



# B G S

n e w s l e t t e r

## National Service Framework - the standards

**T**he National Service Framework (NSF) sets standards for the care of older people across health and social services. These are summarised\* below.

### Standard 1: Rooting out age discrimination

NHS Services will be provided, regardless of age, on the basis of clinical need alone. Social Care Services will not use age in their eligibility criteria or policies, to restrict access to available services.

### Standard 2: Person-centred care

NHS and Social Care Services treat older people as individuals and enable them to make choices about their own care. This is achieved through the single assessment process, integrated commissioning arrangements and integrated provision of services, including community equipment and continence services.

### Standard 3: Intermediate care

Older people will have access to a new range of intermediate care services at home or in designated care settings to promote their independence by providing enhanced services from the NHS and councils to prevent unnecessary hospital admission and effective rehabilitation services to enable early discharge from hospital and to prevent premature or unnecessary admission to long term residential care.

### Standard 4: General hospital care

Older peoples' care in hospital is delivered through appropriate specialist care and by hospital staff who have the right set of skills to meet their needs.

### Standard 5: Stroke

The NHS will take action to prevent strokes, working in partnership with other agencies where appropriate. People who are thought to have had a stroke have access to diagnostic services, are treated appropriately by a specialist

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stroke service, and subsequently, with their carers, participate in a multidisciplinary programme of secondary prevention and rehabilitation.

**Standard 6: Falls**

The NHS, working in partnership with councils, takes action to prevent falls and reduce resultant fractures or other injuries in their populations of older people. Older people who have fallen receive effective treatment and rehabilitation

and, with their carers, receive advice on prevention through a specialist falls service.

**Standard 7: Mental health in older people**

Older people with

mental health problems have access to integrated mental health services, provided by the NHS and councils to ensure effective diagnosis, treatment and support, for them and their carers.

**Standard 8: The promotion of health and active life in older people**

The health and well-being of older people is promoted through a co-ordinated programme of action led by the NHS with support from councils.

**Medicines and older people**

The Medicines Management Booklet aims to ensure that older people:

- 1 gain the maximum benefit from their medication to maintain or increase their quality and duration of life; and
- 2 do not suffer unnecessarily from illness caused by excessive, inappropriate or inadequate consumption of medicines.

**\*The full version of the National Service Framework for Older People - Executive Summary is available on: [www.doh.gov.uk/nsf.olderpeopleexecfore.htm](http://www.doh.gov.uk/nsf.olderpeopleexecfore.htm) or from: Department of Health, PO Box 777, London SE1 6XH. Fax: 01623 724524.**

**NSF MILESTONES - APRIL 2001 TO APRIL 2005**

**June 2001**

Local arrangements for implementing the NSF are established.

**July 2001**

Joint appointed co-ordinators for intermediate care designated, framework for user/carer involvement agreed, baseline exercise complete.

**October 2001**

Audits of all age-related policies complete.

**January 2002**

Intermediate care joint investment plan is agreed.

**March 2002**

- 1 1500 additional intermediate care beds compared with 1999-2000 baseline.
- 2 40,000 additional people receiving intermediate care services promoting rehabilitation compared with 1999-2000 baseline.
- 3 20,000 additional people receiving intermediate care preventing unnecessary hospital admission compared

with 1999-2000 baseline.

**April 2002**

- 1 Strategic and operational plans will include initial action to address identified age discrimination.
- 2 Councils will have reviewed their eligibility criteria for adult social care to ensure that they do not discriminate against older people.
- 3 Single assessment process will be introduced.
- 4 Information provided to older people is reviewed and action plans developed to correct shortcomings - reflected in Better Care Higher Standards charters.
- 5 Specialist multidisciplinary teams will be identified and interfaces for care of older people throughout hospitals will be agreed.
- 6 Structures identifying nursing leaders with responsibility for older people will have been developed. Specialist/Nurse Consultant, and Clinical Leaders (Modern Matrons) will have been considered.
- 7 Every general hospital, which

cares for people with stroke, will have plans to introduce a specialised stroke unit from 2004.

- 8 People over 75 will have an annual review of medicine and those with four or more medicines will be reviewed six-monthly.
- 9 All hospitals will have a 'one stop dispensing/dispensing for discharge' schemes.

**October 2002**

Analysis of levels and patterns of key intervention rates will have been carried out to help establish best practice benchmarks.

**April 2003**

- 1 From 2003-4 local health systems to demonstrate year-on-year improvements in moving towards benchmarked intervention rates.
- 2 Systems exploring user/carer experience will be in place in NHS and PSS organisation.
- 3 Strategic and operational plans will include the development of an integrated continence service.

4 NHS organisations will have systems in place to analyse complaints from older people and carers.

5 Skills profile of staff who care for older people in general hospitals will be completed. Plans to address identified gaps will be completed.

6 Hospitals caring for people with stroke will have established clinical audit systems to ensure delivery of the RCP clinical guidelines for stroke care.

7 Risk management procedures will be in place in all providers of health and social care to reduce risk of older people falling.

8 Local health systems will demonstrate year-on-year improvement in measures of health and well-being of older people.

9 Strategic and operational plans will include a programme to promote healthy ageing and to prevent disease in older people.

#### March 2004

1 5,000 additional intermediate care beds and 1700 non-residential inter-

mediate care places compared with 1999-2000 baseline.

2 150,000 additional people receiving intermediate care services that promote rehabilitation compared with 1999-2000 baseline.

3 70,000 additional people receiving intermediate care which prevents unnecessary hospital admission compared with 1999-2000.

#### April 2004

1 Systems to explore user and carer experience in PCTs to be in place.

2 Single integrated community equipment services will be in place.

3 Integrated continence services will be in place across all health and social care systems.

4 GP practices, using agreed protocols, will be identifying, treating and managing patients at risk of stroke.

5 GP practices, using agreed protocols, will be identifying and treating people who have had a stroke.

6 GP practices will be using agreed protocols for rapid referral of patients

with TIAs to local specialist services.

7 GP practices will have established clinical audit systems for stroke.

8 100% of all general hospitals caring for people with stroke will have a specialised stroke service.

9 Strategic and operational plans will include the development of an integrated falls service.

10 Strategic and operational plans will include the development of a mental health service for older people.

11 GP practices, using agreed protocols, will be diagnosing, treating and caring for older people with depression or dementia.

12 Protocols are in place across health and social care systems for the care and management of older people with mental health problems.

13 PCG/Ts will have schemes in place so that older people get more help from pharmacists in using their medicine.

14 All health and social care systems will have established an integrated falls service.

# Letter to all members

## of the British Geriatrics Society

This letter was sent to all members of the Society following the publication of the National Service Framework.

Dear Colleague

5 April 2001

### Re: The National Service Framework for Older People

The long awaited National Service Framework for Older People was finally launched last week. Unfortunately, it was a very low key affair with remarkably little press interest. Although pertaining specifically to England, it will be of

interest to those elsewhere in the UK. We are therefore writing to all members of the society in order to:

- 1 ensure you are aware it has been published;
- 2 encourage you to read it at: [www.doh.gov.uk/nsf/olderpeople.htm](http://www.doh.gov.uk/nsf/olderpeople.htm) until a hard copy arrives;
- 3 to let colleagues know what should start to happen locally; and
- 4 to emphasise how important it is that the BGS either through its regional networks, or by writing to us directly, obtains feedback over the next two years on the progress or otherwise in all localities.

Although it is a very large document, we would particularly commend a number of paragraphs for immediate inspection.

**Paragraph 2.36**

“If admission to long-term care is a possibility, full multidisciplinary assessment should take place to identify opportunities for rehabilitation and to reduce inappropriate admission. This would involve assessment by the most appropriate team - such as the specialist stroke team, old age multidisciplinary team or the old age mental health team.”

**Paragraph 3.27**

“Intermediate Care Services will be provided by a core team of professionals including, general practitioners and hospital doctors, nurses, physiotherapists, OT’s.... Key elements will be: For medical care, the underlying principle is one of shared care between general practitioners and hospital based specialists. Locally agreed protocols and care pathways will determine the precise arrangements within a particular intermediate care service, and ensure that at any time the locus for medical responsibility is clear. In most cases the hospital based consultant will be a specialist in old age medicine... The arrangement should wherever possible, build on existing relationships and good practice locally.”

**Paragraph 4.43**

Referring to the three accepted models of geriatric care, age related, integrated and needs related. “There is no evidence that any one model is better than any other and each has its strong advocates. Any age defined model in operation will need careful scrutiny as set out in standard 1.”

**Paragraph 4.26**

“Clinical leaders (modern matrons) who will be easily identifiable to patients and responsible for groups of wards will provide the support and development for ward managers to improve the care of older people in hospital.”

**Paragraph 4.29**

“The NHS Plan includes a commitment to ensure by 2004 that every NHS patient has a discharge plan developed from the start of hospital admission.”

**Paragraphs 4.31 & 4.32**

“There should be a specialist old age multidisciplinary team in all general hospitals.... The team should be based around a specialist unit which will

serve as a Centre of Excellence for developing and disseminating best multidisciplinary practice throughout general and acute wards and A&E departments”.

**Paragraph 5.20**

“All patients who may have had a stroke will usually require urgent hospital admission.”

**Paragraph 5.21**

“Immediate management to improve chance of survival and minimise the risks of complications should include: brain scan within 48 hours....”

**Stroke Milestone**

By April 2004, 100% of all general hospitals which care for people with stroke will have a specialised stroke service as described in the stroke service model.

**Falls Milestone**

By April 2005, all health and social care systems should have established an integrated falls service.

These are only a very small number of paragraphs that we have picked out that may be of particular interest immediately to geriatricians. Throughout the document there are timetables for action and expectations and plans to be made and delivered.

We will want to know where there are difficulties, problems, timetables not being followed and action plans not delivered. We will be particularly concerned if the expectations set out about assessment for long-term care and involvement in intermediate care are being ignored. There is potentially a lot in the NSF for older people and all the staff that work with older people. The Modernisation Board of the NSF and the National Older Peoples’ Task Force, chaired by Prof Ian Philp, are responsible for ensuring the delivery of the NSF over the next few years. A major role for the BGS will be to provide accurate feedback about the reality on the ground.

