impressive of any recent BGS consultation, was scrutinised in depth, and resulted in substantial modification and adjustment of the final paper. The latter has now been circulated to all Council members.

With greater national prominence being given to professional self-regulation almost by the day, there is widespread support for ensuring that Geriatric Medicine has in place an accepted

method of clinical governance appropriate to the speciality and retains its current lead profile across the specialities. A notable finding of the baseline survey of clinical governance activity amongst geriatricians, mounted at the Society's December meeting, was that 98% supported the principle of external peer review of departments, although only 46% indicated they had a recognisable departmental development plan. (The questionnaire was circulated again at the Spring Meeting 2000 - full results are detailed overleaf).

In the feedback to the document members voiced a selection of broad commendations (e.g. 'a basis from which clinical governance can be effectively integrated into our practice') and reservations (e.g. 'get real'; 'clinical governance for cloud cuckoo land'). They also highlighted a range of specific concerns which have been carefully considered. These include the following in no particular priority order:

- ◆ The likelihood of 'half cock' procedures being introduced irrespective of College and Speciality recommendations
- ◆ The pace and scale of implementation, given the manpower and training implications

- ◆ The special problems of small departments
- ◆ The risk of duplication with clinical governance procedures for General Internal Medicine
- ◆ The possibility of conflicting roles of departmental versus trust Clinical Governance Leads
- ◆ The content of the primary list

A significant number of these have been reflected in the final document, and respondents should be able to identify corresponding elements of their handiwork. No document can comprehensively anticipate all operational detail or local negotiation. The overall view of Council, the Executive and individual respondents has, however, been overwhelmingly in favour of providing BGS members with as clear a statement as possible of the speciality position on implementation and taking this forward into the ongoing discussions. A number of safeguards have been further emphasised, and the document has, of course, to be read in conjunction with its predecessor (*Clinical Governance - a Joint Position Paper of the British Geriatrics Society and the Royal Colleges of Physicians*). The latter was widely disseminated last year and approved by the Councils of the BGS and the London College and the equivalent College bodies in Scotland.

The following points are stressed and have been relayed to the latest London College meeting in May and to the Scottish Clinical Governance group.

- ◆ The BGS does not endorse any alternative approach to Clinical Governance for the speciality at this point in time, although it is recognised that an evolutionary timescale for the achievement of a fully satisfactory system is realistic.
- ◆ BGS members may wish to make use now of some elements of the document for local purposes and planning, but there is no requirement to implement the procedure as outlined unless and until the specified manpower needs have been met.
- ◆ The process will not be formally implemented in this speciality in isolation from comparable systems across the range of subspecialties of Medicine under the aegis of the Royal Colleges. The latter situation has not so far materialised, although the way forward is being energetically pursued by the relevant committees on clinical standards.
- ◆ The use of 'screening standards' in isolation from the other clinical governance processes is unsound, and this section of the document has been relegated to an appendix.

The clinical governance group will continue to monitor developments and provide advice to the Executive, but it is clear that a substantial agenda in this area and in other aspects of peer support lies ahead for everyone, perhaps particularly at regional level.

Cameron Swift
President Elect

Results of baseline Clinical Governance Assessment for Consultant Geriatricians

	1999 (n=58)			2000 (n=106)	
	Yes	No	Don't know	Yes	No
1. <i>Appraisal</i>					
a. Have you had a job plan review in the last year?	56%	44%		51%	49%
b. Is your trust currently planning to introduce an appraisal system?	75%	18%	7%	84%	16%
c. Have you personally been appraised in the last year?	30%	70%		36%	64%
2. <i>Personal Development Plan</i>					
a. Through appraisal, or any other mechanism, have you had the opportunity in the last two years to agree a clinical or non-clinical personal development plan?	36%	64%		33%	67%

	1999 (n=58)			2000 (n=106)	
	Yes	No	Don't know	Yes	No
3. Departmental Development					
a. Is there a nominated lead clinician in your elderly care department responsible for service quality in developing the service?	54%	46%		50%	50%
b. Do you have a recognisable "Departmental Development Plan"?	46%	54%		36%	64%
c. Would you and your department know how to develop a "Departmental Development Plan"?	58%	42%		56%	44%
4. Outside Peer Review					
a. Do you support the principle of external peer review of whole departments?	98%	2%		96%	4%
b. Has your service had a review by the new Health Advisory Service (HAS2000) in the last two years? [SHAS in Scotland]	11%	89%		10%	90%
c. Do you have any audit or benchmarking systems in your department which use clinical outcomes of the service?	54%	46%		45%	55%
d. Are you confident that a Commission for Health Improvement visit could find a clear audit trail in your department, with regard to audit complaints, critical incidents etc? [C.S.B. in Scotland]	38%	62%		37%	63%

BGS Spring Meeting



Shakespeare country on a fine day, enjoying the fresh open campus of Warwick University as we went to register for the BGS Spring Meeting - it was a good start for the first BGS conference in the new millennium.

The 'Programme at a Glance' pamphlet promised a packed, interesting meeting. There were parallel sessions on each full day, which on the Thursday with the 'Interdisciplinary Rehabilitation Day' meant that at times there were four sessions from which to choose. The social programme

provided even further appetising choices with visits to Stratford, Warwick Castle, the Cotswolds, Coventry Cathedral and Stoneleigh Abbey, as well as the BGS golfing day.

Warwick University is situated nearer to Coventry than Warwick and covers almost 800 acres of the outskirts of the city. The doors opened to students in 1965. Those studying English have the benefit of tuition from Professor Germaine Greer, who has remained in the public eye since the publication thirty years ago of her famous book 'The Female Eunuch'. Student accommodation was adequate, thin walls and rather noisy water systems being offset by the convenience of having the

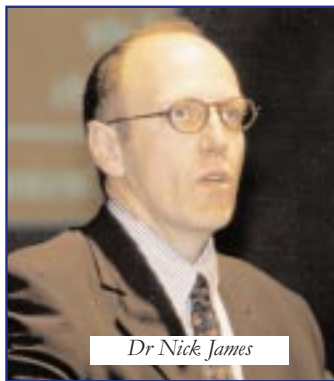
conference centre within easy walking distance. The comfort of hotels was preferred by some, which meant travelling 10-20 miles or so each day to and from Leamington, Stratford or Warwick. There was a problem with overbooking, with our President-elect being unlucky - rumour has it Professor Swift was to be seen roaming the depths of Warwickshire in the dead of night looking for somewhere to sleep!

