



Editor: David Lubel

# BGS

n e w s l e t t e r

A Lynx eye view of

## Queen Mary's Hospital, Hampstead



**Q**ueen Mary's Hospital is associated with the Royal Free Hospital in London. This article, an external reportage, is a story of quality in a time of change.

*Whilst every effort has been made to provide an accurate picture, the descriptions given and any views expressed are the perceptions of the reporting team; they do not purport to represent the policy or views of the Royal Free Hospital NHS Trust or any of the hospital staff. The reporting team is grateful to the hospital and its staff for the opportunity to visit Queen Mary's.*

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### The history

Founded originally by Queen Mary after the Great War as a maternity home for the wives of officers and soldiers, the mansion style building has long been a prominent feature on the top of Hampstead Hill overlooking London to the south.

Prior to 1985, Professor Archie Young and Dr Jackie Morris had managed 125 acute and chronic beds divided between the modern



Royal Free Hospital in South Hampstead and the old-style workhouse facilities in New End, half way up Hampstead Hill. In 1986, New End was sold and Queen Mary's acquired, whereby two new wings were added on to each side of the old mansion, effectively creating an 'I'-shaped building, but also forming, on the east side, 'welcoming arms' to the entrance courtyard along the style of the London Lighthouse building. On the west side, the tranquil garden of the old mansion remains, enhanced by a substantial conservatory, built onto the old mansion entrance and funded by the very active Friends of Queen Mary's, who, in addition to

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**President:** Dr Brian O Williams, MD, FRCP (Glas, Lond, Ed) **President Elect:** Prof Cameron Swift, PhD, FRCP  
**Honorary Secretaries:** Dr David D Lubel and Dr Rebecca Dunn **Meetings Secretary:** Dr Margot A Gosney  
**Honorary Treasurers:** Dr Jonathan M Potter and Dr Robert J Shepherd **Administrative Director:** Richard Lynham **Sub Editor:** Rawia Habiby

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## FOR HEALTH IN OLD AGE

# Editorial

page



**To treat patients differently primarily on the basis of their chronological age is discriminatory.**

Numerous examples of age-discriminatory practice exist within the NHS and most are to the detriment of older people. Access to ITU beds, renal replacement therapy, oncology services, cardiac rehabilitation programmes and screening for breast carcinoma are just a few examples. Ageism is as endemic within our health care system as it is in society at large.

### Age Limits on Health Care Bill

It was, therefore, pleasing to see a Bill designed to address this situation, proposed by Dr Vincent Cable, Liberal Democrat MP (Twickenham), and passing the first stage to make it into print on 16 February 1999. The *Age Limits on Health Care Act 1999* amends the *NHS (Primary Care) Act 1997* to prohibit the refusal or delay of treatment on the basis of age and also establishes an inquiry into the prevalence of age discrimination in the NHS. This Private Member's Bill was brought in under the 10-minute rule and is most unlikely to clear all the hurdles to become law. The more general *Age (Prevention of Discrimination) Bill*, proposed by Mr Robert MacLennan on 13 March, never even made it into print.

### Is the system of geriatric medicine discriminatory?

Perhaps we need to question whether the system of geriatric medicine itself is discriminatory? Strangely enough, advocates of both integrated and age-related geriatrics would probably agree that it is, but for very different reasons. The age-related camp regards working to an age cut-off as positive discrimination. By taking all patients over a given age, their system avoids needy patients slipping through the net. In contrast, integrationists regard triaging by age as potentially ageist. In their system, only the complex and frail acutely ill older patients and those in

need of rehabilitation need be under the care of a geriatrician and the decision is always made on the basis of individual need rather than age.

### Separation of young and old

As a speciality, we live with these differences in philosophy and practice in the knowledge that all geriatricians are basically trying to achieve the same ends: high quality care for the elderly patients in their patch. But what if the separation of services for the young and old might in some cases actually be facilitating ageism? In my local hospital, a patient with complex disability under the age of 65 has access to a regional rehabilitation unit with facilities and staffing levels beyond the wildest dreams of most geriatricians. Out in my local community, a young disabled person can expect aids, adaptations, special housing and levels of care far beyond that offered to the much larger number of elderly disabled.

### Access to better facilities often denied older people

We all ultimately work within, and set our sights, according to the resources available to us. Carving up resources in an age-defined fashion will, inevitably, deny some worthy older people access to better facilities and, potentially, a higher quality of life. One of my consultant colleagues specialising in adult rehabilitation once sought my advice on the management of an MS sufferer who was causing him some concern. This lady had finally become wheelchair bound and was now confined to the upstairs of her house. Adaptations were not possible and she was not willing to move to alternative accommodation. My suggestion was to respect her wishes, provide her with a commode and a full package of care and just accept that she would have to stay upstairs. He was shocked that I considered this an acceptable situation but could see that there was little choice. I was shocked that there was so much difference between us in terms of expectation for our patients, but could see the reason for it: a marked difference in available resources.

David Lubel

# President's column



**F**rom time to time, BGS members ask me, “What does the BGS do for me?”. Sometimes this question is put out of mischief, but more often it is a genuine query.

At first, I thought that this was an odd question, as I had been ‘a BGS man’ for half of its history, but, on reflection, there may well be a good case for us to consider our public relations approach and communication with members and the wider public.

The BGS has its bureaucratic side, of course. We have a large Council, an Executive Committee, and four standing committees for finance, policy, scientific and training matters. This core administrative structure is ably facilitated by Richard Lynham and his small band of support staff at our headquarters in the precinct.

### Recognised professional association

As a recognised professional specialist association, the BGS represents your views to the Government, opposition MPs, civil servants, the Royal Colleges and Faculties, ageing charities and various national and international gerontology associations. Our national biannual scientific meetings are very well attended and provide excellent opportunities for continuing medical education, updates, a platform for an increasing number of special interest groups, and of course social intercourse and gossip. *Age & Ageing* continues to have a well-deserved international reputation, and its impact factor is rising. In addition, the Newsletter helps to inform and educate our membership.

### Members’ involvement

The 17 BGS regional branches are mainly in excellent health and promote local education and social events for members and their guests. At present, almost 150 BGS members (approximately 10% of our UK based membership) are

serving as national office bearers, standing committee members, branch office bearers or representatives on outside bodies. Most of these individuals are democratically elected and you clearly will get whom you elect. There are plenty of opportunities for members to become involved and help to influence BGS policies. Perhaps I should ask you, “What can you do for the BGS?”.

At the May Executive Committee meeting, we debated further the major issues which exercise us at present. Foremost in our thoughts are clinical governance, support for the recommendations of the Royal Commission on Long Term Care, and proposals for the purchase of BGS premises. We are continuing to promote closer liaison with the British Society for Gerontology, the British Society for Research into Ageing, and the Faculty of Public Health Medicine.

### Calmanised training

I have harboured mixed feelings about our current higher training programmes for specialist registrars. Some of my doubts were reinforced when I attended the Spring meeting of the Scottish branch in Paisley in May. I had the opportunity to attend the lunchtime trainees’ meeting and it involved a good representative sample of the Scottish specialist registrars. The change from the earlier four-year period of higher specialist training to five years has certainly increased the time required to accredit (usually dual GIM/GER accreditation), but the GIM double counting formula still causes difficulty in some training rotations. There are also some concerns about the quality of some of the training and experience in GIM in some centres. Years four and five still give me a little cause for concern. Was it better before the Calman dawn? Perhaps the rose coloured lens in my retrospective is cloudy. Please let me know if you share my doubts. Our Training Committee and representatives on the SAC in Geriatric Medicine are working very hard to improve the quality of training and experience in our speciality.

**Brian Williams**

SUPPORT FOR THE ROYAL COMMISSION

The Society is encouraged by the evidence of support for the Royal Commission’s proposals.

As members are aware, the Society recently wrote to all the MPs, seeking their support for the Royal Commission’s recommendations (see insert in May Newsletter).

We have received over 70 replies from MPs, an encouraging number of whom already have some knowledge of the Royal Commission and apparently take a keen interest in the welfare of their elderly constituents. Although not all the respondents agree with every issue in the report, specifically on the matter of financing, most of them favour the basic principle behind it and support the Society’s belief that the recommendations should be implemented

without delay. Many promise actively to urge the Government to take swift action in this respect.

**Age Concern and Help the Aged**

These are amongst sister organisations in the voluntary sector who have replied to Dr Williams advising the BGS of the action they have taken in support of the Commission.

**Royal College of Physicians London**

We quote below in full the letter written by Prof Alberti, the President of Royal College of Physicians London, to the Secretary of State for Health.

**House of Commons Health Committee**

The report responding to the Commission’s recommendations is summarised on page 7.

Royal Commission report  
- Royal College of Physicians London reply



This letter is reproduced by kind permission of the President, Royal College of Physicians London.

