



Editor: Rebecca Dunn

# BGS

n e w s l e t t e r

## Royal Victoria Hospital, Edinburgh

**T**he Victoria Hospital was first opened in November 1894 when, under the guiding influence of Sir Robert Philip, the then Craighleith House became a 12 bedded unit for the treatment of tuberculosis - the first in Scotland.

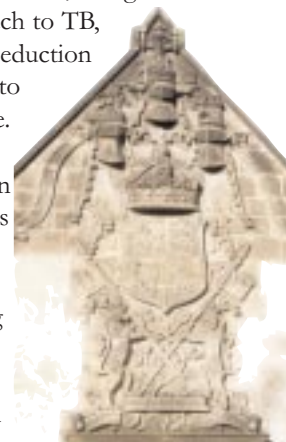
### History

Over the next 15 years the number of beds increased with the building of three “butterfly” wards and an administrative building (complete with campanile!) in 1903, and a further two “butterfly” wards in 1907. Royal patronage was granted in 1913. The three stages of

“treatment” for TB were rest (including exposure to the elements in open huts which ran on rails to follow the sun), gentle exercise, including walking the measured mile (still visible round the periphery of the site), and increasing activity such as washing and cleaning the walls of the wards and then work in the grounds.

In 1957 Edinburgh carried out a mass miniature radiography exercise which, along with the new triple therapy approach to TB, caused a significant reduction in the beds required to cope with the disease.

One of the chest physicians involved in this MMR survey was a James Williamson. With great foresight he saw the dwindling need for TB doctors and the future need to beset the new



National Health Service - the increasing number of elderly people. Against the advice of his peers he took up the challenge of geriatric medicine and set up a service for the elderly population of North Edinburgh, East Lothian and Midlothian. In 1959 the beds in the butterfly wards were converted for continuing care for the elderly patients who were unable to return home when

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specialist medical society for health in old age

# Editorial

page



**H**ealth informatics is the term used to describe the science of information management in health care and its application to support clinical research, decision-making and practice.\*

### Information Matters

Information management as a discipline brings order to what is often a disorganised process and with the appropriate use of information technology can lead to better patient care and enhanced professional development for clinicians.

Medical students and trainee doctors usually know how to word process, communicate by e-mail and carry out literature searches electronically, but established practitioners may be resistant to change and frightened of computers. Rather than being unknown however, much of what is encompassed by health



informatics is already familiar to us and with this realisation the topic can seem less daunting.

Every time we take a history and examine a patient, write in the case notes, discuss the management of patients in the multi-disciplinary team and explain the results of investigations to

for example a patient and her daughter, we are gathering and processing data, making decisions and communicating. In other words we are

managing information. It is the central process of medical practice. We need to build on what we are doing and learn to use computers appropriately to improve patient care.

This year has seen important developments in matters to do with information at three levels.

Nationally, *Learning to Manage Health Information – A Theme for Clinical Education*, was published jointly by over 20 organisations including the GMC, Academy of Medical Royal Colleges and the NHS Executive, as a core framework for health informatics within career-long professional development. Professor Martin Severs (a geriatrician and BGS member) was one of the two principal authors. The paper concentrates on what needs to be learned by health care professionals in the following areas: communication which includes authoring and reading health records, clinical language and team working; knowledge management; data quality and management; confidentiality and security; secondary uses of clinical data and information; clinical and service audit; working clinical systems; telemedicine and telecare; and basic computing skills. These are illustrated by examples of guidance and standards relating to health informatics from the GMC and the equivalent bodies for dentistry, nursing and the other clinical professions. This document is a tremendous achievement and is the starting point for those professional, educational and NHS organisations who contributed to it, to work together to create well designed and accessible ways to learn health informatics.

Within the Society there have been changes. The latest BGS handbook included the e-mail addresses of members, where these were known. Observant visitors to the BGS office will have noticed that a computer has appeared on Richard Lynham's desk and some may have caught him at the keyboard. At the July meeting of the Finance Committee it was agreed to set an example within the Society by distributing agendas and minutes electronically. Was this our first step

towards paperless committees?

Finally, at a personal level, I had my first on-line computer at work and within a day was convinced that e-mail was better than sliced bread.

All of these changes, however small, illustrate a big cultural change namely the recognition that information matters, with informatics skills being a core professional requirement.

As the year draws to a close, we should celebrate successes like these and not let them be overshadowed by concerns about problems

that may arise as we go from 1999 to 2000.

A happy and information-rich New Year to all.

**Rebecca Dunn**

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*'Learning to Manage Health Information – A Theme for Clinical Education'*, is available on the world wide web at <http://www.enablingpp.exec.nhs.uk>

\*Wyatt J. Meth. Inform. Med. 1996; 35:197-200

## President's column



**W**ith the President Elect, Cameron Swift, and Alan Sinclair, I led an intrepid band of fifty UK geriatricians to take part in the 2<sup>nd</sup> Franco-American Geriatric Meeting in Paris.

The meeting was held at the Palais des Congres at Porte Maillot from 1 to 3 September 1999. This second Transatlantic Meeting was redesignated as the Franco-American-British Meeting or FAB Meeting. The themes were on prevention and treatment in geriatrics. Six hundred delegates included a majority from France, 50 from the USA and 50 from the UK. There were also representatives from Germany, Ireland, Holland, Belgium, Spain, Romania, Switzerland, Hong Kong and New Zealand.

The programme was well balanced and comprised plenary sessions, parallel workshops and more than 100 poster representations. The British contributions were recognised to be of a very high standard and as an adjudicator I was very impressed by some of the posters.

The conference was dual language in French and English with translation headsets. The standard of translation was excellent apart from the odd anomaly. I finally realized that an octopus was someone over eighty years of age!

The social programme included a reception in the Paris City Hall and conference dinner in a rather elegant outdoor restaurant in the Bois de Boulogne. There was some suggestion that a 3<sup>rd</sup> Transatlantic Conference might take place in Paris in 2001. I would recommend this event to you.

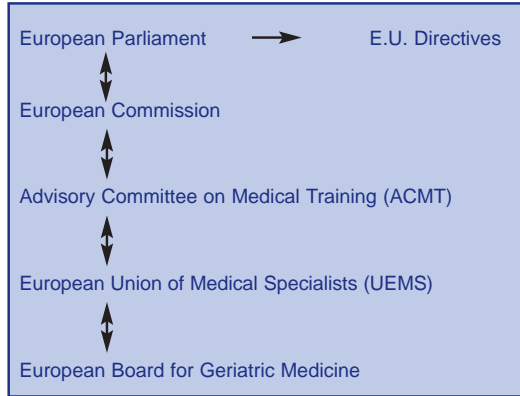
### European geriatric medicine initiatives

During the conference I co-chaired an ad hoc meeting of representatives of seven of the European Union countries and Switzerland. Geriatric medicine as a specialty has a variety of networks on the international scene and in Europe in particular. The two most prominent organisations are the European Union of Medical Specialists (UEMS, referring to its French title) (see below) and the International Association of Gerontology (IAG) European Regional Section on Geriatric Medicine.

The ACMT is the standing committee for medical advice on training and its deliberations

are informed by the Boards on Medical Specialties of which geriatric medicine is one.

The European Regional Section of the IAG has 33 constituent societies but probably only the BGS could be recognised as almost exclusively a clinical society. The majority of European Societies are multi-disciplinary and include social



and biological gerontologists. These groups in the UK affiliate to the IAG through the British Society of Gerontology (BSG) and the British Society for Research in Ageing (BSRA). There are other groups including the European Academy of Yuste Foundation Working Party which comprised a group of European and American

experts who produced a useful policy document on curricula for undergraduate and postgraduate training in geriatric medicine at a meeting in Spain in June of 1998, but the other groups are probably less representative of the European Union countries or indeed of wider Europe.

At the Paris ad hoc meeting there was a majority of geriatricians from Europe who shared some concern that there was no recognisable European Association for Geriatricians. Clearly the IAG European Region has a well developed regular Clinical Section meeting which commits itself to the presentation of clinical research in the medicine of old age but it would appear that clinical geriatric medical associations are unlikely to be permitted to affiliate to the IAG because they are not multidisciplinary i.e. more than clinical. It was agreed that the chairman of the UEMS specialty board on geriatric medicine would produce a discussion document on the way forward.

The institution of a new separate European Association for Geriatric Medicine would need a great deal of careful consideration on the part of geriatricians within the European Union or greater Europe.

**Brian Williams**

**Continued from page 1**

hospitalised. A more “acute” assessment and rehabilitation ward was opened at the Eastern General Hospital where other wards were converted to continuing care. By this time Jimmy Williamson had been joined by Tony Lowther - a formidable Glaswegian team carrying out “missionary” work in Edinburgh. In the 1970s, the consultant staffing increased to four with the recruitment of Anwar Akhtar, Gordon McAndrew and Sadie Walsh and the service had contracted, covering only north Edinburgh. Jimmy Williamson had left in 1973 to take up the chair of geriatric medicine in Liverpool, returning in 1976 to the first chair in Edinburgh based at the City Hospital. The appointments were accompanied by a major new building programme and by 1984 there was a medical day hospital and a total of 300 beds on the RVH site,

of which 180 were for geriatric medicine - acute assessment, rehabilitation and continuing care - and 120 for psychiatry of old age with 60 acute beds and 60 continuing care beds. A new day hospital for psychiatry of old age was also incorporated in the new building - 50 places.