The main lecture theatre and the two halls used for poster presentations were housed close together in the Arts Centre. Lunch was available across the road and parallel sessions were held in the Science Department, only a few minutes walk away.

Nearly 700 members registered for the conference. This included members from far afield, with representatives from most European countries, the USA, Canada, Japan, New Zealand and Australia.

The first session

Wednesday evening focused on 'Emerging Frameworks for Stroke Care in the UK'. Dr Wade from Oxford kicked off by describing difficulties faced when producing the RCP Guidelines for Stroke Care; particular problems included decisions regarding which evidence-base should be used and what to do when no evidence was available. John Gladman then discussed cost effectiveness of strategies in stroke care. There was no rumble of dissent from the audience when he commented that doctors are generally poor at assessing economic data. It hardly seemed to matter though as he confessed that 'heroic assumptions' are often buried within economic assessments, so the same data can show a strategy to be both significantly cost-effective and significantly cost-ineffective at the same time. Professor Tallis entered the arena to tell us about the National Service Framework for Stroke.... or so we thought; he announced the Government had sealed his lips, so in effect he had nothing to say! As could be expected from him, he very amusingly managed to say nothing with great authority, at times augmenting his 'tour de farce' with the odd TS Eliot quote.



Dr Nick James

Scientific programme

There were 32 oral and 78 poster presentations over the two full days, covering a wide range of topics. During one oral report we were reminded how precarious presenting can be nowadays, as the speaker pushed the wrong button, which immediately extinguished the slide and all lights, as well as prompting automatic closure of black curtains across the white screen on the front wall. We were totally in the dark! On a brighter note, this session may have produced a BGS record for the youngest attendee; a baby of only

a few months gently added an occasional chuckle to the proceedings. Whether the registration fee had been paid is being investigated. Dr Quiong (Liverpool) assessed the influence of iron status and age on transferrin receptors in rat small intestines; young small intestine cells were likened to babies, while mature cells were likened to footballers - surely a flawed assumption! One could

unfortunately argue that football supporters should also be included amongst the immature, for later that day came the ghastly news of the two Leeds supporters being stabbed to death in Istanbul.

Prizes

Dr Doyle (Dublin) was awarded the prize for the best oral presentation, which showed a link between lack of humoral immune response and the development of clostridium difficile disease. The poster prize went to Dr Kayan (Sheffield) for assessing the prevalence of osteoporosis in older women who fulfilled the RCP clinical referral criteria for bone densitometry. Two posters received honourable mentions: Dr Burns (Dundee) found that nearly three quarters of elderly people wear ill-fitting shoes and Dr Shah (Cardiff) showed there to be high levels of endomysial antibodies in osteoporotic patients. It was also announced that Dr Morris received the Hall Cup for winning the golf. The prize included full CME points for the day, or did I get that wrong?

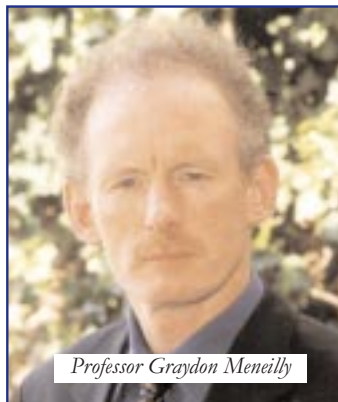
The 28 pharmaceutical exhibition stands were encircled by the posters, leaving plenty of space. Some pharmaceutical representatives felt that

had the Science Department and lunch building been closer, greater interest would have been shown in their exhibits during tea, coffee and lunch breaks. This may have had some effect, but the exhibits are of course in competition not only with the posters and coffee, but also the inevitable and enjoyable casual meetings with friends and colleagues. In view of the concern our President, when chairing a scientific session, encouraged members to make a conscious effort to visit exhibits. The consequences of the pharmaceutical industry withdrawing support do not bear thinking about.

Special Interest Groups

There was a real dilemma choosing between the Diabetes SIG and sessions on the ‘Scientific Understanding of Frailty and Surgery in Old Age’. Missing presentations is a disappointment and there may be an argument for videoing parallel sessions. Those who went to the Diabetes SIG were treated to first class lectures by Dr Tim Dornan and Dr Simon Page. New drugs and metabolic emergencies in diabetes were covered in clear, practical presentations. This included discussion on the need for insulin in thin insulin-deficient elderly diabetics, insulin clamping and cellular overhydration in HONK.

The Interdisciplinary Day was intended primarily for PAMS – Professions Allied to Medicine. There was a rush of interest and after 230 applicants all tickets had gone, so many were turned down. Areas covered included rehabilitation in primary care, pulmonary and stroke disease, as well as evidence-based rehabilitation. On the day, a large number of members decided to gate-crash so the lecture rooms were bursting at the seams; we are grateful to University staff for rapidly organising a video link and chairs in an area outside the hall to accommodate the extras.

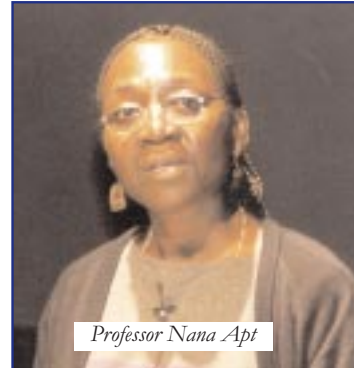


Professor Graydon Meneilly

Lectures

For the first Guest lecture, Professor Swift welcomed Professor Nana Apt from Ghana. The number of elderly and very elderly in Africa is dramatically increasing, while urban-

isation has led to a disintegration of the extended family, with young adults moving into towns, leaving the elderly in villages, often looking after grandchildren. A further social problem is that women earn little to no money, and what is earned is usually given to their partners. The women are then bereft of provision when their husbands either die or leave. To Professor Apt, resources going into the community mean that jobs can be created in rural areas so young adults will stay, allowing family structures to be maintained..... and we think we have problems.



Professor Nana Apt

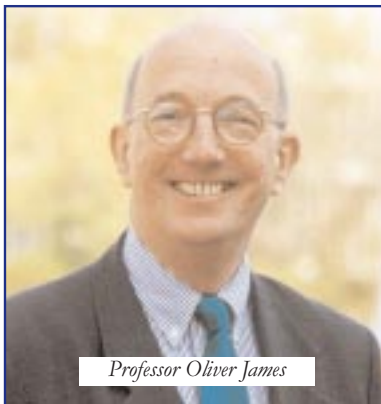
Friday started with Dr Nick James from Birmingham describing advances in radiotherapy as curative treatment; 3D planning techniques, better beams and better targeting now allow larger doses to be given with no increase in damage to normal tissue.

