BGS newsletter

Editor: David Lubel

Clinical governance

The Society recently initiated a draft position paper on the subject of clinical governance.

The concept of clinical governance was initiated by the White Paper, *The New NHS, Modern, Dependable,*[1] December 1997. *"The new NHS will have quality at its heart… Every part of the NHS, and everyone who works in it, should take responsibility for working to improve quality."*

The concept was further developed in the second White Paper, *A First Class Service - Quality in the New NHS,*[2] July 1998, which defined it as *"a framework through which the NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish."*

It is against this background that the BGS initiated a draft position paper for geriatric medicine leading to the document prepared by its working group, chaired by Prof Cameron Swift and reproduced below.

Prof Swift described its principles as generic so that it could be adopted by the Royal Colleges in England and Scotland, and adapted to Northern Ireland and Wales, to reflect the different health structures, within existing and future regional political frameworks.

Clinical governance in Scotland - steps ahead!

There already exists a Scottish Clinical Governance Group (SCGG) which, since this Newsletter went to press, has already provided addenda to Prof Swift's document to reflect the different legal and organisational structures in Scotland. Unfortunately, we could not incorporate these amendments in this issue of the Newsletter, but will report them in the July issue.

The aim is to achieve common standards across the UK.

General introduction

This position paper has been prepared by a joint working group of the BGS (see Appendix, page 11 for membership). The concept of

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FOR HEALTH IN OLD AGE

The Royal Commission on Long-Term Care published its findings in March in a voluminous report entitled *'With Respect to Old Age'.*

Unfortunately, the flurry of media interest surrounding its launch did not last long and, more worrying, the Government has remained remarkably silent - leading many to fear that the report is destined to end its days on a civil servant's shelf, gathering dust.

Appraisal of options

'With Respect to Old Age' does not deserve this fate. It is a well researched, nicely produced (but not without the odd typo) and attractively presented document. Maybe it is a bit lengthy at 196 pages for the main report and the three volumes or 764 pages of background information. It does, however, contain a lot of interesting demographic and other data, and looks good on a bookshelf! More importantly, the report intelligently appraises the various options and then suggests a number of apparently credible reforms, to what is widely perceived to be an unfair system, in order to achieve a more fair, equitable, logical and transparent system for funding long-term care.

I would strongly recommend those who have not already done so to read, or perhaps more realistically, to browse, the report for themselves. For those with internet access it can be found in full at: http://www.open.gov.uk/royal-commission-elderly/index.htm.

Separation of costs

Perhaps the most fundamental proposal is the separation of nursing and personal care costs from living and housing costs. In this option, the full cost of both nursing and personal care would be met by the state and excluded from the means-testing system; this would apply to care provided in all settings, as long as this is deemed necessary, following an assessment.

Definition of personal care

'Personal care' is defined within the report as the care needs giving rise to the major additional costs of frailty or disability associated with old age (see table, page 5). More specifically, it is the care that directly involves touching a person's body and, thus, incorporates issues of intimacy, personal dignity and confidentiality, and is distinct both from treatment/therapy and from indirect care, such as home-help or the provision of meals. This type of care is the main source of contention in the debate about the distinction between health care and social care. It falls (according to the report) within the internationally recognised definition of nursing, but may be delivered by people who are not nurses, e.g. care assistants.

Means testing

The current health/social care boundary is also often the boundary between means-tested and non-means-tested care for frail older people. The gradual shifting of responsibility from health to social care over recent years has moved both these boundaries and increased the burden of means-testing, particularly within long-term care, without any prior debate.

If the report's suggestions are adopted, the funding issue will become totally independent of the health/social interface, allowing the boundaries between health and social care to become more blurred - which can only be a good thing. This proposal appears to offer a logical, understandable, workable and more just approach to the issue of funding personal and nursing care. The system, however, would not be perfect. Perverse incentives would remain and perhaps increase - such as a tendency of those with capital to want to stay at home at all cost - and, undoubtedly, demand for free personal care would rise inexorably, rapidly exceeding the prevailing supply. Such is the nature of health economics. But if anything sinks the proposal it will be the politically sensitive fact that the more affluent will benefit most from such a change.

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President's column

I t was just as I had predicted - the BGS Spring Meeting in Cork was an outstanding success.

The organisation committee, led by Cillian Twomey, did a marvellous job. Cork is a delightful, friendly city and the University College provided a very elegant setting for the two-and-a-half day meeting. Even the weather was kind to us.

Record numbers

A record 580 delegates and 100 partners were registered, and the academic and social programmes were very full. Cork was bedecked by red and black delegate bags as members drifted to and from the university conference rooms and local places of historic and culinary interest. We were updated and educated by state-of-the-art lectures and 215 platform and poster presentations. My personal favourite was the lecture delivered by Liam Plant, a Cork man, of course, who is currently a nephrologist in the Edinburgh Royal Infirmary. He gave us a spirited plea for older patients with renal insufficiency. He did this with clarity and a pawky humour..

Royal Commission on Long Term Care

Prof Bob Stout provided a very thoughtful insight on the Royal Commission's recommendations on long-term care during a Care-Home Medicine Special Interest Group seminar. He highlighted that there was much more substance to the final report than was published in the executive summary or picked up in press coverage or, indeed, conveyed to us by statements in the House of Commons. As a member of the Royal Commission, he conveyed the apparent widespread public outrage and sense of betrayal experienced by many older people over the current funding principles of long-term nursing care in the UK. He underlined the Commission's important statements on proper assessment, adequate rehabilitation and equity of healthcare funding for older sick or disabled people. His contribution certainly gave the office bearers food for thought.

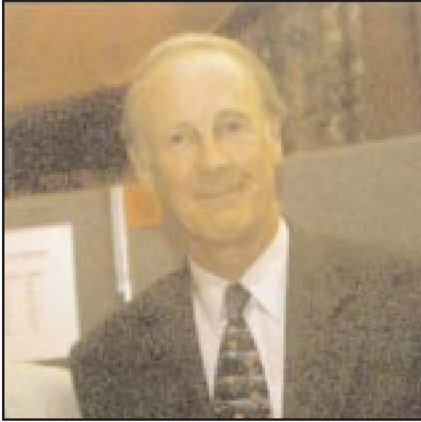
We in the BGS have, of course, supported the recommendations of the Royal Commission in a press release, but there was a general feeling that the Commission's findings would be kicked into the political long grass, perhaps forever. We were also concerned about the overt political polemic surrounding funding. Nevertheless, we have marshaled our thoughts and will be contacting Health Ministers and Members of Parliament to offer our firm support for the Commission's recommendations, paying special emphasis to the principles of assessment, rehabilitation and equity in health care. I invite members, as individual geriatricians, to take every opportunity to highlight and combat ageism in all of its ramifications. You may wish to communicate your views to your local politicians of all persuasions.

Official opening of exhibition

In Cork, I met colleagues from Holland, Israel, Australia, Canada and the USA and there were other delegates from Finland, Denmark and Sweden. As President, I was given the pleasant task of officially opening the pharmaceutical exhibition. This was a bit like speaking with a microphone at Hyde Park Corner or Paddington station during the rush hour. Almost 40 companies were represented at the conference venue and their support and encouragement is very welcome and highly valued by our membership. I suspect that many of the pharmaceutical representatives have a certain fondness for geriatricians and our meetings. I hope that we reciprocate and try to make them feel welcome at our attendance events.

The entertainement

The conference dinner was sumptuous and the 320 members and guests were entertained by good food, Irish music, and a delightful address from Prof Barry O'Donnell, the current President of the Royal College of Surgeons in Ireland.



It was a delight to share in the presentation of a retiral gift to Dr Michael Hyland of Cork. He is a charming, gracious man, who has accomplished a great deal for our specialty in Ireland. We wish him well in his active retirement.

Future fund-raising exercise

Perhaps the most important decision made at the Council meeting in Cork (see page 22) was to support the Finance and Executive Committees' recommendations to fundraise with a view to purchasing, eventually, an appropriate property for the Society's headquarters. The Society currently rents accommodation from the RCP London and, after wide debate, the Council unanimously agreed to aim to move from rented accommodation to purchased property and to raise funds to augment existing BGS reserves over two or three years. You will certainly be kept well informed of our progress and the reasons for our decisions. The BGS is your professional specialist association and depends heavily on your support and participation.

Brian Williams

Editorial page **continued from page 2**

The report emphasises the requirement for proper assessments of need, and even recommends that, for those with complex needs, assessment should be carried out by a multidisciplinary team, including, e.g. a geriatrician (or psychogeriatrician). There is also recognition of the importance of providing rehabilitation and allowing sufficient recovery time before making irreversible long-term care decisions. These are commendable suggestions.

Proper assessments necessary

However, absent from the report is any recognition of the importance of a proper medical assessment when an individual first fails to manage independently, perhaps at the time of an acute illness, in order to identify and address potentially treatable medical conditions. The vital, yet seemingly unrecognised, point is that, regardless of the source of funding, no individual should enter long-term care without prior exposure to an effective system of assessment, backed by appropriate treatment and rehabilitation.

But what constitutes effective assessment? The effectiveness of geriatrician-led, multidisciplinary assessment and management compared with that of alternative hospital-based specialists and primary care teams has been demonstrated *(Stuck et al, The Lancet, 1993; 342: 1032-6)*. For example, patients receiving their inpatient care within a geriatrics unit are significantly more likely to be living at home after six months (odds ratio 1.8) and one year (odds ratio 1.68) than patients managed in other inpatient settings.

Specialty's need for promotion

That geriatricians were referred to only once within the report is a little disappointing. It undoubtedly simply reflects a general failure of the specialty to promote itself at all levels, compounded by our inexorable withdrawal from the long-term care arena over the past decade. These are both issues that I feel the specialty needs to address with some urgency.

David Lubel

Royal Commission definition of 'personal care'

Personal care would cover all direct care related to:

- ♦ personal toilet (washing, bathing, skin care, personal presentation, dressing and undressing and skin care);
- ♦ eating and drinking (as opposed to obtaining and preparing food and drink);
- ♦ managing urinary and bowel functions (including maintaining continence and managing incontinence);
- ♦ managing problems associated with immobility;
- ♦ management of prescribed treatment (e.g. administration and monitoring medication); and
- ♦ behaviour management and ensuring personal safety (e.g. for those with cognitive impairment - minimising stress and risk).