In 1990 the Royal Victoria service became responsible for the new 15 bed assessment unit in the Western General Hospital. Patients were either discharged directly from the ward or transferred for on-going rehabilitation to the Royal Victoria Hospital. This was the beginning of a closer working relationship with the acute sector. Most of the consultants at the Royal Victoria now have designated liaison and responsibilities with medicine, surgery, urology, oncology and neurosciences. Recently, the number of acute medicine of the elderly beds on the Western General Hospital site increased and

the stroke rehabilitation ward moved from the Western General to the RVH. As with other smaller hospitals, the Eastern General was closed apart from the day hospital, OPD and some continuing care beds. In line with national changes the two continuing care wards for psychiatry of old age were also closed. This reduced the psychiatry beds to 47 beds - one ward for functional illness and one for organic illness.

In 1999 with the re-organisation of Trusts into one Acute and one Primary Care, the psychiatry of old age service was included in the PCT while the medicine of old age service remained in the Acute Trust (not without a considerable fight!). This division is to be regretted as for nearly 30 years there has been a very close relationship between the two services managed by one team.

### The present

All of the pioneers of geriatric medicine have now retired and been replaced by an increased number of younger (mostly!) consultants who, because of their varied interests, provide the wide spectrum of care required for the elderly population of North Edinburgh. There are now seven consultants covering the 52 acute and stroke beds at the Western General Hospital, 200 assessment and rehabilitation beds at the RVH (including dedicated stroke rehabilitation and orthopaedic rehabilitation wards), remaining



services at the Eastern General, 90 continuing care beds at Corstorphine Hospital and at Ferryfield House which is effectively an NHS nursing home. The consultants are as follows.

- ◆ **Dr Ann Capewell** (P/T senior lecturer)  
Major interest - continence
- ◆ **Dr Martin Dennis** (Reader stroke medicine)  
Major interest - stroke

- ◆ **Dr Andy Elder** (Hon senior lecturer)  
Major interest - cardiology
- ◆ **Dr Richard Lindley** (P/T senior lecturer)  
Major interest - stroke
- ◆ **Dr Elizabeth MacDonald** (Hon senior lecturer)  
Major interest - osteoporosis and falls
- ◆ **Dr Roger Smith** (Hon senior lecturer)  
Major interest - Parkinson's Disease
- ◆ **Dr John Starr** (P/T senior lecturer)  
Major interest - dementia

The expansion into acute medicine of the elderly has been balanced by greater community outreach. One such initiative, "Hands-On", provides additional input to vulnerable patients on discharge over the first few days to complement social services. This has reduced the number of quick re-admissions due to failure to cope or lack of confidence on returning to live alone. Another is the "First" project - flexible immediate response support team. This is a multi-disciplinary team available to visit at short notice elderly persons in their own home. The project was designed to prevent admission by input of medical, nursing, paramedical and/or social care for a short period of time. This has been operating for the past two seasons with winter bed money. More recently health and social services have funded a community rehabilitation team to allow early discharge with multi-disciplinary and social support available for up to five weeks.

### Teaching

The hospital is part of the University of Edinburgh Medical School geriatric medicine department. In Edinburgh all medical undergraduates receive four weeks full time of geriatric medicine within the final two years. There is an initial three day tutorial and visit programme for all and then students are sent to a number of units throughout the south of Scotland, of which the RVH is one. In addition, the RVH hosts first year Problem Based Learning Projects and the Introductory Clinical course for third years. The RVH also has a steady stream of elective students from overseas - Germany, Italy, Austria, Spain, USA and Australia.

### Research

The RVH has a long history of high quality research. Jimmy Williamson, in 1967, obtained funding for a five-year longitudinal research

programme with Dr Ian Milne as the research fellow. Normal elderly people were seen on three occasions during the five years and numerous papers were produced using this data. In 1974 Anwar Akhtar ran the first randomised controlled trial on a Stroke Unit. This work was highly proclaimed at the time but seemed to take an inordinate time before it was appreciated and replicated. (A man before his time!)

Current research reflects the interests of the consultants with well over £1 million of grants being held, mostly from research councils or other government bodies. In addition to the internationally acclaimed stroke unit, with its associated Cochrane Centre, a Centre for the Study of the Ageing Brain has been established with access to the latest molecular biological techniques and imaging resources such as



functional MRI. Much of the research, especially that relating to incontinence and cognitive impairment is community-based.

**The future**

With the new Trust structure we are joining with our colleagues on the south of Princes Street - the Academic Department, Royal Infirmary and Liberton Hospital. This gives us the opportunity to look at the best of each service and to provide the best possible service to the elderly people of Edinburgh. It also allows closer co-ordination of training, teaching and research. Geriatric medicine in Edinburgh has always been in the forefront of change and is likely to continue to do so with a bigger critical mass. Roll on 2000!

**Dr Roger Smith**

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# 1<sup>st</sup> Tripartite/ 2<sup>nd</sup> French-American Geriatrics Meeting

**T**he following is a report on this conference, which took place in Paris from 1 to 3 September 1999.

The principal drawback in accepting an invitation to write a report about a conference is that one has to attend the scientific sessions! This, however, was a conference with a difference, and I should not have been worried.

The original idea for the meeting arose following discussions between the British and American Geriatrics Societies, and increasing participation by UK geriatricians in AGS Annual Meetings.

The success of the 1st French-American Conference suggested that a tripartite meeting would be mutually advantageous, and so it proved to be. The organisers had invited leading experts from all three countries to present state of the art reviews in plenary and workshop sessions. In addition, there were over 100 posters displayed throughout the meeting.

**Topics discussed**

A wide range of subjects was covered including diabetes, stroke, respiratory disease, dementia, health policy, longevity, health promotion and nutrition - something for everyone. We all have our prejudices about how other countries manage common conditions of later life compared to ours. I am no exception. As usual, the similarities

rather than the differences were striking. In the first session on health policy, all of the speakers commented on the issues of separate policies and funding for health and social services. We may moan about postcode prescribing for donepezil or differences in NHS continuing care criteria between different health authorities. Yet we heard that France has different policies for each Département, Switzerland for each Canton and the United States for each State and insurer. It still amazes me how some speakers advocate their point of view with absolute conviction.

### Display of posters

There was a quite eclectic display of posters. One of the two prizes for the best poster (a trip to the American Geriatrics Society) went to Sinead O'Mahony of Cardiff (a member of the BGS Scientific Committee). I was particularly struck by one on nutritional issues which was displayed on a series of blue and white plates rather than laminated sheets of A4 paper. It may not have met the standards of our Scientific Committee; however, as they say in France, "vive la différence!"

### A grand welcome!

The conference arrangements were superb. The scientific sessions were held in the Palais des Congrès with many of the delegates staying in the adjacent Hôtel Concorde – La Fayette. I did wonder whether there was any significance in the choice of venue. Concord was, of course, the place where the American War of Independence



(or Revolution) started and La Fayette was the French nobleman who served as a Major-General in Washington's Army. However, this Franco-American collaboration could never have taken place without British involvement in the first place! The view over Paris from the 33rd floor bar was marvellous. There can't be many conferences where lunch includes as many

oysters as you can eat, and the dinner took place al fresco in one of the restaurants in the Bois de Boulogne. I will keep secret the list of UK geriatricians who went to Euro-Disney!



### Translation of sessions

The simultaneous translation worked well, except I found it difficult watching the speaker explain what was on the slide when the translator was still explaining what was on the previous one. Perhaps this could be overcome by making bilingual (or trilingual for American English) copies of the slides available to the delegates. As one of the speakers, it would be interesting to know how my presentation could be made more intelligible to those who had it translated into French.

### Continuing medical education

There seems to be a growing view that this type of meeting, focussing on continuing medical education rather than on the presentation of research findings, is an effective way of bringing the geriatricians of Europe together. If this conference is anything to go by then future meetings will be a great success.

### Thanks to organisers!

Finally, it is important to recognise that conferences don't just happen. They depend on people organising them. Congratulations, therefore to Alan Sinclair who recruited the UK speakers and to Michael Bia and his team from Mediaflash, who masterminded the organisation.

I look forward to the next one.

**Professor Peter Crome**

Report on

HAS 2000



The New Health Advisory Service establishes itself as a powerful player in health services evaluation and development.

**Background**

HAS 2000 is now just two and a half years old. The first year was spent in devising and refining the evidence based standards for the five work areas including health and social care of older people. During the latter part of that year the investigation into the care of older people commissioned by the Health Secretary (*‘Not because they are old’*) was carried out, completed in June 1998 and published in November 1998. As a direct result of that, the National Service Framework (NSF) for older people was announced one or two years earlier than had been planned, and is now undertaking its preliminary work with the involvement of a number of BGS members.

**The future of the organisation**

The second year (April 1998) started uncertainly with the effects of tapering funding starting to bite. At first the order books seemed a bit light but a number of factors have contributed to what now seems a more certain medium term future for the organisation:

1. HAS 2000 has been asked to assist with developing and validating the indicators for the acute care of older people within the NSF in a project based in the West Midlands probably during the autumn of 1999;
2. Following the pilot reviews in 1997, the Older Peoples’ programme is having sufficient demand for “paid reviews” to secure work for more than a year, and requests seem to be accelerating;
3. The other programmes in adult, child and adolescent mental health are also attracting steady work, as well as assisting the Government with

the methods and field work of enquiries into serious incidents, especially in relation to mental health.

**Demand for service reviews**

As the organisation moves into its third year the completion, publishing and launch of the standards and indicators for services has resulted in a rise in demand for service reviews. Indeed the demand for reviews has now out-stripped the internal capacity of the organisation and it is planned to appoint two new Specialist Development Advisors (SDAs). One will be for our programme so that the older peoples’ programme will have three SDAs and two Specialist Advisors to cover physical and mental health programmes for older adults. Another reason for optimism is the expectation that the newly formed Commission for Health Improvement will wish HAS to carry out some of its work. In its early deliberations it has taken a keen interest in the working methods of HAS 2000.