**Dr David Black<sup>1</sup> and Dr Paul Knight<sup>2</sup>**

<sup>1</sup> Chair of RCP/BGS Geriatrics Committee & Member of the Older Peoples Task Force

<sup>2</sup> Chair of Policy Committee

**Enclosures (sent with the letter):  
BGS Press Release (page 6); and 8 National Service Framework Standards (page 1).**

## BRITISH GERIATRICS SOCIETY PRESS STATEMENT

### The National Service Framework for Older People: Delivery is the key - but we see some pitfalls to be addressed!

The British Geriatrics Society (BGS), the voice of specialist practice in the medical care of older people in the UK - welcomes the initiative of the Department of Health (DoH) in developing a National Service Framework (NSF) for Older People in England. Several members of the BGS have been heavily involved in providing advice to the multidisciplinary groups developing the NSF over the last 18 months.

We wholeheartedly endorse the objective of rooting out ageism and driving up standards of health care (and social care) for older people. We particularly welcome the clear pivotal responsibility laid down for physicians and psychiatrists specialising in the care of older people in:

- 1 developing, together with GPs and other professionals, new intermediate care services to compliment current acute, rehabilitation and primary care services;
- 2 rolling out best practice in stroke care across the whole country - a group of patients far too often marginalised and ignored in the past;
- 3 delivering specialist services for people who fall and suffer accidents;
- 4 taking action to meet the challenge of mental health problems in old age.

The BGS will be energetically involved in helping to implement the NSF but its successful delivery will depend on the avoidance of some apparent pitfalls in the following areas.

**1 Funding streams.** There is no clear funding stream set out in the document and local implementation groups must have ring fenced funds tied to clear, costed local programs to deliver the NSF. Past experience shows that teams with no budgets or accountable general management are hostage to competing interests,

lending credibility to a cosmetic process. Already the first £150m of the £900m designated for intermediate care appears to have disappeared into a black hole of deficit retrieval.

**2 Specialist training needs.**

Driving up standards will require not only real changes in attitude throughout the system, but training, expertise and leadership across the professions in the multidisciplinary skills and knowledge required in the special needs and care of older people. Greater impetus than is apparent in the document will be needed to encourage more career specialism in the care of older people.

**3 Information technology needs.**

A common assessment protocol should in principle help to provide appropriate care. However, many professionals are already overburdened with paper systems and a massive investment in information technology will be required to deliver an effective and efficient system and to avoid substituting bureaucracy for professional ineptitude.

**4 Risk of ageist discrimination.**

Pre-occupation in the National Plan with preventing “inappropriate” admissions of older people has produced anxiety that “appropriate” admission for older people to acute hospitals will be more difficult and specialist resources for their care in acute hospitals reduced. Such an ageist approach to care is an important risk that will need to be addressed by all those implementing the NSF. Furthermore, to ensure that intermediate care does not become a “lower grade” substitute, decisions to admit older people to intermediate care must involve consultation with physicians in this speciality.

**5 Professional manpower needs.**

The workforce requirements to improve the care of older people are

considerable. To deliver the plan smoothly an immediate increase in the numbers training to become medical specialists in the care of older people must be implemented. This should run in parallel with the proposed human resource increases for those professionals who form part of the multidisciplinary teams so essential to the effective care of older people.

**6 The continuing issue of long-term care.**

We are disappointed that another opportunity has been missed to resolve the difficult issues of long-term care, in particular to set in place clear procedures to ensure the free delivery of long term care to older people based on multidisciplinary assessment and need.

**7 Accountability.** Performance management is vital. Although each locality will have a planning team and an older people’s “champion”, it is not clear who will be held managerially, financially and clinically responsible if the NSF agenda for delivery of services, standards and milestones is not met. This must be resolved.

The BGS will work closely with the newly established National Directorate for Older Peoples’ Services and the associated Modernisation Task Force. The Society, through its membership, will do everything possible to ensure that this National Service Framework succeeds for the benefit of older people in England and beyond. The risk of the cosmetic is, however, significant. Ultimate success or failure will depend at least in part on the DoH response to the pitfalls we have highlighted.

27 March 2001

Contact: Richard Lynham, Administrative Director, BGS (see page 27 for address).

# Editorial

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**S**pring has sprung with a successful Scientific Meeting in Cardiff, 5 to 7 April, that will be reported fully in the next Newsletter.

## The beginning of the end?

The National Service Framework for Older People was born with barely a whimper on 27 March. At 7.30 that morning Radio 4 announced the government's intention to outlaw ageism in the NHS and as far as I'm aware was otherwise silent on the matter.

My SHO wondered whether this heralded the end not only of geriatric medicine but also paediatrics. I think there's a real danger that the drive to get rid of age discrimination could be misdirected to the specific services needed by frail old people and lead to poorer quality care for this group at greater overall cost.

The BGS will resist this, helped by evidence from members. So please be vigilant about the implementation of the NSF and report back as requested by David Black and Paul Knight in their letter (page 4). I'd like to feel that the NSF would lead to the best of geriatric medical practice being provided to older people wherever they find themselves. Then it could be time to shout, "geriatric medicine is dead, long live geriatric medicine".

## The unified multidisciplinary way

John Evers' article, entitled "*The geriatric 'method' - can it be enshrined in an integrated care pathway*", (page 11) is a timely reminder of the need to share documentation for the benefit of patient care. Pioneers of this approach know just how much work is needed to achieve such a fundamental change to patient records. The transition cannot be achieved overnight and until sharing on paper is the norm, electronic patient records will remain a dream.

## Help the BGS and your CV

Look out for the separate flyer accompanying this Newsletter seeking out volunteers to be poster assessors at the Society's Scientific Meetings (see also page 21).

John Gladman, Abstracts Editor of *Age and Ageing*, tells me that any BGS member who wants to have a go and has an area of interest and knowledge is eligible. So don't delay, fill in and return the form. Pleasure and honour will be your rewards!

## Closer links between newsletters

It has been agreed that articles of mutual interest can be shared between our Newsletter and that of the Faculty of Old Age Psychiatry, subject to the authors' agreement. Browsing through the Spring edition of *Old Age Psychiatrist*, I noticed that in a comparison between three websites, i.e. International Psychogeriatric Association, BGS, and Alzheimer's Disease International, the BGS site came out best for presentation, access and scope. This commendation follows that in the *BMJ* (15 April 2000) and is another feather in Recia Atkins' cap!

## NCCG doctors – this is your meeting

Professor Mark Castleden, Director of CME/CPD, will hold a meeting for non-consultant career grade doctors at this year's Autumn Meeting in London (17-19 October 2001). Please send agenda items to him at BGS HQ.

## Marjory Warren House comes into her own

Any lingering doubts about the wisdom of buying a property were dispelled when, on 15 March, three different meetings were accommodated separately at Marjory Warren House. This would have been impossible in the rented premises at St Andrew's Place and would have led to the additional expense hiring extra rooms.

**Dr Rebecca Dunn**

# President's column



## Responding to the National Service Framework (NSF) for Older People.

Adapting to the eventual emergence of the long-awaited English NSF for the care of older people is rather like adjusting to a new time zone – but there it is. Colleagues in Northern Ireland, Wales and Scotland are in the advantageous position of scrutiny from without, but are aware that each respective administration will also be examining the document and the English Framework's implications.

The BGS despatched its press release within 30 minutes of the NSF appearance and copies have now been circulated to members together with a joint covering letter from the Chairmen of the Policy Committee and the Chairman of the Joint RCP/BGS Committee (pages 4-6). Be sure to read the NSF and these responses. Members will also be aware of responding articles and letters in the general press, the *BMJ*, the General Practice and Nursing press and elsewhere. The process of debate is on going and will continue as the realities of success or failure in implementation are addressed.

**At the heart of the Society's position is the recognition that standards in the care of older people are driven by specialist knowledge of ageing and its implications and by specialist training, skills, service configuration and management in providing for their health and social care needs.**

Its membership and activity reflect over 50 years of accumulated experience in these domains, in which respect I would remind you the BGS, as a professional organisation, is unique not only in Britain, but worldwide. The pitfalls and opportunities identified in our press release are rooted in this position, which was recently reaffirmed by your Council in reviewing the Society's aims.

### Specialist input

The NSF in its early stages involved alongside other "stakeholders" a significant number of BGS members in formulating the advice to ministers. Such specialist input is probably most significantly reflected in the Framework's defined service models (stroke, falls, mental health) where the legacy of genuine evidence and specialist experience can be called upon.

In other components the influence of other considerations is greater relative to evidence or expertise. These include pre-determined policy under the current NHS plan (including a pivotal role for intermediate care in reducing acute hospital bed-occupancy), a large dose of political correctness (not all bad), and the "stakeholder" philosophy of the present administration. In my view there is also implicit a somewhat dangerous perception that since such a wide range of providers contributes to care (e.g. in the primary care, social care and long-term care sectors) specialist skills, training and partnerships might be partly substituted by other, theoretically cheaper methods of standard-setting (e.g. exhortation to attitude change accompanied by improved, systematic and more extensive documentation). History shows that accountability is elusive or lost within such substitutes.

The latter elements of the NSF reflect a greater input of non-specialists and originated substantially from within the DoH itself during the long interval between ministerial advice and launch. This is true, for example, of the section of the NSF on intermediate care almost in its entirety. They are the elements where the BGS is most concerned about standards and therefore where members locally, regionally and nationally must now seek to lead rather than follow opinion, even (or perhaps particularly) where such doubtful opinion appears set to govern the direction in which money will flow. The NSF should not, therefore, be regarded as a consistently expert document and the Society's

initial response endeavours to draw the attention of members and others to some of the key elements of concern.

The challenge at all levels will be to tread the fine line between grasping such opportunities as the NSF provides to raise standards and refusing to lend credibility or sign up to those initiatives we know to be amateur, wrong or wasteful. If the speciality fails to lead opinion, based on expertise, then it is certain no one else will. We should certainly be encouraging colleagues in primary care and the allied professions to join with us in incrementally embracing programmes of accountable specialist knowledge, training and accreditation.

The lack of hard evidence (and therefore susceptibility to fanciful or perverse opinion) was a recurring theme as the NSF evolved. While recognising that our academics compete with one another for research funds, there seems to

me a duty to at least some collective initiative to ensure that any impetus to R&D emerging from the NSF and the Topic Working Group delivers on the key questions underpinning services for older people.