'Clinical governance' **continued from page 1**

clinical governance is, in many respects, built into the heart of the specialty of geriatric medicine. In the UK this has been reflected particularly in:

1 the commitment of specialists in this branch of medicine to assume accountable leadership in the delivery of comprehensive services to a patient population historically vulnerable to sub-optimal standards of provision; and

2 the degree to which progress in the field (in the British Isles and beyond) has been regularly achieved through internal and external scrutiny of successful and cost-effective models of care.

The move towards a more formal recognition and scrutiny of standards - in professional practice, patient care and service organisation - is, therefore, warmly welcomed by both the BGS and the Royal Colleges of Physicians of the UK (respectively the representative specialty society and the institution responsible for the training and recognition of specialists). It has provided an opportunity to prepare a strategic and organised approach to the measurement and maintenance of standards, in which we believe the specialty is well placed by virtue of its background and evolution to take a creative lead role.

A MORE FORMAL RECOGNITION AND SCRUTINY OF STANDARDS IS WARMLY WELCOMED BY THE SOCIETY

1 Policy background

1.1 The first White Paper[1] introduced the concept of clinical governance requiring practitioners to accept the responsibility for developing and maintaining standards within their local NHS organisation.

1.2 The second White paper[2] developed this topic in some depth. Paragraph 3.11 states that a clinical governance framework will:

- modernise and strengthen professional self regulation and build on the principles of performance review; and
- strengthen existing systems for quality control, based on clinical standards, evidence based practice and learning lessons of poor performance.

1.3 The British Association of Medical Managers, states[3] that clinical governance sets out to ensure that:

- systems to monitor the quality of clinical practice are in place and functioning properly;
- clinical practice is reviewed and improved as a result; and
- clinical practitioners meet standards, such as those set by national professional regulatory bodies.

1.4 In July 1998, the RCP London published a discussion document[4] *'Self Regulation in clinical governance'* and encouraged all fellows and members to participate fully in local mechanisms to achieve it. The Colleges have indicated their wish to work in close collaboration with specialist societies.

1.5 In February 1999, the RCP[5] set out the key components of clinical governance for physicians as:

- appraisal;
- continuing professional development (CPD) (the term within this paper will be understood to incorporate continuing medical education (CME);
- participation in national audit; and
- peer led service review.

1.6 The General Medical Council (GMC) has voted to accept the principle of revalidation, liable to involve personal portfolios of appraisal, CPD and audit.

1.7 This position paper has been developed as a collaboration between the RCP and the BGS.

2 Basic concepts

2.1 Developing a framework to promote clinical governance presents an opportunity to integrate a range of important initiatives in the quality of patient care, professional practice and service provision.

2.2 These include (for example) clinical audit, service organisational audit, patient charter standards, benchmarking, peer review, clinical guidelines, and clinical pathways, all of which are currently disparate, and to all of which the profession exhibit variable commitment.

2.2 Clinical governance offers a distinctly positive focus on the quality of care of patients (both as individuals and groups) as the unifying *raison d'etre* for these policy initiatives.

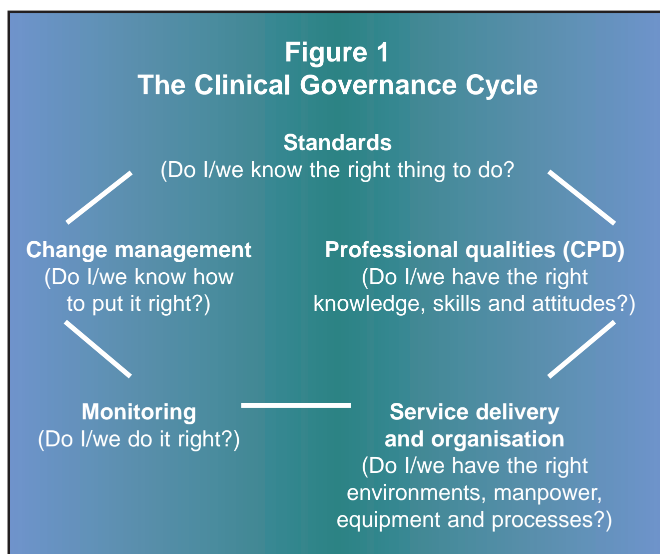
2.3 A properly structured system will ensure clear lines of accountability and coordination within which the practising consultant will operate for clinical governance purposes. It will entail a degree of mutual responsibility encom-

passing the individual specialist and the organisational context of his or her professional practice. Thus, clinical governance procedures are anticipated to be widely represented at departmental, trust, local district (e.g. Commissioning Authority/PCG Commission) and national levels, with advisory input as required.

2.4 This paper comprises four sections:

1 an integrated common scheme for clinical governance; and

clinical governance recommendations for:



2 individual practitioners;

3 the service within an organisation; and

4 the services within a group of organisations (i.e. focused on a natural community as opposed to a single provider organisation).

2.5 The emphasis is on the key principles and practice of clinical governance implementation that are broadly applicable to all settings within the UK. Details of procedure are expected to vary, particularly in Wales, Scotland and Northern Ireland.

2.6 The recommendations are applicable to consultant practice in geriatric medicine. Further work will be required to clarify the requirements for specialists in non-training grades other than consultant.

3 Integrated common scheme for clinical governance

The following outline endeavours to integrate the components of clinical governance, and to incorporate the different strands of activity within those components.

3.1 The purpose of this approach is to enable individual specialists and the organisations in which they work to utilise all of the elements of clinical governance effectively, and not add to a disparate list.

3.2 Clinical governance can be viewed from three main perspectives, i.e.:

- the individual consultant;
- the service within an organisation; and
- the service within and between organisations (including non-NHS organisations, e.g. Social Services and the independent sector).

The recommendations in this paper have been separated for each level, even though, in practice, the division is less clear cut.

3.3 The clinical governance cycle

Each set of recommendations has been made with reference to the model in Figure 1. It should be noted that, unlike other cycles, the clinical governance cycle may be entered at any stage.

A Standards

These include:

1 professional standards, as directed by the General Medical Council;

2 NHS clinical standards, as identified by the National Institute for Clinical Excellence;

3 legal standards, as directed by the law of the land;

4 procedural standards, as directed by external bodies e.g. the Clinical Negligence Scheme for Trusts;

5 Patient Charter standards; and

6 National Service Frameworks.

B Professional qualities

These are generic as well as specific to the service characteristics and needs, are developed by CME/CPD, and should be focused on a continual lifelong learning philosophy.

C Service delivery and organisation

This includes structures and processes of care, use of guidelines and protocols, routine procedures such as the use of assessment technology, and the systems for generating data for monitoring. It will involve identification both of the evidence-base underpinning practice and the relevant criteria and structures for performance monitoring e.g. peer review, external agency evaluation, benchmarking, national audit

programmes and patient satisfaction.

D Monitoring

Monitoring includes (amongst others):

1 clinical and service audit (local and national);
2 complaints;
3 Health Ombudsman reports;
4 risk assessment;
5 Caldicott Guardian reports;
6 national indicators' results;
7 critical incident reviews;
8 Royal College training visit reports;
9 national patient surveys;
10 service agreement performance;
11 health improvement plan performance; and
12 external body reviews (e.g. peer review/ Health Advisory Service (HAS) 2000 visits).

E Change management

This includes all those processes that can be utilised to improve the quality of care, which should initially be focused, where possible, on positive actions to improve the system of care rather than on negative actions to blame and discipline. Such actions may include improvements in service, operational policy, education, training, manpower, environment, equipment and funding. Approaches that include continuous quality improvement and total quality management should also be considered.

4 Clinical governance recommendations for individual practitioners

4.1 Standards, professional qualities and service provision

4.1.1 Central to maintaining and improving standards are the concepts of CPD (including CME) and self-assessment. Consultant physicians will be required to demonstrate their state of knowledge and organised and demonstrable CPD is expected to become mandatory. Innovative and interactive CPD programmes that incorporate self-assessment are currently being developed.

INNOVATIVE CPD PROGRAMMES INCORPORATING SELF-ASSESSMENT ARE NOW BEING DEVELOPED

4.1.2 *A First Class Service*[2] states that personal development (CPD) plans should be developed for all staff by April 2000.

4.1.3 Each consultant should ensure and be able to demonstrate that part of his/her personal CPD portfolio is dedicated towards a 'departmental development plan' (DDP) (see 5.2).

4.2 Monitoring and change management

4.2.1 Appraisal can be defined as *"the use of systematic methods regularly to review the work of senior hospital doctors. It is an inclusive term whose use can only be justified if it includes both the clinical and non-clinical aspects of a consultant's work and focuses on both the performance of the individual and the performance of the units and departments in which they function"*.[6]

4.2.2 All consultants in geriatric medicine should have an annual appraisal, including an annual review of the job plan. This will include review of clinical activities, audit, CPD and information from all other monitoring arrangements. The process should involve at least one other consultant in geriatric medicine.

4.3 Educational aspects of CPD

4.3.1 Education should help to attract, motivate and retain high calibre staff.

4.3.2 Education includes the following:

- maintaining and increasing the knowledge base;
- honing and teaching professional skills e.g. teaching, learning, appraisal, interviewing, management, team work; and
- reassuring consultants on their clinical skills and professional abilities.

It also enables consultants to:

- keep up-to-date;
- identify their strengths and potential;
- identify their defects, and to correct them;
- learn new skills to meet service requirements or developments; and
- apply their knowledge and skills in the practice setting.

4.3.3 Education is largely based and assessed locally. Each department will be required to ensure that:

- suitable facilities exist (5.8);
- a local CPD co-ordinator is appointed;
- a yearly appraisal of each individual occurs, identifying strengths and deficiencies (over the range in 4.3.2);
- the educational and training needs of the service are discussed with individuals;
- suitable educational opportunities are known to the individual and are present locally or nationally, taking into account different preferred ways of learning;

♦ sufficient work time is protected for both internal and external education;
♦ methods of self-audit are available and confidential; and
♦ every consultant has a personal learning plan, derived from personal wants and needs, as directed by the national programme, DPP and remedying potential identified deficits.
4.3.4 Education programmes will be developed nationally. This professional curriculum will be at several levels, with time intervals set for completion and repetition. It will outline the knowledge and expertise that:
♦ every consultant must possess and demonstrate as up-to-date (locally taught);
♦ are desirable for consultants in this specialty (locally taught and evidence-based); and
♦ are optional (acquired at national level, not necessarily evidence-based subjects requiring analysis and consensus, 'what's new' list, and courses to cover such subjects).