Professor Graydon Meneilly as a guest speaker from Vancouver reminded us that mild exercise programmes and weight loss in Type II diabetics can increase glycaemic control with no other change. Accepting that lifestyle changes are not uniformly helpful, he went on to describe new concepts in drug treatments. The acarbose tolerance test was a new one to me. This is used by Prof Meneilly for patients who need insulin but are reluctant to have injections. The test comprises giving maximum doses of acarbose from the start, so the overpowering GI side effects usually result in patients begging for insulin! For intrigue, this test is up there with the haggis tolerance test (*BMJ 1988; 297:1632-4*).

During Prof Meneilly's lecture one felt embarrassed at the thoughtlessness of some of our members. Mobile telephones went off on no less than five occasions, with one member actually having a short conversation. This was not the only session in which phone calls interrupted proceedings. The time has surely come when the Chairperson should ask audiences to turn off mobiles at the start of each session.

In the Clinical Update session Professor Roger Sturrock (Glasgow) gave very practical advice on the management of acutely inflamed joints, Professor Sir Netar Mallick (Manchester) discussed chronic renal failure, and Dr Stephen Young (Birmingham) brought us up-to-date with the immune system.

Professor Oliver James, standing in for Professor McMaster who was unwell, gave a typically stimulating lecture discussing the reasons for and consequences of low vitamin B12 and folate concentrations; this included



Professor Oliver James

describing the French 'Trout' and Boston 'Kentucky Fried' Schilling test equivalents in which radiolabelled vitamin B12 is added to trout and chicken respectively. Professor James' forthrightness is part of BGS folklore and he was true to form on this occasion, concluding his reply to one question with '...of course, you know I'm bullshitting really'.

The last morning featured end of life issues with palliative care, the case for and against euthanasia and clinical perspectives of euthanasia being presented. There was potential here for a rather spirited interchange. This did not though materialise, partly, no doubt, because some were thinking about heading

home. The session unfortunately only skated around the burning issue for geriatricians of withdrawing/not giving fluids and food. The matter is not at rest.

The BGS dinner

There was a generous drinks reception before the always enjoyable BGS dinner. We were



Baroness Mary Warnock

privileged to welcome Baroness Warnock as the guest speaker, who also chaired the last morning's session on 'End of Life'. She admitted being relieved that we were expecting to hear about ethical issues from her as she had recently been asked to give a speech and on the phone to the organiser gave the title as 'The Origin of Ethics'. This was misheard, and on arrival

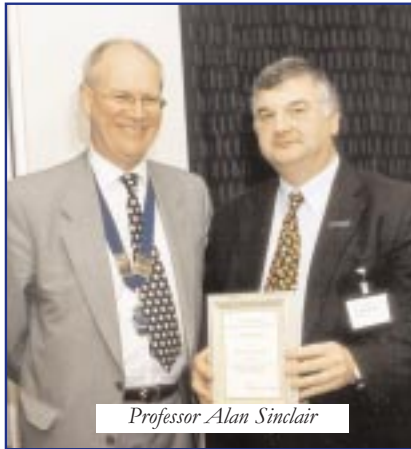
at the meeting she found she had been booked to speak about 'The Origin of Essex'! There was a lively reply to her most distinguished address by Dr Portsmouth, during which the many achievements of Baroness Warnock were acknowledged.

The President thanked all those involved in arranging an excellent conference. This included Dr Viswan (Chair), Professor Sinclair (Chair, Scientific Programme), Drs Ritch, Desai, Vaz and Lismore and the Secretariat. He presented flowers to the medical secretaries who put in a great deal of time and effort helping to prepare for the meeting (Ann, Sheila, Sue and Judy). Very many thanks also, of course, go to the BGS Central Office and Dr Margot Gosney, our Meetings Secretary, for so much hard work behind the scenes.

For those who did not go, you missed a really first class conference. For those who did go and for all those who will be going in the future, please keep those mobiles out of lecture theatres. Thank you.

Roger Lewis
England Representative on the
Executive Committee

The Warwick organising committee



Professor Alan Sinclair



Dr Kumaran Viswan

Members of the local organising committee receiving their certificates from the President at the BGS dinner.

Dr Viswan collected the certificate for Dr Vaz, who was unable to attend the dinner.



Dr Harsadroy Desai



Dr Alistair Ritch



Dr Jon Lismore

'IMPROVING ASSESSMENT OF CARE NEEDS FOR OLDER PEOPLE' CONFERENCE REPORT

This conference was organised by Laing & Buisson as part of a programme of health and social care conferences. Four assessment instruments were discussed: the inter-RAI MDS, EASY-Care, the RCN Assessment Tool and the HOOP. Discussion of these was packaged between an opening session on policy context and a closing session on the perspective from the independent sector and from social services.

DoH activity

I was impressed by the volume of current Department of Health activity on older people. Seven initiatives were described by Raymond Warburton, Section Head for Social Care of Older People at the Department of Health. Within months the Government will publish their plans for the balance of hospital and intermediate care beds (the National Beds Enquiry), the National Service Framework for NHS Care for Older People, Fair Access to Social Care, Continuing Health Care criteria, Housing Strategy, One-Stop Shops for integrated access to services and (at last) their response to the Royal Commission Report on the Funding of Long-term Care Services. Assessment is central to many of these policy initiatives. There is a team at the Department of Health looking at developing an integrated approach. There were clues to how this will shape up with a stronger user perspective, equal emphasis on psychological as well as physical well-being, sensitivity to the needs of ethnic minority groups and a focus on measuring outcomes.

National studies

The Audit Commission has also been busy working on older people's issues, with no less than four national studies being completed recently: on mental health of older

adults, disability equipment, charging for domiciliary care, and rehabilitation services for older people. Assessment systems were again viewed as central to initiatives in these areas. In particular there is a need to develop systems to identify older people who most need specialist multidisciplinary care in hospital and care settings. It is clear that new models of intermediate care are being developed at pace, but with high scope for local variation. Geriatricians must engage with these initiatives locally and at national policy level to ensure that older people's needs for specialist acute care and rehabilitation services are not overlooked.

The assessment systems

The four assessment systems had very different purposes: MDS –RAI for case-mix classification of residential and nursing home patients (with a developing family of linked instruments for other settings); EASY-Care for first stage assessment of older people in primary health and social care; the RCN tool to undergird excellence in nursing care of older people in nursing home settings; and HOOP to capture a holistic view of housing needs of older people. I was intrigued by HOOP, and felt it was a very promising approach in this neglected area of assessment.