**Service development workshops**

The crucial aim of moving beyond the “old” HAS remit of finishing with a report, is now a reality. For example, having completed a review of a service in Yorkshire, the recommendations were accepted and as a result we will be running some “evidence based service development workshops” to assist with the implementation of our recommendations, and we shall retain an on-going relationship with that service. We hope this will be the pattern for the future.

I have been retained as one of four Specialist Advisors and thoroughly enjoy the work. In a future episode of the Newsletter, I will draw members’ attention to some of the strengths and weaknesses of geriatric services around the country, as the organisation draws together examples of good practice as well as common problems in service organisation and delivery.

**Dr Alistair Main**

# Royal College of Physicians, London

# Geriatrics Committee



**G**eriatricians are the largest group of physicians in the Royal College of Physicians, London since the paediatricians declared independence.

Representation of geriatric opinion, certainly in terms of policy, occurs either when geriatricians are elected to Council and/or through the College Geriatrics Committee. Currently there are three geriatricians on the Council of the Royal College of Physicians, London (Professor Peter Millard, Dr Martin Thomas and Dr Bim Bhowmick) and until very recently, Professor Oliver James was a Vice President of the College. Apart from Council the main body that advises the Royal College on geriatric matters is the Geriatrics Committee. However the following are some of the recent problems: the committee only met twice a year, so it was difficult to be responsive; half the members were not geriatricians but appointees from other bodies to act as liaison, (e.g. public health doctors and general physicians); the members of the committee have been directly appointed by the College and there was no requirement for the BGS to take on board the views of the College or vice versa.

### **Liaison between RCP and BGS**

Despite these challenges and with the aid of two extra emergency meetings, the college committee has tried to act as an effective interface between the Royal College and the BGS, particularly over the last year which has been crucial with much potential change affecting geriatricians. The joint Clinical Governance Working Group between the Royal College and the BGS under the chairmanship of Professor Cameron Swift, successfully developed a strategy for Clinical Governance accepted by the Council of both organisations. Further work will flow from this working group as Clinical Governance becomes increasingly

embedded in the culture of the Health Service. As part of the initial effort the RCP/BGS also agreed on *Improving Geriatric Services - Sources of Help*, a document which has been widely distributed around the Health Service to help trusts and PCGs deal with areas of concern in geriatric medicine.

The College Committee has worked closely with the BGS Manpower Committee, and in particular John Bendall, over the last year to ensure a consistent picture of manpower planning appears in all national documents. Recent publications such as *Organisation of Acute General Hospital Services* produced by the BMA and *Consultant Physicians Working For Patients* include BGS figures of one consultant per 4000 population over 75 or 1 consultant per 50,000 of the population. This should be seen as an absolute necessity for any department providing a “fully integrated” service.

The RCP Geriatrics Committee has also been extremely exercised about the lack of a Government response to the Royal Commission on Long Term Care. The results of their deliberation formed the basis for Professor Alberti's letter to Frank Dobson, which appeared in the July BGS Newsletter.

A continuing unresolved issue within the College is that ad hoc working parties may be set up at the request of the President or Council to report on any issue. Strangely, there is no current requirement that a document which might significantly affect the work of geriatricians has to be discussed with the College Geriatrics Committee, although committee members will usually be on the membership of any such working party.

### **Future documents**

Two current documents are shortly to come to fruition. The first has been a two-year working party on the interface between General Internal Medicine and Geriatric Medicine, now entitled *Comprehensive Management of the Older Medical*

*Patient -A Journey of Care*. This currently contains very helpful statements on training and man-power requirements in geriatric medicine. At present though it has not received Council approval but hopefully will appear at the end of the year. The second working party, chaired by Bim Bhowmick, is on medical care in nursing homes. This will be in the form of a discussion document and has involved several members of the BGS Special Interest Group in Care-Home Medicine. This document will probably be published to coincide with a conference at the Royal College of Physicians on 27 January 2000.

As mentioned in last month's Newsletter, The Royal College is now reviewing the way it works and there is an understanding that the Geriatrics Committee cannot work in isolation from the British Geriatrics Society. At least we have only one main professional society, others such as the diabetologists have considerably greater problems. Hopefully, we are now close to finalising the future arrangements of such a joint committee which, I have no doubt, will give considerable greater influence to the British Geriatrics Society on geriatric matters within the College.

Dr David A Black

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## New health partnership arrangements - opportunities and threats



**T**he Health Act 1999 comes into force in April 2000. It includes powers available to local authorities, health authorities, NHS trusts and primary care trusts to develop new ways of working in partnership.

These arrangements are as originally proposed in the discussion document *'Partnership in Action'* (Department of Health 1998) to which the BGS gave a generally warm welcome.

They are now clarified in Health Act Partnership Arrangements regulations which will be put before Parliament fairly soon.

Departmental guidance will also be issued explaining the processes of setting up and running the new partnership arrangements, and describing the evaluation process to be carried out by the Department of Health, the application process and guidance on information sharing.

The new powers will enable:

- ◆ Pooled budgets and resources
- ◆ Lead commissioning
- ◆ Integrated provision

The partnership arrangements are designed to enable better joint working in practice at a local level, necessary to fulfil a number of the strategic purposes of recent government legislation and guidance. This includes *'Better Services for Vulnerable People'*, *'Modernising Social Services'* and the recent health promotion paper *'Saving Life: Our Healthier Nation'*.

### The Partners

This legislation does not alter the statutory duties of either the NHS or local authorities but does enable them to work together in new ways when there is a health component to the provision. Thus the partners might include education departments, housing departments, private and voluntary organisations as well as the main players who are likely to be local authority social service departments working with either primary care trusts or health authorities. An important safeguard is that the main NHS service provider must be a co-signatory to any partnership arrangements where the work of the partnership encompasses the provision of health services.

### **Pooled Funds**

This is about partners creating a ring-fenced fund to provide one or more services for a specified client group. Regardless of what share the NHS bodies or local authorities commit to the pool, the pooled fund loses its health or local authority identity and is used on the agreed services as set out in the partnership arrangements. This is intended to result in expenditure being based on the needs of individual users and not on the level of contribution from each department. Whereas both the expenditure by each partner and the overall expenditure of the pooled fund will be audited, there will be no effort to track specific sums of money through from the partner to the individual user.

The sort of thing this could be used for is to develop a single team providing assessment, rehabilitation and personal care as part of a rapid response team to avoid hospital admission. In circumstances when a means tested contribution would generally be paid by the recipient when it is provided by a local authority, it may still be paid for even if managed as part of a pooled fund, although the DoH guidance suggests the cost of managing that process may not always be worthwhile.

One of the partners will host the pooled fund and appoint a pooled fund manager who will then allocate the resources according to the objectives set out in the Partnership, and will be accountable to a Partnership board, not to the host partner.

### **Lead commissioning**

This is about one agency taking on the function of commissioning for services on behalf of others. Only local authorities, health authorities and primary care trusts are commissioners. In this arrangement one of the partners will be assigned the role of commissioning NHS or health related local authority services. This will not however alter the statutory responsibilities of the other partners in respect of their individual service. Lead commissioning is an extension of joint commissioning which many authorities have already used in learning disabilities, mental health, equipment etc. Where the NHS delegates funding under the provisions of lead commissioning, such NHS funding is restricted to commissioning NHS functions.

### **Integrated provision**

This will allow different workers, including different professionals, to work within one management structure with the intention of providing “a seamless service for the user”. The guidance suggests that it may be possible for one member of staff to perform several tasks and there is general a implication towards the greater use of generic multi-skills (or deskilled?) workers. It is perhaps in this area that we might have most concern about potential “dumbing down” of specialist services for older people.

### **Practical Issues**

The guidance covers consultation, governance arrangements, performance management, inspection, handling complaints, sharing information, financial management, work force issues, eligibility criteria, assessments, exit strategies and evaluation.

Perhaps the most important of these issues is to do with governance. Clinical governance gets three paragraphs in the guidance. It will be a requirement that an identified clinician has clinical governance responsibility for any individuals working within these new arrangements. There is a concern however. The application process requires that the partners are happy that clinical governance arrangements are satisfactory. In our response to the consultation process, we have suggested that the lead clinical governance individual be identified in the application, and that person be required to confirm that the proposed new working arrangements do not jeopardise clinical governance. Concern could arise as follows. A doctor may be appointed to join an integrated provision providing a range of health and social care to residents of nursing homes. There is nothing in the guidance that would guarantee that the clinical governance arrangements for such an individual would be clearly tied in either with primary healthcare or a specialist department of geriatric medicine. Thus the element of peer support and review needs emphasising.

### **Comprehensive Services**

Another concern is that whereas it may be possible to provide a series of integrated provisions for particular aspects of a service, the comprehensiveness and total integration of service may well be disrupted by these arrangements. The reassurance in the Act and the guidance is that

all these new partnership arrangements must relate to issues included in the Health Improvement Programmes, generated locally between the health and local authorities. Thus the intention is that they would be part of a strategic development of joint working. This would be more reassuring for us if there was evidence up and down the country of geriatricians being closely involved in the development of these programmes.

**Evaluation**

The guidance suggests that there will be a Department of Health led evaluation of a random sample of the new Partnership arrangements. The details are not clear but the implication is that they will be seeking identified processes which have worked satisfactorily according to the judgements of the local partners. It is unlikely that there will be an evaluation of the effectiveness or efficiency of the service itself or that there will be any analysis of the impact of the Partnership arrangements on overall comprehensive services. Unfortunately in this guidance, as has become the Department’s habit, several

examples have been cited of what they describe as “good practice”. This is not based on any evidence but rather on these enthusiastic local anecdotes. In our consultation we suggested that they finance and support more adequate evaluation than this and desist from mistaking enthusiasm for evidence.

**Summary**

These Partnership arrangements provide a real opportunity for taking forward joint working in a way that creates opportunities for us to develop services and also, perhaps using Clinical Governance requirements, to establish or strengthen the role of specialist practice in intermediate care settings. However it also has the possibility of health activities with older people being switched to local authorities or voluntary organisations without adequate reference to specialist expertise or to the comprehensive nature of service provision.