'DEPARTMENTAL DEVELOPMENT PLANS' SHOULD BE FORMALISED

4.3.5 Assessment of every consultant will be undertaken annually by:
♦ individuals using self-audit and distance learning programmes on national curriculum and core requirements;
♦ local appraisal by colleagues and managers, and attendance at courses and meetings; and
♦ national CME returns of attendance at meetings.
4.3.6 The implementation of assessment in practice will include the following.
♦ Individual consultants will be required to demonstrate that they have undertaken self-audit activities and that, when necessary, specific measures to deal with unmet performance or CPD needs have been pursued.
♦ Clinical governance lead consultants at the departmental and Trust level will be required to provide evidence of the appropriate annual appraisals and the identification of personal learning/CPD plans.
♦ Colleges (in partnership with the BGS) will be able to produce, for every individual consultant and for organisational clinical governance lead consultants, a national CME return of attendance at CPD and related activities.
♦ RCP visits and Commision for Health Improvement (CHI)/HAS 2000 visits will require from each individual consultant an up-to-date personal learning/CPD portfolio. (Such a personal portfolio will include the personal learning/CPD plan, the resultant activities that have taken place, and an evaluation of the impact of both on professional practice. If an activity was in response to an explicit need, evidence of the appropriate professional development will be required).

5 Clinical governance recommendations for the service within an organisation

5.1 Standards

5.1.2 Each department of geriatric medicine should have a nominated lead consultant in organisational service quality.
5.1.3 All consultants in geriatric medicine (especially the lead consultant in organisational service quality) should be able to demonstrate their knowledge and expertise with respect to each element of the clinical governance cycle for organisational service quality.

5.2 Professional qualities

5.2.1 Each department of geriatric medicine should draw up and formalise a DDP to overcome identified deficits and develop the quality of service provided.
5.2.2 Each consultant should ensure and be able to demonstrate that part of his/her personal CPD portfolio is dedicated towards the DDP.
5.2.3 Departments of geriatric medicine should have available to them a set of expert services to help improve the quality of their services. These services should be at the organisation or district level and include:
1 educational facilities in CPD, work-based learning, distance learning and the ability to access skills laboratories or skills training centres;
2 library resources including access to the medical and scientific knowledge and research base e.g. electronic libraries, literature search facilities, up-to-date internet technology resources;
3 'clinical effectiveness' resources;
4 information management and technology resources, to acquire and manipulate national data, especially benchmarking data; and
5 monitoring resources, especially in clinical audit.

5.3 Service delivery, organisation and monitoring

5.3.1 Each department of geriatric medicine should be able to demonstrate its application

and integration of the range of quality of care monitoring activities.

5.3.2 External peer review should be welcomed and planned on a recurring basis. This can be undertaken:

- ♦ with reference to existing and developing mechanisms identified by the BGS/RCP; and
- ♦ as part of the CHI, as a statutory NHS process.

5.3.3 Organised peer review has been a long-standing part of the culture of British geriatric medicine and its strengths and multidisciplinary nature are represented in the recently reformulated HAS 2000 which, it is hoped, will become the statutory arm of CHI for geriatric medicine services. In 1996-97, the BGS was instrumental, together with the Royal College of Nursing Research Unit, the Royal College of Psychiatrists and the Office for Public Management, in a successful initiative to re-establish the HAS as a new organisation. HAS 2000 has now developed as a new and effective organisation, actively involved in systematic service evaluation[7]. It recently produced a key report *Not Because They are Old*[8], expected to have a major impact on the development of the new National Service Framework for the Care of Older People.

EXTERNAL PEER REVIEW SHOULD BE WELCOMED AND PLANNED ON A RECURRING BASIS

5.4 Change management

5.4.1 Deficiencies in service provision in any setting (especially if they occur frequently or arise from differing monitoring methods) will be required to have an explicit, available, remedial action plan.

5.4.2 The effectiveness of any action plan should be measurable by one or both of the following:

- ♦ the development of a new service; and
- ♦ improvement in the monitoring data which first identified the problem.

5.4.3 Consultants in geriatric medicine should have available to them:

- ♦ organisational (e.g. Trust level) clinical governance arenas for the resolution of quality issues which cannot be resolved within their own departments; and
- ♦ district level clinical governance arenas for the resolution of quality issues, which cannot be solved without changes in other organisations.

6.0 Inter-organisational service quality

6.1 Each natural community, e.g. a district health authority boundary, should have a clinical governance group which oversees the inter-organisational service quality issues and ensures the system of care for the patient is appropriately integrated. This should include the input from non-NHS agencies and the public, as well as local NHS organisations.

6.2 The ‘district’ clinical governance group should consider district-wide quality initiatives, e.g. the health improvement plans, or district-wide concerns about the quality of a service due to inter-organisational factors.

6.3 The reports and recommendations of the district group should be made available to the clinical governance lead for departments of geriatric medicine.

6.4 The district group should act as an arena whereby quality of service issues, which cannot be solved through normal departmental and organisational routes, can be addressed if they meet the criteria identified in 6.2.

6.5 The district group should have access to a similar set of expert services as the organisational groups (see section 5.2.3)

6.6 Inter-organisational service quality will need external assessment by the CHI. As yet, HAS 2000 does not include these measures as part of its portfolio, but it is anticipated that these will be developed over the next one to two years.

7.0 Summary of immediate recommendations

7.1 All consultants in geriatric medicine should welcome and introduce local appraisal mechanisms, including personal development plans, by April 2000

7.2 All departments of geriatric medicine should identify a nominated lead consultant in organisational service quality and a CPD co-ordinator, and should set in place a DPP.

7.3 The BGS and the Royal Colleges of Physicians will continue to collaborate in the development of the necessary innovative and interactive CME programmes.

7.4 The BGS and the RCP will support work to enable HAS 2000 become the statutory arm of CHI for geriatric medicine services.

7.5 The BGS will undertake and promote further work in the identification and evaluation of national and individual performance measures.

References

1 *NHS: Modern, Dependable.* DOH, 1997.
2 *A First Class Service, HSC 19991033.* DOH, 1998.
3 *Clinical Governance and the New NHS.* The British Association of Medical Managers, 1998.
4 *Role of the Royal College of Physicians in Regulation of Clinical Governance Consultation Government.* RCP, July 1998.
5 *Physicians Maintaining Good Medical Practice: Clinical Governance and Self-regulation.* RCP, February 1999.
6 *Appraisal for Senior Hospital Doctors: Statement from the Central Consultants and Specialists Committee.* BMA, London 1998.
7 *HAS First Annual Report.* HAS 2000, 1998.
8 *Not Because They Are Old.* HAS 2000, 1998.

Appendix

Membership of the Joint BGS/RCP Clinical Governance Working Group:

- Prof C G Swift (Chairman) (BGS President Elect);
- Dr D Black (RCP Geriatrics Committee Chairman);
- Prof C M Castleden (BGS Director of CME/CPD);
- Dr F C Martin (BGS Policy Committee Chairman); and
- Prof M Severs (Professor of Health Services Research, University of Portsmouth).

Performance Assessment Framework

The NHS Performance Assessment Framework was launched in April 1999

The Framework's accompanying *Health Service Circular (HSC 1999/078)* made clear that Health Authorities, Primary Care Groups and NHS Trusts working with local Social Services departments were to begin using the Framework from April 1999 to assess local performance, support the development of local Health Improvement Programmes and account to Ministers and the public for performance.

The Framework was outlined in The NHS White Paper, *'The New NHS, Modern Dependable'*. It covers six areas, namely: health improvement; fair access to services; effective delivery of appropriate healthcare; efficiency; the patient and carer experience; and the health outcomes of NHS care. It is accompanied by a set of High Level Performance Indicators (HLPIs) which are intended to flag up the need for further investigation and action. Last spring, details of both were published in a consultation document to which the BGS responded (see Newsletter May 1998). The present document, which is for action, is the outcome of this consultation exercise and road testing of the Framework and HLPIs which involved all Health Authorities last summer.

The following points are worth emphasising.

1 The revised Framework seems to be identical to the one put out for consultation.

I Health improvement

Aspects of performance - The overall health of populations, reflecting social and environmental factors and individual behaviour as well as care provided by the NHS and other agencies.

II Fair access

Aspects of performance - The fairness of provision of services in relation to need on various dimensions: geographical; socio-economic; demograghic (age, ethnicity, sex); and care groups (e.g. people with learning difficulties).

III Effective delivery of appropriate health care

Aspects of performance - The extent to which services are: (1) clinically effective (interventions or care packages are evidence-based); (2) appropriate to need; (3) timely; (4) in line with agreed standards; (5) provided according to best practice service organisation; and (6) delivered by appropriately trained and educated staff.

IV Efficiency

Aspects of performance - The extent to which the NHS provides efficient services, e.g.: (1) cost per unit of care/outcome; (2) productivity of capital estate; and (3) labour productivity.

V Patient/carer experience

Aspects of performance - The patient/carer perceptions on the delivery of services, e.g.: (1) responsiveness to individual needs and preferences; (2) the skill, care and continuity of service provision; (3) patient involvement, good information and choice; (4) waiting times and accessibility; and (5) physical environment, organisation and courtesy of administrative arrangements.

IMPORTANT ISSUES RAISED BY THE BGS WERE NOT ADDRESSED IN THE REPORT

VI Health outcomes of NHS care

Aspects of performance - NHS success in using its resources to: reduce levels of risk factors; reduce levels of disease, impairment and complications of treatment; improve quality of life for patients and carers; and reduce premature deaths.

2 There have been some changes to the HPLIs but the document only gives a summary of the revised HPLIs

Two indicators about which the BGS had expressed concerns have been removed. These were district nurse contacts and avoidable diseases.

The High Level Indicator Set, 1999-2000

I Health improvement:

1 *deaths from all causes (for people aged 15-64);*
2 *deaths from all causes (for people aged 65-74);*
3 *cancer registrations;*
4 deaths from malignant neoplasms;
5 deaths from all circulatory diseases;
6 suicide rates; and
7 deaths from accidents.

II Fair access:

1 surgery rates;
2 size of inpatient waiting list per head of population (weighted);
3 adults registered with an NHS dentist;
4 children registered with an NHS dentist; and
5 early detection of cancer.

III Effective delivery of appropriate health care:

1 disease prevention and health promotion;
2 early detection of cancer;
3 inappropriately used surgery;
4 surgery rates;
5 acute care management;
6 chronic care management;
7 mental health in primary care;
8 *cost effective prescribing;* and
9 discharge from hospital*.