Common themes emerged in discussion: the need for the individuality of the older person to be facilitated rather than suppressed by an assessment; the need to work towards common practice in assessment, including use of common assessment methods; and the need to link assessment systems within the framework of a national strategy for the assessment of the health, social care and housing needs of older people.

Enablement

In the last session, enablement emerged as the theme which underpins good practice in the care of older people. Cornwall is clearly a good place to live if you need social services in old age, according to Nigel Druce, Director of Social Services for Cornwall County Council. Developing front line staff, developing budgets and using technology intelligently were key features for success. The new agenda is to link community nursing with social work. If only community care was being developed along these lines elsewhere.

Independent sector ambitions

Peter Churley from Westminster Healthcare demonstrated the ambitions of the independent sector to work in the areas of rehabilitation and intermediate care of older people. It seems to me that we are at a break point in the care of older people. Radical policy initiatives are on the near horizon. Social services, primary health care, our colleagues in the nursing and therapy professions and the private sector are rapidly adapting their work. Our specialty of Geriatric Medicine has had the most experience, and is the most advanced specialist service for older people, pioneering development in healthcare for older people for fifty years.

We must exploit our rich heritage and experience to shape these initiatives and, in particular, help to ensure that frail older people have continued access to specialist acute care and rehabilitation services.

Prof Ian Philp

Centre for Ageing and Rehabilitation
University of Sheffield

Reflections on an HAS 2000 visit



Early in 1999, the wearying news that my local health authority was looking at yet another review of services for the elderly met my ears.

As with all of you who have had the goalposts moving so fast you don't know where to shoot, it was a depressing thought. Only three years before, an in-depth review had been held, with perhaps a less than decisive outcome; now all the arguments would have to be rehearsed all over again. However a new star was now hovering in the firmament of older people's services reviews: HAS 2000. As a newly trained reviewer, I was aware of what HAS 2000 could provide; nevertheless, I felt it to be ironic to be inspected by HAS, having never been on a review!!

History of HAS

I had been in on the re-birth of HAS as a BGS national committee member for North East Thames in 1996-7. (HAS 2000 was reorganised to be run by a consortium of the Royal College of Psychiatrists, the RCN, the BGS, and the Office of Public Management). Prior to this, HAS had been a form of 'quango' more or less (and often less) listened to, following reviews conducted regularly in most districts in the country. I had some trust in its abilities to provide a reasonably fair, informed and appropriate review, and therefore when the local health authority chief seemed to be opting for a 'quick and dirty' option, I pressed for my trust and others to insist on a proper and authoritative assessment by HAS 2000.

HAS 2000 is now a management consultancy, sinking or swimming by being hired by Government, health authorities, trusts and others to conduct in-depth enquiries into various services including older people's. The normal 'lead in' time to conducting such a review would

normally be nine months or so, but HAS was able to compromise and get involved much more quickly, given our local time constraints.

Our local concerns

The local issues revolved around where the management of two Units for the Elderly would end up; both had been managed by community trusts for approximately seven years, sitting for the large part within acute trusts with (often unfairly) not always benign views of both services. With the inevitable dissolution of community trusts, as mental health in London forms large monolithic blocks separately, the health authority was looking for a way of making the decision to place both elderly services within the acute trusts' remit. This formed one of the main planks of the visit.

Multi-disciplinary review team

The HAS party was made up of a representative mixture of therapists, nurses, managers (health and social service experience), a geriatrician, and administrator. Their time frame seemed ridiculously short to get to grips with two separate localities, two acute/community trust relationships, PCGs, two social services, if only one health authority! The technique employed was to assess services against a set of carefully derived and validated standards published by the HAS.

The visit was extremely intensive for the team, but gave relatively little time (understandable from the time constraints) to each individual or area. The interviews were conducted in a pleasant, professional and informal manner which lend themselves to getting to the truth, if only by making the individuals relaxed! One certainly got the distinct impression that HAS is always on the side of the older person, and by association, with older peoples' services. Tours of wards were opportunities to show off good practice, though other deficiencies were of course thrown up.

Feedback

At the end of three days of very hard work on the part of the team, a feedback session with all key stakeholders was arranged at a local hotel. This was a moment of undeniable tension, similar I'm sure to the initial OFSTED inspection report, if not quite in the same league as opening one's A level results! The first big surprise was how well they were able to assimilate all the information in the available time and produce a coherent report. The second was their ability to almost ignore suggesting anything around management change, which had been the *raison d'être* of the whole thing for the health authority! The subsequent draft report was followed by a formal feedback meeting with two managers from HAS. I and my department were extremely pleased on the whole with the outcome. The report supported virtually all of our main plans including a new consultant, the moving of a day hospital to the acute site to run it along medical assessment unit lines, the further development of stroke services (likely within Medicine for the Elderly), and singled out my unit for special praise! It would be churlish to pick holes too much, though one or two ideas did seem a little far-fetched i.e. converting a 25 bed ward to become the day hospital (with no other reprovision). There was no statement at all, however, about where the two units should be

managed in the future; this was left to discussions with the PCGs!

A worthwhile visit?

Do I think the visit was worthwhile, and well conducted? Do I believe it will make a difference to my unit's future? I would have to give it a resounding 'yes' on several counts. Firstly, it is less likely that the acute trust would bother to hold such an enquiry in the future; secondly, it will prove extremely valuable negotiating material with the acute trust and health authority; lastly, it gives valuable independent credence to a lot of points made by us over the past few years about our lack of resources.

One or two minor whinges: some of the HAS team took a rather social and not medical view of old people becoming unwell, who required medical sorting out; there were differences between the text of the final report and its conclusions. Nevertheless, it has been extremely worthwhile for us and I look forward to helping another area in the way in which we have been helped.

Robert Luder

Consultant in Medicine for the Elderly
Haringey Healthcare NHS Trust

A pride of presidents

Past, present and future Presidents of the BGS met recently to mark the new Millennium.

Pictured from left to right are:

Front row: Prof Cameron Swift (President Elect); Prof Jimmy Williamson (1986-88); Dr Marian Hildick-Smith (1988-90); Prof George Adams (1973-75); Dr Brian Williams (current President)

2nd row: Dr John Dall (1990-92)

3rd row: Dr Michael Denham (1992-94); Dr Arup Banerjee (1996-98); Prof John Brocklehurst (1984-86)

Back row: Prof Peter Millard (1994-96); Dr Bobby Irvine (1981-84)



Expert innovators



In the November 1999 issue of the Newsletter, Alistair Main reported on the 'Expert Innovators', who presented their particular service innovations at the SpR conference 'Understanding and running a comprehensive geriatric service'.