*The Rt Hon Frank Dobson MP, Secretary of State for Health, Richmond House, 79 Whitehall, London*

*9 June 1999*

*Dear Secretary of State*

**Report by the Royal Commission on Long Term Care**

The report by the Royal Commission on Long Term Care “*With Respect to Old Age*” sets out major and very positive re-thinking of this country’s contract with older people and their needs for long term care. This College believes that this large and highly consultative document is a remarkable opportunity that must not be missed.

Through the daily clinical work of its Fellows and Members, The Royal College of Physicians has, for many years, supported the development of hospital based and community supportive services for older people. Consequently, we encourage the Government to take on board the recommendations as set out by the Royal Commission. This report has provided a clear value based approach and vision for the future to deal with many of the current perceived inequalities and perverse incentives in present systems. While there is need for work to be done on the detail underlying the recommendations, we wish to support the vision set out by the Royal Commission.

The values set out in Chapter 1 underpin the whole approach of the commission to issues of long term care. It is sad that they had to emphasise that older people are a valuable part of society and should be valued as such but re-

stating these core values, emphasises how important a positive and constructive response to this document is required not just by professional bodies but also by government. We agree that values, dignity, and a positive view towards old age are essential and the opportunity should be grasped to enable people to live at home. However, we would also argue that an essential component of community care is ready access to properly staffed and equipped hospital beds. We support the Commission's desire for partnership and the concept of a National Care Commission to monitor how long term care cost provision change, over a three year cycle.

The document is also strongly underpinned by an emphasis on good epidemiological data. The conclusions that we draw from the information provided is that long term care is clearly affordable by the United Kingdom and indeed we are not convinced that there is such a great gap between the main body of the report and the note of dissent, in terms of affordability, or even approach, as some commentators have suggested. What is important, is a need for equity towards all aspects of the care process including the assessment process, the funding process and the nature and provision of care nationally. The report emphasises that any system must be fair, logical and transparent. However we also note that the brief of the Royal Commission was to decide how a sustainable form of funding should be provided. Although they mention key words like 'assessments' and 'rehabilitation', we feel that they did not pay sufficient attention to the needs for professionalism, and especially the needs for medical intervention in the lives of older people in order to reduce dependency.

The Royal College is particularly supportive on the emphasis towards multi-disciplinary team work and rehabilitation emphasised in Chapter 8. While the report argues for more research into the effectiveness of rehabilitation, it was clear that the principle of maximising rehabilitation and ensuring that irreversible choices and decisions were not made before maximum potential had been achieved is a very key and powerful statement. Genuine multidisciplinary assessment and rehabilitation should not be an aspiration but a requirement now for older people. That process must be timely, and we would strongly support the need for it to be appropri-

ate for the individual. To achieve this there must always be full understanding of the medical problems and it is therefore vital to see specialist medical services playing an important role within the assessment process. In itself proper medical assessment and rehabilitation may have net financial benefits to the state (evidence previously submitted to the Royal Commission and the Health Select Committee) as it will ensure that long term care is only provided for those that do not have remedial or reversible problems. Single point of contact for clients and single budgets for aids and adaptations are all keys to starting to produce a seamless service.

Both the main body of the report and the note of dissent talked in detail about joint working. We genuinely believe that real joint working is the key to making the assessment and rehabilitation process work for patients while removing the perverse incentives in the current system for people to either provide inappropriate care or no care at all. Most of the submissions were about the components of care, but there was no structure suggested on how the care should be organised. Further, the report contained no evidence in its major part relating to the national disparities in the number of people in long-term care, nor did it take into account the different numbers of institutionalised older people on a European basis. These differences would indicate that it is the structure of the services and their organisation and the behaviour of the staff which influence the number of people in long term care, not simply the ageing of the population.

We were impressed by the time and thought given to improving quality of care by improving cultural awareness of ethnic minorities, and by ensuring effective advocacy Systems by continuing to enhance the services offered to carers. It is also important that all older people should have a choice and a range of options based on proper assessments and rehabilitation built within a transparent National Framework. The interest in new technology is also to be supported.

One of the main recommendations of the report was the setting up of a National Care Commission. We would see this as a natural path to develop and lead the changes that will be necessary based on the recommendation of the Royal Commission report. Where we would

slightly depart from the Royal Commission is that we believe the National Care Commission will need to have clearer relationships with other bodies such as NICE, CHI, and any outcome of the National Service Framework for Older People. However, the Commission should not just have a monitoring role and an oversight of regulatory functions but should be looking in detail at the assessment process in particular, to promote the use of standardised assessments instruments. This would be a major advance towards an ability to assess and monitor national standards. It was also unclear from the report, exactly the power the Commission would have to directly intervene or influence processes rather than simply being advisory. This exact role of the Commission will need to be clarified further.

The report debates at some length the problems caused by the current divisions between nursing care and social care and the difficulty this causes for patients and carers as well as professionals, in operating what often seemed to be Byzantine processes. The Commission suggests that ongo-

ing nursing need is always healthcare and that personal care as well is a health function. We would support this definition and believe it is right and proper that the disinvestment of the state in long term care over the last 15 years should be reversed. We feel it is also important to stress issues such as the role of prevention, access to acute hospital medical and surgical services, and pre-admission rehabilitation assessment prior to residential and long term care admission. Medical intervention by physicians with specialised knowledge is an essential component of success in long term care.

In conclusion we find this to be a comprehensive and enlightened, holistic, needs led report. Much of the report indicates that we can get better best value for money now out of what we do but emphasises that proper long term care is affordable for all in the United Kingdom. We would encourage the Government to accept and implement its recommendations.

**K G M M Alberti**

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## House of Commons Health Committee report on the long-term care of the elderly



**W**e quote below a summary of the Health Committee's report responding to the Royal Commission's recommendations.

'*With Respect to Old Age*', the Royal Commission's report, examines the options for a system of funding long-term care for older people, and recommends how the costs may be covered. The Health Committee welcomes the report and are generally in agreement with the conclusions reached.

### Principal recommendations

The report contains two principal recommendations, which are that:

1 a clear distinction between living costs, hous-

ing costs and personal care must be drawn; and  
2 the creation of a National Care Commission to monitor trends, ensure transparency and accountability, represent the interests of consumers and set national benchmarks.

### National Care Commission

The Health Committee recommends that the Government accepts the idea of a National Care Commission and that its remit should include the requirements to pay proper attention to preventative care and to advocate the benefits, both in cost and social terms, of encouraging qualitative improvement in the lives of older people through exercise, constructive leisure pursuits and education.

### Personal care

The Health Committee approves of the new category of personal care, defined by the

Commission as: “...care that directly involved touching a person’s body...and is distinct from both treatment/therapy...and from indirect care such as home help or the provision of meals”. This would be a positive and appropriate step forward in the care of older people which should reduce most of the absurdities caused by the current division between health and social services. In addition, the separation of personal care (which would be provided free and funded from general taxation) from living costs and housing costs (which would be mean-tested), would also introduce a long-overdue clarity about who pays for what.

The operation of the new distinction between personal care and other aspects of daily living should be monitored closely, with the boundaries being adjusted if necessary.

The Health Committee recommends that “...a full and widespread debate on the case for integration of health and social care” takes place. However, the Government stressed the action it is taking to improve joint working (see *Partnership in Action*), but rejected the need for formal integration between health and social services. The Health Committee recognises that there are significant problems with introducing major structural change, yet remains unconvinced that, in the long-term, a sensible, efficient and seamless service to patients is possible, without an integrated health and social care system. It, therefore, wishes to urge once again the Government to give the matter further consideration.

### Funding proposals

The Committee looks forward to wide-ranging debate on the subject of funding proposals, e.g. the Commission’s recommendation that long-term personal care should be funded by general taxation and its rejection of the proposals for a social insurance scheme.

### Need for reliable data

Following the Commission’s findings that there was a lack of information relating to total expenditure from all the various agencies on long-term care for older people, the Health Committee feels that there needs to be an immediate improvement in the availability of reliable, consistent and universally accepted data to inform debate in the field of health and social services.

### Parallels between the conclusions

The Health Committee, in 1995-96, undertook two inquiries into aspects of long-term care for older people. It is pleased to note the parallels between the conclusions reached in these reports and those drawn by the Royal Commission, e.g. the opportunity and encouragement for rehabilitation, improved domiciliary care, the importance of housing, the need to avoid perverse incentives leading to inappropriate care, and the call for closer liaison between health and social services. All the reports agree that the UK faces no demographic time bomb in terms of long-term care of the elderly and, therefore, there is no imminent crisis of affordability.