**A highly successful Spring Meeting**

The Wales Organising Committee is to be congratulated on the success of the Cardiff meeting. The scientific programme was superbly formulated and generated much interchange at the cutting edge – for example the interdependency of osteoporosis and falls in medical gerontology research coinciding with the launch of the new SIG, and scrutiny of some contemporary ethical issues based on an incisive “vintage Grimley” review. All in all, a meeting well up to expectation. The July IAG meeting in Vancouver will have a hard act to follow.

**Prof Cameron Swift**  
President

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# Intermediate care

- Health Service/Local Authority Circular

**O**n 19 January, the Department of Health (DoH) released its initial guidance on intermediate care in the form of a combined Health Service and Local Authority Circular, HSC 2001/01 : LAC (2001)1.

The full text can be downloaded from the DoH website at <http://www.doh.gov.uk/coinh.htm>. The document is relatively short with the substance covering only eight pages.

This circular will be extremely important to those working in England as it describes how a major plank of the NHS Plan is to be implemented at a cost of £405 million by 2003/4. We are promised more guidance when the

National Service Framework for Older People is published.

Superficial reading would suggest that the guidance seems to have taken on board much of the advice given by the Society on this topic in the last few months. However, there are some concerns. These centre mainly on the lack of a clear role for consultants in geriatric medicine (or any other specialty) as gatekeepers and providers of on-going care. There is no mention of co-ordination with other geriatric medical services and the implicit suggestion that the need is to keep people out of acute hospitals. The language around charging is a trifle obscure, hopefully it will be interpreted as no charge.

The circular gives initial guidance on:  
1 the definition of intermediate care to be

- used in planning and monitoring service development;
- 2 service models;
  - 3 responsibility for intermediate care;
  - 4 charges associated with council-arranged intermediate care services;
  - 5 the factors to be taken into account in planning development of services;
  - 6 the role of the independent sector;
  - 7 funding for intermediate care and community equipment services;
  - 8 the information that the NHS and councils will be asked to include in their investment; and
  - 9 implementation plans for older people's services for 2001/02 onwards.

Below I have abstracted a few points which I think will be of interest to geriatricians.

### Definition of intermediate care

It is a relief to see that the definition was reasonably comprehensive. Indeed, there is insistence that services would need to meet all of the following criteria and, in particular, the reference to comprehensive assessment:

- 1 targeted at people who would otherwise face unnecessarily prolonged hospital stays or inappropriate admission to acute in-patient care, long-term residential care, or continuing NHS in-patient care;
- 2 provided on the basis of a comprehensive assessment, resulting in a structured individual care plan that involves active therapy, treatment or opportunity for recovery;
- 3 planned outcome of maximising independence and typically enabling patient/users to resume living at home;
- 4 time-limited, normally no longer than six weeks and frequently as little as one to two weeks or less; and
- 5 involving cross-professional working, with a single assessment framework, single professional records and shared protocols.

Although it is suggested that the service should be time limited to a maximum of six weeks, an extension may be authorised after a full reassessment and the sanction of a senior clinician.

It is disappointing that the role of consultant staff in the assessment is not mentioned.

Fascinatingly, the circular also tells us what intermediate care is not, viz:

- 1 *“those forms of transitional care that do not involve active therapy or other interventions to maximise independence, i.e. for patients who are ready to leave acute in-patient care and are simply waiting for longer-term packages of care to be arranged*
- 2 *longer-term rehabilitation or support services*
- 3 *rehabilitation that forms part of acute hospital care.”*

The circular calls for clear clinical and managerial accountability but does not actually mention clinical governance (or consultant involvement). It is also made clear that intermediate care should not be used for people with unstable acute medical conditions. At this point the circular also says that: *“Where such a condition has been identified, or in case of any doubt over diagnosis, patients must have access to consultant-led, hospital-based diagnostic and treatment services, with consultant accountability for systems for monitoring their needs. This also applies in cases where new acute medical problems emerge during the course of an intermediate care episode.”*

Depending on how you read this, it could imply that consultants (of whatever variety) may not necessarily be part of the on-going assessment and treatment of patients in intermediate care, but only brought in when someone else thinks it might be reasonable. There is certainly no mention of consultant medical staff being involved in the service models that are discussed later. There is no recognition of a need to expand the numbers of consultant geriatricians so that they may become involved in intermediate care in a meaningful way.

### Service models

Five models are quoted: rapid response; supported discharge; hospital at home; day rehabilitation; and residential rehabilitation.

The models are all currently in existence but the lack of a mention for geriatricians in the staffing list is worrying.

### Responsibilities for intermediate care and charging

This is one of the most interesting sections because it essentially makes clear that intermediate care should be free at the point of use.

*“To ensure clarity for users and carers and consistent take-up of the most appropriate services, and to reflect the longer-term benefits of intermediate care for users/ carers and for efficient use of NHS/ council resources, the Department considers that all intermediate care (as defined in paragraphs 7 and 8 and subject to the normal time limits outlined there) should be free at the point of use.”*

Even more interesting is that when intermediate care takes a residential form, that: *“councils would need to agree with their health service partners that the NHS should have underlying responsibility for such services, within the framework of a jointly planned and jointly funded intermediate care service”.*

Therefore, this circular shows the government’s determination to introduce forms of intermediate care. They seem to be keen to get value for the massive injection of funds that they are proposing and tell us that further guidance will

be forthcoming in the soon to be published National Service Framework.

As I commented in my critique of the Audit Commission report on rehabilitation, this is an opportunity for geriatricians to get involved in a truly comprehensive service utilising the skills that the specialty has built up over many years. However, you will need to have your arguments well marshalled to ensure that you have an appropriate position in the growth of intermediate care. Be assured that if you don’t get your seat on this train early, it will leave the station without you and you will have little control over it’s final destination. In order to try and bring the shortcomings of the guidance to the attention of PCT/PCG’s I will once more be writing their chairmen and chief executives.

**Paul Knight**  
Policy Committee Chairman

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# The geriatric ‘method’

- can it be enshrined in an integrated care pathway?

**G**eriatricians, I believe most would agree, are not good self-publicists.

We are not very good at setting out our wares, a fault which makes us vulnerable when services are, as now, being reorganised. We were found wanting when the internal market flirtation left us vulnerable to the whims of fundholders. We in Cornwall, and I suspect others too, are not certain whether to cosy up to PCTs or to acute Trusts. We generate a lot of angst worrying about which organisation should employ us and whether or not we should be part of an ‘integrated’ emergency system in the District General Hospital (DGH). We do very much less drum-beating about the sorts of patients and the types of problems we should be seeing and much less still about the carefully honed

processes we customarily apply in dealing with patients and problems, processes that distinguish what one might entitle ‘geriatric method’ from other sorts of medical method.

## Blueprint of services

In Cornwall, we have tackled this in two ways. The first has been to produce and promulgate a ‘blueprint’ of our services and the place we think those services should occupy in the modern world. This is largely in line with the document A3 in the BGS *Compendium*<sup>1</sup>, but goes further in defining the types of patient for which our service provides. The second has been, as part of a county-wide move to develop integrated care pathways, an attempt to describe that elusive ‘geriatric process’ and encapsulate it within a pathway, the chief feature of which is that it is ‘generic’, in the sense that it is not disease-specific but attempts to set a series of milestones for the journey of an elderly dis-

abled patient through the health maze.

**What is an integrated care pathway?**

It is a description (even a prescription) of a patient’s journey through that particular part of the health and social care jungle to which it applies. It is a description, the content of which is based on best available evidence, agreed and signed up to by all the disciplines involved and, in its best and final format, should be owned by the patient to whom it applies.

Its paper manifestation is distinguished by:

- 1 being a unified, multidisciplinary record of care;
- 2 including readily recognisable milestones along the pathway;
- 3 including an instruction to practitioners to sign up as they go to their contribution to the achievement of each milestone; and
- 4 indicating why they may have failed to achieve it, so providing (and this is crucial) an in-line audit of the progress - or lack of it - along the path.

Its purpose is, therefore, to provide an insurance of best practice, achieving this by:

- 1 setting down what is agreed best practice;
- 2 encouraging professionals to follow it; and
- 3 saying why they might have fallen short on

occasion, indicating the ‘holes’ that need to be filled (whether in resource provision, training, process, logistics, etc).

Therefore, it is different from clinical guidelines (which are usually involved with specific clinical interventions) in being more

concerned with the process of care than with the detail of its individual therapeutic elements.

**What is ‘geriatric process’?**

We should all know what this is, but rarely climb on to our soapboxes to proclaim its virtues. It may be best to define it by distin-

guishing it from ‘medical’ process, as caricatured (and I exaggerate not) in the scenario in which an elderly lady comes to the DGH with multiple problems of malfunction, i.e. she is immobile, unstable, drowsy and confused, malnourished, impoverished and depressed, and the house officer sums it all up in the immortal words *“Impression: ?UTI”*. ‘Medical’ process is characterised by the doctor’s need to assign a pathological process to every bit of life that comes to his/her attention, and especially that bit that may respond to medication. The bits that can’t or won’t respond (if they are recognised at all) are relegated to the ‘social problem’ bin, and become the province of the therapists, nurses or social services: this process is alive and well and can be found most days in both primary and secondary care settings.

By contrast, ‘geriatric’ process starts off from the assumption that the problems are what the patient says they are, not what the doctor tells him or her they are, lists them, assigns a medical reason for those problems where one exists, and offers (in a multidisciplinary context, and where possible with the agreement of patient and/or family) a range of possible stratagems for managing those problems.

This process is sometimes characterised by the word ‘holistic’. I would rather it were characterised as a problem-solving process, implicit in which is the principle that problems, in order to be resolved, have first to be recognised and understood.

The BGS Compendium document A4<sup>2</sup> sets out in its statement on ‘Rehabilitation - What is it?’ the elements of the rehabilitative process. Our pathway sets out to work these elements into a process which, crucially, should involve the patient in agreeing to the problem list and the range of options for their management, so that patients and carers may make a direct contribution.