The presentations were so popular, that we have asked a number of the contributors to write a piece on their service innovations for the Newsletter. In this issue we look at four of them and more will follow in the next issue.

Movement disorder clinics



Movement disorders become more common and usually worsen with increasing age. Parkinson's Disease (PD) in older patients is often difficult to diagnose, is usually associated with considerable disability and results in complex management problems. Essential tremor, the commonest movement disorder, can also cause considerable handicap in older subjects and is commonly misdiagnosed as PD. Drug related movement disorders, such as drug induced parkinsonism and tardive dyskinesia, also increase in frequency with age.

A challenge for geriatricians
 Movement disorders present a considerable challenge to geriatricians, which can best be met by organising care for these conditions in the form of specialist clinics linked to interdisciplinary teams. As in stroke medicine, the key to success probably lies in the organisation of care, rather than in any particular prescriptive model. Local strengths

and weaknesses should dictate the way in which the service develops. Organised care should embrace the fundamental principles of geriatric medicine namely accurate diagnosis, comprehensive assessment, focussed interventions and outcome review.

Day hospital clinic

Our clinic is based in a day hospital and is supported by a nursing, therapy and welfare team. Clinics are held on two mornings each week and four new referrals and ten review patients are seen in each clinic. Referrals come mostly directly from general practitioners and we try to keep the waiting list to less than four weeks. On arrival at the clinic, patients undergo a detailed nurse led assessment of lying and standing blood pressure, motor function (simple test of upper limb akinesia and timed ten metre walk), mood, ADL and quality of life. Specialist disease specific assessment tools, such as the Unified Parkinson's Disease Rating Scale, are also used at diagnosis and at yearly intervals thereafter. Cognitive function is screened using the Mini-Mental State Examination with more detailed assessment using the CAMCOG section of the CAMDEX assessment package. Detailed assessment usually takes place over at least one pre-clinic assessment visit run by the nursing team for new referrals. The clinic provides a wealth of longitudinal and cross sectional data on patients with movement disorders, held on a computerised database, that can guide individual management, evaluate treatment regimes and drive the audit and clinical effectiveness cycles.

'Group Education Support and Therapy' programme

Most patients in the clinic have PD and are reviewed routinely at six monthly or yearly intervals. Patients with complex disease and rapidly changing disability may need to be seen at more frequent intervals. The clinic also runs a twice monthly Group Education Support and Therapy (GEST) programme for, and largely

designed by, patients with PD and their carers. Increasingly, partly to reduce the frequency of clinic review, telephone contact initiated by the nursing team is made to patients, GP surgeries and nursing/residential homes to monitor treatment response and side effects. Specialist nursing support is also needed to initiate and maintain patients on intermittent injection and continuous infusion apomorphine treatment. The failure to secure funding for a PD nurse specialist has limited our work in the community, although strong links have been established with the local PD Society branch and other voluntary bodies. Sustainable long-term solutions to patients' needs will involve developing expertise in movement disorder management within primary care, possibly involving practice nurses already in post.

Inevitably movement disorder clinics also come to care for patients with primary mobility disorders, particularly gait apraxia, and patients with predominant cognitive impairment. This results in a considerable degree of overlap between the clinical work of falls, memory and movement disorder clinics.

Jolyon Meara

Consultant Geriatrician
Glan Clwyd Hospital, Clwyd

Joint psychiatric assessment

When I was appointed Consultant Geriatrician in Carlisle in 1986 I inherited joint psychiatric/geriatric beds in a separate building on the main DGH site, established by my now retired colleague, Peter Chin. Over the last eight years, with the appointment of John Billett (a consultant colleague) and two consultant psychiatrists of old age (Chris Hallowell and Kate Porter), the unit has become established as a shared joint facility.

Specialist assessment unit

This year the unit has moved on to the main elderly care floor of a new PFI hospital, but has

retained its specialist identity. The 12 bed specialist assessment unit caters for patients with delirium and patients with dementia and medical complications. Most of the patients are over 65, but occasionally we provide a service for younger patients with cognitive impairment - for example with confusion, post cardiac arrest and with encephalitis. The unit provides a secure, safe environment with four single rooms and a male and female four bed area. The nursing staff includes nurses with both medical and psychiatric qualifications and the sister in charge is both an RGN and an RMN. We try to adopt a calm and relaxed atmosphere on the ward, allowing patients to wander if they wish, with minimal use of restraint and major tranquillisers and with use of reality orientation techniques. We have been fortunate in having a very enthusiastic clinical psychologist, Dr Una Holden, who has provided training for the staff.

Multidisciplinary input

As the unit is integral to the acute hospital, it is ideal for managing confused patients, either with dementia or delirium, who need the investigation and treatment facilities of the main DGH. We have a weekly joint multidisciplinary case conference at which both the psychiatrists and geriatricians attend, and follow-up is organised after discharge. Psychiatric input is particularly valuable in advising inpatients with dementia and predominant psychiatric symptoms, and in advising on capacity and risk management. Social Services particularly value a psychiatric assessment in cases when discharge appears to be hazardous and the patient is reluctant to accept care. The psychiatrists of old age are often familiar with many of the patients, as they have previously been seen in their home environment, and they have an intimate knowledge of the nursing and residential homes who cater for residents with mental health needs and can advise accordingly.

Delirium guidelines

The joint assessment unit has provided considerable audit, research and training opportunities. The unit provided a starting point for the development of guidelines on the management of delirium. This project attracted national audit funding and the final guidelines developed by Dr Lesley Young and myself are now available on the BGS website.

Reducing the stigma

Having a specialist unit, we believe, has reduced the stigma of looking after confused elderly people in acute hospitals. Unfortunately, the ‘they shouldn’t be here’ philosophy is still too common regarding confused elderly in acute hospitals, even though many of these patients have serious underlying acute illnesses. We believe having a joint shared assessment unit in the main DGH is a successful model for co-operation between psychiatrists and geriatricians, which benefits both patients and professionals alike. We are aware that other similar models exist around the country. These joint units tend to have arisen out of a re-organisation of service and new appointments. We think that this model is worth publicising as we anticipate similar opportunities will arise in other districts in the future.