**Dr Finbarr Martin**  
**Chairman, Policy Committee**



**THANK YOU!**

We would like to acknowledge with heartfelt thanks, the extraordinary generosity of the following members who have covenanted or gift-aided donations to the Premises Fund:

Dr Ann Capewell (Edinburgh), Dr A Ahmad (Cumbria), Dr Robert Barker (Southampton), Prof Peter Crome (Keele), Dr Ian Sturgess (Canterbury), Dr Alan Whitley (Wakefield).

We are also indebted to the Mersey Region for the flair with which they produced a cheque for £3,000 at the Annual General Meeting!

The Fund currently stands at £317,000 with a further £1,790 having been donated or pledged by members.

# Meet the New Committee Members



The following are new members of BGS committees, representatives of the BGS on outside bodies or officers of the Society.

## COUNCIL

**Dr Hugo Powell** is currently a consultant at The Royal Surrey



County Hospital and Lead Clinician in geriatric medicine for his Trust. Dr Powell has a special interest in neurological disease and cardiology in the elderly.

**Dr Peter Gorman** is a consultant at Derbyshire Royal Infirmary and has been Honorary Treasurer, Honorary Secretary and currently Chairman of the Trent BGS region.



**Dr Jennifer Hanslip** is a consultant at Dundee Hospital and Honorary Senior Lecturer at the University of Dundee.

**Dr Joe McElroy** has been a consultant geriatrician at



Altnagelvin Area Hospital since 1982. His main clinical interest is concepts of frailty in elderly.

**Dr Ganapathyagraharam Sridharan**, a consultant at the Royal Oldham Hospital, has previously spent three years as honorary secretary of the BGS North Western Region



**Dr Richard Prescott** is a consultant at Bishop Auckland General Hospital and a Fellow of the Royal College of Physicians, London.

## HONORARY DEPUTY TREASURER

**Dr Ian Sturgess** is a consultant based at Nunnery Fields Hospital in Canterbury, and is already well known to Society members, having previously served as an extremely enthusiastic and successful Meetings Secretary.



## FINANCE COMMITTEE

**Dr Andrew Elder** is a consultant based at the Western General and Royal Victoria Hospitals in Edinburgh and also Honorary Senior Lecturer in Geriatric Medicine at the University of Edinburgh. He was Treasurer of the organising committee for the 1998 BGS meeting in Edinburgh.

Council have also nominated **Dr Sheilagh Baillie** and **Dr Tom Smith** to the Finance Committee, subject to ratification at the December EGM.

## RELATIVES ASSOCIATION

Dr Tony Luxton has kindly volunteered to represent the Society on the Relatives Association, a new link for the BGS.

## TRAINING COMMITTEE

Dr Nicki Colledge was nominated by the BGS National Training Committee to succeed Dr Ronnie Barber after the Committee's meeting in December.

**SCIENTIFIC COMMITTEE**

**Professor Robert Stout** will serve as Chairman of the committee. He is President of the Ulster Medical Society, Dean of the Faculty of Medicine & Health Sciences and Head of the School of Medicine at Queen's University. Professor Stout currently chairs the Editorial Board of the *Age & Ageing* journal and was heavily involved in work on the Royal Commission on Long-Term Care.



**Dr John Pounsford** is a consultant and the Clinical Director of medicine at Frenchay Hospital in Bristol. He has a long-standing research interest in respiratory disease, has published widely on the subject and also founded the BGS Respiratory SIG.

**Dr Martin Connolly** is Senior Lecturer in Medicine and Geriatrics at the University of Manchester and Honorary Consultant Physician at Manchester Royal Infirmary where he runs the stroke and respiratory rehabilitation services for the elderly. His research interests centre around respiratory disease. Be warned he holds a purple belt in karate!

**POLICY COMMITTEE**

**Dr Pradeep Khanna** is consultant and lead clinician for the integrated Adult Medicine Services at Nevill Hall and District



NHS Trust in Abergavenny. Dr Khanna has been a BGS Council representative and Secretary for the BGS Welsh branch.

**Dr Stuart Bruce** is a consultant and has previously been clinical director of medical and elderly services at the Conquest Hospital in Hastings. Dr Bruce is currently Honorary Secretary of the BGS Gastro-Enterology/Nutrition SIG.



**Dr Gillian Turner** is a consultant at Southampton University Hospital and currently Clinical Services Director and Chair of the Clinical Effectiveness Group for her Trust.

**PRE-RETIREMENT ASSOCIATION**

**Dr Peter Overstall** is a consultant at Hereford General Hospital and has previously been on the BGS Policy Committee and BGS representative on the Liaison Committee with the Old Age Psychiatrists. Dr Overstall continues as one of the "midwife" committee members of the newly formed SIG on cerebral ageing and is the BGS representative on the Parkinson's Disease Research Group.



**HONORARY DEPUTY SECRETARY**

**Dr Chandhi Vellodi** is a consultant at Barnet General Hospital. She has previously been lead clinician for the elderly, Chairman of the Medical Staff Committee and Medical Director for Barnet Healthcare Trust as well as regional specialty adviser.



**HOSPITAL ACCREDITATION BOARD**

**Dr Gill Jenner** is a consultant and medical director at Basildon and Thurrock General Hospitals NHS Trust. Dr Jenner played a key role in preparing her Trust for its success in achieving full King's Fund Accreditation and is now involved in the work for further accreditation.



**EXECUTIVE COMMITTEE**

England appointed Dr R R Lewis and Northern Ireland Dr P Gawley to be their respective representatives on the Executive Committee.

**BGS/RCPSYCH LIAISON**

**Dr John Bendall** is a consultant at Queen's Medical Centre in Nottingham. He is chairman of the BGS Manpower Subcommittee and is regional "Father Figure" for the Trent Region. He has a particular interest in psychiatry.

Five pages of reports from

# Special Interest Groups



## CARDIOLOGY SIG INAUGURAL MEETING

The inaugural training meeting of the Special Interest Group in Cardiology, held at The Belfry on 24 and 25 September 1999, was attended by almost 90 participants. The theme of the meeting was the Heart-Head Axis and it was sponsored by an educational grant from Napp Pharmaceuticals.

After lunch on Friday afternoon a session on isolated systolic hypertension was chaired by Professor Rose Anne Kenny, Newcastle. Two excellent presentations from Professor Chris Bulpit, Hammersmith Hospital, and Professor John Potter, Leicester, covered cognitive dysfunction in isolated systolic hypertension and the new British hypertension guidelines in relation to treatment of isolated systolic hypertension.

A Society dinner on Friday evening was much enjoyed by all and this was followed on Saturday morning by two sessions on atrial fibrillation. The first session covered cognitive function in atrial fibrillation and implications for intervention and service provision. Four speakers gave excellent lectures on the topics; they included Professor Richard Thomson, Newcastle, Dr Janice O'Connell, Sunderland, Dr Howard Marshall, Birmingham and Dr Cliff Garrett, Manchester. The session was chaired by Professor Chris Gray, Sunderland.

A business meeting on Friday evening formally elected the standing committee: Professor Rose Anne Kenny, chairman, Dr Anthony Martin, vice-chairman, Dr Shona McIntosh, secretary, Dr Christopher Byatt,

treasurer. These will hold office for two years. A peer review committee was also elected to:

- 1) supervise awards for travel fellowships and
- 2) select abstracts for presentation at future society meetings.

The next meeting, joint with the British Heart Failure Society (BHFS), will be at the Autumn BGS and will involve a debate by two eminent members of the BHFS on appropriate intervention strategies for heart failure in the elderly.

The membership of the Special Interest Group is 400 to date and growing!

**Professor Rose Anne Kenny**

## CARE HOME MEDICINE SIG - "MODELS OF CARE" SYMPOSIUM

A whole day symposium on Models of Care was held in Cambridge on 4 October. The aim was to familiarise delegates with the range of services which provide specialist health care for older people in care homes and training for care home staff in and around Cambridge. The concept of the Teaching Nursing Home was also described.

### Enhanced Community Health Service

The meeting began with words of welcome from Richard Taylor, Chief Executive of Lifespan Healthcare NHS Trust which hosted the event. Tony Luxton, who organised the meeting, then introduced the programme and described his post which

is made up of seven sessions with the community trust and four at Addenbrooke's hospital, and how his work fitted with his five Addenbrooke's-based colleagues who also have some community sessions. His duties include work with inpatients, outpatients and many management and educational meetings. His post complements a range of other appointments of community based therapists and specialist nurses to form the Enhanced Community Health Service (ECHS).

### Health Authority investment

The ECHS formed as result of the health authority reinvestment of about £1.3 million released following the closure of 120 continuing care beds.

This released about £5 million, the bulk of which was used to fund acute services. The authority intended that this new service would compensate for the loss of beds and satisfy general practitioners that they would not be left with the sole responsibility of providing services for the relocated patients. Besides providing care, ECHS members were expected to provide training to care home staff so they could carry out what were seen as basic or general care after advice from specialist members of staff. The general aim is of "enablement" - that users of services are encouraged to exercise choice in their care and staff become equipped with additional skills to improve standards.

**Range of staff**

The range of staff comprised additional community nurses, physiotherapists, occupational therapists, podiatrists, dietitians, speech and language therapists, specialist nurses for continence, Parkinson's Disease, tissue viability and diabetes, and a geriatrician.

Delegates heard from several members of staff about the general principles of their work and how the physiotherapists in particular had to combat preconceptions about their role - initially seen as mere providers of walking frames for poor mobility. Particular recurring problems surrounded the issue of training because staff turnover in some care homes was so high that skills were lost and training sessions had to be repeated. Another problem was that care home staff were sometimes too busy to attend so that training events were either abandoned or were attended by too few to make the event worthwhile. ECHS staff also told of their methods of evaluating their work and the results of training sessions with before and after questionnaires.