**The care pathway**

It should follow, then, that the geriatric process is integral to the approach to be adopted by all health and social care practitioners coming into contact with elderly people presenting to them with a problem in any setting. At the time of writing, the National Service Framework for

Table 1	
The main features of a generic Integrated Care Pathway	
1	A multiprofessional approach to care.
2	A problem-oriented approach to care (based on the patients’ perception of the problems).
3	Describes a guided journey through the health maze.
4	Allows the ‘bolting on’ of disease-specific pathways or guidelines.
5	Enables in-line audit of reasons for breakdown of pathway.

Older People is still to appear; it will be interesting to see whether the process of ‘assessment’, which we believe is to be a central part of that document, approximates to these principles.

**Definition and inclusion**

In Cornwall we started off trying to elaborate a care pathway for elderly people ‘off their legs’ and quickly ran into the problems of definition and inclusion. Over a matter of some months, we awakened to the realisation that what we were describing was indeed a central, defining approach to the care of sick elderly people.

Following a prolonged process of discussion and negotiation with representatives of all the relevant disciplines in the county, an agreed pathway of care was elaborated, based on the principles set out above. It became a locally published document,

the aim of which was to replace the multiple records kept by the individual professional groups with a unified single (generic) document in which the gathering of information, the listing of agreed problems, their agreed solutions and the record of progress towards specified and agreed outcomes was set out.<sup>3</sup>

**Pilot study in rehabilitation ward**

It is estimated that the use of such an approach has resulted in savings in record keeping (paper and time spent on it) of about 30%. A specialist rehabilitation ward for elderly people was selected as the pilot site for the first 20 patients. The results of the pilot were recorded, learned from and incorporated into a revised document, then further piloted in a GP-led community hospital. The process described has excited a great deal of interest among the care pathway fraternity and has been the subject of presentations at several national conferences. However, we are now only a short distance down the road of establishing this method across the county, let alone elsewhere.

**Future challenges: generic pathways and intermediate care?**

We confidently expect our method<sup>2</sup> to be adopted in time by all the smaller hospitals

providing local in-patient care for disabled elderly people in Cornwall. It may not be too much to hope that our approach and its supporting documentation should be adopted as the central plank of ‘intermediate care’, whether in local hospitals, residential homes or even in the patients’ own homes. It may also be a reasonable aspiration to expect the generic nature of this approach should commend itself to those setting out to establish care pathways for people with, e.g. stroke or limb amputation. The principles are the same, particularly in the context of rehabilitation, where a team’s understanding of problems and possible solutions, based on patients’ informed aspirations, is essential to progress. Thus, the generic pathway becomes the central template on to which others may ‘bolt’ their more particular requirements for a given pathological condition.

At this point we have not taken on the challenge of applying these principles in the DGH, although there is no prohibitive reason for not attempting this in the course of time. It will have to go hand-in-hand with a thorough overhaul of the system of care meted out to elderly people in the DGH, where the ‘integrated’ take system leads to something of a lottery in the management of older people with complex problems.

One major local challenge is the need to propound a method which is compatible with a major push to implant electronic health records (EHR) in our midst. This initiative is largely centrally driven and supported by a lot of cash; care pathways are, in financial terms, very small beer, however great the weight of the clinical push behind them. Common sense would lead one to suppose that cooperation rather than confrontation with the proponents of EHR should steer us into calmer waters.

**Summary**

Geriatricians the world over may agree that the problem-orientated approach to care, not just of elderly people, must be right. The reductionist approach, which requires a doctor to give a pathological explanation of every human difficulty, should be rejected and replaced, from medical school onward, by the common sense method of agreeing problems and their possible solutions, and recognising that the strictly

Table 2	
Future development of the Cornwall generic ICP	
1	Harmonisation with electronic health records.
2	Introduction into the DGH.
3	Use of the approach and the document in all intermediate care settings?

'medical' element of the problems, though often important, may be small.

The care pathway we describe enables patients and their teams of carers, professional and informal, to cooperate fruitfully in this process and to achieve, by carefully noting the points at which the pathway breaks down, the best available resources for the job. The process of care that geriatricians aspire to needs to be trumpeted abroad; the generic care pathway described here may be the living evidence that it is alive and well.

**\*Dr John Evers**

\*Consultant Physician  
Camborne-Redruth Community Hospital,  
Cornwall

#### References

- 1 BGS: *Guidelines, Policy Statements and Statements of Good Practice*. Document A3 (1997)
- 2 BGS: *Guidelines, Policy Statements and Statements of Good Practice*. Document A4 (1997)
- 3 *A generic pathway for older people admitted to a community hospital in Cornwall*. Available from Mrs M Mallett, ICP Coordinator, MacMillan and Marie Curie Centre, St Clement Vean, Truro, TR1 1RN. Or email: [eversjo@cht.swest.nhs.uk](mailto:eversjo@cht.swest.nhs.uk) or [malletma@cht.swest.nhs.uk](mailto:malletma@cht.swest.nhs.uk).

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# The Gerontological Nursing Programme



**T**he RCN Gerontological Nursing Programme is preparing nurses for their new role in assessing the nursing needs of older people.

This article aims to highlight the pivotal role of the registered nurse (RN) in the assessment of older people, and to introduce the work of the Royal College of Nursing's (RCN) Gerontological Nursing Programme (GNP) in preparing nurses for their key role in the assessment of nursing needs, outlined in the NHS Plan<sup>1</sup>.

This Plan has now been published and emphasises improved care for older people. The proposals for intermediate care and the emphasis on maximising the potential of older people are significant and offer exciting opportunities for older people and the nurses who work with them. The NHS plan sets out to remove the artificial divide that exists between social and health care, which has long been seen as detrimental to the needs of older people who

have inter-related health and social care needs. As nurses who work with older people will know, integration of services is needed to maximise the older person's potential and to respond to their expressed needs and wishes.

#### Funding nursing care

Key within the NHS Plan is the proposal that older people in all settings will receive free NHS nursing care by October 2001. This is good news for older people living in nursing homes and who are, at present, paying for their nursing care. The Royal Commission on Long Term Care<sup>3</sup> recommended that all personal and nursing care be funded, but this has been rejected by the Government, which has stated that nursing care but not personal care is free, thus creating a new artificial divide between the two. The Government says it will meet the costs of registered nurse time spent on providing, delegating or supervising care in any settings (DoH 2000). However, this threatens to restrict nursing care to care actually provided by a registered nurse. This could mean that care delivered by a registered nurse will be free, but care delivered by a health care assistant, working under the supervision or delegation of a registered nurse, will still be means tested.

### Implications for nurses

The Government has made explicit that the assessment of nursing need will be the province of the registered nurse. Whilst the RCN welcomes the acknowledgement of the nurse as central in the assessment of older people, there is concern at the implications for older people and nurses. Nurses will be forced to decide between delivering care themselves, which is funded, or delegating to a health care assistant, which is means tested. Take, for example, Mrs Smith (see boxed text).

#### Example

**Mrs Smith has been in her nursing home for nine months. When she came to the home she felt low and depressed and would only trust key nurses and carers with aspects of her care. Her named nurse in the home developed a particularly close bond with Mrs Smith, as did the health care assistant who worked with her named nurse. The named nurse worked with the care assistants to help them build up the same close relationship with Mrs Smith.**

**The named nurse assessed Mrs Smith's needs and supervised aspects of Mrs Smith's care. For example, she delegated her hygiene care to the health care assistant and stressed the importance of working with Mrs Smith in a therapeutic way, whilst helping her with her hygiene needs. This may include asking her how she was feeling, giving her time to express herself, listening to what she was saying and exploring her feelings. Mrs Smith was able to express how she was feeling and would talk to the healthcare assistant, expressing how helpful she found their time together during the time she was being assisted with her hygiene needs. The health care assistant fed back the information to the named nurse and, in this way, the nurse was able to monitor Mrs Smith's mood and anticipate and plan for her care needs. However, Mrs Smith's hygiene needs were assessed as not warranting the free nursing care of a registered nurse as her care was carried out by a health care assistant under the supervision of a registered nurse. As most of Mrs Smith's care was carried out by health care assistants under the supervision, direction or management of her named nurse, her care was means tested. The care she received was based on government policy and not on her individualised care needs.**

### Structured assessment framework

Nurses will find themselves making key decisions which could significantly affect the care an older person receives. It is therefore important for the RN to ensure they have a structured assessment framework to underpin their decision making. Through a comprehensive assessment, the RN can focus on the important aspects of care needs that maximise the person's potential for independence. In this way, nurses can make expert and informed decisions about whether care must be delivered by a nurse or if it can be delegated to a care assistant. It is important that the nursing assessment is viewed as a continuous holistic process, rather than a series of tasks

### Nurse's role in assessment

The RCN believes that decision making on the precise input of the RN should be based on assessment of health status. This should be: focused on need rather than dependency; holistic; ongoing; carried out within multi-agency context; aimed at maximising the older person's potential; and carried out by a nurse who knows the person.

The RCN has developed an assessment tool<sup>2</sup> which provides a way of measuring an older person's need for care from a RN in any setting. It looks at an older person's needs in an holistic way and aims to increase the overall quality of their life. The holistic approach means that a wide range of information about an older person is collected and assessed. The tool has been designed to help both purchaser and providers to cost more accurately nursing care for older people. For the first time, it is possible to work out the level and amount of nursing care required which, in turn, helps to identify just how much nursing care costs.

The assessment tool offers:

- 1 the comprehensive assessment of an older person's health status;
- 2 the identification of the need for a registered nurse input;
- 3 the estimation of the level of nursing assistance needed;
- 4 an estimation of the number of RN hours required; and
- 5 the identification of evidence to support decision making in practice.

### RCN assessment seminars

The GNP is offering a series of national seminars to raise awareness and understanding of the nurse's role in the assessment of older people. It is keen to help nurses working with older people develop their expertise in assessment and their knowledge base of policy and practice.

The three-hour seminars cover:

- 1 the nurse's role in assessment;
- 2 underpinning philosophy for assessment - a person-centred approach;
- 3 an overview of the RCN assessment tool; and
- 4 ethical considerations of nursing and personal care relationships.

The seminars are delivered locally to members through the RCN branch and membership group networks. The seminars will also offer details on RCN publications and the services available to support nurses in assessment, and complement the current research, publications and conference presentations facilitated by the Gerontological Nursing Programme.