Dr Jim George

Consultant Physician and Clinical Director
Cumberland Infirmary, Carlisle

**Continence

services**

Incontinence has always been a major challenge for geriatricians, but there has been a heartening change in attitude since pioneers such as Brocklehurst and Isaacs first highlighted and researched the problem. No self-respecting nurse in charge of a ward or nursing home would now tolerate the all-pervading smell of urine that so often used to greet you on arrival. Patients are now more willing to admit to urinary problems and all medical students receive at least some instruction in urinary incontinence, albeit only about three hours on average during their four and a half years of training. Although the scientific study of incontinence is now respectable and the International Continence Society (mainly urologists and gynaecologists) is vigorous and active with a membership in the thousands, it is still unfortunately true that the care of individual patients often leaves a lot to be desired. A recent study on community nurses

showed that continence care was generally poor. Many general practitioners have never had any training in the subject and there doesn’t appear to have been any change in the high prevalence rates of incontinence among elderly people, whether living at home or in institutions. So there is still plenty to be done.

Urodynamic assessment

My own interest in incontinence began when I was working with Norman Exton-Smith at St Pancras Hospital. Norman had formed a link with the Institute of Urology and a continence clinic was started at St Pancras run by a research registrar from the Institute. When I moved to Hereford I obtained funding from a drug company for a cystometrogram, and set up a continence clinic where for some years I took all referrals for urodynamic assessment. We now have a urologist and a uro-gynaecologist, who do their own urodynamics and we all share the same equipment. Even in a small district such as ours there is more than enough work for three different specialities, and every DGH has room for a ‘continence physician’. We have local guidelines advising GPs which patients are most appropriately seen by each consultant, but since we share the clinical nurse specialists in continence care and cross-refer amongst ourselves, the patients get sorted out no matter to whom they were initially referred.

Helpful DoH guidelines

If you are interested in developing continence services locally I would recommend the recently published ‘*Good Practice in Continence Services*’ (Department of Health 2000)*, which sets targets not only in primary care, but also in residential and nursing homes and for hospital in-patients. The emphasis is on a pro-active approach asking patients routinely if they have bladder problems, ensuring that they have an initial assessment by a suitably trained person, followed by a treatment plan. Continence services should be integrated with a director of continence services (usually a clinical nurse specialist) who will ensure that care pathways are in place, that regular audit is carried out, training needs are addressed, and that targets set out in the guidelines are met.

The model of an integrated continence service cries out for the involvement of a local

geriatrician and ideally one who is willing to hold regular clinics with urodynamic investigations where required (the techniques are not difficult to learn), to support the clinical nurse specialists in developing care pathways, particularly in residential and nursing homes and re-discovering core geriatrics. Come on in and get your feet wet!

Peter Overstall

Consultant in Geriatric Medicine
Hereford Hospitals NHS Trust

* *'Good practice in continence services'*, Department of Health, 2000. Available from Department of Health, PO Box 777, London SE1 6XH. Tel: 0541 555455. The document can also be downloaded from the DoH website: www.doh.gov.uk/continenceservices.htm

Community geriatrics

Background

The government is investing a lot of money on schemes which provide alternatives to hospital care and which may reduce the need for long-term care. Over the last few years Winter Contingency, Continuing Care Challenge, Health Action Zone, Partnership and Joint Investment Programme funds have been orientated towards community care schemes.

With Primary Care Groups carrying responsibility for commissioning of health care, you can be certain that every opportunity will be taken to develop services in the community to reduce the need for what is considered expensive hospital care.

At the same time geriatricians have been under pressure to become increasingly involved in the acute care of medically ill adults in hospital.

Furthermore in 1983 Rhodes-Boyson, then minister for social security, made the decision to

increase social security funding for long-term care, which has as a result largely moved into the community.

Community geriatrics fosters developments in community care, joint work with the local authorities, primary health care, private and voluntary organisations and takes specialist skills for care of the sick elderly into the community.

If we neglect this opportunity to work with primary health care and use the new money, we will fail to maximise the opportunity to develop new and exciting alternatives for specialist work in caring for sick older people.

What are the possibilities?

◆ Acute Care

There are many different hospital at home schemes, some of which have specialist medical involvement on a day to day basis, but most have specialists involved in the planning and the development of protocols of care. For example acute care schemes in nursing homes are developing very often with specialist medical involvement. These may either be to provide care for existing nursing home residents, or patients with acute illnesses can be admitted to a nursing home as an alternative to hospital direct from their own homes. It requires specialist input to decide which patients can be safely managed in this setting, using community based investigation when appropriate. There are successful schemes dedicated to management of particular conditions in the community e.g. Chronic Obstructive Pulmonary Disease or Deep Venous Thrombosis or unstable diabetes.

◆ Rehabilitation

Community outreach teams, domiciliary and outpatient therapy services are expanding in many cases as an alternative to day hospital care. Specialist medical staff may be involved in case review meetings, though often initial assessments are by therapists. A number of schemes providing rehabilitation and assessment in residential and nursing homes have been developed, with the purpose of avoiding hospital care and preventing unnecessary long-term institutional care.

◆ **Continuing Care**

There are many schemes providing alternatives to nursing home care in the patients' own home. These schemes can easily cost more than nursing home care but often are very popular with patients.

◆ **Respite Care**

Respite Care can be provided in the patients' own home by care staff rather than in an institution. Many schemes have developed to provide respite care in nursing homes as an alternative to hospital.

◆ **Palliative Care**

Palliative Care may be provided in the patient's own home or in specialist nursing homes rather than in a hospice or hospital.

◆ **Assessment for Long Term and other forms of care**

Geriatricians are often involved in community assessments for long term care supported by

specialist nurses. This work is often in conjunction with social services.

Conclusion

There are a range of exciting opportunities to develop community care, many of which benefit from specialist medical involvement with planning, if not with the direct provision of care. In the end there will be a comprehensive range of services in the community, which will prevent unnecessary hospitalisation and institutional care. As geriatricians we have a responsibility to be involved in order that patients can benefit from our specialist skills and knowledge. This will involve co-operative working with many other agencies including primary care groups, social services and the voluntary and private sectors.

Christopher Turnbull

Consultant Community Geriatrician
Arrowe Park Hospital, Wirral

INTERNATIONAL NETWORK FOR THE PREVENTION OF ELDER ABUSE

The 1997 IAG World Congress of Gerontology and Geriatric Medicine in Adelaide, Australia gave the opportunity to highlight the issue of elder abuse from a global perspective. The number of contributions far exceeded those in previous years and included two roundtable discussions, one invited symposium, a keynote lecture, one free paper session (with seven presentations) and three posters. Speakers' contributions represented North America (including Canada), the South America region, Europe and Oceania. Elder abuse was incorporated into the Adelaide Declaration.