### Building regulations

*Part M (Access and Facilities for Disabled People)* of the *1991 Building Regulations*, as amended, which promotes health and safety through building design and construction, will be extended to all new buildings from October 1999. In addition, the Commission called on the Government to initiate further regulations relating to basic house design, i.e. the provision of cabling to prepare for the use of up-to-date technology. The Health Committee supports this recommendation, having seen examples of the so-called ‘smart homes’, e.g. the Joseph Rowntree Foundation homes at Hartrigg Oaks, York, and models of care of the elderly in Denmark.

It recommends that if such schemes are initiated, the introduction of proper regulatory safeguards would be required.

### Care for the elderly in Denmark

The Danes regard the period of old age as being filled with potential, which is in common with the Committee’s way of thinking. Enormous care and attention is given by the state, municipalities and councils to ensure that the elderly are cared for in the most appropriate fashion, with prevention and rehabilitation being high priority goals. As in Denmark, with appropriate safeguards, the Committee believes that care in the home, so far as that is feasible, should be available for as long as possible. It sees the development of multi-skilled teams of support workers, similar to those employed in Denmark, as assisting this process.

However, the cost to the taxpayer of the

Danish system is large. For historical and financial reasons it would be impossible to transpose exactly the Danish system of care onto the UK, though there is much to be learned from it, e.g. the assistance available ‘at the touch of a button’. The Committee recommends that the Government looks closely at the Danish models of care for older people with a view to extracting ideas relevant to the UK’s own sustainable progress and development in this area.

**Conclusion**

With regard to the current system of care for the elderly, which is “...*mean, inequitable and ...often inadequate...*”, the Commission stated categorically that the status quo is not acceptable and there is a need for change. The Health Committee agrees with this statement and states that failure by the Government to act urgently would be a serious dereliction of duty.

**Rawia Habiby**

**‘Queen Mary’s Hospital’ continued from page 1**

fundraising, also provide other support such as entertainment to patients.

The circular wards at New End are still remembered by staff; the narrow inner circumference of the ward meant that you could not bend over to examine a patient on one side without coming into contact with the patient on the other side! Ironically, the old workhouse style New End is now a fashionable apartment block with flats worth £250,000 each.

Queen Mary’s; this effectively doubled the throughput of patients. Needless to say, whilst the media trumpeted the closure of New End to the extent of its inclusion on ‘News at Ten’, the opening of Queen Mary’s only warranted a mention on the back page of the local paper.

**An unselected age-related admission’s policy**

The Department now operates an ‘age 75 and over’ unselected admissions policy, except in the case of stroke patients, where the age for acceptance is 65 and over.



**Sweeping changes**

When Queen Mary’s was commissioned in October 1991 (the official opening by Prince Charles occurred in May 1992), it both enhanced the total number of geriatric beds and provided for an improved *modus operandi*, with patients being first admitted to the acute ward in the Royal Free and then, if necessary, transferred to the rehabilitation facilities at



Between 180 and 200 in-patients are currently admitted monthly from A&E and directly from their GPs. The average length of stay is 12.5 days. In addition to the 70 beds in the three acute wards at the Royal Free, there is a 25-place Day Hospital, open five days a week, catering for a mixture of new referrals and recent hospital discharges who require medical monitoring or multidisciplinary management of disability (some 60-70 new patients are seen each month). In addition, four medical outpatient clinics are held weekly, with 500 new referrals per year.

Fifty percent of Queen Mary’s admissions are discharged to their own homes.

**Rehabilitation**

Queen Mary’s provides a service for patients from Hampstead (North Camden) and South/ Mid Barnet who are transferred from wards in the Royal Free.

The facilities comprise 36 beds for mentally frail patients, 36 rehabilitation beds, five continuing care beds and two respite beds. Whilst there are some single bed units, most are four bed bays to lessen the isolation of patients and to aid better nursing supervision. Approximately 250 patients are admitted per year, with an average length of stay being seven weeks.

There is a stately gymnasium for physiotherapy (the power house of the hospital), built to the dimensions recommended at the time, good occupational therapy facilities, including a model kitchen, and fully equipped dental surgery, hairdresser and chiropodist.

The Service Manager, Mandy Parfitt, is described as having the attributes of the old style hospital matron, including the ability to present tactfully her consultants with a list of things to be done!

The Department shares the hospital with two psychiatrists, Drs Graham and Blanchard, who have a 36-bed EMI ward and a Day Hospital on the site.



**The team today**

The clinical team at the Royal Free comprises consultants Anne Davies, Dan Lee, Jackie Morris, Sheldon Stone and Alex Wu, all dedicated rehabilitationists, in addition to the five specialist registrars, five SHOs and two clinical assistants. Of the Department's former luminaries, Dr Michael Green, in the Department from 1974

to 1985, is now in Guernsey, Shah Ebrahim (there from 1987-89) is now Professor of Epidemiology of Older People at Bristol, whilst Prof Archie Young returned to Scotland in



1998 to take the Chair of Geriatric Medicine in Edinburgh. The academic work of the Department is now overseen by Prof James Malone-Lee at UCH.

**The service today**

The Department aims

to provide a comprehensive service to its catchment area and its philosophy, as stated, is:

- 1 to keep older people in its district as healthy and independent as possible;
- 2 to provide immediate access, when needed, to its acute, rehabilitation, day hospital, outpatient, liaison and hospital continuing care services;
- 3 to effect safe and timely discharge from hospital; and
- 4 to facilitate the management of older people with disability in the community.

There is a particularly strong emphasis on multidisciplinary work, with daily multidisciplinary meetings within the department and in A&E.

**Liaison services**

Liaison forms an important component in the service provided by the Department and includes: a daily medical liaison to effect the same day review of older patients who have 'overspilled' onto medical wards; a twice-weekly



review of older orthopaedic patients; a weekly liaison on the Old Age Psychiatry assessment ward as well as the older surgical patients, particularly those from

urology and vascular surgery; and daily

multidisciplinary meetings in the Day Hospital. A key feature is the Fast Track Day Hospital from A&E and direct from GPs. In addition, the consultants attend the weekly Eligibility Panel for Placement in Nursing Homes, run by Social Services.

The success of the Department is attributed to its multidisciplinary approach, its enthusiasm and

intelligence enhanced by regular teaching, coupled with the support of 'wonderful junior staff'.



strong emphasis placed on its community links, both to GPs and to residents in care homes. In one borough alone, there are 2400 residential care beds. The service provided by the Department includes training care home staff. A special project looked at 400 residents requiring special needs and provided for specialist intervention. As a result of this work, Camden set up a special Homes Team.

The Department, working together with the primary care teams and Social Services, is con-



**What's new**

A Falls Clinic is being set up to research, with basic sciences, the physiology of unexplained falls and to investigate the primary and secondary outcome measures of falls.

An IT service project includes an Information Net with transferable information in order to provide a comprehensive patient record (patient 'smart cards') to cover older patients in the community so that their details are available before they ever need hospital care, as well as improving the operational link to GPs. (Discharge summaries are sent out on the day of discharge.) Immediately under development is an intra-departmental IT network to share information within the hospital.

Other research projects include a service evaluation related to A&E, and to the service provided by care homes, and work on hypertension. In addition, a stroke service for patients over 65 is being developed with the neurologists.

**Service to the community**

A key feature of the Department's work is the



stantly striving to improve the quality and the scale of care for older people in the community.

**Teaching**

The Department runs courses in Health Services for Elderly People for fifth-year medical undergraduates, perceived as 'very successful and very clinical' and concentrating on the 'giants of geriatric medicine', as well as ENB courses for nurses. The medical curriculum

provides for both short case teaching and long case teaching to develop the taking of histories, medical examinations and clinical management.

The Service Manager, Mandy Parfitt, the Senior Physiotherapist, Sian Goldberg, and Senior Occupational Therapist, Chris Popplewell, all contribute to multidisciplinary training and the Department will be looking to expand the scope of this in the next year.

**The future**

*'May you live in interesting times'* (an old Chinese curse). Notwithstanding the many challenges it has to face, the Department is confident that it will continue to adapt to and meet the requirements of government policy and the needs of its local population.

# A sound base for the future

## - the Society's "Millennium Appeal"



**T**he *Sunday Times* Housing Special of 25 April 1999 asks the question, "Why pay rent when it is much cheaper to buy?"

Whilst the *Sunday Times* article referred to the purchase of private property, the principle is also true for a corporate entity such as the BGS. In the ten years since 1990, the Society will have spent £192,000 in rent for its current accommodation at 1 St Andrew's Place, not to mention other costs related to the premises. This is effectively £192,000 lost (£109 per member based on the average membership over this period), with nothing to show for it.

The Society is now 52 years old and set to continue well into the next millennium, with an increasingly important role to play in the development of old age medicine to match the demand of an ageing population.