The role of the Parkinson's Disease specialist nurse was described by Dr Forsyth. She acted as a resource available to advise patients, relatives and care home staff as well helping in the clinic and seeking out patients who had been admitted to hospital or to care homes.

Two nursing home managers gave their view of the service, describing

how in the early stages they felt like passive recipients and later became more actively involved with the training events to achieve more convergence of the aims of the ECHS and that of the home. It became apparent to everyone that the whole-hearted support of the nursing home manager and senior staff was essential for the success of ECHS.

A local GP then gave his views of the difficulties involved in providing general medical services to nursing home residents, the lack of an expert medical assessment before admission, poor transfer of information and the sheer sense of overload resulting from trying to look after 60 residents. He was generally complimentary about ECHS and recognised that staff accepted referrals from each other, from users, informal carers and home staff; that much work went on in the background without the need for the GP to make separate referrals. The potential disadvantage was that he was not always aware of the activities of ECHS staff. The message was that he would like to have been more involved but that there was not enough time for full liaison to take place.

The health authority principal registration manager then gave a presentation linking the Homes Registration Act 1984 which governs her work, with standards of care and briefly discussed the consultation document *'Fit for the Future'* (this consultation document requires

comment by 3 December)

**Teaching nursing homes**

Finally, Dr Clive Bowman drew on his great experience to describe the Teaching Nursing Home concept which started in the USA with an example being developed in Rochdale under the auspices of BUPA. Such homes can provide teaching and training for nurses, therapists and even medical students. Such training might have advantages because individuals reside in nursing homes for comparatively long periods so that students would not only get to know their patients but would better appreciate the change in disease over time. This contrasts vividly with the situation for hospital lengths of stay which are in low single figure days, depriving students of the chance to study illness, recovery and the patients' and relatives' reaction over time.

The two models of care may be complimentary and there may be room for both, perhaps one teaching nursing home per region with a network of specialist staff providing systematic support to care homes in general.

The Care Home Medicine committee provisionally intend to meet on Friday 14 January 2000 to further develop their work.

I wish to thank all my colleagues who contributed to this successful event.

**Dr Tony Luxton**

**RE-ENGINEERING CARE FOR OLDER PEOPLE - CONFERENCE REPORT**

Laing & Buisson hosted a conference in London on 14 September that explored innovations in integrated approaches for improving the health and care of older people.

David Raw, a well known recently retired member of the social services

inspectorate, gave an informed personal view of the emerging agenda for older people. In particular he outlined the opportunities in rehabilitation, interventions that prevent emergency admissions, services for confused elderly people and the need for tracking patients through the sys-

tems of care using tools such as the minimum data set. The development of housing with care as an alternative to residential questioned the fundamental need for residential care at all. The length of stay in care homes is falling but David drew attention to the fact that since 1994 the number

of beds had increased by 11% and that a third of nursing home and a half of residential care home residents still resided for more than three years in care. Furthermore the proportion of patients continuing to receive "preserved rights" in 1996-7 exceeded expectations by about 10%. The misguided expense of an inappropriate admittance to institutional care was emphasised using Peter Millard's nursing home data, revealing that post admission some 33% of residents show improvement and 17% no longer needed care in this setting. The audience was then reminded that three years of nursing home care cost £51,000.

#### Change of systems

Janice Robinson, director of the Kings Fund Community Care Programme, elegantly argued the need for systems to change, in particular that the dominance of long-term and acute hospital care needed to be reduced with a new emphasis on rehabilitation and preventative care. Principles for change had to encompass review, commissioning and provision and needed to involve all sectors.

#### Successful initiatives

The conference provided an opportunity to hear about several successful initiatives: the Rapid Response Integrated Care System developed in the Bournwood Trust (Bev Castleton), the North Devon Reablement Project (Jean Dodds) and the Elderly Persons Integrated Care Service (EPICS) from South Buckinghamshire (Chris Foote). Dr Jonathan Berry from Trafford gave an upbeat perspective as the chair of an ambitious primary care group, engaging with elderly people in the shaping of service development.

An air of realism regarding the unlikely release of new monies and consequent need to recycle money presently committed to acute hospitals and long-term care was emphasised. This point that had been practically demonstrated by Beverly Castleton, staff shortages and consequent ward closure had led to the development of an innovative rapid response integrated care model. Pauline Ford and Brendan McCormack from the RCN championed the emergence of the gerontological nurse specialist and the need for individual care needs assessment, planning and

provision. Finally Catherine Elcoat and Peter Grime from Birmingham spoke enthusiastically on whole systems and intermediate care.

#### Emerging themes

- 1) New systems need to have planned and measured goals
- 2) Innovations should not become substitutes until confidence in their reliability is established
- 3) Managing demand is fundamental and the further upstream services are developed (particularly preventative and chronic disease management systems in the community), the less the flooding downstream in acute units.
- 4) Population approaches are necessary to yield the capacity to provide individual solutions.
- 5) The lack of clarity of what constitutes free healthcare and means tested personal care blights much innovation. Whilst blurring of services is desirable the funding issue just stops confident development.

The dust could be rising from Geriatric Medicine!

**Dr Clive Bowman &  
Dr Beverly Castleton**

## INAUGURAL MEETING OF CEREBRAL AGEING AND MENTAL HEALTH SIG

This SIG is a development of the Joint Liaison Committee of the BGS and the Royal College of Psychiatrists' Faculty of Old Age Psychiatry. The new SIG hopes to attract more members and grow into a significant force in the field of mental health for older people.

The inaugural meeting of this joint SIG promoting the interests of older people with mental health problems, held at the Stakis Metropole Hotel in Birmingham on 22 September, was met with enthusiastic support by attending geriatricians and old age psychiatrists.

Guest lectures were given by Prof Lawrence Whalley from Aberdeen and Prof Alastair MacDonald from Guys, Kings and St. Thomas'. Plenary workshops discussed the future role of the SIG with respect to links with PCGs, R&D, and education and training.

#### Membership

Anyone with a research interest into cerebral ageing or interested in contributing to improving the care of older people with dementia and depression is invited to join the SIG. There is currently no subscription fee. Health professionals, including hos-

pital and community based doctors and nurses, as well as those working for social services and voluntary agencies would also be welcome as members of the SIG. As chairman of the Joint Liaison Committee, I will help oversee the transition to a fully fledged SIG.

#### Aims

The focus of this SIG will be to forge closer links between those working in the field of old age psychiatry and those caring for the physical wellbeing of older people, both in hospitals and the community. By providing a forum for discussion the SIG hopes to

generate interest in research in the area and to develop care programmes that will make a difference to the way patients' needs are met.

"There is currently no estimate of the number of inpatients whose psychiatric needs are not being met", said Professor Alastair MacDonald, Professor of Old Age Psychiatry at Guy's, King's and St Thomas' Schools of Medicine in London. But there is a significant group of patients who "fall through the net" and who require both psychiatric and medical care, but who receive only one form of intervention, or in some cases neither.

The SIG hopes to develop strategies for seamless care so that the physical and mental health care needs of older people are picked up

and acted upon at the earliest opportunity. The SIG also aims to advise on education and training for health professionals.

"We are at a turning point both in a policy context - the National Service Framework for older people is due out in Spring 2000 as is the Carers Strategy and HIMPs - and in the context of scientific and clinical advances, such as the arrival of the antedementia drugs," summarised Dr Tom Dening, consultant old age psychiatrist in Cambridge and Department of Health adviser, at the end of the day's discussions. "It is very useful to have an opportunity to meet people and set things out in an organised way."

The flavour of the inaugural meeting was described as one of "active participation" by Dr Linda Brown, con-

sultant old age psychiatrist at Bootham Park Hospital in York - a theme she hoped would continue at the next meeting of the group to be held in April 2000, proximate to the BGS Spring meeting. An Autumn meeting is also planned at which committee members of the SIG will be elected.

The inaugural meeting was sponsored by an educational grant from Novartis Pharmaceuticals UK Ltd.

Anyone interested in joining the Cerebral Ageing and Mental Health SIG should contact Tia Snell at The Workhouse, Bridge House, Heron Square, Richmond, TW9 1EN. Tel: 0181 948 8388.

Email: [tiasnell@workhouse.co.uk](mailto:tiasnell@workhouse.co.uk).

**Dr Duncan Forsyth**

## RESPIRATORY SYMPOSIUM

The Annual General Meeting of the Respiratory SIG took place at the Royal College of Physicians, London on 6 October. Dr Pounsford updated members on a number of research projects that are currently ongoing and being developed by the section. There are two or three projects under development and hopefully they will be submitted with grant proposals in the near future.

Dr John Pounsford, Chairman, and Dr Charlie Teale, Treasurer, resigned, having been in post for the maximum period allowed by statute. Dr Martin Connolly was elected Chairman, and Dr Subir Mukherjee was elected Secretary. There were two proposals

for the post of Treasurer. Election to the post will be determined by postal ballot.

The next meeting of the section will be determined by the new Chairman, but there is a respiratory satellite symposium before the BGS winter meeting on Wednesday 15 December. This will be chaired by Martin Connolly and there will be papers by Dr John Pounsford on bronchodilator therapy in the elderly, Dr Mark Woodhead on pneumonia in the elderly and Dr Wisia Wedzicha on outcome measures in COPD.

The section's AGM was followed by a respiratory symposium on asthma

which formed part of the education programme for members of BGS Council. The meeting was well attended and there were two excellent presentations by Dr Chris Corrigan, Senior Lecturer in Respiratory Medicine at King's College Hospital on cellular mechanisms in asthma, and Dr Subir Mukherjee on inhaler therapy in the elderly. Both presentations were followed by a lively discussion on various aspects of asthma management in the elderly.