Foundation of the network

One of the roundtable sessions established the first International Network of national and regional organisations working in the field of

elder abuse. The aim was to promote awareness and knowledge of the problem; disseminate information, education and training; promote research; and to assist with the development of responses within individual countries. The main goal of the International Network for the Prevention of Elder Abuse (INPEA) is to increase society's ability, through international collaboration, to recognise and respond to the mistreatment of older people in whatever setting it occurs, so that each individual can achieve an optimal quality of life in keeping with his or her cultural values and traditions.

The committee

A Steering Committee was established consisting of a Chair

(Rosalie Wolf, Worcester Mass USA), Vice-Chair (Lia Daichman, Buenos Aires, Argentina), Clerk (Gerry Bennett, London, UK) and Treasurer (Toshio Tataru, Tokyo, Japan). Regional representatives were established to co-ordinate the organisation globally, assigned to Europe, North America, South America and the Caribbean, Africa, Asia and Oceania. A meeting of the Steering Committee was facilitated by generous funding from Health Canada in February 1998 as part of the Ontario response to elder abuse and their establishment of a Canadian National Committee. Mission statement, aims and objectives and charitable legal status were ratified. A Board was formed reflecting the global nature of the organisation and free membership

for individuals, groups and organisations established. The development of a regular Newsletter and webpage (www.Inpeabuse.org) aided communication and dissemination of information. INPEA undertook to play a major role in the key conference of that year, the first World Conference on Family Violence in Singapore in September 1998. The issue of elder abuse achieved equal recognition with child abuse and domestic violence.

Rapid expansion

1999, the United Nations Year of the Older Person, saw rapid expansion in many of the regional components of INPEA. Preceded by an IAG Congress of Geriatric Medicine and Gerontology in Buenos Aires, Argentina in November 1998 and culminating in an IAG Congress in Havana, Cuba in September 1999, the South American Region saw the largest increase in membership and interest concerning elder abuse. Similar responses, however, were seen following the IAG European Congress in Berlin in June 1999 and a series of high profile conferences

in Africa and across Australia. Also in 1999 INPEA was honoured by the acceptance of Dr Alexandre Kalache, Chief of Ageing at the World Health Organisation (WHO) in Geneva, to be a Special Observer.

A global organisation

INPEA is now firmly established as a global organisation raising awareness on the issue of elder abuse. It will be a major contributor to two important documents concerning violence and older people to be launched in 2000 by the United Nations and WHO. Elder abuse featured prominently in the programme of the Brazilian Congress of Gerontology in June 2000 and will do so again at the next World Congress in Vancouver in 2001.

Living longer is both an achievement and a considerable risk. After 25 years and increased worldwide involvement, the causes and consequences of elder abuse are uncertain and the effectiveness of elder abuse treatment and prevention efforts unknown. By the

year 2025, three quarters of the elderly population will be in the developing world.

Our commitment

It is our commitment as gerontologists to go on working in this field during the forthcoming years at local, regional, national and international levels, combining efforts with other international groups sharing similar interests, in the belief that this work will be an important factor to better the quality of life in the world ageing population.

If you are interested in becoming a member of INPEA, please contact the UK Regional Representative, Bridget Penhale, Lecturer in Social Sciences, Social Work Division, University of Hull, Hull HU6 7RX. Tel: 01482 466 228. Fax: 01482 466 306. Email: b.l.penhale@comhealth.hull.ac.uk

Rosalie Wolf, Chair
Lia Daichman, Vice-Chair
Gerry Bennett, Secretary

ELDER ABUSE CONFERENCE

Abuse and Neglect of Older People: Clinical or Social Governance?
Novotel Hammersmith, London
18 October 2000

This conference is organised by the British Geriatrics Society and Action on Elder Abuse in association with St Bartholomew's & Royal London

School of Medicine & Dentistry.

Sessions include:

- ◆ The Government agenda on elder abuse
- ◆ Elder abuse 1988-2005: Policy and Practice
- ◆ Institutional abuse
- ◆ Physical abuse
- ◆ Abuse and neglect of the elderly mentally frail
- ◆ Research outcomes 1988-2000

- ◆ Abuse and neglect and the complaints system
- ◆ Social Services response to abuse and neglect
- ◆ The medical practitioner's role in abuse and neglect of older people

For further information contact: BHM Ltd, 1 Arun House, River Way, Uckfield, East Sussex TN22 1SL. Tel: 01825 769337. Fax: 01825 768864. Email: bgs@bhm.co.uk

BGS AUTUMN MEETING

**British Geriatrics Society
Autumn Meeting**

Novotel Hammersmith, London

19 to 20 October 2000

Full details and booking forms for the Society's Autumn Meeting are enclosed with this Newsletter.

Accommodation

As October is a very busy month for conferences in London, we would encourage anybody requiring accommodation at the meeting to book as soon as possible. Bookings at the Novotel can be cancelled without charge at any time up to 4 days prior to arrival. Cancellations received after that time will be subject to a charge equivalent to the first night's accommodation.

Further information: BGS Autumn Meeting Secretariat, BHM Ltd, 1 Arun House, River Way, Uckfield, East Sussex, TN22 1SL. Tel: 01825 769337. Fax: 01825 768864. Email: bgs@bhm.co.uk

DIABETES SIG

**Diabetes Special Interest Group
Annual Meeting**

**Provisional venue:
Stoke on Trent**

22 to 23 September 2000

Contact: Mrs E Clarkson, Personal Assistant to Dr Simon Croxson, Bristol General Hospital, Guinea Street, Bristol BS1 6SY. Tel: 0117 928 6101. Fax: 0117 928 6245.

HEALTH PROMOTION & PREVENTIVE CARE SIG

The Health Promotion and Preventive Care Special Interest Group is working with the Nuffield Trust in London to consider how comprehensive approaches to healthy ageing can be adopted nationally.

A small workshop will be held in London in late Autumn 2000 to be followed by a larger conference for BGS members in Spring 2001 to disseminate its findings.

Contact: Dr J E Morris, 7th floor, Royal Free Hospital, Pond Street, London NW3. Tel: 020 7830 2409. Fax: 020 7830 2681.