Against this background, Council, at its April meeting in Cork, unanimously accepted the recommendations of the Finance and Executive Committee that it was not in the long-term interests of the Society or its members to continue to lose money on rented accommodation, and that the Society should, therefore, increase its reserves in order to purchase a property by the year 2005.

### Methods of fundraising

To this end, Council approved a plan to raise £550,000 - the sum required to enable the Society to purchase a suitable property. The plan would include a fundraising campaign to obtain donations from:

- ◆ commercial companies associated with the Society;
- ◆ other outside bodies; and
- ◆ individuals.

The possibility of raising funds at regional level would be explored. In addition, Council agreed

that, in order to convince outside donors of the Society's commitment, it would be essential that members of the Society were seen to be contributing to the cause. It, therefore, unanimously agreed that this commitment should be via an increase in subscriptions over the next five years. The sum proposed would be in the region of £25 in the case of standard members, which, allowing for tax relief on professional subscriptions, would represent a cost to members of approximately £15 per annum, or £1.25 per month for those on a higher rate of tax. It was proposed that the rate for trainees would be half the standard rate.

It is envisaged that, if suitable premises can be obtained, running costs can be reduced in the medium to long-term. Furthermore, the possibility may arise for income generation via subletting of space, the use of rooms for functions or small meetings and, possibly, even the provision of some overnight accommodation.

### Location, location, location

"Why London?" For years the question has been debated as to why the Society should be located in London when the Society could rent or buy more cheaply elsewhere. The overwhelming conclusion has always been that London was the most convenient point for travel for the majority of office holders from across the UK. There is, in addition, the added advantage that, being in relatively close proximity to the Department of Health, the BMA and at least one of the Royal Colleges of Physicians, it facilitated liaison and meetings with third parties.

### Contribution of members

Why should members contribute? Undoubtedly, the Society will continue to give value to its members through:

- ◆ its scientific meetings;
- ◆ its contribution to clinical governance;
- ◆ CME/CPD;
- ◆ the SAC on training;
- ◆ the Newsletter;
- ◆ *Age & Ageing*; and

◆ its representation of the interests of older patients and geriatric medicine to the Department of Health and Government.

There is, therefore, every reason for younger members to invest in the future of their specialist association. It is hoped that those

closer to retirement will also have the welfare of the specialty at heart, the specialty that they have devoted their working life to building up, and will therefore be willing to help secure its operational base.

Membership rates for specialist societies vary from £100 - £268, with only two having subscriptions lower than the BGS; even with the increase for the “Premises Fund”, the Society will still compare favourably with the average subscription rate for other societies. Of the specialist societies, three (Cardiology, Dermatology and Paediatrics) have, in recent years, acquired their own premises and have set a precedent in previously building their reserves to do so.

I very much hope members will understand the efforts that are being made to establish “a sound base for the future” and will support wholeheartedly the Society’s Millennium Appeal.

**Brian Williams**  
and **Jonathan Potter**



## CHANGES TO BGS OFFICE EMAIL ADDRESSES - URGENT NOTICE FOR MEMBERS

Please note that the BGS Administrative Office email addresses have now changed and we would be grateful if you replace the old address with the following in your address book.

To contact Richard Lynham, the Administrative Director, for general management enquiries, use:

◆ **[Richard-Lynham@bgs.org.uk](mailto:Richard-Lynham@bgs.org.uk)**

For Policy Committee, financial matters and Compendium enquiries, contact:

◆ **[Recia-Atkins@bgs.org.uk](mailto:Recia-Atkins@bgs.org.uk)**

For Scientific Committee, Newsletter and Annual Report enquiries, contact:

◆ **[Rawia-Habiby@bgs.org.uk](mailto:Rawia-Habiby@bgs.org.uk)**

For Training Committee, Handbook, grants/awards, CME and membership enquiries, contact:

◆ **[Caroline-Houston@bgs.org.uk](mailto:Caroline-Houston@bgs.org.uk)**

For the submission of abstracts or any other abstract enquiry, contact:

◆ **[Abstracts@bgs.org.uk](mailto:Abstracts@bgs.org.uk)**

# Abstracts

- important new guidelines



**T**he BGS Scientific Committee has developed further guidelines for authors of abstracts submitted for BGS Spring and Autumn Meetings.

These are intended to continue the process of raising the standard of the scientific activities of the Society and to make clearer the criteria for acceptance and rejection of abstracts.

### **New guidelines**

Abstracts submitted to BGS conferences must show something of significance for the science and/or practice of geriatric medicine and make a contribution to knowledge in the subject area. In general, descriptive studies are accepted for publication only if they address a specific research question, open up new ground or replicate other recent and new findings. Prospective studies are generally preferred to retrospective ones, for methodological reasons.

Audit is commonly a process of local quality control and is part of professional practice and training. Such activity, however worthy, does not automatically warrant publication. Audit worthy of publication must meet standards of scientific acceptability; it must be well conducted, and provide information of use to others. Case note review is rarely a reliable scientific method, unless very systematic. Audit projects may be acceptable if the audit loop has been closed and the benefit shown is original and demonstrably of general rather than purely local relevance to practice. Some audits do clearly identify original questions hitherto unrecognised. These may warrant submission as primary data collection before “the audit loop has been closed”.

Writing an abstract is difficult, and overcoming this is part of the process of research. The abstract should be able to be read on its own, and enable readers to get a fair impression of

the research carried out. Authors must practice a concise and precise writing style. They are recommended to get someone not involved in the research to read the abstract through carefully to test intelligibility. The introduction of an abstract must be brief, because the majority of the text should describe the methods and the results. Similarly, the conclusions can be kept brief. If you are using a lot of abbreviations, is this because you are not adequately pruning the rest of the text? The abstract should correspond accurately to the content of the poster and should present the key data in summarised form.

Figures and tables are often difficult to reproduce in print, to fit within available space on the page. If used, they should be simple, economical of space and undisputedly the best way to present the information.

### **Introduction**

This should comprise above all else a clear statement of the objective of the study - what is the research question? - supported by any available concise information on relevant previous work.

### **Methods**

Describe clearly how and from which population or sample the data were collected. Make clear the inclusion and exclusion criteria used. Describe any measurement method used, with reference to its validity, either directly or by referring to its prior publication. Specify how the data were collected and analysed. Make sure that the data and manner of collection and analysis of the data can answer the research question. If in any doubt, ensure that statistical advice and/or the assistance of your nearest academic department has been obtained.

### **Results**

Give results, with actual numbers. Statements like “data will be presented” are unacceptable, as is claiming a statistical significance without presenting the actual results. For clinical or

epidemiological studies give the general population characteristics and the characteristics of those who dropped out or were excluded from the study. Are the data and analytical methods reliable and valid? Are the appropriate statistical tests used? Make sure that the results answer the research question.

**Conclusions**

Be brief. Ensure that your conclusions relate to the question asked by the study, and that the

conclusions are supported by the results. Many abstracts are rejected because conclusions drawn from the results are not supported by the findings provided in the 'Results' section.

**Dr I Carpenter**  
**Dr J Gladman**  
**Prof C G Swift**

*N.B. Those wishing to comment on the guidelines are welcome to write to the BGS office (address on page 27).*

The work of the Society's  **Policy Committee 1999/2000**

**T**he general purpose of the Policy Committee is to give lead to the Society's efforts externally to promulgate its aspirations, opinions and concerns about the health and social care issues affecting older people.

Much of this effort is concerned with Government policy, responding to white or green papers, official guidance and the like, and also participating in whatever set piece opportunities exist as part of consultation processes and workshops.

**Pushing forward issues of concern**

Largely, this work is responsive and there is certainly plenty to do to keep up with steady stream of policy developments from this Government. We will, however, need to seek opportunities to push forward issues of vital concern. Thus, we must find ways of supporting the Society's wish to galvanise the Government into action on the key aspects of the Royal Commission Report on Long Term Care, i.e. specialist assessment linked to provision and consistency on funding. In this, we are acting in harmony with Age Concern, Help the Aged, Carers National Association and others.

During the period up to April 1990 several strands of government policy and action will come into play, i.e. specialist assessment linked to provision, and consistency on funding Joint Investment Plans are already being established and arrangements for joint commissioning, pooled budgets and such, as enabled by *Partnership in Action*, will be an increasing trend. For us, one of the key aspects of the white paper, *Modernising Social Services*, will be the creation of the regional Commissions for Care Standards. The Policy Committee will seek to be involved in consultation on the structure and purpose of these.