The meeting was supported by Glaxo Wellcome Pharmaceuticals.

**Dr John Pounsford**

## FALLS GUIDELINES

A UK/USA Falls Guidelines Task Force has been set up by the AGS and endorsed by the BGS. The task force will develop guidelines for use in older patients with falls. Participants

in the task force panel include members from all appropriate professional bodies in the UK or USA. The chairpersons are Dr Laurence Rubenstein of UCLA and

Prof Rose Anne Kenny of Newcastle.

**Continued on page 24**

## LAUNCH OF HEALTH SERVICES RESEARCH SIG

Over 100 people attended the launch conference of the BGS Special Interest Group in Health Services Research at the University of Leicester on 8 October. The conference was jointly run with the Trent Region and co-hosted with the Trent Institute for Health Services Research (Universities of Nottingham, Sheffield and Leicester Medical Schools).

The presenters reflected the wealth of local expertise in Leicester, Nottingham, Derby & Sheffield. Attendees included doctors in geriatric medicine, rehabilitation, public health and primary care (overall accounting for about 50%), along with social gerontologists, epidemiologists, nurses, therapists, psychologists and others. The academic weight was evident with eight professors in attendance.

The programme consisted of platform presentations on three themes: older people in the community, assessment and long term care, augmented by 15 posters. The meeting was introduced by Prof Clair Chilvers, Trent Regional Director of Research and Development, a cancer epidemiologist from the University of Nottingham. She drew attention to the relative exclusion of older people in the evidence base guiding both clinical practice and health technology assessment.

Three presentations drew on the wealth of data generated by the series of epidemiological studies of the older population of Melton Mowbray, a town of 30,000, all registered with one group practice and representative of the age and gender distribution of England and Wales. This important work stretches over 20 years and has been led by Carol Jagger and Michael Clarke from the University of Leicester's Department of Epidemiology and Public Health. The work included the development of a risk assessment tool to predict

hip fractures. From an enormous variety of putative measures, seven items (not including measures of bone density) identified the one third of the population of older women in whom 80% of the fractures would occur in the next three years. All of these items such as walking speed, cognitive impairment and hand grip strength could potentially be incorporated into routine screening in a primary care setting.

Professor Tony Warnes (Sheffield Institute for Studies in Ageing, SISA) gave an interesting review of the projects in Nottingham, Sheffield and Boston (Lincolnshire) which have developed to meet the needs of homeless older people. He also discussed the extent to which government initiatives help or hinder.

### Assessment

Pam Enderby (Professor of Community Rehabilitation in Sheffield and a speech & language therapist by background) opened the session on assessment. She reviewed the development of a new tool: the Therapy Outcome Measure. This scores grades of impairment, activity (previously known as disability), participation (handicap) and well-being and is designed to be incorporated into the routine practice of rehabilitation teams to describe individual patients, to set rehabilitation goals and monitor outcomes. It has now been tested on 20,000 patients in 17 trusts. Interesting findings are emerging. There is massive variation between trusts and also between therapists in the scores obtained by patients considered suitable for starting rehabilitation, scores at the time that patients are discharged from rehabilitation and also in the type of therapies offered to apparently similar patients. This work looks promising for the difficult but vital task of goal setting in clinical rehabilitation, as well as in unpacking the battered but elusive black box.

Peggy Newton from the University of Sheffield's Department of General Practice and Primary Health Care described a feasibility study to introduce standardised multi-dimensional assessment of older people into routine screening practice in primary care. This is part of a European collaborative project led by Prof Ian Philp. The preferred tool, EASY-CARE, proved widely acceptable in practice and generally reduced the time needed for nurses to do their screening, compared with the routine over-75 check.

The SF-36 has been proposed as a useful tool for "quality of life" in older people. Stuart Parker from Leicester's Division of Geriatric Medicine, presented data demonstrating that, in a purposive sample of older patients, many of whom had significant disability, only 50% could complete the questionnaire. The more disabled were less likely to complete. Although the tool may be useful for population screening, it seems less suitable in its present form as an outcome measure for clinical studies.

### The importance of dignity

The keynote address was given by Vera Ivers, a member of the External Reference Group supporting the Department of Health's National Service Framework for Older People. She spoke eloquently about the absolute necessity of putting dignity and autonomy at the centre of the standard setting for services for older people, and urged the NHS to adopt a policy of zero tolerance of health services or practitioners who undermine the dignity of older patients.

### Long-term care

The first presentation in the long-term care session gave an overview of the Leicestershire-wide surveys of older people in residential or nursing home care, the first of which was conducted in 1977. Recent work

showed that residents are now on average more physically disabled, more cognitively impaired and more likely to be incontinent than were residents in 1990. There was no significant change in the rates of being in long-term care. The meaning of these changes is uncertain. Does it suggest that this care is being used more appropriately for those in need or does it mean that the quality of care itself has deteriorated and caused an increase in dependency? Clearly further work is needed.

Dr Kevin McKae, a psychologist, presented an interesting investigation of the determinants of wellbeing, including friendship and nursing home layout, among residents of residential care. The final presentation

was from Dr Catherine Sackley, a physiotherapist from Nottingham. Her survey of the availability and use of therapists by nursing homes in Nottingham revealed the paucity of general use despite the apparent need, and that many of the practitioners were not qualified and had no specialised training for the work being undertaken. Clearly in terms of access to adequate quality health-care, residents of long-term care settings are at the bottom of the pile.

The posters added further evidence of the interesting multidisciplinary collaborations currently going on in Trent. Overall, this was a highly successful launch conference - interesting, informative, friendly and optimistic. It was also a great opportunity

for sharing ideas, picking brains, and hopefully has fostered new partnerships. Congratulations to Stuart Parker and colleagues in Leicester for organising it and good luck to John Young (Treasurer) and Ian Philp (Chairman) in leading the steering group of the SIG.

For information on the SIG, contact: Dr S G Parker, University of Leicester, Division of Medicine for the Elderly, Leicester General Hospital, Gwendolen Road, Leicester, LE5 4PW. Tel: 0116 2584081. Email: [sgp5@leicester.ac.uk](mailto:sgp5@leicester.ac.uk) <http://mailbase.ac.uk/lists/bgs-hsr-group> or <http://mailbase.ac.uk/cgi-bin/files/bgs-hsr-group>

Dr Finbarr Martin

## COMMITTEE ATTENDANCE LISTS

Following in the steps of open government and pursuant to requests from the Regions, we will regularly publish details of the attendance of members of the Society's Council of Management and Committees. Other specialist associations already follow this procedure.

### Policy Committee 9 September

**Present:** Dr F Martin, Dr G Halstead, Dr T Hendra, Dr P Knight, Dr D Lubel, Dr P Murdoch, Dr J Playfer, Dr A Ritch, Prof C Swift  
**Apologies:** Dr P Overstall, Dr B Williams

### Finance Committee 9 September

**Present:** Dr J Potter, Dr M Gosney, Dr T Luxton, Dr R Shepherd, Dr I Sturgess, Dr C Turnbull  
**Apologies:** Dr N Beckett, Dr R Dunn, Dr B Williams

### Executive Committee 23 September

**Present:** Dr R Dunn, Dr M Gosney, Dr D Lubel, Dr F Martin, Dr M Roberts, Dr R Shepherd, Prof C Swift, Dr B Williams  
**Apologies:** Dr R Barber, Prof M Castleden, Dr P Flanagan, Dr A Main, Dr J Potter, Prof K Woodhouse

### Scientific Committee 21 October

**Present:** Dr I Carpenter, Dr M Connolly, Dr J Gladman, Dr M Gosney, Prof S Jackson, Prof G

Mulley, Dr S O'Mahony, Dr S Parry, Dr J Pounsford, Dr H Rodgers, Prof G Seymour, Prof C Swift, Dr B Williams.

**Apologies:** Prof M Castleden, Prof R Stout

### Council 7 October

**Present:** Dr B Williams, Dr D Ames, Dr R Barber, Dr P Belfield, Dr G Bhan, Dr C Borland, Prof M Castleden, Dr J Close, Dr D Forsyth, Dr P Gawley, Dr M Goodman, Dr M Gosney, Dr J Graham, Dr J Hanslip, Dr A Lehmann, Dr D Lubel, Dr G MacPhee, Dr F Martin, Dr E MacDonald (substituting for Dr N Colledge), Dr J Potter, Dr S Samadian, Dr R Shepherd, Dr G Simpson, Dr T Smith, Dr A Starczewski, Dr I Starke, Prof C Swift, Dr C Vellodi, Dr W Wilkins

**Apologies:** Dr P Carr, Dr N Colledge, Dr R Dunn, Dr P Flanagan, Dr J Gadsby, Dr N Gunasekera, Dr D Howard, Dr R Lewis, Dr S Parry, Dr R Prescott, Dr M Roberts, Dr G Tobin, Prof K Woodhouse

## “UNDERSTANDING AND RUNNING A COMPREHENSIVE GERIATRIC SERVICE” A CONFERENCE FOR SENIOR SPECIALIST REGISTRARS

About a year ago it occurred to me that there was cause for concern about some aspects of SpR training in geriatric medicine, bearing in mind the demands of accreditation since ‘Calman’ training became established. What are these ‘Causes for Concern’?

In some areas of the country, the training of registrars (and in many cases the balance of the local service) has become dominated by acute medicine to the detriment of the bedrock of geriatrics, of rehabilitation and long-stay care (not to mention community aspects). Registrars under Calman are being recruited into the specialty much earlier in their careers than hitherto. Rotations have become more rigid (often because of the demands of acute medicine) and trainees now seem to have less opportunity to take time to see other services and how others do things. More than ever, consultants have to understand the essential services for older people, how to argue for innovations and defend against the increasing threats to geriatric services (especially rehabilitation). They need the tools to measure and justify the services they operate, and to understand the evidence base for effective geriatric practice.