Details of dates and venues of the seminars will appear in future issues of the RCN Bulletin, free every fortnight to RCN members.

**Jayne Wright\*** and **Emma Pritchard\*\***

Development Fellows  
RCN Gerontological Nursing Programme

\*Email [jayne.wright@rcn.org.uk](mailto:jayne.wright@rcn.org.uk)

\*\*Email [emma.pritchard@rcn.org.uk](mailto:emma.pritchard@rcn.org.uk)

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- 1 Secretary of State for Health (2000). *The NHS Plan: Government's response to the Royal Commission on Long Term Care*, Cm4818-11 Department of Health, London: Stationary Office.
- 2 Royal Collage of Nursing (1997b). *The RCN Nursing Older People Assessment Tool*. London, RCN.
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## Improving the environment of care for older people in acute hospitals

This conference, organised by the Health Advisory Service (HAS), Pavilion Publishing and Help the Aged, took place on 8 March 2001.

The New Connaught Rooms, Covent Garden, provided a roomy setting for this conference in the 'Because They Are Old' series.

#### Focussing on acute hospital care

'*Environments of Care*' was the third in the series of four conferences focussing on the acute hospital care of older people and have run in parallel to service development programmes being undertaken by the Service Development Team for Older People with acute hospital trusts. These focus on the four areas of service delivery identified in '*Not Because They Are Old*', the national inquiry into the hospital care of older people, undertaken by HAS in 1998.

The four main areas identified within the report

were:

- 1 the quality of care;
- 2 clinical care;
- 3 the environment of care; and
- 4 the involvement of older people and their carers in care delivery.

The key aims of this conference were to:

- 1 provide an overview of the environmental issues regarding the acute care of older people;
- 2 examine the key environmental factors within acute hospitals that impact upon an older person's experience of illness and recovery; and
- 3 promote environments of care that enable the needs of older people to be effectively met.

Seventy delegates attended, including clinicians and professionals directly involved with care delivery, managers of hospital services and those commissioning services for older people. Sue Simmonds, team leader of the Service Development Team for Older People, HAS, doubled as Chair and Facilitator and commenced the proceedings assisted by Lynn Waight, a Service Development Adviser within

the team. They began the day by giving an overview of the findings of *Not Because They Are Old* in order to provide a focus for the day. Details of the audit methodology used within the study were given, while the particular issues that arose within the inquiry were examined, issues which, for example, related to the physical layout of wards, the general décor and a lack of essential equipment.

One of the surprising findings of the study was that some of the newer hospitals studied had the most environmental problems.

### **Dementia care and its environment**

The next speaker was Maria Parsons, Assistant Director of the Oxford Dementia Centre (currently developing a good practice handbook *Design for Dementia* which is to be published next year). Maria's presentation, entitled 'Translating the Lessons from Dementia Care', included some thought-provoking results from studies in the USA, Scandinavia and Australia about how environmental design and innovation can influence the behaviour of older people suffering from dementia or an acute confusional state. The studies show that environments can be responsible for positive changes in mood, cognition and orientation and that these factors can not only compensate for sensory loss but can also reduce anxiety. Maria ended her presentation advocating a person-centred approach at the care/environment interface and the need to involve all staff in research and development.

Derek Ward from the University of Portsmouth then provided a thought-provoking talk focusing on care environments and their link to successful rehabilitation for older people. Derek is a researcher undertaking a three-year project exploring the effectiveness of different care settings providing rehabilitation for older people. The two environments to be examined within the study are hospitals and care homes. This would appear to be particularly important in light of the current lack of evidence regarding the impact of the environment on rehabilitative care, the intermediate care agenda and the drive towards the use of beds in care homes for the provision of rehabilitation 'closer to home'.

### **The use of audits**

The next speaker was Nicky Pendleton, a Trust

Development Manager in Portsmouth. Her talk was about how environments of care can be improved through the use of audits. Nicky outlined a project that she undertook in her previous post as General Manager in a Department of Medicine for Elderly People. Her talk proved educational, entertaining and lively, and gave the delegates a real sense of how important the environment of care can be, and how the use of audit may implement change and improve overall care delivery.

The environments that this project concentrated on were ward toilets. Nicky was able to give an overview of this focused project and showed how the undertaking of environmental audits, alongside the auditing of the number of clinical incidents (such as falls) occurring within those environments, provided a powerful tool to improve the environment and reduce the number of incidents.

Jonathan Ellis from Help the Aged, in the first workshop of the afternoon, focused on the initiatives being developed within the delegates own hospitals to improve the environments of care. Sarah Gresham and Claire Weaving, occupational therapists working in the A&E department at Wexham Park Hospital, facilitated the second workshop.

The last part of the day was taken up with an interactive audience debate entitled 'Can good care be delivered in a poor environment?' The audience was split in two according to their initial response to the question. The initial introduction caused a flurry of activity and noise until there were, more or less, about equal numbers of delegates debating each side of the argument. A lively and impassioned debate ensued but by the end it was apparent that all the delegates had wished that they were able to sit in the aisle! The debate was the climax of an informative and enjoyable day.

### **Next conference in the series**

The next conference in the series will focus on developing partnerships in care and will take place on 27 June 2001 at the New Connaught Rooms, London.

**Lynn Waight**

Service Development Adviser, HAS

# Geriatric medicine in Germany



Like all industrialised countries, Germany will experience the consequences of substantial demographic changes during the next decades. This article outlines how the country is adapting health care for older people to face that challenge.

Heidelberg, a city in Baden-Württemberg in the south west, is a good example of how geriatric services developed throughout the country. The city is probably one of the most beautiful in Germany and was first mentioned in a document from a nearby monastery in 1196. Almost 200 years ago romantic poets and writers like Hoelderlin, von Arnim or Brentano established the myth of 'romantic Heidelberg'. The earliest testimony of human life in the area is, however, the lower jaw of 500,000 year-old '*homo heidelbergensis*'. Because of the relatively short history of geriatric medicine in Germany, it seems unlikely that he was seen by a geriatrician!

## Sociodemographic data

Today, 13.3 million of Germany's 82.1 million inhabitants are over 65 years old (16.2%). From national care insurance statistics, about 1.8 million people (2.2%) of the total population (i.e. 20% of the 80-85s, 35% of the 85-90s, 55% of the 90+) were in need of daily care in 1998. However, over 70% of these people lived in their own homes, and only 30% in long-term care facilities. Between now and 2050, the percentage of 60+ year-olds is expected to increase from 22% to 36%, and that of the 80+ from 4% to 12%. During this time, there will be no increase in total population, and, therefore, the age distribution will have changed dramatically. In 1950, those less than 20 years of age were double in number to those 60 or more; a 100 years later, the 60+ are going to be twice as many as the under 20s. During this time, life

expectancy (now being 74.4 years for men and 80.6 for women) will increase. A woman of 60 years old today can look forward to 23 more years (as compared to 19 years in 1970); a man of 60 on average can expect 19 more years now, and only 15 in 1970.

## History of German geriatric medicine

Germany has a tradition of internationally highly-recognized gerontologists, but, before the 1980s, almost no-one in the country realised that providing health care for older people was going to be one of the most challenging for health care. At the end of the 1960s, Germany's first geriatric hospital started in Hofgeismar. There were only a handful of geriatric hospitals when, in 1980, the first geriatric rehabilitation hospital (Albertinen Hospital) was built in Hamburg. Bethanien Hospital, Heidelberg, in 1979, was one of the first geriatric hospitals in the country.

It was not until the 1980s, under the pressure of today's foreseeable demographic changes, that the government of Baden-Württemberg woke up to the need to provide a health care specialty for older people. Part of that response was to establish Geriatric Centres at all university locations, and Geriatric Subcentres in every administrative district. The purpose of the university-affiliated Geriatric Centres was the medical care of in-patients, teaching and research, while the Subcentres were responsible for providing basic geriatric management within acute hospitals. The government's plans were translated into action during the 1990s.

When the Baden-Württemberg government started improving geriatric health care, Bethanien Hospital had just decided to add a long-term care facility for older patients to the hospital. As the hospital was chosen as an academic-affiliated Geriatric Centre, a geriatric rehabilitation clinic was built instead. The geriatric rehab clinic opened in 1991 with great enthusiasm for geriatric rehabilitation. Everyone

expected it to save money by preventing future disability. It did not, of course, but rather emphasised the gulf between need and provision. As financial resources tightened throughout the 1990s, with health care being considered prohibitively expensive, optimistic moods changed. Times have got harder for German geriatric medicine.

### **Bethanien Hospital, Geriatric Centre**

Bethanien Hospital today consists of four facilities: geriatric acute care (97 beds), geriatric rehabilitation (60 beds), geriatric day hospital (25 places) and intermediate nursing care (20 beds). The mean age of the patients is 81. Part of the geriatric acute care is a stroke unit (12 beds) and an intensive nursing care unit (3 beds). Most of the patients in geriatric acute care are admitted directly from their homes, while in the rehabilitation wards they mainly come from acute care departments. The largest groups are patients post-fracture and post-stroke, and they come from traumatological or neurological units. Patients with confusion and dementia make up another large important group. The hospital does not provide outpatient geriatric care, which in fact only exists throughout the country for the purpose of research.



The multiprofessional geriatric team includes doctors, nurses, physiotherapists, occupational therapists, speech therapists, sports therapists, social workers, music therapists, dietitians, and psychologists.

Once a week, there is a team conference on every ward.

Like most German geriatric hospitals, the medical director is also professor of internal medicine. Physicians of all specialties are available for consultative advice and attend weekly. Apart from nursing and rehabilitation, there are many facilities of interest to patients, such as taking tea in the cafeteria, discussion groups, singing groups, memory training,

balance and strength training. Also once a week, patients and therapists meet to eat the cakes the patients bake during occupational therapy. As the hospital is funded by the Methodist church, the staff includes priests who are supportive in end-of-life decisions and palliative care.