**Primary care**

A major uncertainty is how the primary care groups and primary care trusts, particularly those that will have a commissioning remit in England, will influence the pattern of service provision locally. The National Service Framework, published with the intention of influencing commissioning of hospital services for older people (geriatric medicine and other services), should alter the focus for quality and audit activity. In many areas, the PCGs are not well prepared to take on this large agenda concerning the care of older people, particularly at the hospital community interface and in the community. Whether the PCGs generally identify a role for specialist geriatric services outside the hospital should not be left to them

alone. We must seek to influence them. The Policy Committee can assist by:

- 1 reviewing the current statements and guidelines in the Compendium and translate their intent into the language of the current policy framework, accessible to PCGs; and
- 2 Proposing models of local non-acute service developments, drawing on successful examples in which members have been involved, to provide members with help to influence the work of their local PCGs.

### Clinical governance

The BGS Clinical Governance statement is currently out for consultation with members and the BGS Council Study Day on 1 July explored the issue further.

The scope of this is from individual clinical practice at one end to aspects of service provision at the other.

How this impinges on issues such as job plan review will need further consideration as will the possible models of the proposed departmental development plans. The Policy Committee should

assist members of the

Society to use these initiatives to develop the specialty both in and outside the hospitals.



### Compendium and clinical guidelines

As mentioned above, aspects of the Compendium will need reviewing to bring them up-to-date with the 'new realities'. There are several statements which will need to be finalised and published shortly including the one on continence (which will be consistent

with the national continence guidance) and the development of wound treatment and prevention. We will also be developing a statement on day hospitals, reflecting the current debate about their role.

It has been recently agreed that the Policy Committee as presently constituted is not competent to take on the issue generally of producing guidelines for clinical practice areas such as might be necessary to take forward the work of Clinical Governance. At present the Society has no clear mechanism of doing this but perhaps the role of the Policy Committee will be to create a resource, in written form and on the website, to point members and other enquirers towards relevant reputable guidelines.

### Public relations

For a period of time some years ago, the Policy Committee also incorporated public relations in its remit. Despite fairly constant badgering from Richard Lynham, the Society has not generally attended to this issue, preferring, by design or default, to let the work of the office, committees and members to maintain the profile of its specialty. This may not be enough, particularly as the word "geriatric" still has ambivalent connotations, and the role of geriatrics as a whole is being squeezed into a narrower acute clinical remit.

The Executive Committee has recently asked the Policy committee to consider whether there is a need for a public relations strategy and to advise upon it. This work will begin in the summer and comments from the members are welcome.

### Other priorities

The Policy Committee feels that it would be helpful to maintain regular surveys on the pattern of work of its consultant members. Substantial alterations in this have taken place over the last few years. With the exception of data on the involvement of consultant geriatricians in providing acute general medicine on take service, there is very little information generally available. If it was, it could contribute to obtaining a clearer idea of the way in which the role of the specialty is changing and provide information to guide manpower and training decisions in the Colleges.

The developments within intermediate care continue to be of interest, particularly to the extent that traditional aspects of assessment and rehabilitation are moving towards a generic community-based model. Opportunities arise both nationally and locally to inform the debate on this and, therefore, the Policy Committee will need to be up-to-date on things that are developing and views of its members.

Although the Policy Committee is elected from Council ( and through Council) and is, therefore, accountable to the Society's membership, there may be occasion when a more direct method is needed to find out the opinions and concerns of the membership. The feasibility of doing this on a regular basis will be considered.

The Scottish Parliament and Welsh Assembly will no doubt create distinct challenges of their own. Both the Scottish and Welsh branches of the BGS have already been closely involved with policy development locally. Indeed, it seems likely that national seem will be influenced for

the good by the progress they have made.

If members feel that this perspective for the years' work does not meet concerns they feel are vital, we want to hear about it.

**Dr Finbarr Martin**  
Chairman of the Policy Committee

### COMPENDIUM UPDATES

The Policy Committee is in the process of reviewing and updating Compendium documents. Among the new documents being prepared is a reference list of good Clinical Guidelines which would be useful to the profession. Members are invited to send suggestions for inclusion in the reference list to Dr Finbarr Martin, c/o of the BGS office (address on page 27). Please make sure that the recommended guideline, title and provenance is accurate.

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## What we do not know about...

- contributions to *Age & Ageing*



**T**he Editor of *Age & Ageing* proposes to introduce a new initiative to the journal.

In much of medicine, there are areas of doubt and ignorance; but these have not always been made explicit. If we acknowledge what is unknown or uncertain, it could alleviate anxiety. People will be reassured that it is not just they who do not know the answers. Identifying the gaps will also provide research ideas, especially to those new to research, who may not know where to look for topics which have not yet been fully explored.

With this in mind, contributions to the

proposed new section in *Age & Ageing* should:

- 1 be short - no more than a single page of the journal;
- 2 list briefly the main points where knowledge is secure;
- 3 list areas of doubt, ignorance or misconception; and
- 4 have two to three key references.

All submissions to this section will be peer-reviewed.

**Prof G P Mulley**  
Editor, *Age & Ageing*

*Those interested in contributing should contact the Editor at Age & Ageing, Elderly Services Directorate, Level 7, Room 168, Gledhow Wing, St James's University Hospital, Leeds LS9 7TF. Tel/fax: 0113 246 9275. Email: aa@age-and-ageing.demon.co.uk.*

# Council Study Day

1 July 1999



**A** Council Study Day, on the subject of clinical governance, took place in London on 1 July 1999. The following is a summary of the sessions which took place that day.

The position paper on this topic, written by a working group of the Society (Profs Swift, Castleden & Severs and Drs Black & Martin), and published in the May Newsletter and endorsed by Council, formed the basis of the programme which was divided into three sessions, half of each being devoted to questions and discussion. It was hoped that those attending would return to their Regions with a better understanding of clinical governance and how to take it forward in their departments.

## Clinical governance in context

The first session, entitled '*Clinical Governance in Context*', was chaired by the President, Dr Brian Williams. Cameron Swift explained the professional and service elements by reference to the comments on revalidation made by the President of the Royal College of Physicians London in the College Commentary for May/June 1999, and the National Service Framework for Older People (May Newsletter, page 13). He stressed the importance of accountability and referred to the various levels of clinical governance, i.e.:

- ◆ the individual consultant;
- ◆ the consultant within a service;
- ◆ the service within an organisation; and
- ◆ the service between organisations.

The comments expressed throughout the day provided evidence to support Prof Swift's view that, in their response to clinical governance, doctors fell into four categories, namely: alarmist; nihilist; evangelist; or opportunistic realist.

## Definitions of clinical governance

David Black reminded us of the definitions of clinical governance, used by the working group and commended the use of the clinical governance cycle (May Newsletter, page 6), pointing out that change management was the most difficult stage. His practical implications for the individual consultant and for departments included: the suggestion of mentoring for newly appointed consultants along with induction to the department and a personal development plan to cover the first two years; and the setting up of groups in each department to systematically review national initiatives and advise on implementation. Nationally, work had to continue on performance measures, clinical guidelines and audit, and to persuade the Government of the urgent need for more consultants.

## Compulsory CPD in two years

Mark Castleden chaired the second session at which Dr Parveen Kumar, CME Director, RCP London spoke on '*CME/CPD in Clinical Governance - a Royal Colleges Perspective*'. She confirmed that CPD would become compulsory within the next two years. Assessment will be incorporated into CME activities, despite the lack of a reliable way to measure the benefit of learning. The Colleges will be working with the specialist societies to devise electronic methods of assessing factual knowledge for career grade doctors although, as was pointed out in the discussion, there is a move away from factual knowledge at undergraduate level. Dr Kumar was emphatic that there would not be exams.

Annually, in addition to meeting the CME/CPD requirements, each of us will have to be appraised locally by a clinical or medical director who will need to have completed successfully College-approved training in appraisal. A College Standards Adviser is likely to be present at the appraisal every five years. External peer review every five years is proposed, but the manpower implications are considerable. The

Colleges hope that revalidation by the GMC will be automatic for every doctor who participates successfully in these processes and national audits.

### Standards

Finbarr Martin chaired the final session on 'Clinical and Service Standards', in which Martin Severs, an opportunistic realist, took a practical, 'inside out', approach to measuring improvement. He involved us in two working examples to get over his message that, by using

existing sources such as complaints and clinical indicators, as well as existing standards, we could identify individual learning needs, formulate personal and departmental development plans and improve our service. He suggested that the BGS develops an educational and enabling role in this area, covering topics such as clinical indicators, because we all need to know how they are derived and how to explain them.

**Rebecca Dunn**  
Honorary Deputy Secretary

## Health Promotion and Preventative Care Special Interest Group workshop



The following is a report of the parallel workshop of the Special Interest Group (SIG) held in Cork at the BGS Spring Meeting 1999.

The workshop, entitled *Putting Policy into Practice*, had a particular emphasis on accident prevention. Dr Mayer gave a brief introduction prior to the two main presentations.