IV Efficiency:

1 *day case rate;*
2 *length of stay in hospital (case-mix adjusted);*
3 unit cost of maternity (adjusted);
4 unit cost of caring for patients receiving specialist mental health services (adjusted); and
5 *generic prescribing.*

V Patient/carer experience of the NHS:

1 *patients who wait more than two hours for emergency admission (through A&E);*
2 *patients with operations cancelled for non-medical reasons;*
3 delayed discharge from hospital for people aged 75 or over*;
4 *first out-patient appointments for which patients did not attend;*
5 out-patients seen within 13 weeks of GP referral; and
6 percentage of those on waiting list waiting 12 months or more.

VI Health outcomes of NHS health care:

1 conceptions below 16;
2 decayed, missing and filled teeth in five-year old children;
3 adverse events/complications of treatment;
4 emergency admissions to hospital for people aged 75 and over*;
5 emergency psychiatric re-admission rate*;
6 *infant deaths;*
7 survival rates for breast and cervical cancer;
8 *avoidable deaths;* and
9 in-hospital premature deaths.

Those in italics were in the draft list and have not been revised so presumably any reservations expressed by the BGS remain. Those marked '*' are now termed 'interface indicators' because

they relate to performance at the health/social care interface and will be included in the HPLI sets for the NHS Framework and the indicator set for the Personal Social Services Performance Assessment Framework. No details are given, so our concerns in these areas may not have been addressed. The other indicators have been amended or added from other sources such as the White Paper *'Our Healthier Nation'*. In the absence of more data no comment can be made. One suspects that important issues raised by the BGS, such as the need to look at outcome in terms of disability, have not been addressed.

3 The need to improve data quality must be given high priority

It was reassuring to read the acknowledgement *'that the information requirements of the Framework are beyond the scope of currently established information flows'*. Most of us do not have access to information systems that are clinically driven and know that much of the data collected routinely does not reflect clinical practice; therefore comparisons can be meaningless. *Information for Health* sets out the Government's intention to ensure that information is accessible, to help managers and clinicians assess their own performance, to support the identification of best practice, to compare one organisation with another and to improve performance. There is a long way to go before this vision is realised.

4 Use of the Framework this year

The Government intends the Framework to be used: locally to review current performance across the six areas of the Framework and, thereby, to support decisions to secure improvements in local health and health care; by Health Authorities, Trusts and Primary Care Groups to inform performance and accountability arrangements and for monitoring progress across the six areas of the Framework; and by Ministers and the NHS Executive to account for the use of public funds to meet the Government objectives for the Department of Health (DOH).

THE FRAMEWORK IS NOW GOVERNMENT POLICY AND WILL INCREASINGLY AFFECT CLINICAL PRACTICE

It is clear that the Framework will become increasingly important: in Health Improvement Programmes; annual accountability arrangements between a Health Authority and local Primary Care Groups; service agreements developed at clinical directorate level; the NHS/social care interface; and the annual performance agreement between each Health Authority and its regional office.

5 Development of Framework and HPLIs

In the short-term, the indicator set will be extended: to support the assessment of NHS Trust performance; to include quality indicators following the development of National Service Frameworks; and to support the development of the new NHS charter programme.

Work continues to develop a comprehensive, high quality indicator set capable of providing a basis for national and local assessment. This work is linked to that set out in the Information Strategy aimed at improving data quality and timeliness. It will be linked to other indicator sets and the results collated and published annually. To ensure the continued development of the Framework, a Performance Framework Reference Group will be established.

To aid comparison of performance, new units of account will be developed: 'a provider spell' to cover care provided from admission to discharge; and 'a programme spell' to cover all care delivered from beginning to end of treatment relating to a particular need. These are likely to be particularly relevant to the elderly.

Key points

1 The NHS Performance Assessment Framework is Government policy. It will affect us increasingly in everyday clinical practice.
2 We need to work within our Trusts and local Primary Care Groups to ensure that information systems are clinically driven and that the data collected are relevant to the work we do.
3 The setting up of the National Service Framework for the elderly is timely as the need to set national standards and establish performance measures for our specialty is urgent.

Rebecca Dunn
Hon Deputy Secretary

Copies of *'The NHS Performance Assessment Framework'*, can be obtained free from DOH, PO Box 410, Wetherby LS23 7LN, or telephone the NHS Staff Response Line on 0541 555 444.

National Service Framework for Older People

The BGS has participated in the National Service Framework (NSF) External Reference Group

The aim of NSFs

The White Paper, *'The New NHS',* set out a package of measures to drive up quality and reduce variations in service, including the introduction of NSFs. These will: set national standards and define service models for a defined service or care group; put in place strategies to support implementation; and establish performance measures against which progress within an agreed timescale will be measured.

The use of External Reference Groups

The NSFs will adopt an inclusive process to engage the full range of views of health and social care professionals and managers, service users and carers, partner agencies, and other advocates. In this way, the NSF for Older People will focus on those parts of the NHS that are particularly important to older people. One of the key ways to gather these views is through the advice of an External Reference Group (ERG), whose members will be drawn from the groups of people mentioned above and from organisations who know how to access their views.

Prof Ian Philp co-chairman

Frank Dobson appointed Prof Ian Philp, and Denise Platt, Chief Inspector, Social Services Inspectorate, as co-chairmen of the ERG, supporting the NSF for Older People. Amongst the other members of the ERG are Dr Chris Dunstan (see page 20), Prof Alistair Burns, Psychogeriatrician, Manchester, Prof Cameron Swift, and Theresa Harding from Help the Aged.

The ERG commenced work on 17 March 1999 with the task of advising the Department of Health (DOH) on the development of 'generically applicable' standards of health care and guidance on implementing the standards in relation to older people experiencing:

- stroke;
- injuries sustained as the result of accidents, especially falls, and organic and functional mental illness;
- care in acute hospitals, including palliative care;
- models of care in primary and community settings;
- transition to and from hospital;
- assessment and care management; and
- performance measures to monitor the standards.

Task Groups

The NSF for Older People is in turn supported by several Task Groups, comprising between 10-12 members with an active interest in the particular subject. These include a group on Accidents (particularly falls), on which the Society is represented by Prof Sir John Grimley Evans and Prof Cameron Swift (chairman). Other Task Forces cover acute hospital care (including palliative care), models of primary and community care, transition to, from and within hospital, models of assessment and care management, mental illness and stroke. BGS members involved in these groups are Dr David Black, Dr Finbarr Martin, and Dr John Young (Bradford).

Timetable

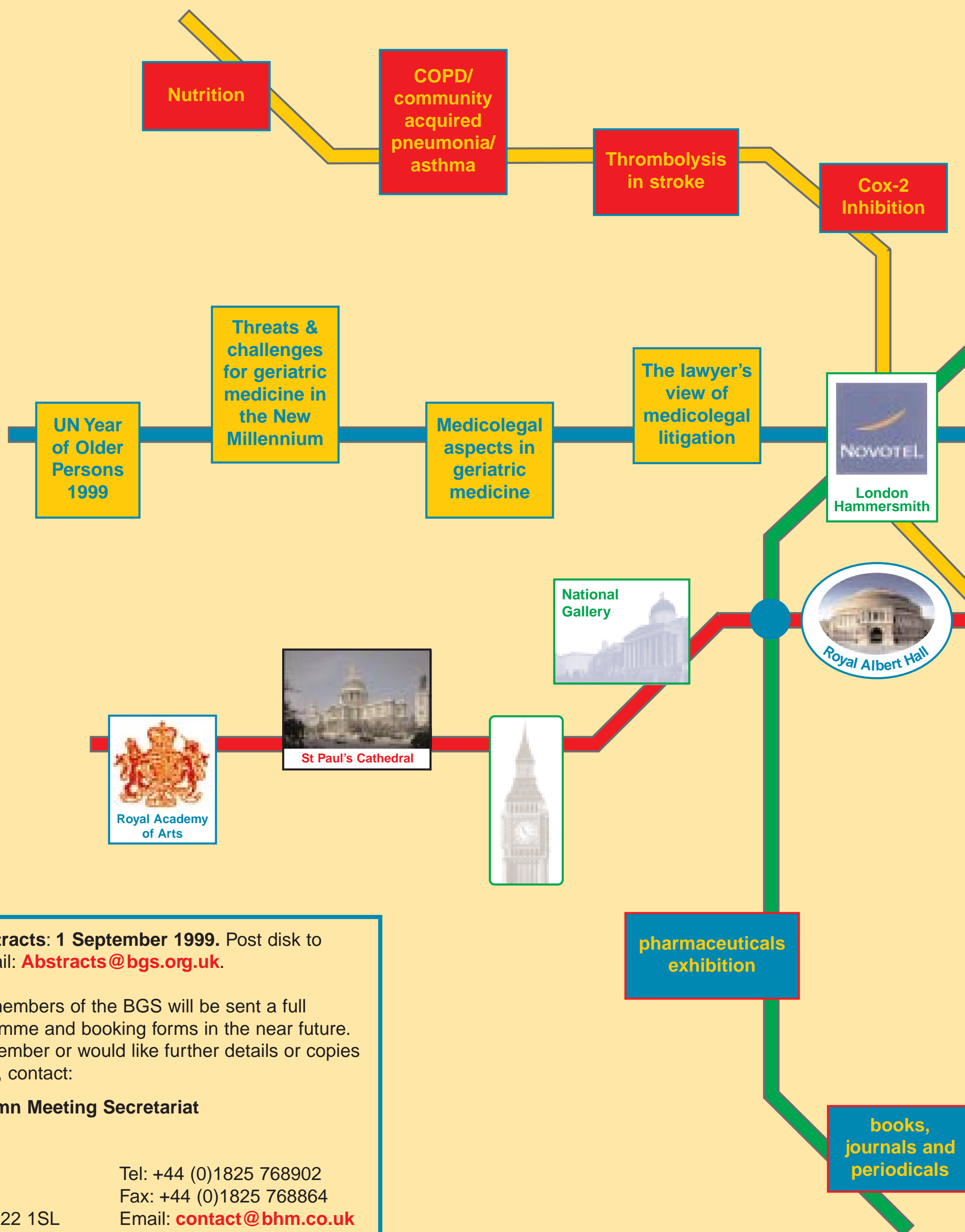
'Emerging findings' will be published this autumn and the final framework by April 2000. Speaking to the first meeting of the ERG in March, John Hutton, Health Minister, said *'This is an opportunity to make a real difference to the lives of older people …It is an ambitious remit, but timely. In this United Nation's Year of Older People, I am determined that we shall prepare to enter the new millennium with health and social services working together to deliver standards of care in which we can all take pride'.*

Richard Lynham

provisional programme

BGS Autumn Meeting 1

(for this year only) 15, 16 & 17 December



Deadline for abstracts: **1 September 1999.** Post disk to BGS office or email: **Abstracts@bgs.org.uk**.