As a university-affiliated Geriatric Centre, the hospital teaches medical students, students of gerontology, doctors, nurses, and workers of all professions within the field of geriatric medicine. A geriatric academy was started five years ago, supported by grants from the ministry to educate and teach all professions. All courses provided by the academy combine theory and practice, and participants prove their acquired skills on the hospital wards under the supervision of teachers or mentors. Fields of research are training interventions in the prevention of secondary stroke and fractures, perception and treatment of pain, fracture epidemiology, nursing home medicine and continence care. A recent study of a three-monthly intervention to improve balance and strength in very frail patients showed remarkable results (Hauer et al., J Am Geriatr Soc 49: 1-11, 2001). A grant has been obtained from the Robert Bosch Foundation to provide continence advice and visits by specialist nurses in the community.

### **The problems**

Not all German regions have separated geriatric acute care from geriatric rehabilitation, but although the management of older patients is slightly different, results are very similar. Despite the regional variations, it is still true today that there is a narrow network of geriatric care over the country. Between 1993 and 1997, the total number of geriatric hospitals increased from 84 to 236 (141 had geriatric acute care with a total of 7818 beds, and 95 geriatric rehabilitation with 4684 beds). During the same period, the number of geriatric day hospitals increased from 13 to 66 with a total capacity of 1072. The average, therefore, is 15.3 geriatric beds per 100,000 inhabitants of all ages, but there are substantial regional differences (42-44 beds per 100,000 inhabitants in Hamburg and Berlin, but only 3 per 100,000 in some regions in East Germany). The Federal Association of Geriatric Rehabilitation Hospitals states there is a need for 60 geriatric beds and 15 geriatric day

hospital places per 100,000 inhabitants, and in 1997 there were plans to build another 86 geriatric hospitals and 87 geriatric day hospitals.

The quick and widespread realisation that geriatric care was needed, but without waiting for the training of the necessary number of specialists with the right skills and attitudes, resulted in serious difficulties in the quality of care, teaching and research. There are some units that merely changed their names and not their treatment policies. Moreover, with community health care, there still exist large deficits in the basic geriatric skills of general practitioners. Such problems could be solved by future medical education, but a lack of academic-affiliated geriatric departments and a small number of professors of geriatric medicine (only five chairs of geriatric medicine throughout the country) means that geriatric medicine is poorly integrated into medical teaching programmes in Germany.

### What can be learned from Heidelberg history?

After the Thirty Years' War, the count palatine married his daughter, known as *Lieselotte from Palatine*, to the brother of the Sun King to find peace with France. Without success, however. When the count died, Louis XIV<sup>th</sup> began a war of succession, and between 1689 and 1693 French troops destroyed the city and castle. So what can a German geriatrician learn from

Heidelberg history? He must be aware that he is the little count palatine and should avoid inviting in the Sun Kings of the big medical specialties, but he must work with them. To bring the metaphor to an end, the Heidelberg of today is the lively and cosmopolitan centre of the Rhein-Neckar region, with about 140,000 inhabitants, 30,000 of which are students. It is seat of Germany's oldest university, founded by Ruperta Carola in 1386, and now consists of 15 faculties. Heidelberg has international science and research facilities (e.g. the German Centre for Cancer Research, German Centre for Research on Ageing, Max-Planck-Institute, etc), and many international companies. And, by the way, who remembers the empire of the Sun King?

**Dr Norbert Specht-Leible\***,  
**Prof Peter Oster\***  
and **Prof Mark Castleden\*\***

#### N.B.

\*Norbert Specht-Leible is senior physician and Professor Peter Oster medical director at Bethanien Hospital, Geriatric Centre at the University Hospital, Rohrbacher Strasse 149, D-69 126 Heidelberg. Email: [nspechtleible@web.de](mailto:nspechtleible@web.de).

*Visitors to the hospital and city are always welcome.*

\*\*Director of CME/CPD

## PROFESSOR ALAN J SINCLAIR - MOVING ON TO PASTURES NEW

After six years as the Charles Hayward Professor of Geriatric Medicine at the University of Birmingham, **Prof Alan Sinclair** has decided to move on to experience a new challenge.

He has been appointed Professor of Medicine at the University of Warwick and Consultant Physician in Age-Related Medicine at the West Midlands largest teaching hospital

Trust, University Hospitals Coventry and Warwickshire NHS Trust.

Warwick University has recently established an undergraduate Medical School in partnership with the University of Leicester. Prof Sinclair will be taking the lead in the development of geriatric services in Coventry and Rugby, and will head a new section of Geriatric Medicine and Gerontology at Warwick where he

will be based in the internationally-recognised Centre for Health Services Studies (CHESS), part of Warwick Business School.

Prof Sinclair is accompanied by his clinical lecturer, **Dr Nick Balcombe**.

Dr Balcombe has been appointed as Consultant in the Trust and will assist Prof Sinclair in developing both clinical and academic initiatives.

# Autumn Meeting 2001 - abstracts & assessors



**T**he Society's Autumn Scientific Meeting will take place at the Novotel Hotel, Hammersmith, London, on 18 to 19 October 2001.

### Deadline for abstracts

The deadline for abstracts for the Autumn Meeting is **1 June 2001**. They should be posted to the BGS office or emailed (using email: Abstracts@bgs.org.uk) by this date.

With this Newsletter is a flyer entitled "*Instructions for the Submission of Abstract (revised May 2001)*". Please use these instructions and discard any previous printed instructions, as they have been extensively updated by the BGS office. Those abstracts not conforming to the revised version will be rejected and returned to the submitting authors.

### No modifications will be accepted

In particular, please note that modifications of abstracts submitted will not be accepted - only the first version received by the BGS office will be logged and used thereafter, as matching up modified versions to those previously submitted is a time-consuming task for the administration.

### Abstract reference numbers

For those sending abstracts by email, the BGS will send out an initial acknowledgment by email. You should receive an abstract reference number within 7 days. If you have not done so, call the BGS office to ensure that your abstract was received (do not call before the 7 day deadline). Authors should only call within **7 to 10** days after sending the abstract. If they do not ring within this time, the abstract will be rejected.

### Poster assessors wanted!

Also with this Newsletter is a flyer entitled "*Expertise needed*". The scientific meetings are growing annually in both attendance and participation in the form of poster presentations. This increase in the number of posters requires a large number of assessors. The Society is building a database of assessors with the intention of limiting the numbers of posters to be reviewed by each pair of assessors, and to limit their involvement to not more than once every two years.

If you feel you are able to provide poster presenters with constructive criticism in any of the fields listed on the flyer, the Society would be grateful of your expertise. Full details are available on the flyer itself.

## THE IGNATIUS NASCHER PRIZE OF THE CITY OF VIENNA IN GERIATRICS 2001

This prize will be awarded to **Prof James Williamson** in recognition of his special contributions as an international leader in enthusiastic teaching, perceptive study and compassionate, innovative practice in geriatrics.

Prof Williamson was appointed the first chair of geriatric medicine at the



University of Liverpool in 1973. In 1976, he became the chair in geriatric medicine at Edinburgh University. He created the 2-week training course in geriatric medicine, which is well known worldwide.

The ceremony will take place during an evening reception on 18 May 2001 at the Kunsthistorische Museum, Vienna.

## CME/CPD topics for 2002-2006

You will have seen the list of topics for CME/CPD published in the BGS Newsletter (January, page 24). Although not complete, they are regarded by the Scientific Committee and the Executive as incorporating what geriatricians should know about. It is difficult to ensure coverage of all the topics, especially the less popular, by allowing programme selectors for the BGS national and regional meetings to decide on the content of their meetings. Council have therefore decided that all of these topics will be visited at the national and regional meetings in rotation. This does not mean that a topic may not be visited several times if it is of particular interest or there are new ideas or information about this topic, but the programme is primarily designed to ensure that there are no omissions.

With this in mind, and also to enable all members of the society to plan coverage for their CME/CPD needs, a rolling programme of the topics is programmed into the regional and BGS meetings for the next five years. This programme is only part, of course, of any meeting, and so there is still a lot of latitude for local requirements to be met in regional meetings and other topics to be added to the national meetings.

Please feel free to comment on this rota and also to

add any additional topics you feel have been omitted. We would very much like to hear from you.

The new programme will start from 2002 and last five years. The SIGs (which embody the specialist knowledge within the society for each of their groups) will be asked to provide the CME for their specialty interest, which we regard as part of their role as a specialist group. They may incorporate the CME for their specialty into their own meetings or advise and contribute to keynote speakers. Because some of the SIGs have a greater number of topics in their group than others they will be asked to contribute more CME than others, but this does not mean that they have preferential time for their own business meetings or non-CME topics at the national meetings. There is no restriction on what part of the topic will be covered, as we only wish to ensure that each topic is visited and aired. Meeting secretaries will therefore be able to decide the slant of the topic that is visited. The Spring and Autumn Meetings Secretaries will meet in January of each year, one year before their meetings and divide out the topics for the year between them in order to produce balanced meetings.

**Prof Mark Castleden**  
Director of CME/CPD

## EDUCATIONAL CURRICULUM FOR CME/CPD FOR GERIATRICIANS 2002 to 2006

### Topics for 2002

- ◆ Counselling
- ◆ Attitudes
- ◆ National guidelines and policy
- ◆ Evidence based practice and statistics
- ◆ Adverse drug reactions
- ◆ Vascular dementia
- ◆ Anxiety disorders
- ◆ Bereavement
- ◆ Candidiasis
- ◆ Periodontal disease
- ◆ Toothlessness
- ◆ Gallstones

- ◆ Chronic subdural haematoma
- ◆ Aneurysms and dissections
- ◆ Occlusive peripheral vascular disease
- ◆ Lipids
- ◆ Headache
- ◆ Health promotion
- ◆ Exercise
- ◆ Carer issues
- ◆ Pleural effusion
- ◆ Service development
- ◆ Macular degeneration

- ◆ Gout
- ◆ Osteoarthritis
- ◆ Polymyalgia rheumatica
- ◆ Rheumatoid arthritis
- ◆ Rotator cuff tendonitis and tears
- ◆ Osteoporosis
- ◆ Paget's disease
- ◆ Osteomalacia
- ◆ Hyperparathyroidism
- ◆ Sexual function
- ◆ The treatment of common symptoms in palliative care
- ◆ Hypercalcaemia

- ◆ Intermediate care and long-term care

### Regional topics

- ◆ The management of diabetes mellitus
- ◆ Ketoacidosis
- ◆ The risk of hypoglycaemia