### Accident prevention strategy

The first presentation came from Mima Cattán and was entitled *'Accident Prevention: strategy into action'*. It described the development and implementation of a local accident prevention strategy in Newcastle, i.e. the establishment of two multidisciplinary working groups in 1994 with broad representation, which based their work on a survey of accidents among older people in North Tyneside, and a review of accident and emergency data in Newcastle. The seminars were used to involve organisations and to ensure the strategy met the needs of older people. It was launched in October 1998.

There were, however, major problems because of differing organisational structures, agendas, funding cycles and timetables, as well as member-

ship changes within the group, and an assumption that someone else would do the work.

The development of the strategy has been successful by continuous fostering of multi-agency collaboration, the development of internal and external networks and 'spin-offs', e.g. surveys, project establishment, as well as keeping in touch with reality through older members and a couple of 'champions'. It is now in the stages of early implementation and acts as a lever for the funding of voluntary projects, for a local pilot scheme in primary care, and to prioritise accident prevention in the Health Improvement Programmes (HIMP). Lastly, the key factors that sustain the strategy were reported, including the continued commitment by the organisations and the maintenance of collaborative working and partnerships. The strategy recognised the need for continued review and development, and to base actions on evidence, where available.

### Dao Yin in Jersey

Dr Michael Richardson, Consultant Physician in Geriatric Medicine, St Helier, Jersey, gave an illustrated presentation on the practice of Dao Yin (a form of Tai Chi), successfully established in Jersey. The states of Jersey have combined health and social services and manage a health promotion department which works closely with the Department of Geriatric Medicine. As

a consequence of the FICSIT trials in the USA, a Dao Yin group was piloted in Jersey and has become very popular following a pilot study with up to 100 patients in regular exercise groups, as well as input into public clubs and associations. The Dao Yin classes are part of a programme which includes specific falls programmes for patients at high risk, and a prescription of health initiatives which provide a variety of sports and exercises at a local leisure centre.

Dao Yin was specifically developed as a system of exercises to benefit people's general health and can be used by those who are very frail, with mobility problems and major disorders, e.g. Parkinson's Disease and multiple sclerosis. The

pilot showed particular benefit to people with Parkinson's Disease, whose mobility improved; the exercises can be performed sitting as well as standing. The classes are run on a multigeneration basis and the exercises strengthen the legs, increase flexibility and aid balance, as well as improve concentration and the ability to relax.

The scheme has proved very successful but is dependent on the co-operation of the agencies involved, again with the presence of a 'champion' and the development of trainers who have visited China, have had visits from Chinese experts and developed the programmes within a positive climate for falls prevention.

**Dr P P Mayer**

## Mental Health & Cerebral Ageing

- new Special Interest Group



**T**he inaugural meeting of this new Special Interest Group (SIG), entitled '*Advances in Mental Health Care and Cerebral Ageing*', will take place on 22 September this year.

It is widely accepted that not only do we live in a society with an ageing population, but that life expectancy is also increasing. With medical advances in prevention and treatment of disease progressing rapidly in areas such as cancer and stroke, the new hurdles to overcome are becoming more neurologically related. Understanding the causes of cerebral ageing is therefore becoming an increasingly important challenge for clinicians to meet, both now and in the future.

Amongst the most common conditions that the elderly now face are Alzheimer's and Parkinson's Diseases, and depression. In recent years, the understanding of the scientific basis behind these conditions has progressed rapidly and produced a concurrent improvement in the medical management of each. However, there is still room

for further advances and improvements in the available treatments. The introduction in the last two years of a new wave of acetylcholinesterase inhibitors as a treatment for delaying the progression of cognitive decline in Alzheimer's Disease can be used to illustrate how the increase in understanding of the molecular cause of disease leads to new and better treatments.

For advancement to continue within the field of cerebral ageing collaboration between geriatricians and old age psychiatrists is essential. This is to ensure that specific groups of the elderly do not fall between the remit of the two disciplines, and to make sure that the full potential of new advances and medical treatments are recognised. To this end, a new Special Interest Group, which is a joint initiative between the BGS and the Faculty of Old Age Psychiatry (FOAPsych), is being developed.

The SIG aims to identify new areas arising in the field of mental health, from new treatments and diagnostic protocols to government policy, and open the floor for debate and discussion early on. Such discussion also creates an ideal opportunity to develop a targeted medical

education programme in this field. Once the SIG has become established, there may be a role for the group in enabling its parent bodies to develop policy and consensus statements and to advise government and professional bodies on matters relating to mental health care and cerebral ageing.

The inaugural meeting for this SIG, entitled *'Advances in Mental Health Care and Cerebral Ageing'* (sponsored by an educational grant from Novartis Pharmaceuticals (UK) Ltd), is to take place on **22 September** at the **Metropole Hotel, Birmingham** (for further details

contact Tia Snell on 0181 940 0648). The program will include:

- ◆ the role of new receptor technologies in developing therapies for conditions such as Alzheimer's Disease and Parkinson's Disease, and depression;
- ◆ what causes the elderly to miss out on services and support from both geriatricians and psychiatrists; and
- ◆ defining the role of the SIG in Primary Care Groups and joint service developments, training and developing research.

**Duncan Forsyth**

# Election of Officers

- Council Meeting, 1 July 1999



**T**he ballot of Council members at the recent meeting resulted in the appointment of the following Committee members and officers.

- ◆ Hon Deputy Secretary: Dr C Vellodi
- ◆ Hon Deputy Treasurer: Dr I Sturgess
- ◆ Finance Committee: Dr A Elder
- ◆ Policy Committee: Dr S A Bruce, Dr P Khanna and Dr G F Turner
- ◆ BGS Representative on the Hospital Accreditation Board: Dr G Jenner
- ◆ BGS Representative with the Pre-Retirement Association: Dr P Overstall
- ◆ BGS Representative on the BGS/RCPsychs Liaison Committee: Dr M J Bendall

The meeting agreed that the election procedure should, in the future, be improved by including the following aspects:

- ◆ at every stage of the process, the current composition of the committees on which vacancies arose should be made known, together with a précis of the Committee's role and focus;
- ◆ the citation form would be standardised to

include a biography and motivation for the nomination;

- ◆ a personal statement by the nominee, illuminating his/her vision for the Society from the perspective of the position he/she hopes to occupy (endorsed by a proposer); and
- ◆ any nomination which not complying with the conditions above would be disqualified.

## ANNUAL GENERAL MEETING AND NEXT COUNCIL STUDY DAY

**Annual General Meeting, 12.15 pm,  
Council Study Day 9.00am to 12.00pm  
7 October 1999**

**Royal College of Physicians London**

As the Autumn Scientific Meeting will not be taking place until December, the Annual General Meeting of the Society will be held separately in October to transact the routine statutory business of the Society.

The Council Study Day on the same day is open to members of the Society, subject to the possible limitations of space.

Contact: the BGS office on 0171 935 4004, email: [Caroline-Houston@bgs.org.uk](mailto:Caroline-Houston@bgs.org.uk) for further details.

## REPORT ON MEMBERS' ACTIVITIES: CONTRIBUTING TO CONSULTATION PROCESSES

The BGS is regularly contacted by government departments, medical associations and other NGOs in the consultation processes for white papers, policy documents and other initiatives related to the care of the elderly. The Society's Policy Committee takes the lead in this, although they are regularly assisted by expert contributions from BGS members who devote a great deal of time and effort to this important cause. We would like to thank the numerous individuals who assisted in the preparation of the Society's response to the Royal Commission Report on Long Term Care, and those mentioned below who contributed in the past year to the following responses.

- ◆ *Our Healthier Nation*, Department of Health Green Paper, Apr 1998 - **Dr D MacMahon**
- ◆ *Better Government for Older People*, Cabinet Office, Jun 1998 - **Dr D MacMahon**
- ◆ *Consent: The Ethical Considerations*, General Medical Council, Jul 1998 - **Dr D Portsmouth**
- ◆ *Speaking up for Justice*, Home Office, Jul 1998 - **Dr D Portsmouth**
- ◆ *Service Standards on the Care of Older People*, Health Services Accreditation, Sept 1998 - **Dr D MacMahon, Dr Tim Hendra**
- ◆ *Withdrawing and withholding treatment*, British Medical Association, Sept 1998 - **Dr D Portsmouth**
- ◆ *A First Class Service: Quality in the New NHS*, NHS, Sept 1998 - **Dr D MacMahon, Dr R Dunn**
- ◆ *Partnership in Action*, Department of Health, September 1998 - **Dr F Martin**
- ◆ *Provision of Medical Care to Nursing Homes*, Royal Commission, Sept 1998 - **Dr C Bowman, Dr D MacMahon** (to complement previous BGS submissions)
- ◆ *Provision of Acute General Hospital Services*, British Medical RCP London/Royal College of Surgeons of England, Sept 1998 - **Dr F Martin, Dr A Dunn, Dr D Black**
- ◆ *National Framework for Assessing Performance*, NHS, Sept 1998 - **Dr R Dunn** (to complement previous BGS submissions)
- ◆ *GIM & Specialty Medicine: Time to rethink the relationship*, RCP, Oct 1998 - **Dr D Black, Dr J Morris**
- ◆ *Aids and Appliances*, Audit Commission, Oct 1998 - **Dr R Dunn**
- ◆ *Medication Management*, British Medical Association/National Pharmaceutical Association, Oct 1998 - **Prof S Jackson, Dr R Dunn**
- ◆ *Modernising Social Services*, Department of Health White Paper, Jan 1999 - **Dr F Martin**
- ◆ *Inquiry into the Regulation of Private and Other Independent Healthcare*, Health Committee, Feb 1999 - **Dr F Martin**
- ◆ *Review of Policy on Continence Services*, NHS, Mar 1999 - **Prof C M Castleden**
- ◆ *Food Standards Agency Consultation on Draft Legislation*, FSA, Mar 1999 - **Dr A Thomas**

The BGS would also like to thank the following members who have represented the Society in various Advisory Groups over the last year.