I therefore suggested to the Society’s Executive and subsequently to the Training Committee that there might be elements of training about services for older people which are not well covered in locally based SpR training programmes. The idea and a draft programme were put to the BGS Registrars’ Group by Jacqui Close at the Cork meeting. “Yes, good idea!” they all cried, “so get on with it!” With Jacqui’s help, a two-day conference was planned and held at the Belfry on 11 and 12 October 1999.

The idea was to examine services for older people in a broader context than is conventionally available in a

locally based training scheme. As well as giving some new ideas about how the quality of a service should be measured, we focused on innovative practices in the development of specialist services and in relationships with other relevant services. By popular demand we included “old chestnuts” such as “identity and integration” (in the form of a good humoured debate) as well as the popular but less mature chestnuts of clinical governance and a session on “how to case the consultant job”.

### Several themes emerged:

- ◆ The broader picture, in which the politics in the NHS, the evolution of the private care sector, important recent legislation and the Health Advisory Service framework for examining services for older people were introduced.
- ◆ Components of a comprehensive geriatric service and its interfaces were presented, based on the BGS Compendium.
- ◆ The quality agenda was addressed by examining Clinical Governance, what it means for a Trust and for the individual consultant (individual performance review or appraisal). Registrars presented an analysis of their own services and HAS 2000 staff, Helen Bowers and Mo Flynn, presented the HAS approach using a framework with service standards, criteria, indicators and patient care flows.
- ◆ How to do it. This was the most popular theme of the meeting in which expert innovators (see Table 1) were asked to describe why and how their service innovation came about and its strengths and weaknesses. Towards the end Chris Patterson from Bradford gave an entertaining and popular account of the how to “case the consultant job”, with much useful and practical advice.

At the end, delegates were asked for their views of the conference and 33

returned a questionnaire covering the content, additional ideas for a future conference and thoughts on the organisation and domestic arrangements. Comments were overwhelmingly positive, with the main criticism being the lack of time for discussion, particularly the questioning of service innovators. A strong feeling of the delegates was that this sort of training is needed and there was support for the notion that it should be a regular event for senior trainees. Some suggestions for future meetings are set out in Table 2.

My sincere thanks go out to over a dozen consultant colleagues, nurses and staff from HAS 2000, who gave their services free and to Jacqui Close, whose reflections on this conference are included. Thanks to her for revving up the trainees and arranging substantial sponsorship. Thanks to the BGS for support and encouragement; to my secretary, Luisa Massey for administering the conference; and to Procter and Gamble, 3M, Searle and Lilly for substantial financial support

**Dr Alistair Main**

### Reflections of the SpR Chairman

Just six months ago I was approached by Alistair Main enquiring of my thoughts on a management course for trainees in geriatric medicine designed to address areas relevant to the specialty. In true democratic style, I took this back to the trainees at the Cork Scientific Meeting where there was overwhelming support for the idea.

Over 50 enthusiastic trainees in their final years of training from all four corners of the UK subscribed to the conference. There can be little doubt it was a resounding success. Much of the thanks goes to Alistair, whose hard work and dynamism ensured an exciting programme.

The meeting kicked off with an overview of the politics in the NHS, key components of a comprehensive geriatric service and that omnipotent subject, Clinical Governance.

Trainee participation was encouraged and Catherine Bryant and Rosemary Kelly presented a detailed analysis of the history and development of geriatric services in their respective hospitals.

**Integration**

A few bunches of fermented grapes soon livened up proceedings and the debate on integration resurrected. Amidst the jeers and cheers, Ian Sturgess delivered an Oscar winning performance opposing the motion for integration, and despite valiant

attempts by myself, Claire Pulford and Mark Ardron, the audience could not be persuaded otherwise. Dr Sturgess ran off with the prize (more fermented grapes!). The debate continued in the bar and well into the small hours.

The Health Advisory Service started off the second day with a presentation on health service evaluation and this was followed by a talk on performance review. Much of the day concentrated on the development of subspecialty services within geriatric medicine and the workshops led by enthusiastic service innovators. Lunch was followed by an enlightening talk on the potential pitfalls of applying for a consultant post, by Chris Patterson.

The conference came to a close with Jed Rowe extolling the virtues of “geriatrickery” in his own inimitable and infectious style, whilst Finbarr Martin delivered a thought provoking talk on the future of geriatric medicine.

Our biggest thanks go to the consultant geriatricians who gave of their time and participated at their own cost in the conference. Their enthusiasm and dedication to the speciality was clearly evident over the two days. Thank you also to the BGS for its support. I hope this venture is something it will continue to support in future years.

**Dr Jacqui Close**

**Table 1  
Contributors to the meeting**

Topic	Contributor	Location
Orthogeriatric services	Dr Ian Sturgess	Canterbury
Joint psychiatric assessment	Dr Jim George	Carlisle
HAS approach to service evaluation	Ms Mo Flynn Ms Helen Bowers	HAS 2000
Innovative Day Care	Mrs Frances Colley Dr Finbarr Martin	Birmingham London
Care support and respite care	Mrs Ann Pemberton	Birmingham
Falls Assessment	Dr Jed Rowe	Birmingham
Stroke rehabilitation	Dr Rod Brooks Dr Tony Rudd	Walsall London/RCP
Parkinson's clinic	Dr Jo Meara	Cheltenham
Community Geriatrics	Dr Chris Turnbull Prof John Young	Wirral Bradford
Continence services	Dr Peter Overstall	Hereford
How to prepare for consultant job	Dr Chris Patterson	Bradford
Politics, service configurations, appraisal, managing junior doctors, clinical governance	Dr Alistair Main	Birmingham

**Table 2  
Suggestions for future meetings**

**Delegates wanted to know more about:**

Health care needs in the community, clinical governance, impact of changes in primary care, preparing for consultant interview, 'Things I wish I had known when I became a consultant', leadership training and working in a multidisciplinary team, intermediate care  
 Managerial issues: Business planning, budget management, interface between consultant and manager, problem colleagues, secretarial services, elder abuse

## 25TH ANNUAL GENERAL MEETING

The 25th AGM was held in the Royal College of Physicians, London together with the Council Study Day and Autumn Council Meeting, with 28 members of the Society attending.

Those attending were with few exceptions members of Council. However Dr Knox, present as an ordinary member, expressed concern that the timing of the meeting precluded most members from having an opportunity to attend, particularly when there were issues such as the plan for the Society to purchase its own premises to be debated. In reply the President explained that this was an unusual meeting in that it was being held separate from the Autumn Meeting on account of the latter having, for 1999 only, been moved to December due to the availability of suitable locations. It was not practical to postpone the AGM on account of the need to provide for continuity in the management of the Society by electing new officers to replace those whose mandate had expired.

#### Statutory matters

The meeting then covered the routine statutory requirements, re-electing those members of Council eligible to serve and appointing the new members nominated by the Regions: Dr McElroy (Northern Ireland), Dr R Prescott (Northern), Dr G Sridharan (North West), Dr J Hanslip (Scotland), Dr J Powell (SW Thames), and Dr W Gorman (Trent). Dr P Gawley and Dr R Lewis were appointed as national

representatives on the Executive Committee for Northern Ireland and England respectively, the latter following a ballot of the English representatives on Council.

The nominations for Dr Ian Sturgess and Dr Chandi Vellodi as Deputy Treasurer and Deputy Secretary respectively were approved.

The following nominations to posts on the standing committees and outside organisations were approved: Finance Committee, Dr A T Elder; Policy Committee, Dr P B Khanna, Dr S A Bruce, Dr G F Turner; Scientific Committee, Prof R Stout, Dr J C Pounsford; Hospital Accreditation Board, Dr G H Jenner; Pre-retirement Association, Dr P Overstall; RCPsych Liaison Committee, Dr M J Bendall

The report of Council and the audited accounts for the financial year ended March 1999 were approved and Sargent & Co were re-appointed as auditors.

#### Subscription rates

The subscription rates for the next year were approved with one abstention, namely £145 for standard members, £75 for UK trainees and £65 for associate, overseas and retired members. A surcharge of £3 was agreed where payment is made by means other than direct debit. The UK rates include a levy of £20 and £10 for standard and trainee members

respectively to support the Premises Fund. The basic subscription for 2000 is unaltered by comparison to 1999, but the meeting agreed that it should be collected a month earlier i.e. 1 December 1999 to avoid any "year 2000" problems that might affect the banking system.

#### BGS premises

The main item of discussion centered on Council's recommendation that the Society purchase its own premises in London and raise funds for this purpose, which proposal was accepted when put to the vote with one member voting against, and 24 members voting for the motion.

In the course of the discussion at the AGM and in Council, Dr Knox pointed out discrepancies in the information provided on the project and also asked for the membership at large to be given an opportunity to ask questions about the plans. It was agreed that Council members would be sent more financial data and that at the Extraordinary Meeting in December members would have an opportunity to ask questions.

The Extraordinary Meeting will be held during the postponed Autumn Scientific Meeting in December to confirm the nomination of Dr Rebecca Dunn as Secretary and Dr Robert Shepherd as Treasurer and the additions of Dr S Baillie and Dr T K Smith to the Finance Committee.

**Richard Lynham**

#### "Falls guidelines"

##### Continued from page 19

Sponsorship is provided by Medtronic Inc, USA and Roberts Pharmaceuticals, USA.

UK membership includes Prof W Wallace, Nottingham, Dr F Martin, London, Prof A Young, Edinburgh, Ms M Ellis, London and Ms J Cantrill, Manchester.

The first consensus meeting is in New York in February, to be followed by a final meeting at the Spring AGS.