Programme: all members of the BGS will be sent a full provisional programme and booking forms in the near future. If you are not a member or would like further details or copies of the programme, contact:

The BGS Autumn Meeting Secretariat
BHM
1 Arun House
River Way
Uckfield
East Sussex TN22 1SL

Tel: +44 (0)1825 768902
Fax: +44 (0)1825 768864
Email: **contact@bhm.co.uk**

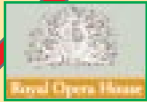
1999

Harrods

medical equipment

British Museum

Ageing skin



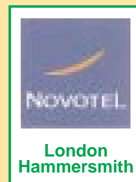
Evidence based practice for surgical management of varicose ulceration

Are we failing the elderly and disabled?

Government's approach to care of the elderly & disabled

clinical management update - oral papers

medical education update - oral papers



London Hammersmith

Registration, main sessions, exhibition, sponsored symposia, annual dinner and (early booking necessary) accommodation - all under one roof

Provisional scientific programme, including oral/poster presentations

Sponsored symposia and updates - oral papers

Exhibition

Social & leisure options for members and partners/guests

It was a Corker!

Dr Rebecca Dunn gives a personal view of the Society's Spring Meeting held in April at University College Cork.

Most of us shared taxis from the airport to our hotels. Trust Finance Directors please note! Our taxi driver enquired our purpose in Cork and on being told we were there for the British Geriatrics Society meeting responded vehemently, "Nutters". Either he needed his hearing tested or the Society's image needs an overhaul.

We came from the four points of the compass in numbers never seen before at a BGS Spring Meeting. The final tally was 580, coming from the UK, Ireland, Australia, New Zealand, Canada, USA, Holland, Finland, Denmark, Sweden and Israel. It was a time for reunions. I hadn't seen Pete Robson since he was my SR in Exeter 20 years ago! It was a delight to meet up again.

The campus

University College Cork (UCC), dating from 1845, has as its motto *'Where Finbarr Taught, Let Munster Learn',* apparently not a reference to the chairman of the Society's Policy Committee (Finbarr Martin) but to the Patron Saint of Cork, St Finbarr. The campus made an attractive venue, covering 44 acres on the wooded banks of the river Lee, a short distance from the city centre.

The meeting itself was held in the Boole Basement, George Boole (of Boolean Algebra fame) having been the first Professor of Mathematics at UCC. There was no lecture theatre large enough to accommodate all the delegates so the oral papers and keynote lectures were relayed from the main auditorium to the adjacent theatre via an audio-visual link. This arrangement worked well, the overflow theatre tending to attract a more laid-back audience.

Exhibition success

The 34 pharmaceutical companies who supported the meeting exhibited in the foyer outside the lecture theatres and rooms leading off it. Tea and coffee, with what could have been homemade cakes and shortbread, were served in the same area. Doors led out to a terrace and, weather permitting, delegates were able to drift in and out. The layout made it easy to circulate around the Exhibition, obtain refreshment and discuss the latest therapeutic advances.

The main restaurant was in the next building. The posters were displayed down one side, screened off from the dining tables. This confined space made poster viewing an intimate experience…. but at least they were easily accessible. Lunches and the supper on the Thursday evening were served in the main restaurant. These were self-service meals, offering a selection of hot and cold dishes of high quality. The jugs of water on the tables even contained a slice of lemon, an illustration of the attention to detail evident in all the catering.

The latest fashion

The white BGS sweatshirts were a great success. They sported the meeting logo, a representation of the clock tower forming part of the main quadrangle of UCC, which at a quick glance could have been mistaken for a hieroglyph. They were on sale for I£20, but everyone got a 'special discount' and paid the bargain price of I£15! They were worn by several of the organising committee and the core of students who, with unfailing courtesy

and good humour, acted as stewards, microphone holders and cutters-up of Velcro!

Dr Cillian Twomey, Chairman of the local organising committee, opened the proceedings on Thursday morning by welcoming us all to Cork and chairing the first scientific session. In his sweatshirt (a verification of the claim, 'one size fits all') he became a familiar figure at the podium. He appeared at regular intervals to entertain us with his one-man show under the guise of 'housekeeping announcements'.

Scientific programme

On the first day, there were 12 oral papers covering Health Services Research (HSR) and stroke. Ninety-seven posters were displayed, rather more than one could do justice to in the time. The sections were HSR and epidemiology, clinical practice, stroke, and gastroenterology and continence. The sheer number and limited space in which they were displayed made it inevitable that one was selective in what one viewed and may have missed the odd nugget. Eight were selected by the adjudicators for short platform presentation as the final scientific session of the day.

SIGs

On Friday, the early birds attended a symposium on *Orthostatic Hypotension* at 7.30am. The 6.45am wake up calls disconcerted those who had thought the meeting was at 7.30pm! For the rest of us, it was enough to get back to Boole Basement for 9am and choose from six Special Interest Group (SIG) meetings and an oral paper session on neurology. (Future organisers please try to minimise the number of events in parallel.)

Catching up!

Not surprisingly, the Care-Home Medicine SIG was well attended by those eager to hear Prof Stout talk about the Royal Commission on Long Term Care, of which he was a member. It seemed a pity that this important presentation was not delivered in plenary session but understandable when one considers that the subject is specific to the NHS. However, it has served to galvanise the BGS into action. There is to be a campaign to lobby ministers, MPs and others for Government action on the recommendations of the Commission. Details will be sent to the Regions.

The remaining oral papers covered bones, falls and fractures. There were 87 posters covering cardiology, bones and falls, pharmacology and psychiatry, and neurology and Parkinson's Disease. As before, eight of these were selected for platform presentation that afternoon, including two from our Dutch members.

Congratulations to prize winners!

Dr Lorraine Kyne and her colleagues from Harvard won the Elizabeth Brown Prize for the best oral paper, entitled *'Natural immunity to Clostridium Difficile protects against diarrhoea'*. The Ferguson Anderson Prize for best poster was awarded to Mrs Jane Mickleborough, a physiotherapist, and her colleagues from Salford, for the poster entitled *'An evaluation of conventional physiotherapy and treadmill re-training of higher level gait disorders in patients with cerebral multi-infarct states'*.

Keynote lectures show talent

Five keynote lectures were dispersed throughout the two days. The organisers

used these to demonstrate the talent of Irish doctors, many of whom seemed to have some association with Cork itself and all of whom must have spent time in Blarney.

Prof Declan Lyons, a member of the local organising committee, spoke on *'Blood Vessel Dysfunction - the key to the ageing process'*. As he intended, we were surprised to learn that the endothelium weighs as much as the liver, although, on reflection, we wondered how he knew. Should we be designating the endothelium as 'the organ of the new millennium'?

Dr K Fullerton, Keynote Speaker

After lunch on Thursday, Dr Liam Plant, an Irish émigré to Scotland, updated us on *'Renal Failure in the Elderly'*, making a case for closer links between renal medicine and geriatrics. It may not be long before we see adverts in the *BMJ* for geriatricians with an interest in renal medicine, something specialist registrars could do well to ponder.

On Friday, Prof Rose Anne Kenny, who has moved to England, explained how she is now directing her missionary zeal to the association between disorders of blood pressure control and cognitive decline. Her lecture, *'Neurovascular instability and dementia'*, was delivered with verve and included the interesting therapeutic anecdote that GTN patches may be helpful in demented patients with nocturnal hypertension and daytime hypotension.

Prof R A Kenny, Keynote Speaker

The vascular trio was completed by Dr Ken Fullerton from Belfast, who, with a subtle change of accent, spoke on *'Acute stroke intervention strategies'*. It was a comfort to many of us to hear that there isn't something we should be doing that we aren't, and a reminder to get organised with our stroke care if we have not done so already.

Friday's proceedings were rounded off with erudition by Prof Davis Coakley from Dublin who spoke on *'Ageing and literature - an Irish perspective'*. The beautiful language and wit could not hide the almost universally bleak view of these writers. Perhaps there is a need for guidelines on the use of the Geriatric Depression Scale in ageing Irish writers! These would not be needed for composers, judging by the material on the CD, *'Sins of my old age'*, compiled by Dr Desmond O'Neil and included in our welcome pack. The evidence we have does not allow us to determine whether the primary risk factor for depression in old age is being Irish or a writer!

Some of the abstracts and texts of the keynote lectures will be published in a supplement to *Age & Ageing* later this year.

Saturday morning was devoted to a scientific symposium on *'Cognitive impairment in the elderly'*, which I was unable to attend as Aer Lingus had rescheduled flights!

President's reception

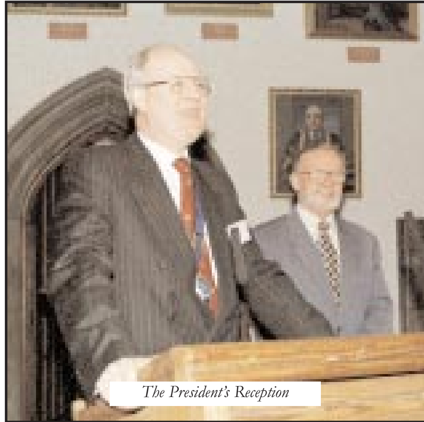
On the Thursday evening, the President of UCC hosted a reception in the Aula Maxima, or Great Hall, of the College built in 1849. This hall is part of the main quadrangle, at the heart of UCC, modelled on a typical Oxford College in Gothic revival style. The wine and Guinness flowed here and at the supper held afterwards.

The Society's reputation?

The reception and banquet on the last evening were held in the Devere Hall, the new student centre built in 1995. The reception in the lounge (a bar) was an even cosier affair than the poster viewing sessions. The banquet was held in the adjacent hall, complete with balloons and live Irish music. We suspect that the medical students, who warmly welcomed us at the door and looked after our coats, were chosen because as members of the successful UCC rugby team they could have doubled as bouncers. Had the reputation of BGS members preceded us?

This feast is the only occasion I have been to

where, at a meal for hundreds, there was a choice of main course. This exceptional standard of catering was typical of the whole conference. The supply of food and drink seemed endless and it was invariably good and generously served.


The President's Reception

An elderly leprechaun, aka Barry O'Donnell, President, Royal College of Surgeons of Ireland, gave the after dinner speech. He started with *"When you get to my age, and you address the British Geriatrics Society, you wonder on whose behalf you are speaking"*. He then entertained us for half an hour with one-liners delivered in a style reminiscent of George Burns.