- ◆ *National Collaborative Audit for Rehabilitative Management of Elderly People who Have Fallen*, Chartered Society of Physiotherapy, Aug 1998 - **Dr P Overstall**
- ◆ *Low Vision Services Working Group*, 1998/99 - **Dr B Kaufman**
- ◆ *National Required Standards for Residential and Nursing Homes*, Centre for Policy on Ageing, Oct 1998 - **Dr M Denham**
- ◆ *National Service Framework for Older People*, NHS, Oct 1998 - **Dr B Williams, Dr D MacMahon, Dr F Martin, Prof C Swift**
- ◆ *Government Strategy for Older People*, Cabinet Office, Nov 1998 - **Dr B Williams, Dr D MacMahon, Dr F Martin**
- ◆ *Action on Elder Abuse*, Dec 1998 - **Dr A Homer**
- ◆ *Eyesight in Older People*, Royal College of General Practitioners/Royal College of Ophthalmologists/College of Optometry, Jan 1999 - **Dr B Kaufman**

Letters to  
  
 the Editor

**Dear Editor**

**Re: Spring Meetings in Ireland**

First of all, I can't imagine what the Cork cabby meant when he described geriatricians as "nutters" (see article on *Cork in May BGS Newsletter*), though sometimes over the years I've felt inclined to echo him when I felt frustrated about trying to get people to see our point of view and wondered was I nuts not to go into some other branch.

May I make one small comment on your last paragraph? A meeting of the Society was held in Dublin as far back as 1963 and was, in fact, the first to get sponsorship from a pharmaceutical company. Some of the more conservative members expressed horror at what they felt was a sell-out to vested interests. Where would we be without sponsorship nowadays?

A meeting was also held in Belfast in the fifties. On this occasion, when George Adams' secretary rang the bus company to get transport for 'The Medical Society for the Care of the Elderly', as we then were, the girl in the bus office said, "Will you be sure to have a Red Cross or St. John's orderly in each bus in case any of the old dears collapse". Both the British and Irish Societies have come a long way since then.

**Dr John Fleetwood, Senr**

**Dear Editor**

**Re: Special Interest Groups**

Along with 570 other colleagues, I attended and greatly enjoyed the regional meeting in Cork, Ireland in April this year. The multi-faceted interests of geriatricians ensures that most attending had interests in more than one Special Interest Group. The concurrent timing of six Special Interest Groups and one set of platform presentations ensured that many people, like me, were unable to attend more than one Special Interest Group.

With the proliferation of Special Interest Groups, it must now be time to have a day set aside for these, running in series, so that we may dip in and out of them according to our interests.

**Dr D Mukherjee**

BASE

*The Guildford Institute of the University of Surrey  
 Ward Street  
 Guildford  
 Surrey GU1 4LH*

**Dear Editor**

**Re: British Association for Service to the Elderly (BASE)**

Your January issue contained an obituary tribute to Dr Kenneth Hazell. The article rightly stated that Dr Hazell had been an early Chairman of BASE (originally the Geriatric Care Association) but gave the impression that we no longer exist: "BASE did valuable work in promoting higher standards". I would like to assure your readers that we still do. The successor journal to *Concord*, which you mention, is *BASEline* (produced by our Practice Research Unit at the University of Wales, Bangor). It still emphasises Kenneth Hazell's principles of multidisciplinary working and is available separately or as part of our membership package.

BASE today is probably the leading charitable organisation concerned mainly with issues of education and training in the field of health and social care for older people: issues, which, in our view, have never been more important. We would be pleased to welcome any of your readers to membership of BASE or to provide information on our wide range of education and training programmes, publications and research activities.

**Christopher Joyce**  
 Chief Executive

# BGS AUTUMN MEETING 1999

*Announcement*  
for 1999 only - 15 to 17 December

The last BGS  
Meeting of this  
Millennium

Innovative  
programme

Exhibition

Annual dinner

Extensive social  
programme

**BGS Autumn  
Meeting 1999 -  
London**

**Secretariat  
BHM  
1 Arun House  
River Way  
Uckfield  
TN22 1SL**

**Tel: 01825 768902  
Fax: 01825 768864**

**Email:  
contact@bhm.co.uk**

## Scientific programme

### Some topics

- ◆ *Cox-2 Inhibition*
- ◆ *Community Acquired Pneumonia*
- ◆ *Clinical Management Update*
- ◆ *Medical Education Update*
- ◆ *UN Year of the Older Person*
- ◆ *Nutrition*
- ◆ *Skin Ageing: Hope and Hype*
- ◆ *Acute Stroke*
- ◆ *Medico-legal Aspects*
- ◆ *Surgical Management of Varicose Ulceration*

### Some speakers

- ◆ Malcolm Coptcoat
- ◆ Chris Wells
- ◆ Christopher Griffiths
- ◆ Peter Langhorne
- ◆ Carol Jagger
- ◆ Joan Williams
- ◆ Chris Evans
- ◆ Clive Rawlings
- ◆ Nick London
- ◆ Ian Philp
- ◆ Danielle Harari

## What's on in London

### Exhibitions

Renaissance Florence  
Botticelli Mystic Nativity  
Voyages of Discovery  
Turner Prize  
The Art of Bloomsbury  
Art of the Victoria & Albert  
Museum

### Theatre

Whistle Down the Wind  
Beauty and the Beast  
An Evening with Billy Connolly  
The Lion King  
The Gingerbread Pig  
CATS  
Les Miserables  
The Snowman  
Dick Whittington  
Rent  
The Mousetrap  
Buddy  
Miss Saigon

### And

The Nutcracker  
Christmas concerts  
Harrods sightseeing tours  
International Show Jumping

- to name but a few!

## WANTED - ARTICLES FOR BGS NEWSLETTER

The Editor invites members to provide articles on their departments for inclusion in the BGS Newsletter over the next few years (see article on Queen Mary's Hampstead in this issue).

The intention is to provide a representative picture of geriatric medicine across the UK, reporting on, for example:

- 1 departments with innovative features;
- 2 the challenge of providing a service in, for example, a deprived inner-city area or rural area; and
- 3 particular services, e.g. day hospitals, rehabilitation facilities, collaboration with other specialties, hospital-based services to the community.

The BGS office will, where feasible, provide a reporting team to help prepare the article, take photographs, etc.

Those interested should contact the Editor c/o the BGS office in London.

## CHAIRMANSHIP OF TRAINEES GROUP

The appointment/re-appointment of officers for the Trainee Group would normally take place in October, during the Trainee Group meeting held at the Society's Autumn Scientific Meeting in London.

As the Autumn Meeting and, in consequence, the Trainee Group meeting, have been postponed to December this year, the present office holders, Dr Jacqueline Close and Dr Steve Parry, have been asked to remain in office until the meetings take place in December.

## RESEARCH INTO AGEING AWARDS

Research into Ageing (RiA) is the registered national charity dedicated to improving the health and quality of life of older people by funding research into the causes and incidence of disability and disease in later life. RiA offers funding twice a year, in November and March.

In November, RiA will consider applications for research project grants and prize PhD studentships. In March, applications for research project grants and post-doctoral fellowships will be considered. Applicants should first submit two-page outline proposals. Candidates shortlisted will be invited to submit full applications.

**Deadlines** for outline proposals:

- 1 for November 1999, **20 August**;
- 2 for March 2000, **29 November**.

**Enquiries and requests** for forms: Dr Jemma Borg, Research Manager, Research into Ageing, Baird House, 15/17 St. Cross St, London EC1N 8UW. Tel: 0171 404 6878. Fax: 0171 404 6816. Email: jemme@ageing.co.uk.