### Topics for 2003

- ◆ Teaching, training, appraisals
- ◆ Community care

- ◆ Clinical pharmacology of specific drugs
- ◆ Diffuse Lewy body disease
- ◆ Sleep disorders
- ◆ Bipolar disorder
- ◆ Vitamin deficiencies
- ◆ Mineral deficiencies
- ◆ Aspiration
- ◆ Diverticular disease
- ◆ Faecal incontinence
- ◆ Superficial and deep venous insufficiency
- ◆ Syncope
- ◆ Coronary artery disease
- ◆ Hypotension
- ◆ Spasticity
- ◆ Progressive supranuclear palsy
- ◆ Movement disorders
- ◆ Peripheral neuropathies
- ◆ Infectious diseases
- ◆ Immunisations
- ◆ Primary care assessment
- ◆ Living wills
- ◆ Enduring powers of attorney
- ◆ Court of protection
- ◆ Mental Health Acts
- ◆ COPD
- ◆ Chronic bronchitis
- ◆ Mechanisms of research
- ◆ Dry eye
- ◆ Eyelid problems
- ◆ Gynaecological problems
- ◆ Prostatic cancer
- ◆ Therapeutic options for managing type II diabetes
- ◆ Service provision for managing the older diabetic in the community

#### Regional topics

- ◆ Delirium
- ◆ Epidemiology
- ◆ Key features assessment
- ◆ Medications
- ◆ Management

#### Topics for 2004

- ◆ Writing reports and papers
- ◆ Management and leadership
- ◆ Comprehensive geriatric assessment
- ◆ Interviewing skills
- ◆ Age and drug action
- ◆ Psychotic disorders
- ◆ Liaison psychiatry
- ◆ Malnutrition and under-nutrition
- ◆ Obesity
- ◆ Caries and xerostomia
- ◆ Inflammatory bowel disease
- ◆ Coeliac disease
- ◆ Colorectal cancer
- ◆ Dizziness and falls
- ◆ Transient ischaemic attacks
- ◆ Investigation of stroke
- ◆ Nutrition of stroke
- ◆ Development of a stroke service
- ◆ Parkinson's disease
- ◆ Essential tremor
- ◆ Chorea
- ◆ Feet
- ◆ Lifestyle advice
- ◆ Consent to treatment
- ◆ Chest infections
- ◆ Tuberculosis
- ◆ Hospital infection
- ◆ Urinary incontinence
- ◆ Glaucoma
- ◆ Haematological problems
- ◆ Renal problems
- ◆ Dermatology
- ◆ Diagnosis of the causes of symptoms in palliative care
- ◆ Cord compression
- ◆ Communication with dying patients and families
- ◆ Setting up and running an annual review diabetic clinic
- ◆ Vascular risk in diabetes
- ◆ Introduction and monitoring of insulin treatment

- ◆ Epidemiology of diabetes

#### Regional topics

- ◆ Age-related cognitive disorder
- ◆ All dementias, especially Alzheimer's disease

#### Topics for 2005

- ◆ Audit
- ◆ NSF
- ◆ Clinical pharmacology – principles
- ◆ Depression
- ◆ Assessment of mental capacity
- ◆ Chemosensory perception
- ◆ Oral malignancy
- ◆ Dysphagia
- ◆ Arrhythmia
- ◆ Atrial fibrillation
- ◆ Heart failure
- ◆ Hypoxia in stroke
- ◆ Glucose in stroke
- ◆ Motor neurone disease
- ◆ Seizures
- ◆ Vaccinations
- ◆ Dietary advice
- ◆ Elder abuse
- ◆ Asthma
- ◆ HIV
- ◆ Immuno dysfunction
- ◆ Radiotherapy
- ◆ Provision of service
- ◆ Age-related hearing impairment
- ◆ Tinnitus
- ◆ Retinopathy
- ◆ Oncology
- ◆ Rehabilitation
- ◆ Confusion in an older person with diabetes mellitus

#### Regional topics

- ◆ Pressure ulcers
- ◆ Epidemiology
- ◆ Risks
- ◆ Prevention
- ◆ Documentation

- ◆ Management

#### Topics for 2006

- ◆ Quality improvement
- ◆ Substance abuse
- ◆ Nursing homes
- ◆ Understanding and implementing the Mental Health Act
- ◆ Feeding
- ◆ Dry mouth
- ◆ Angiodysplasia
- ◆ Constipation
- ◆ Liver disease
- ◆ Ascites
- ◆ Treatment of stroke
- ◆ Management of acute stroke
- ◆ Hypertension
- ◆ Valvular heart disease
- ◆ Deep venous thrombosis
- ◆ Pre-op assessment
- ◆ Risk factors for cardiovascular disease
- ◆ Myelopathy
- ◆ Prevention of ill health
- ◆ Physiology of endurance function, training and strength
- ◆ Exercise prescription
- ◆ Training in frail, older people
- ◆ Getting inactive patients active
- ◆ Pre-exercise evaluation
- ◆ Respiratory rehabilitation
- ◆ Carcinoma of the lung and pleura
- ◆ Cataracts

#### Regional topics

- ◆ Gastro-oesophageal reflux disease
- ◆ Hiatus hernia
- ◆ Peptic ulcer

*(It is recognised that 2005 and 2006 have less topics in them but this is to leave space for burning and new topics as they develop).*

THE 4<sup>TH</sup> WORLD STROKE CONFERENCE MELBOURNE, AUSTRALIA

More than 1300 delegates from 64 countries worldwide gathered in the sunshine of the 'Elegant City', Melbourne. They gathered to hear and share views about stroke, the third largest killer in the developed nations. This conference, held every four years, was well organised and successful. Some of the highlights below show that several large multicentre randomised trials are in progress.

- u The impact and global burden of stroke was discussed - 5.5m strokes occurring yearly worldwide. The problem is increasing in the developing countries but is static in developed countries.
- u Stroke management should be a part of an overall 'vascular risk factor management of atherothrombosis'.
- u rTPA is the thrombolytic therapy for acute stroke. However, only 4% patients are eligible, its efficacy is proved upto 6 hours only, urgent imaging is essential, monitoring is a must and rTPA is still not licenced in the UK for routine use. MRI brain is better than CT brain and DWI/PWI MRI scans are ideal. Further trials are under progress and IST 3 trial was presented (a UK based multicentre RCT started in May 2000).
- u Several 'neuroprotectants' in the acute treatment of stroke are under trial. There has been limited success in humans, though animal experiments have been encouraging so far. Results of Class T and Class H trials using clomethiazole were presented, showing no significant improvement in outcomes.
- u IMAGES Trial: using intravenous magnesium in acute stroke is an ongoing multicentre stroke trial funded by MRC (UK).
- u Heparin in acute stroke is not recommended, based upon data from the HEAST trial (using Dalteparin) and TAIST trial (using Tinzaparin). Trials ongoing are TOAST II AND RAPID. There was a lively debate between an American expert (favouring heparin) against a UK expert (disagreeing) on the routine use of heparin in acute ischemic stroke.
- u ABESTT Trial: an ongoing multicentre RCT in 40 countries since May 2000, studying the effect of Abciximab in the management of acute stroke. Abciximab is an antiplatelet drug found beneficial in acute coronary syndromes but results in stroke have been disappointing so far.
- u Aspirin remains the drug of choice for the majority of stroke patients. Early use within 48 hours can prevent 12 extra deaths per 1000 ischemic strokes (IST and CAST trials). It is cheap, safe and widely tested.
- u ESPIRIT Trial: a Netherlands-based RCT, randomising stroke patients into 3 groups: aspirin; anticoagulation; or aspirin + dipyridamole. So far, 1300 patients from 61 centres have been recruited (target: 4500). Results are due in January 2004.
- u TACIP study results were presented showing that Triflusal (an antiplatelet agent) is a safer alternative to aspirin (but costs more and not available in the UK).
- u Clopidogrel: an antiplatelet drug available in the UK which is useful in patients intolerant to aspirin (CAPRIE trial) for secondary stroke prevention (marginally better but costs more). Ongoing trials include MATCH, WATCH, SPS 3, CURE AND COMMIT.
- u Statins: indicated in stroke patients with high cholesterol (>5 mmol/L) and background ischemic heart disease. An ongoing SPARCL study is a multicentre RCT using atorvastatin in patients without past ischemic heart disease.
- u VITATOPS Trial: a multicentre RCT from Australia, studying the effect of vitamins B6, B12 and folate in secondary stroke prevention. Target: 8000 patients; 600 have been recruited so far.
- u ICSS study: randomising patients into carotid endarterectomy or stenting. Ongoing surgical trials are ICST and CREST.
- u RESPECT Trial: studying the effect of Cerivastatin in primary stroke prevention and no previous IHD. Results are due in 2004.
- u PROSPER Trial: a multicentre RCT being conducted in elderly >70 years age group randomising pravastatin for primary stroke prevention.
- u ENCORE I and II trials: studying cerivastatin and nifedipine on endothelial function and cardiovascular end points.
- u FOOD Trial: ongoing, largest trial of feeding in stroke patients.
- u Our own study shows that multiple modifiable risk factors are common in stroke patients and are inadequately treated making an argument for dedicated stroke prevention clinics.
- u STICH Trial: a UK MRC and Stroke Association funded trial to see if early surgical treatment or conservative treatment influences the outcome in intracranial hemorrhage.

**Dr Abhaya Gupta**  
SpR, Dept of Integrated Medicine  
University hospital of Wales,  
Cardiff

**TRAVEL FELLOWSHIPS - RESPIRATORY**

**Respiratory Section/Glaxo Smith Kline Travel Fellowships**

**Award: £500**

These fellowships are awarded to defray part of the travel/presentation costs for presentation of abstracts at the American Thoracic Society or European Respiratory Society meetings. Eligibility is: **(1)** non-consultant BGS Respiratory Section member; **(2)** all professions eligible; and **(3)** proof of abstract accepted for ATS/ERS meeting. Abstracts will be judged by the officers of the BGS Respiratory Section and a medical representative from Glaxo Smith Kline.

Send to: Dr M J Connolly, Chairman, Respiratory Section, Platt Rehabilitation Unit 2, Manchester Royal Infirmary, Oxford Road, Manchester M13 9WL.