Choice of venue vindicated

The whole meeting was a great success. The BGS was thoroughly vindicated, once again, in having the peripatetic Spring Meeting in the Republic of Ireland. There were rumours of a possible bid to run a future meeting on mainland Europe! Dr Margot Gosney, Meetings Secretary, and the BGS office staff, Richard Lynham, Recia Atkins and Rawia Habiby, dealt (wo)manfully with the challenges of supervising the meeting abroad in an electronic age. They were inadvertently omitted from the profusion of thanks at the end of the banquet.

To Cillian and the rest of the organising committee, *"Mile buiochas"* - "a thousand thanks". We had a wonderful time. 1985 Dublin, 1999 Cork, 2013… now what is the third city of Eire?

Rebecca Dunn
Honorary Deputy Secretary

From assessment into action
- changing process and culture

Dr Chris Dunstan, a GP in West Byfleet and valued contributor to the BGS Care-Home Medicine SIG, describes the project effected by his Primary Care Team and colleagues in Social Services *et al*, to achieve an integrated approach to patient care.

One way of measuring time, I have come to realise, is by the passing of catch phrases used in the NHS and Social Services. In terms of our particular project, it developed in the 'Seamless Care' period of the era of the Primary Care led NHS, continuing through the 'Whole System' period of that same era and coming to maturity in the period of 'Motherhood and Apple Pie'. In fact, this summarises the project. It is based very much in the community and primary care. It aims to give seamless care, focuses very much on the way the whole system of health and social care works, and if 'Motherhood and Apple Pie' means a supportive and sustaining system, it encourages that for both patients and their carers, be they professionals or family.

Background

Our work started about five years ago and was born out of frustration at the way we were not working well together. It is not unusual for patients, even those with not very complex needs, to have a number of health and social care professionals involved in their care. The information needed to make appropriate decisions about care, either health or social, is collected independently by each agency and even each professional group within a single agency. We knew that much of the information that each of us needed is, in fact, the same, but we all wanted to record it on our own forms, locked in our own filing cabinets when we were out of the office. The 'glazed look' in the eye of

our patient/client as we asked our questions was not a sign of incipient coma, but a sign of the boredom at having to answer the same questions yet again. There had to be a better way of carrying out assessments of health and social care needs.

The inter-agency assessment

When a group of us got together, representing a number of disciplines in both the NHS and Social Services, we reviewed the current practice of collecting assessment information. It was found that a lot of paper was involved in the process and duplication or triplication of effort was the rule rather than the exception. In addition, we were surprised to find that 70-80% of the information collected was the same whoever collected it, the rest being special to each professional. Therefore, to make progress in assessments and to make the process more efficient, we had to:

THE COLLECTION OF ASSESSMENT INFORMATION WAS IN NEED OF REVIEW

1 develop a common format for assessment, so that once information was collected it could be shared with others needing it;
2 agree the domains it should cover, i.e. social care, carer needs, daily living, domestic risks, finances, communication, mental function, continence, nursing needs, medication;
3 define the terms being used so all those using the assessments know what is meant by any particular phrase;
4 design 'triggers' leading to further inquiry, so that those carrying out assessments can call in the expertise of others, when appropriate;
5 computerise assessments so that information can be more easily shared;
6 design software to summarise assessments in order to produce reports giving key findings and rapid overviews of the problems involved (which become the basis of patient-held records);
7 collect data in a way that maximises the flexibility of use, for individual patient care in community and hospital settings, and aggregated for population-needs assessment; and
8 simplify data entry as much as possible, e.g. by the introduction of hand-held PCs (which has now been done).

'Whole system' working

Two years ago we carried out our Whole System Audit, the first in the country. One of the main findings related to assessments: the length of time they took; the difficulty of getting multi-agency input; and the problem of knowing what to do with the results of the assessment. In consequence, both the Health Authority and local Social Services recognised the potential benefit of a common assessment process. Our community assessment project suddenly had a great boost.

Once we began to share information, trust each other's assessments and save time by reducing duplication, we were able to develop other ways of working together effectively. A Care Manager now works in the Primary Care Team, leading to greater respect for each other's skills and professionalism and a greater understanding of the constraints under which we all work. Resources are now viewed as not 'mine and yours', but 'ours', to be used as effectively as possible. If improved rehabilitation at NHS expense can save care costs accruing to the Social Services budget, that is as worthwhile as a saving to our own budget. Obviously, it is hoped that the savings will be diverted, in part at least, to help us in areas of particular difficulty, where an enhanced social care input will relieve pressure on the NHS.

We realise now that, at times, each agency would come up with their own solution to the same problem that a patient had. At others, difficult problems were passed on if solutions were not found, usually by reassuring the patient that another agency would solve the problem to their total satisfaction. Colleagues were denied any room for manoeuver if it helped us get rid of the problem more quickly. A GP might say, *'I will send you up to the hospital for you to be admitted'*, or a consultant may say, *'The care manager will arrange for you to be admitted to a nursing home'*. We thought in terms of uni-agency solutions and, if no agency could come up with a solution, we waited until the situation deteriorated in order to redefine the problem and then 'pinned' it on a particular agency. By working together, instead of throwing the problem over our shoulder to the next in line, colleagues in other disciplines are now consulted about difficult problems and together try to come up with a solution, multi-agency if necessary.

The bottom line

There is, of course, a price to pay for this system. We have all had to learn to change the way we work and, more importantly, the way we think.

In essence, we are attempting to:

1 learn to respect each other's role and understand the restraints under which we all work;
2 learn to trust each other's professionalism;
3 lose individual ownership of information, processes and resources;
4 gain joint ownership of responsibility for meeting the needs of our patients/clients; and
5 try not to make 'promises' on behalf of others.

The focus of the work

But what about the patients/clients? How do they benefit? By cutting out the duplication of assessment and information gathering we stop the 'glazed look' coming into their eyes. More importantly, we have speeded up the processes. The Whole System Audit shows, in our area at least, that, in emergency situations, the NHS acts and Social Services initiate an assessment. Unfortunately, the NHS emergency response to any complex situation was to admit the patient to hospital. Now, effective information sharing allows faster decision-making and, thus, quicker access to services. By sharing the results of an assessment with patients in the form of a patient-held record, they become informed and involved in the decisions about their care. They are also able to check the accuracy of the information.

These days, patients and ourselves, as healthcare providers, have the choice of a number of services provided by Health and Social Services, or a combination of the two. The system developed has helped us move towards the ideal of patient-centred care, delivering 'the right care, at the right time and in the right place'.

Dr Chris Dunstan

COUNCIL MEETING 7 APRIL 1999, UNIVERSITY COLLEGE CORK

Clinical governance

The meeting reviewed the draft paper on clinical governance (see article page 1), prepared by a working party, chaired by Prof Swift.

Policy Committee

Dr F Martin summarised the Committee's recent activities and invited feedback in respect of areas for which additions to the BGS Compendium of Guidelines were needed.

RCP London/specialists societies

Dr Williams advised that the RCP London were studying their relationship with the specialist societies to see how the linkage could be improved.

Hon Secretary's Report

Dr Dunn, Hon Deputy Secretary, read from a written report from Dr Lubel, Hon Secretary, covering the work to date of the GIM/GER working group in the London College and on Help the Aged's continuing *Dignity on the Ward* campaign. Dr Lubel had also reported on the Royal Commission's report (see Editorial page), which prompted further discussion in the meeting in respect of future developments.

Hon Treasurer's Report

Dr Potter advised that the Society's finances were in good order and that he expected to achieve a surplus in the financial year ending 31 March 1999, to be used to finance training and research grants and to build reserves for the possible acquisition of premises.

Premises

The major part of the meeting was devoted to the question of whether the Society should, to reduce its dependence on rented accommodation made available by the RCP London, seek to build up funds with a view to acquiring its own freehold. The outcome of the vote was unanimously in favour of an eventual move from rented accommodation to a purchased property. With one abstention, the meeting voted in favour of raising £350,000 to augment its reserves for this purpose. The meeting was unanimous that funds should be raised over a period of three years and could, if necessary, include a levy on members.

Mode of electing officers

Dr Williams summarised the response received from the regions to the effect that only five had voted in favour of a change from current procedure to a postal ballot, six had voted against and six had effectively abstained, in so far as they had sent no response. Under the circumstances, the representatives for the West Midland region, the originators of the proposal, withdrew the proposal for change.

CME Programme

Prof Mark Castleden reported on his ongoing enquiries as to members' requirements and potential changes to the format of BGS scientific meetings.

Special Interest Groups (SIGs)

The constitution of the Care-Home Medicine Group (see March Newsletter) was approved. Prof Swift reported that there was good support for a new Health Services SIG, and Dr Duncan Forsyth reported good progress on organising an inaugural meeting of the SIG on Cerebral Ageing in the autumn of 1999.

Geriatric medicine in India

- the present scenario

Dr Sharma, General Secretary of the Geriatric Society of India, reports on the history of geriatric medicine in India and the situation today.

Background

In 1947, when India saw the dawn of independence, life expectancy was only 32 years. One third of the country's population was in the paediatric age group. Deaths due to tetanus neonatorum, cholera, smallpox, puerperal sepsis, gastroenteritis and other infectious diseases were rampant. The budgetary allocation for health was only 6% of the GNP and most of it was spent in salaries and other infrastructure development. There was no concept of medical expenditure in a common man's own family budget. Health was always supposed to be provided by government, private trust hospitals, religious institutions, NGOs etc. The multiple system of treatment existed and modern medicine was in its infancy, with only a handful of medical colleges in Bombay, Calcutta, Madras and Lucknow.

Then came the intervention of world bodies such as the World Health Organisation (WHO) and UNICEF, and missionary hospitals, which tried to support the medical infrastructure. Various programmes like smallpox and malaria eradication were introduced to control the epidemics and other preventable diseases. Soon it was realised that the population was growing rapidly and, to check this 'menace', a family control programme was instituted. Thanks to the improvements in health and hygiene, control of infectious diseases, of epidemics, mass vaccinations, availability of drugs, and increased number of medical and para-medical manpower, etc, the average life span improved. At present, this is close to 64 years. The pendulum of the population clock thus started drifting towards older persons, resulting in the present estimated geriatric population of around 70 million, i.e. 7% of the total population.

Formation of professional societies

In the late 70's, some of the clinicians and basic scientists in India took the lead and two societies were formed. The clinicians formed the Geriatric Society of India (GSI), whilst the scientists (from basic and social sciences) formed the Association of Gerontologists India (AGI). GSI organised lectures, symposia, and mid-term and annual conferences on geriatric medicine. The latter is held jointly with the Association of Physicians of India in the third week of January every year, whilst the mid-term conferences are in April or September.