## CLINICAL TRAINING FELLOWSHIP IN STROKE MEDICINE - EDINBURGH

This post, for the **Western General Hospital and University of Edinburgh**, has been funded by Glaxo Wellcome and aims to enhance the training of physicians who plan to sub-specialise in stroke medicine. The post would be appropriate for **specialist registrars** in neurology, geriatric or general internal medicine. The post is flexible and will be tailored to the needs of the individual but we envisage it will be for a **period of six months**. The successful candidate would be able to start **from 1 August 1999** or when convenient to fit in around their own training.

Salary will be on the appropriate point of the Specialist Registrar Scale. The post is recognised by the JCHMT for higher specialist training in neurology and geriatric medicine.

Further details and a full job description are available from: Dr Martin Dennis or Prof Charles Warlow, Dept of Clinical Neurosciences, Western General Hospital, Edinburgh, EH4 2XU. Tel: 0131 537 1719. Fax: 0131 332 5150.

## NCCA BECOMES PART OF NICE - MAY 1999

The NCCA's services will be absorbed into the National Institute for Clinical Excellence (NICE). NICE's work will support/be supported by National Service Frameworks, professional self-regulation, lifelong learning, the Commission for Health Improvement, the National Performance Framework, and the National Patient and User Survey, depending on, and strengthening, clinical governance.

Contact the NCCA at: BMA House, Tavistock Square, London WC1H 9JP. Tel: 0171 383 6451. Fax: 0171 383 6373. Email: [ncca@ncca.org.uk](mailto:ncca@ncca.org.uk). Website: <http://www.ncca.org.uk>.

**BGS NORTHWEST**

**Forthcoming meetings -  
ATTENDANCE  
MANDATORY FOR SpRs**

All meetings not labelled "SpRs only\*" are open to consultants and other career grades.

**CME:** 3 hours.

**26 August 1999**

**Education Centre, Royal  
Bolton Hospital**

*Masterclass on Infection/Immunology.*

Those other than SpR wishing to attend contact Dr Paul Baker in advance for catering estimates.

**1 September 1999**

**Bolton area**

*Topics include UKPDS and depression in the elderly*

**Sept/Oct 1999**

**Low Wood Hotel, Windermere  
SpR Training Weekend (\*SpRs only)**

**13 October 1999  
Crumpsall**

*Topics include falls, hypertension and lipids*

**3 November 1999**

**Leigh**

*Masterclass in Haematology in the Elderly*

**1 December 1999**

**Oldham**

*BGS business, Brocklehurst Prize meeting*

**29 January 2000**

**Four Seasons Hotel, Hale Barns  
BGS NW Annual Dinner and  
presentation of Brocklehurst Prize**

**2 February 2000**

**Bolton**

*Osteoporosis Masterclass*

**Contact:** Dr Paul Baker, Lurden House, 149 Wigan Road, Standish, Wigan WN6 0AG. Tel: 01257 427571. Fax: 0870 056 9670. Email: paulbaker@drivehard.demon.co.uk.

**STROKE ASSOCIATION**

**Centenary Conference on  
"New perspectives from stroke  
research - treatment, recovery  
and rehabilitation"**

**7 to 8 September 1999**

**University of Nottingham**

Topics include: OT in the community; driving after stroke; cognitive behavioural therapy after stroke; and and multi-modal MRI.

**Fees:** £35 per day; £60 two days; £95 two days residential.

**Contact:** Sharon Wainer, Conference Organiser on 0171 566 0325/0300. Email: swainer@stroke.org.uk.

**CARE IN NURSING  
HOMES**

**Conference on "Care in the  
Nursing Home Sector -  
Challenges and Opportunities"**

**16 September 1999**

**RCP Edinburgh**

This is a Joint Symposium by the Royal Colleges of: Physicians of Edinburgh; General Practitioners; and Nursing. Topics include: Royal Commission report on long-term care; standards of care in nursing homes; admissions from nursing homes to hospitals; and ethical and medico-legal dilemmas. Examples of innovative practice in the UK will be given.

CME and PGEA approved.

**Tickets from:** Ms Eileen Strawn, Symposium Co-ordinator, RCP of Edinburgh, 9 Queen Street, Edinburgh EH2 1JQ. Tel: 0131 225 7325. Fax: 0131 220 4393. Website: www.rcpe.ac.uk.

**DIABETES SIG**

**Diabetes Special Interest Group  
Annual Meeting**

**17 to 18 September 1999**

**Leicester**

**Contact:** Dr S Croxson, Bristol General Hospital, Guinea Street, Bristol BS1 6SY. Tel: 0117 928 6101.

**FALLS PREVENTION**

**Elderly Directorate conference  
on "Establishing a Falls  
Prevention Service"**

**21 September 1999**

**Moseley Hall Hospital,  
Birmingham**

Topics include: the well-balanced clinic; the falls prevention nurse specialist; and ward-based and community falls prevention. Falls Prevention Toolkits will be available. An exhibition and literature "fest" on site.

**Fees:** £150 (reduction for groups).

**Contact:** Mrs Sheila Shakespeare, Moseley Hall Hospital, Alcester Road, Moseley, Birmingham B13 8JL. Tel: 0121 442 3557.

**CARE HOME MEDICINE**

**Care Home Medicine  
Special Interest Group  
Symposium on "Models of Care"**

**4 October 1999**

**Training & Development  
Agency, Ida Darwin, Cambridge**

Topics to be covered: the delivery

**Continued on page 27**

'Care Home Medicine' notice continued from page 26

of specialist care into nursing homes; and the teaching nursing home concept.

**Contact:** Dr Tony Luxton, Lifespan Healthcare NHS Trust, Ida Darwin, Fulbourn, Cambridge CB1 5EE. Tel: 01223 884014. Email: tonyluxton@kings-lynn1.demon.co.uk.

### HEALTH SERVICES RESEARCH SIG

**Official launch of new BGS Health Services Research Special Interest Group and conference on "Health Services Research for Older People"**

**8 October 1999**

**University of Leicester**

The Trent Institute and University of Leicester will host the first Trent Health Services Research for Older People conference. It will include research from the Trent region as well as from the new HSR SIG (chaired by Prof Ian Philp).

Topics include: acute and post acute care; primary and community care; and institutional care.

**Contact:** Dr Stuart Parker, Senior Lecturer, University Division of Medicine for the Elderly, Leicester General Hospital, Gwendolen Road, Leicester LE5 4PW. Tel: 0116 258 4081.

### SpR TRAINING EVENT

**"Understanding and running a comprehensive geriatric service"**

**11 to 12 October 1999**

**Belfry Golf/Conference Centre, Wishaw, North Warwickshire**

Numbers are limited so preference will be given to early bookings and to SpRs in final two years of training

See flyer in this issue of the BGS Newsletter for more details and application form or contact: Luisa Massey on tel: 0121 627 2262, fax: 0121 627 2204.

### JEWISH SERVICES FOR THE ELDERLY

**First World Conference on "Jewish Services for the Elderly"**

**7 to 11 November 1999**

**Jerusalem, Israel**

Call for papers: 200 word abstract in agreed format to follow social or medical track.

For further information see website on: [www.ortra.com.jewish.elderly](http://www.ortra.com.jewish.elderly). Email: [elderly@ortra.co.il](mailto:elderly@ortra.co.il), tel: 00972 3 638 4455, fax: 00972 3 638 4444.

In UK, contact: Dr P P Mayer on email: [peter.mayer@btinternet.com](mailto:peter.mayer@btinternet.com). Tel: 0121 627 8482. Fax: 0121 627 8282.

### AUSTRIAN GERIATRICS CONGRESS

**First announcement of the Austrian Geriatrics Congress**

**25 to 29 March 2000**

**Bad Hofgastein, Salzburg**

Contact: Congress Secretariat, Frau Renate Uher, Krankenanstalt Rudolfstiftung, 4 Medizinische Abteilung, 1030 Wien, Juchgasse 25, Austria. Tel: +43 1 711 65-3402. Fax: +43 1 711 65-3403.

### SCIENTIFIC MEETING IN AUSTRALIA

**First announcement of the Australian Society for Geriatric Medicine's Annual Scientific Meeting**

**3 to 5 July 2000**

**Cairns, Australia**

To be held conjointly with the New Zealand Geriatric Society.

**Theme:** 'improving with age'.  
**Keynote speaker:** Prof R A Kenny.

**Contact:** Dr Paul Varghese, Convenor ASGM 2000 Annual Scientific Meeting, Dept Geriatrics, Princess Alexandra Hospital, Ipswich Rd, Woolloongabba 4102, Brisbane, Queensland. Tel: +61 7 3240 2312. Fax: +61 7 3240 2900. Email: [varghesep@health.qld.gov.au](mailto:varghesep@health.qld.gov.au).

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