**Respiratory Section/Glaxo Smith Kline Travel Fellowships**

**First award to: Dr Charlotte Ruse, Leicester**

**Abstract:** *"The NcoI polymorphism of the hlyphotoxin alpha gene predicts disease severity in COPD"*. Dr Ruse will be presenting this paper at the ATS.

**HEALTH SERVICES RESEARCH SIG**

**Change in office/new website**

**Dr Iain Carpenter** is the new chairman of the Health Services Research Special Interest Group.

**Contact:** Dr Carpenter, Senior Lecturer in Health Care of the Elderly, Centre for Health Service Studies, University of Kent at Canterbury, Kent CT2 7NF.

The new SIG **website** is at: [www.sheffield.ac.uk/misc/groups/bgshrsi](http://www.sheffield.ac.uk/misc/groups/bgshrsi).

**JOB WANTED!**

**Dr Muhammad Ilyas Vohra** is looking for a geriatric medicine post in the UK. His special interest is in geriatric endocrinology with some research experience in prostate and testosterone.

**Contact:** Dr M I Vohra, Geriatric and Extended Care Service Line (181a), McGuire Veterans Affairs Medical Center, 1201 Broad Rock Boulevard, Richmond, Virginia 23249. Tel: (804) 675-5088. Fax: (804) 675-5551. Email: [vohra.muhammad@richmond.va.gov](mailto:vohra.muhammad@richmond.va.gov).

**NEW SIG WEBSITE**

**Parkinson's Disease Special Interest Group website**

[www.parkinsons-bgs-sign.org.uk](http://www.parkinsons-bgs-sign.org.uk)

Future communications with members of the Parkinson's Disease SIG will take place through its new website. In addition, all future issues of the SIG's newsletter will be posted on the site. The SIG welcomes any comments regarding the website. **Contact:** Dr D Stewart, Secretary.

**GERIATRICS SOCIETY OF INDIA**

The Geriatric Society of India is now enrolling overseas members. Membership is open to all doctors interested in geriatrics and all organisations related to geriatrics.

The membership fee is US \$250 or equivalent, as a one-off payment only.

**Contact:** Dr O P Sharma by email: [opsharma@geriatricsindia.com](mailto:opsharma@geriatricsindia.com).

**DIARY DATES - PREVIOUSLY ADVERTISED EVENTS**

For further details on all these notices, see the March 2001 Newsletter

<b>22 May</b>	Royal Society of Medicine "Respiratory disease in older people"	<b>London</b>
<b>29-30 June</b>	1st Congress of the International Academy on Nutrition and Ageing	<b>Paris</b>
<b>4 July</b>	3rd Biennial Sunderland Stroke Meeting - "A stroke odyssey"	<b>Sunderland</b>
<b>31 May-1 June</b>	BGS/Research into Ageing "Masterclass in research methodology and grant applications"	<b>Manchester</b>
<b>9-10 July</b>	2nd National Conference for SpRs on "How to run a geriatric service"	<b>Birmingham</b>
<b>19 July</b>	Multidisciplinary care in Parkinson's Disease/Parkinsonism - "From science to practice"	<b>London</b>
<b>30-31 August to 1 September</b>	1st Congress of the European Union of Geriatric Medicine Society	<b>Paris</b>
<b>June 2002</b>	International Association of Gerontology: European Section of 6th European Congress of Clinical Gerontology	<b>Moscow</b>

## CARDIOVASCULAR DISEASE

Royal College of Physicians  
of Edinburgh

18 May 2001

Queen Mother Conference  
Centre, RCP Edinburgh

Topics include: hypertension in the elderly; diagnosing of heart failure; drug treatment of heart failure; and insights into the biology of vascular calcification.

**Fees:** £40-£75 (includes lunch)

**Contact:** Ms Eileen Strawn,  
Symposium Coordinator, RCP  
Edinburgh, 9 Queen Street,  
Edinburgh EH2 1JQ. Tel: 0131 225  
7324. Fax: 0131 220 4393. Email:  
e.strawn@rcpe.ac.uk.

## NOURISHING OLDER PEOPLE

Nourishing Older People  
in Care Homes

May to December 2001

**Locations:** various

The Royal Institute of Public Health & Hygiene is arranging one-day courses during 2001. The courses will take place on different dates in London, Edinburgh, Exeter, Birmingham and Northern Ireland.

They aim to provide guidance on the nutritional needs of older people and practical advice on catering for this age group.

**Fee:** £125.

**Dates/venue** details from: Geri Maylin, RIPHH, 28 Portland Place, London W1B 1DE. Tel: 020 7291 8362. Email: info@riphh.org.uk. Website: www.riphh.org.uk.

## ELI LILLY TRAVEL AWARD - £300

**Closing date: 31 May 2001**

Eli Lilly International has provided support for a £300 bursary for financial assistance to SpRs and Registrars training in geriatric medicine who are presenting research papers at international meetings.

Candidates should submit an application to the BGS Administrative Director (address on page 26). This should consist of an abstract not

longer than one A4 sheet of paper, accompanied by a copy of the acceptance of the oral or poster presentation by the meeting in question. Applications may be considered in retrospect of a meeting.

Where none of the applications are deemed suitable, the Society reserves the right to hold on to the award until the following year.

## GASTROENTEROLOGY SIG - REPORT AND AGM

BGS Spring Meeting Cardiff  
5 April 2001

**Gastroenterology SIG  
parallel session report**

The Gastroenterology Special Interest Group (SIG) held a parallel session at the BGS Spring Meeting. This parallel session was popular and well attended.

Three topics were presented, as follows. The first, "Ascites - its complications and management", was presented by Dr Mark Hudson, Freeman Hospital, Newcastle-upon-Tyne. This was followed by a lecture on "Coeliac disease - prevalence and presentation", presented by Dr Gill Swift, Llandough Hospital, Cardiff. The third lecture was on "The management of obesity", presented by Dr Nadim Haboubi.

Annual General Meeting

8 June 2001

**Celtic Manor Hotel, Newport**

The first session will be a symposium on GORD (chair: Prof Oliver James). Topics are: the burden of illness (Prof Bulpitt); presentation and diagnosis (Dr Fowlie); modern management of reflux disease (Dr Thillainayagam); and surgical treatment (Mr J McGuigan). The second session will be on liver disease (chair: Dr Stuart Bruce). The topics are: auto-immune liver disease in the elderly (Prof O James); management of hepato-biliary pathology - a surgeon's point-of-view (Prof B Ammori); and drugs and the liver (Dr P Neville).

**Contact:** Dr N Haboubi on tel: 01873 732158 or fax: 01873 732157.

## OLD AGE PSYCHIATRIC DAY HOSPITALS

**Current developments and messages from the latest research**

21 June 2001 **Commonwealth Institute, London**

Topics include: The NHS Plan and NSF for Older People; and national audits of mental health services for older people. **Fees:** £150 (includes lunch, etc).

**Contact:** Jo Baker, Royal College of Psychiatrists' Research Unit, 6th floor, 83 Victoria Street, London SW1H 0HW. Tel: 020 7227 0827. Email: joanne1.baker@virgin.net.

## MIND THE GAP

**Mind the Gap: intermediate care in health and social services**

**27 to 28 June 2001**

**Birmingham**

Topics include: bridging the gap; primary/secondary care; and care closer to home.

**Fees:** £229.12 for one day; £346.63 for two days.

**Contact:** Health Links, Studio 401f, The Big Peg, 120 Vyse Street, Birmingham B18 6NF. Tel: 0121 248 3399. Email: alyons@health-links.fsnet.co.uk.

## GOOD PRACTICE AND INNOVATION

**Celebrating Good Practice and Innovation within Elderly Mental Health**

**19 September 2001**

**Leicester University**

This conference is for all those working within the speciality of elderly mental health. The programme includes several renowned keynote speakers, and a variety of workshops will allow delegates to learn about national projects of innovative practice.

**Fee:** £90 (includes lunch).

**Contact:** Karen Crabbe, Psychiatry for the Elderly Directorate, The Evington Centre, Leicester General Hospital, Gwendolen Road, Leicester LE5 4PN. Tel: 0116 225 3702. Fax: 0116 225 1003.

## BRITISH COUNCIL SEMINAR

**Health and Social Care of the Older Citizen: a global challenge**

**23-28 September 2001**

**Belfast**

Seminar director is Dr Ken Fullerton. The seminar will be of interest to policy makers and planners, as well as health and social care managers, physicians, nurses, etc.

**Limited places:** only 30 participants will be able to take part.

**Fee:** (residential) £1,200.

**Contact:** International Networking Events, British Council, 1 Beaumont Place, Oxford OX1 2PJ. Tel: 01865 316636. Email: network.events@britishcouncil.org. Website: britishcouncil.org/networkevents.

## GERIATRIC PSYCHIATRY

**29th Symposium of the European Association of Geriatric Psychiatry**

**7 to 11 November 2001**

**Makedonia Palace, Thessaloniki, Greece**

**Abstracts deadline: 15 July 2001.**

Topics include: genetics of dementia; pathophysiology of dementia; differential diagnosis of dementia; and therapy of dementia.

**Fees:** (before 15 July) Euros 50-180; (after 15 July) Euros 100-240.

**Contact:** Forum International Congress Organisers, 18 Mitropoleos Street, GR 54624 Thessaloniki, Greece. Tel: +30 31 257128. Fax: +30 31 231849. Email: forup@otenet.gr. Website: www.forumcongress.gr/eag.

## FALLS AND POSTURAL STABILITY

**2nd National Conference**

**7 September 2001**

**RCP London**

**Abstracts deadline: 29 July 2001.**

Topics to include: the NSF and falls; falls prevention; and physical activity in older people.

**Fees:** from £90 to £150.

**Contact:** J Mowson, Conference Administrator, Postgrad Education Centre, Nottingham City Hospital, Hucknall Road, Nottingham NG5 1PB. Tel: 0115 962 7758. Email: jmowson@ncht.trent.nhs.uk.

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**The British Geriatrics Society  
Marjory Warren House  
31 St John's Square  
London EC1M 4DN**

**Tel: +44 (0)20 7608 1369  
Fax: +44 (0)20 7608 1041  
Email: Info@bgs.org.uk  
Website: www.bgs.org.uk**

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