For the past decade, GSI has also organised programmes for the lay public, which include health awareness, diabetes, and hypertension detection camps, and a multi-generation solidarity walk on 1 October - the UN day of older persons.

The AGI is involved in research on the various facets of ageing. They hold their biennial conferences at national level.

Thus, the last two decades have seen a change in the attitude of the medical profession towards elderly patients. The awareness among doctors towards the special aspects involved in treating an older person has increased. In addition, they have started to consider the fact that an older person is different from the adult patient, e.g. where the manifestation of some diseases is concerned. The immunity, body biochemistry and the pharmacokinetics of drugs in older persons are also different.

The rising number of older persons, and the breaking away of the age-old 'joint family system' in India, has led increasingly to the question of who will care for this section of the population. The planners in the country have also started to consider the fact that the social, psychological, financial and medical problems of older persons require attention. At present, social schemes for older persons, which could look after them after their active life, are literally

non-existent. The medical infrastructure catering for the medical needs of this section of society is grossly lacking. The government has started to give concessions to older persons in air and railway travel etc, but this is only symbolic help. Some of the state governments also considered the matter of pensions for older persons below the poverty line. In addition, NGOs, like Helpage India, have come forward and started to run social and medical programmes for destitute older persons.

Recognition of need for specialty

The Medical Council of India's recognition of geriatrics as a specialty further attracted medical professionals towards this new specialty. The professional associations and NGOs started conducting CME programmes to cover the various aspects of geriatrics. As time passed, the numbers in such programmes started growing. Newer topics were added and soon it gained momentum. The WHO, the Ministry of Health, the Directorate of Health, the Medical Council of India, the Indian Council of Medical Research (ICMR) and the NGOs e.g. GSI, AGI etc, have all become busy with programmes pertaining to geriatrics and gerontology.

CME PROGRAMMES HAVE NOW COMMENCED, COVERING THE VARIOUS ASPECTS OF GERIATRIC MEDICINE

In 1992, the ICMR and the Indian government organised an Indo-British workshop on the public heath implications of ageing. It appears that one of the reasons behind this workshop was that the government had started to realise the infrastructure of the health care of older persons was very poor and that the state will not be able to share the burden of an ageing population, due to fall on them following the deterioration of the joint family system. The workshop recommended the revival of the joint family system, which could take care of social, psychological, economical and medical needs of older persons.

Further education

The Indira Gandhi Open University is gearing up to start a diploma course in geriatric medicine by the year 2001.

Recently, the Director General of Health Services organised a workshop with the support of WHO. Its aim was to develop a training module for medical college teachers, and primary and secondary care physicians, and also to develop self-learning material on healthy living for older persons. The Department of Medicine of the All India Institute of Medical Sciences, the ICMR, the Directorate General of Health Services, the Ministry of Health and geriatricians from all over India participated.

UN Year of Older Persons 1999

To commemorate the UN Year of Older Persons, the GSI is organising an international conference on 12-14 November 1999, to be held in New Delhi (see 'Notices' on page 28). Two parallel sessions will cover the developments in the field of geriatric medicine as well as the various facets of ageing. A large number of medical colleges, hospitals, governmental and non-governmental organisations have joined the GSI in this venture.

Publication of first book on care for older persons in India

However, the situation is still grim; out of 168 recognized medical colleges in the country, only Chennai has an MD in geriatrics, and only a handful of medical colleges have geriatric clinics. Membership of the Geriatric Society of India is still not very large. Though the medical problems of older persons in India are slightly different from those in the west, they are still being treated by geriatricians trained in the west and have access only to western literature. This year, a multi-disciplinary, multi-author text book entitled *'Geriatric Care in India',* edited by Dr Sharma, will be published, covering the comprehensive care of the older persons. Those with experience in the care of older patients in India are contributing chapters in this book.

In India, at present, we are walking at a stage when we are supposed to run. The next century is at the doorstep and to look after the mammoth number of 70 million older persons is going to be our responsibility. A strong, combined effort by the government and NGOs is needed to identify the problems of caring for older persons and then to design suitable solutions for them.

Dr O P Sharma
National Professor - Geriatrics

UN Year of Older Persons - towards a society for all ages

This update reports what has happened since the launch of the UN Year of Older Persons last October (see September 1998 BGS Newsletter for more details).

The official UK programme was launched in London on 12 January 1999 by John Denham, Minister of State for Health.

The BGS has continued to be a member of the 'Organisations Valuing Older People' facilitation group. This is one of four facilitation groups set up by the UK Secretariat, based at Age Concern (see September Newsletter, page 15). The others are: 'Generations Together'; 'Learning Through Life'; and 'Citizenship'.

What will be happening in the UK?

The following are examples of the many activities planned by organisations and Government departments concerned with the elderly or their services.

Media Audit

During the week of 10 May, there will be a review of the portrayal and representation of older people in national and regional newspapers. The results will be published and fed back to editors and journalists with a view to changing their practice. This is the main project of the 'Organisations Valuing Older People' facilitation group. Media Age UK Network comprising voluntary organisations and media professionals, is also involved.

Ministerial roadshows

Members of the Government's Inter Ministerial Group on Older People will participate in 10 regional events at which older people will attempt to make them more aware of the issues that matter to them. This programme is being co-ordinated by the UK Secretariat and representatives of the 'Citizenship' facilitation group.

Intergenerational walk

There is an intergenerational series of walks planned worldwide on 2 October 1999. The UK Secretariat is co-ordinating the UK walk programme in collaboration with other charities. A central walk in London is planned.

What will the BGS be doing?

A collaborative event by the Prince of Wales's five charities concerned with ageing will be in October. The charities are: Age Concern, Help the Aged, Abbey Field, the Almshouse Association (see January 1999 Newsletter, pages 14-15) and the BGS. The President Elect, Prof C G Swift, is the Society's lead for this initiative which is being co-ordinated by Age Concern.

The first combined BGS, American Geriatrics Society and French Gerontological Society meeting is being held 1-3 September in Paris. Further details are available in the flyer attached and on page 25 of this issue of the Newsletter.

At the BGS Autumn Meeting, 15-17 December 1999 (see page 14) there will be a UN Year of Older Persons lecture given by Lady Sally Greengross OBE, Director General of Age Concern England.

The logo will appear on various BGS publications this year.

This gives only a flavour of the wide range of activities going on across the UK. Those wanting to know more can be included on the mailing list by sending their name and address to: Radha Patel, UK Secretariat, c/o Age Concern England, Astral House, 1268 London Road, London SW16 4ER.

Rebecca Dunn
Hon Deputy Secretary

In Memoriam

DR LESLIE ANDREW WILSON, FRCP, 15 JUNE 1917 – 5 APRIL 1999

Dr Wilson was educated at Robert Gordons College, Aberdeen, and Aberdeen University, taking his MA in 1937, his MB ChB in 1941, and his MD (Hons) in 1954. He was made a Fellow of the Royal Colleges of London and Edinburgh in 1970 and 1971 respectively, having qualified as a Member of each in 1948 and 1962 respectively.

He married Helen Marshall Rintoul and leaves three children and three grandchildren.

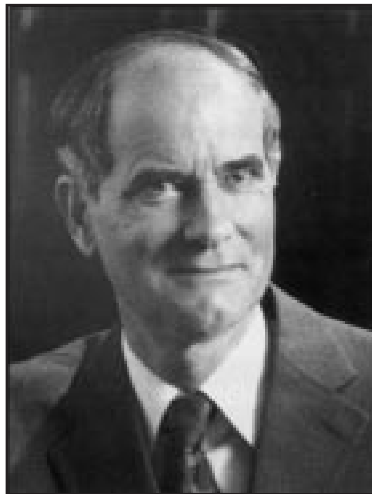
Dr Wilson began his career as House Surgeon in the Aberdeen Royal Infirmary in 1941. He then saw service as Major in the RAMC from 1942 to 1946 in Nigeria, India, Burma and the Middle East, before returning to the ARI as medical registrar until 1950.

His next appointment was a senior registrar in general medicine in the Aberdeen General Hospital from 1950 to 1954, after which he was appointed consultant physician and consultant in charge, geriatric service, North East Scotland Hospital Region, 1955-1982. During this, time Dr Wilson was also Visiting Consultant in general medicine to Orkney, Shetland and Morayshire, from 1955-67, and senior lecturer in clinical geriatric medicine at Aberdeen University, 1962-82.

Dr Wilson established a large geriatric hospital service in the face of many difficulties and contributed significantly to the undergraduate teaching programme as well as training over 300 junior doctors; he always emphasised the complexity and the wide range of medical geriatric practice. He also pioneered mental scoring systems in geriatric assessment.

Dr Wilson was an active supporter of the Society, having served on both the Executive Committee and Council between 1960 and 1973; he was chairman of the Scottish branch 1965-67, and organised the Aberdeen Spring Meeting in 1973.

In respect of the debate on the organisation of geriatric services - traditional, age-related or integrated - Dr Wilson was a firm advocate for the traditional model, believing that the consultant should have his/her independent assessment and rehabilitation wards and should control all aspects of progressive care from pre-admission assessment to placement in and supervision of long stay wards.



He maintained extensive links abroad, with a particular knowledge of Scandinavian geriatrics, and attended most international meetings, lecturing in Australia, New Zealand, North America, Ireland and the Benelux.

He published extensively between 1940 and 1979, on a range of clinical subjects, management and training appertaining to geriatric medicine.

Dr Wilson reshaped the medical record system in Aberdeen, which was reported on in the *BMJ* in 1978.

In recognition of his pioneering work for geriatric medicine in Scotland, Dr Wilson was awarded the Society's 50th Anniversary Medal in 1997.

DR FRANK WALKEY

We were sad to note the death of Dr Walkey recently. Dr Walkey retired in 1989, having graduated in Dublin in 1949. He spent some time as a medical registrar in The Royal Surrey County Hospital in Guildford before going north as a senior registrar in the University Department of Geriatric Medicine, Stobhill Hospital. He became a consultant in geriatric medicine in the 1960s.

During his career in geriatric medicine in the North of Glasgow, he was based at Stobhill Hospital and also had major interests in Foresthall, Broomhill and Ruchill Hospitals. He was fondly remembered by all his staff for his caring and sympathetic attitude to themselves, his staff, and, most of all, to his patients. There are many people in the North of Glasgow who have cause to be most grateful for his care and attention and will mourn deeply his passing.