GERMAN GERIATRICS CONFERENCE

**5th Congress of the
German Society of Gerontology
and Geriatrics**

Nuremberg, Germany

18 to 20 September 2000

Contact: Dr Clemens Tesch-Roemer, German Centre of Gerontology, Manfred-von-Richthofen Strasse 2, 12101 Berlin, Germany. Tel: +49 30 7860 4266. Fax: +49 30 785 4350. Email: tesch-roemer@dza.de

BAPEN ANNUAL MEETING

**Annual Meeting of the
British Association for
Parenteral and Enteral Nutrition**

Harrogate

28 to 30 November 2000

Topics include: pharmaceutical issues of artificial feeding; nutritional aspects of the oncology patient; clinical governance in the management of disease related malnutrition; evidence based nutrition.

Abstract submission deadline: 10am on 30 August 2000.

Contact: Sovereign Conference, Secure Hold Business Centre, Studley Road, Redditch, Worcestershire, B98 7LG. Tel: 01527 518777. Fax: 01527 518718. Email: enquiries@sovereignconference.co.uk Website: www.sovereignconference.co.uk

AGEING COURSE

Short Course on Ageing, Health & Well-being in Older Populations

London

4 to 15 September 2000

The Centre for Ageing and Public Health at the London School of Hygiene and Tropical Medicine offers this course on ageing and its implications at both the population and individual level. The course is aimed at a multi-disciplinary audience.

Topics include: demography and economics of ageing; data sources and methods for studying older populations; health care planning and financing; assessment of health and social care needs; mental health in later life; nutrition and ageing; preventive health care and health promotion.

Course fee: £1,100. CPD applied for.

Contact: Short Courses Registry, London School of Hygiene & Tropical Medicine, 50 Bedford Square, London, WC1B 3DP. Tel: 020 7299 4648. Fax: 020 7323 0638. Email: shortcourses@lshtm.ac.uk

MENTAL HEALTH OF OLDER DRIVERS

The Older Driver with Mental Health Problems - Clinical, Legal and Ethical Issues

London

12 October 2000

This meeting, organised by the Faculty of Old Age Psychiatry of the Royal College of Psychiatrists, will see leading experts discuss an area of increasing clinical importance for a multi-professional audience.

Contact: Conference Office, The Royal College of Psychiatrists, 17 Belgrave Square, London SW1X 8PG. Tel: 020 7235 2351 ext 168. Fax: 020 7259 6507. Email: mkerby@rcpsych.ac.uk

IAG CONGRESS

17th World Congress of the International Association of Gerontology

Vancouver, Canada

1 to 6 July 2001

Theme: global ageing

Abstract submission deadline: 31 December 2000

Contact: Congress Secretariat, Gerontology Research Centre, Simon Fraser University, 2800-515 West Hastings Street, Vancouver, BC, Canada V6B 5K3. Tel: +1 604 291 5062. Fax: +1 604 291 5066. Email: iag_congress@sfu.ca Website: www.harbour.sfu.ca/iag/

JOB SWAP

A New Zealand geriatrician wishes to swap jobs with an English colleague for a year starting ca. December 2000. Trent region, Yorkshire or Lancashire preferred.

Contact: Prof Dick Sainsbury, The Princess Margaret Hospital, PO Box 731, Christchurch, New Zealand. Tel: +64 3337 7899. Fax: +64 3337 7975. Email: richard.sainsbury@chmeds.ac.nz

AUSTRIAN SOCIETY FOR GERIATRICS AND GERONTOLOGY AWARDS

Walter Doberauer scholarship of research of old age

The Austrian Society for Geriatrics and Gerontology awards this scholarship of ATS 60,000 every two years, with the next award being in 2001.

The Society welcomes applications from those undertaking research in

the fields of experimental gerontology or biology; social gerontology; or clinical geriatrics. Applicants must not be over 40 years of age. Directors of institutes or clinics are not eligible to apply.

Application procedure

Send a short CV, a description of the research project and a list of any

publications to:

Prim. Dr. Franz Boehmer, SMZ. Sophienspital, Apolllogasse 19, A 1070 Wien, Austria. Tel: +43 1 52103 1307. Fax: +43 1 52103 1309. Email: bof@cop.magwien.gv.at

Closing date for applications: 15 November 2000

EDITOR - AGE & AGEING

Professor Graham Mulley will by May 2001 have completed his statutory term as editor of the Society's journal *Age & Ageing*. The Society is now seeking to appoint a worthy successor to Professor Mulley, to continue the distinguished and creative work effected by Professor Mulley and his predecessors.

Applications for the post

Members are invited to apply for the post. Applications should be addressed to Professor R Stout, Chairman of the Editorial Board, at the Society's office at 31 St John's Square, London, EC1M 4DN, by no

later than 30 October 2000. Applications should comprise a CV and a letter outlining the applicant's plans for the future of *Age & Ageing*.

Desirable qualifications

Applicants should have a strong academic background, a broad view of geriatric medicine and ageing generally, and an ability to write in clear English. An international perspective and informal links with many academic departments would be an advantage. Tact, diplomacy and team-working skills are essential.

Appointments procedure

A Selection Committee, appointed by the Executive Committee, will consider applications. The Selection Committee will comprise the current editor, the Chairman of the Editorial Board, the President of the BGS and three other members chosen by the Executive. The Selection Committee will convene on 18 December 2000, and may wish to interview candidates. In the event that there are no suitable applications, the Selection Committee may headhunt appropriate candidates. The intention is to make a recommendation to Council by no later than January 2001.

CLOSING DATE FOR APPLICATIONS: 30 OCTOBER 2000

RESEARCH INTO AGEING JOINT AWARDS

Colin Kunkler Memorial Fellowship

The Macular Disease Society and Research into Ageing are seeking applications for a new research fellowship established in memory of the late Air Commodore Colin Kunkler, General Secretary of the Society 1988-1994, to be awarded for any area of research addressing the **causes, prevention or treatment of age related macular degeneration**. This award of up to three years' duration (subject to satisfactory progress), commencing

in Spring 2001, will cover full-time salary and consumables, up to a maximum of £36,000 per annum.

Ageing and the Vascular System

Applications are invited for a project grant to be offered jointly by Research into Ageing and the British Vascular Foundation to be awarded for research related to the **ageing process within the vascular system**. This grant of up to £30,000 is for one year in the first instance, with the possibility of extension for a further year.

Application procedure

Applications for both awards will be considered in November 2000. In the first instance, applicants should submit an outline proposal form (available from the address below) to arrive by **4 August 2000**.

For further information, contact:
Dr Lisa Swanton, Research into Ageing, Baird House, 15/17 St Cross Street, London EC1N 8UW.
Tel: 020 7404 6878.
Email: lisa@ageing.org

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