## COUNCIL STUDY DAY

There was a new format for the Council Study Day which involved interaction between all those attending. The success of the interaction was not only educative but also boded well for further BGS meetings arranged on this format.

The session opened with Professor John Young and Dr James Barrett, each outlining the problems in when to stop rehabilitation after stroke and management of faecal incontinence respectively. The meeting then split into two groups who attempted to produce a consensus statement which would answer the two problems.

Professor Young's group felt they had been challenged by the question which had engendered vigorous debate. They wanted wider co-operation between primary care and rehabilitation for example, but felt that rehabilitation should be goal-directed and individualised, consideration should be given to the physical needs of the patient, but also holistic needs, particularly psycho-social aspects and carer concerns. The rehabilitation should not occur just in hospital but in partnership with primary care, and

ideally there should be a seamless progression. Rehabilitation should continue until the goals that have been set are met, but it may be necessary to revise these goals. The faecal incontinence group felt that successful treatment of the condition was hampered by only 50% of patients with the condition being reported. They felt that the most important aspect of treatment was identification of the causes and contributory factors. The most common causes were mobility in frail people, loading of the rectum and low anal tone. On loading they felt that "impaction" was not a helpful term because only 10% have a hard stool whereas in 90% it is soft. For the same reason, the term "spurious diarrhoea" was probably over-used as the condition was unusual. The diet was extremely important because frequently there was excess fibre given for "suspected constipation." Indeed the group felt that it was the over-treatment of "constipation" which gave rise to discomfort and faecal incontinence. The aim of the treatment should be to empty the bowel at an appropriate time with a formed stool and medication should be given to achieve this object.

Finally there was a short lecture by Dr Zoe-Jane Playdon on how to teach effectively. She differentiated between training and education. Training has known outcomes, uniform procedures, repetitive processes and an attitude of "always and only" do it like this. This design led to protocols and criteria and production-line supervision with strongly hierarchical ideas and not concerned with ethics. Education on the other hand dealt with uncertain outcomes; with individual needs in knowledge, skill and experiences; to deal with problems which may be one-off; it dealt with the concept of "it depends" and was concerned with principles and values and autonomous professional judgement. Education was strongly functional, i.e. not who is the boss, but who is most able to do it, and ethically and morally bound to do no harm. Good teaching was therefore both didactic and discursive, it was enabling, stimulating, interactive, problem-orientated, facilitated, guided, encouraging with a motivated teacher with clear knowledge and enthusiasm. Education contains training, but training never contains education.

**Professor Mark Castleden**

## SYNCOPE AND FALLS STUDY GROUP

The inaugural study day of the group was hosted by the Royal Victoria Infirmary, Newcastle upon Tyne on 19 October.

The purpose of this day was to bring together medical, nursing and other staff who are operating facilities engaged in the investigation and management of older adults with syncope and falls.

The day was a great success, with attendance from all over the country

including Cheltenham, Rotherham, Pontefract and Southend. Attendees presented clinical cases for discussion and Professor Rose Anne Kenny presented "hot off the press" data on beneficial intervention strategies for cardiovascular falls. All those involved in the day agreed the meeting was extremely beneficial and it was decided to have these meetings on a regular basis to facilitate the exchange of ideas and discuss important clinical issues concerning syncope and falls.

The next study day is on 1 February and will be held in Cheltenham.

Anyone interested in taking part in these study days should contact Dr Colette Seifer, Research Registrar, Cardiovascular Investigation Unit, Royal Victoria Infirmary, Newcastle upon Tyne, NE1 4LP.  
Tel: 0191 222 7915.  
Email: c.m.seifer@ncl.ac.uk

**Dr Colette Seifer**

**LETTER TO THE EDITOR**  
**ROYAL COMMISSION ON LONG TERM CARE – AN ALTERNATIVE VIEW**

I must first confess that I am not a health economist and my views are based on personal opinion.

The idea that health and personal care should be free whilst social care is means-tested is superficially attractive and will certainly deal with some anomalies in the present arrangements. However, the question I would pose to advocates of this system is "who would benefit the most?" My own view is that this is more likely to be the better off middle class older person rather than the poorer working class person. The resources that are required to remain at home include not only formal personal, social and health care but also a whole range of other resources including a decent home, supportive

family and friends and the intellectual resources to deal with and to react to future events. As in so many areas of life, the middle-classes are better able to meet challenges and opportunities including those of free personal care at home. My concern is that the money will go to middle class people (and their families) rather than poorer people.

You might also like to consider an analogy with the education service whereby some people presently pay for education. One proposal in this area that has been advocated by right wing thinkers is that of vouchers which could be cashed in both private and state schools. Who benefits? The experience of the nursery school scheme suggests that

it is not the most needy.

Thus I believe that if the way suggested by the Royal Commission is the way the Society wishes to go, and I accept that this is the majority view, then it is important that it is implemented in a way that does not disadvantage those who are already the more disadvantaged.

Of course there are many other recommendations of the Royal Commission which are worthy of support and which I have commended to the local MPs.

**Peter Crome**  
**Professor of Geriatric Medicine**  
**Keele University**

**BGS SCIENTIFIC MEETINGS - A REMINDER**

**BGS Autumn Meeting**  
**Novotel, Hammersmith, London**  
**15, 16 & 17 December 1999**

The Scientific programme includes: Respiratory, cardiovascular, nutrition and stroke symposia; updates on osteoarthritis, clinical management, medical education and the National Service Framework.

There will also be an Extraordinary General Meeting at 12.30 on Thursday 16 December (see enclosed leaflet for agenda)

Closing deadline for registration at standard rate is 9am on 30 November.

**BGS Spring Meeting**  
**Warwick University**  
**5-8 April 2000**

The provisional Scientific programme includes: Symposia on surgery, frailty, diabetes, nutrition, euthanasia and immunology; clinical updates on rheumatology and renal failure.

Thursday 6 April will see an interdisciplinary day running parallel to the traditional medical symposia. (please see details in enclosed poster).

**Deadline for abstracts: 1 December 1999** (see enclosed leaflet for further details)

**Contact:** BGS Meetings Secretariat, BHM Ltd, 1 Arun House, River Way, Uckfield, E. Sussex, TN22 1SL  
 Tel: +44 (0)1825 768864. Email: [contact@bhm.co.uk](mailto:contact@bhm.co.uk)

**BGS SATELLITE SYMPOSIUM**

**Respiratory Disease in the Elderly in the New Millennium**

**Novotel Hammersmith Hotel**

**Evening of 15 December 1999**

Sponsored by Allen & Hanburys and Glaxo Wellcome.

Topics include: pneumonia, bronchodilator therapy, outcome measures in COPD.

A buffet supper will follow.

**Contact:** BHM Ltd,  
 1 Arun House, River Way, Uckfield,  
 East Sussex, TN22 1SL  
 Tel +44 (0) 1825 768864  
 Email: [contact@bhm.co.uk](mailto:contact@bhm.co.uk)

**AUSTRIAN GERIATRICS  
CONFERENCE**

“Ageing in the past, present  
and future”

Bad Hofgastein, Austria

25-29 March 2000

**Topics include:** clinical geriatrics,  
social gerontology, biological  
research, psycho-gerontology.

**Contact:** Renata Uher,  
Krankenanstalt Rudolfstiftung, 4.  
Med. Abteilung, Juchgasse 25, 1030  
Vienna, Austria  
Tel: +43 1698 1000-60  
Fax: +43 1698 1000-66

**CLINICAL  
EFFECTIVENESS**

Clinical Effectiveness in Mental  
Health Services for Older People

Royal College of Psychiatrists,  
London

23 May 2000

Call for presentations

**Contact:** Sam Coombs,  
Conference Planning Group, The  
Royal College of Psychiatrists’  
Research Unit, 11 Grosvenor  
Crescent, London, SW1X 7EE.

**Deadline for submissions:**  
17 December 1999

**GERIATRICS 2000**

IAG Europe Clinical  
Section Congress

Bratislava, Slovak Republic

22-24 June 2000

**Topics include:** clinical cardiology,  
gastroenterology and pneumology,  
anti-infective chemotherapy,  
rehabilitation and prevention.

**Contact:** Conference Secretariat,  
Duranova K, Klinika geriatric,  
Dumbierska 3, 83101 Bratislava,  
Slovak Republic.  
Tel/fax: +421 75477 3628

**BGS NEWSLETTER -  
FORTHCOMING ISSUES**

Please note that there will be no  
January or March 2000 issues of  
the BGS Newsletter.

The next issue is scheduled for  
February 2000 followed by May,  
with bi-monthly editions from then  
onwards.

**RESEARCH  
FELLOWSHIP**

Bernard Isaacs Memorial  
Fellowship  
(Queen Elizabeth The Queen  
Mother Fellowship)

£100,000

Research into Ageing (RiA) is seeking  
applications for a new research fel-  
lowship. Established in memory of  
the late Professor Bernard Isaacs,  
the post-doctoral fellowship, of up  
to three years’ duration, will be  
awarded for research addressing  
one of the areas to which he dedi-  
cated his professional life: stroke,  
falls and dementia, with priority  
being given to projects addressing  
prevention or rehabilitation. Funds  
for this award have been raised for  
RiA by the West Midlands based  
Bernard Isaacs Memorial  
Fellowship Appeal.

Applications will be considered in  
March 2000. In the first instance,  
applicants (from UK institutions  
only) should request an outline  
proposal form, which should be  
completed and returned by 29  
November 1999.

RiA is a registered charity dedicated  
to improving the health and quality  
of life of older people by funding  
research into the causes of  
disability in old age.

**Contact:** Katie Arscott, Research  
into Ageing, Baird House, 15-17 St  
Cross Street, London EC1N 8UW.  
Tel: 0171 404 5878.  
Email: grants@ageing .co.uk

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