He is survived by his wife and son to whom we extend our symphathies.

1ST TRANSATLANTIC GERIATRICS MEETING - 2ND FRANCO-AMERICAN GERIATRICS MEETING 1 TO 3 SEPTEMBER 1999, PALAIS DES CONGRÈS, PORTE MAILLOT, PARIS XVIIE

This conference has been organised by the Société Française de Gérontologie, the American Geriatrics Society, the Fondation Nationale de Gérontologie, the British Geriatrics Society and La Revue du Généraliste et de la Gérontologie. For full details of the programme, accommodation, abstracts, etc, **see the flyer in this issue of the Newsletter** or contact the address below.

Plenary sessions and workshops

The BGS will be represented by several members, including Dr Williams and Prof Swift, who are to chair plenary sessions. Topics include: health policy (interface with ageing - an international perspective); nutrition in ageing; diabetes; stroke; Alzheimer's Disease; and respiratory disease.

Workshops must be booked as numbers are limited. These cover topics which include: exercise and its benefits; falls prevention; therapeutic priorities in older diabetics; ambulatory and specialty care for patients suffering with dementia; and ageing, infection and immunity.

Abstracts

Two copies of each abstract for poster or oral presentation should be sent by **30 May 1999** (using the appropriate application form) to the address below.

Fees

Doctors/physicians £178 (to 15.7.99), £210 thereafter. All other health professionals, £87 to £97. Meals, i.e. lunches and convention dinner, are extra but may be booked in advance.

Travel

On production of the original leaflet at any Air France office, delegates can obtain special rates on both domestic and international flights.

Accommodation

Hotels may be booked at special rates and vary in price from 1200FF/night for a 4-star hotel in the conference centre, to 630 FF/night B&B in a 3-star hotel or 415 FF/night B&B for a 2-star hotel, 10 minutes walk away. A list of hotels close to the conference centre will be sent on request (from conference secretariat).

CME

CME accreditation has been applied for. For further details contact the conference secretariat.

Contact address:

Mr M Bia, Conference Secretariat, M F Congres, 8 rue Tronchet, 75008 Paris. Tel: +33 (0)1.40.07.11.21. Fax: +33 (0) 1.40.07.10.94. Email: MEDIAFLASH@compuserve.com.

TRAINING

JCHMT SAC in Geriatric Medicine - "Training in geriatric medicine - the big issues"

Royal College of Physicians & Surgeons, Glasgow

9 June 1999

Topics include: on the job training; learning from others; elderly care outside hospitals; and research.

Fees: £60 (includes lunch).
CPD: applied for

Applications by 31 May to:
Mr R Littlejohn, Royal College of Physicians & Surgeons, 232-242 St Vincent St, Glasgow G2 5RJ. Tel: 0141 221 6072. Fax: 0141 221 1804.

GERONTOLOGY

4th European Congress of Gerontology

Berlin

7 to 11 July 1999

Topics include: ageing in Europe; dementia; chronic disease; biology of cell and tissue ageing; and geriatric assessment.

Fees: delegates - DM800; students - DM400; and accompanying persons - DM400.

Contact: Geber & Reusch, Habichtsweg 11, D-60437 Frankfurt/Main, Germany. Tel: (49)-69-50 52 29. Fax: (49)-69-50 39 78. Email: 069505229-0001@T-Online.de.

OCCUPATIONAL THERAPY

College of Occupational Therapists conference "Reflect, Research, Revise"

Liverpool

20 to 23 July 1999

Topics cover, e.g.: mental health; physical rehabilition; R&D; assessment; and learning disabilities.

Fees: BAOT member - £295/£320; non-member - £350/£375; and students - £100/£125.

Registration: Concorde Services Ltd/COT, 10 Wendell Road, London W12 9RT. Tel: 0181 743 3106. Fax: 0181 743 1010. Email: cot@concorde-uk.com.

BIOGERONTOLOGY

2nd European Congress of Biogerontology

St Petersburg, Russia

25 to 28 August 1999

This conference is organised by the Gerontology Society of the Russian Academy of Sciences and the International Association of Gerontology. Registration/abstract forms are available on the website: www.gerontology.spb.ru.

Contact: Prof Vladimir Anisimov, GSRAS, NN Petrov Research Institute of Oncology, Pesochny-2 St Petersburg 189646, Russia.

BASP

1st British Association of Stroke Physicians Scientific Conference

University of Nottingham

9 September 1999

UK-based doctors will present the results of research related to stroke. **Deadline for abstracts**: 18 June. Email: basp-abstracts@nottingham.ac.uk for more details.

The Stroke Association conference runs from **7 to 8 September**. BASP attendees can also attend - details on: www.nottingham.ac.uk/stroke-medicine/basp-conference.htm.

Fees: BASP conference - £35; BASP/SA conference - £140.
CME: accreditation applied for.

Registration by 31 August 1999: Prof P Bath, Div/Stroke Medicine, University of Nottingham, Clinical Sciences Bldg, City Hosp Campus, Nottingham NG22 8HE. Tel: 0115 840 4791, fax: 840 4790, email: philip.bath@nottingham.ac.uk.

BRITISH SOCIETY OF GERONTOLOGY

Annual Conference on "Tradition & Transition: Ageing in the 3rd Millennium"

Moat House Hotel, Bournemouth

17 to 19 September 1999

Main topics include: culture; spirituality; oral history; education; and experience of ageing elsewhere in the world.

Abstracts deadline: for papers - 31 May; for posters - 31 July.

Fees: BSG members - £65; non-members - £95; and students - £49/£69.

Contact: Gill Taylor, BSG Wessex Conference, CRPD, Dept of Psychology, University of Southampton, Southampton S017 1BJ. Tel: 011703 594592. Fax: 01703 594597. Email: gt@crpd.psy.soton.ac.uk.

RETIREMENT PARTY

Retirement of Prof Peter H Millard

Party on 30 September 1999

It is proposed to hold a dinner to mark Peter's retirement from the St George's Hospital Medical School, Dept of Geriatric Medicine. Over the years he has been associated with many members who may wish to attend the evening dinner, the venue in London to be confirmed.

Contact: Elizabeth Mosby, Dept of Geriatric Medicine, St George's Hospital Medical School, Cranmer Terrace, London SW17 0RE. Tel: 0181 725 5327. Fax: 0181 682 0926. Email: e.mosby@sghms.ac.uk.

LONGEVITY

Symposia on "Older People and a New Era"

Barcelona

1 to 2 October 1999

This conference, run by the Gerontological Information Centre, covers topics including: nutrition; neuropsychology; rheumatology; and diabetes.

For more details contact: Antonio Carrión Giménez, Director-Co-ordinator, Centro de Información Gerontológica, Aragón, 105, 7º, 1ª, 08015 Barcelona. Tel: 93 226 00 24.

STROKE

RCP London Stroke Conference

Royal College of Physicians

27 October 1999

Topics include: the burden of stroke; is stroke an infectious disease; acute ischaemic stroke: what is happening in the blood vessels and in the brain; and the patient's point of view.

Contact: Conference Office, RCP London, 11 St Andrew's Place, Regent's Park, London NW1 4LE. Tel: 0171 935 1174, ext: 463. Email: conferences@rcplondon.ac.uk.

MEMBERS ON EMAIL

We know you are out there. We just don't know your email addresses! The BGS office would be grateful if you could send an email to: **Caroline@bgs.org.uk**, so that we can add you to the email address book and future Handbooks.

GERIATRICS SOCIETY OF INDIA (GSI)

International Conference on "Active Ageing - March to the New Millennium"

New Delhi

12 to 14 November 1999

The GSI is holding an international conference to commemorate the UN Year of Older Persons. Parallel sessions will cover developments in the field of geriatric medicine and the various facets of ageing. Abstracts deadline is **30 September 1999**.

Contact: Dr O P Sharma, General Secretary, GSI, K-49 Green Park Main, New Delhi, 110016, India. Email: drmohit@del3.vsnl.net.in.

REHABILITATION

"Ready to Go Home - Rehabilitation Re-discussed"

This 32-page publication by Prof Peter H Millard and Julie Sharman, is published by the Policy Unit, Age Concern. It describes the present problems in relating NHS and community facilities to the needs of an increasingly older population, and puts the case for re-instating rehabilitation and co-ordinated carer/patient supportive aftercare as the solution to the pressures in acute hospitals. For copies (price £5) contact Age Concern on tel: 0181 765 7200.

RESEARCH PROJECT

Mandy Leveratt in Australia is currently undertaking a number of projects in relation to low-income older people and access to services, e.g. health and welfare. She would be interested in making contact with similar researchers in the UK.

Her email is: mleveratt@bsl.org.au.

RESEARCH AWARDS

The Stroke Association has recently agreed to fund (amongst others) the following research projects.

1 **£85,000 over three years.** *"Exploring the impact of risk factors for stroke in older people",* from a team in the Dept of Epidemiology & Public Health, University of Newcastle Medical School.

2 **£140,000 over three years.** *"Thrombolysis for acute ischaemic stroke: pilot and service development phase of the 3rd International Stroke Trial (IST)",* from a team in Dept of Clinical Neurosciences, Western General Hospital, Edinburgh.

3 **£19,029 over six months.** *"Investigation of a training programme to increase strength in lower limb musculature following stroke",* from a team in the Dept of Health Sciences, University of East London.

For further details of awards available contact: Mrs T Cracknell, Research Secretary on tel: 0171 566 0300. Fax: 0171 490 2686.

SABBATICAL

Dr Peter Angst, a Swiss physician who has worked for several years at the Zentrum fur Geriatrie und Rehabilitation, Zieglerspital Berne, is planning to take a sabbatical.

Dr Angst specialises in internal medicine with a special interest in geriatric medicine. He would like to spend three to four months on sabbatical in the UK, as a member of staff or guest physician in a geriatric hospital/institution.

If members know of a suitable placement for Dr Angst, contact him at Risere 15, 3303 Jegenstorf, Switzerland. Tel: +41 31 761210.

BGS ABSTRACT INSTRUCTIONS

New abstract instructions for BGS Scientific Meetings

These are included as a flyer in this issue of the Newsletter. The instructions are to be used for submission of abstracts for future BGS Scientific Meetings, including the Autumn Meeting of 16 to 17 December 1999, the deadline for which is **1 September 1999.**

Abstracts which do not conform to these instructions will be returned to authors for editing, if time allows. Otherwise they will not be accepted. Emailed abstracts are to be sent to **Abstracts@bgs.org.uk**.

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