



Editor: David Lubel

BGS

n e w s l e t t e r

Abbeyfield

- where older people find care in housing



In 1692, boatloads of scarlet-coated soldiers were quietly decanted on to the southern shore of Loch Leven. From their camp at Ballachulish, the order was issued for the unsuspecting local population of Glencoe to be put to the sword.

One curious aspect of the infamous Highland Massacre was the instruction to spare those aged over 70. With life expectancy at the time well short of the biblical three-score-years-and-ten, this was indeed a most cynical 'act of mercy'. Old people didn't count. Even in the

context of killing, they were an irrelevance.

New project

Three hundred years later, older people in Glencoe are again in focus - but this time their needs and expectations are recognised in a very positive and dynamic light. Abbeyfield Ballachulish has embarked on a £3 million project which promises to be a landmark in the development of provision for older people in a rural area. As executive committee chairman Rae Grant explains: *"We want to get ahead of the needs of the moment and put in place provision that will be appropriate for the year 2025."*

Ballachulish is one of a number of local Abbeyfield Societies in the UK - some rural, some urban - seeking to 'get ahead' in this way. Local circumstances vary, but they share a common vision: they are striving to put into practice the concept of integrated care.

Traditional methods of care

Care for older people traditionally has been fragmented. Even when, within each 'fragment', the best care is available, the overall pattern of fragmentation has sometimes made people feel vulnerable, insecure, isolated and institutionalised.

Integrated care

Integrated care is radically different. The aim is to provide a full range of care at one location.

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FOR HEALTH IN OLD AGE

Editorial

page



Many BGS members have expressed their concern over ambiguities within the recently published RCP document, 'Consultant Physicians Working for Patients'.

RCP document

The example work programme for a consultant physician in geriatric medicine and general medicine (page 70 of the document) appears to suggest an outpatient workload of 6-8 new patients and 15-20 follow-up patients per session. This is identical to the recommendation for gastroenterology and greater than recommended for other specialities. In infectious diseases, for example the suggestion is 2-4 new and 8-10 follow-up patients per session and in palliative medicine the numbers are 2 and 3 respectively. The concern is that these figures are incompatible with high quality care, but may be waived at geriatricians by their local management or, worse still, adopted as norms at a national level. Undoubtedly, there has been an error in presentation and I am sure that the RCP will provide clarification in due course.

1998 outpatient questionnaire

Given the flurry of interest in outpatient workload, I felt this was an opportune moment to publish BGS data on the topic. Many of you will remember completing and returning the orange questionnaire enclosed with the July 1998 Newsletter surveying consultant outpatient workload. We asked for details of all those clinics attended by the consultant during a specified one-week period. Information was obtained on numbers of patients (new and old) actually seen by the consultant and their team together with details of clinic type and non-consultant support. Where more than one consultant had a joint clinic they were asked to include only their individual share of the patients (and support staff) to avoid double counting.

Summary of data

156 consultant geriatricians returned questionnaires containing details of at least one clinic. 109 included two or more clinics; 44, three or more clinics, and 15 gave details of four clinics. Of a total of 324 clinics, 89 were pure general medicine or sub-speciality and these were excluded from this analysis. The remaining 235 were pure geriatrics with or without general medicine, and form the basis of this analysis. 26% of clinics were supported by a specialist registrar. 34%

included an SHO, 2% a PRHO, 14% a staff-grade doctor and 14% another unspecified doctor. In 39% of clinics the consultant declared no medical support.

The table opposite contains summary statistics that speak for themselves. In order to provide more useful normative data I

Table: July 1998 consultant outpatient clinic survey - summary statistics

	SpR or Staff grade (+/_ SHO)		SHO only		No support	
	New patients	Follow-up patients	New patients	Follow-up patients	New patients	Follow-up patients
Mean	4.1	16.2	3.7	12.3	2.7	6.6
Median	4	15	4	12	2	6
Mode	4	15	4	8	2	7
Count	87	87	47	47	99	99
Range	0-12	0-40	0-9	0-25	0-12	0-18
Interdecile range	2-7	7-30	2-6	4-21	0-5	1-12
Interquartile range	3-5	10-20	3-4	8-18	2-4	4-9

have broken it down into three groups. First, those clinics where the consultant has the support of a specialist registrar and/or staff grade doctor (with or without an SHO). Second, those clinics with only SHO support and finally, those run by a consultant with no other medical input.

Consultants can compare their own practice with the summary data that best fits their own local circumstances. Clearly, appropriate clinic workload depends on many factors, such as consultant style of practice, teaching commitments,

complexity of patients, ancillary support, etc. I would argue that, in terms of maintaining quality, it may be equally undesirable for a service to have clinics with too many patients as too few and I suggest that the interquartile range be taken as the ballpark figure to aim for under most circumstances. It is impossible to know the true validity and generalisability of this data, but one thing is certain - it is better than using figures plucked out of the air.

David Lubel

President's column



Occasionally I detect an element of tension between some BGS members and the Royal Colleges of Physicians (RCP).

I was reminded of this when I studied some of my presidential mail after the circulation of the recently published RCP London report, entitled *'Consultant Physicians Working for Patients'* (see page 5). It must be said that, in the past, geriatricians have had from time-to-time rather uneasy relationships with some of the mandarins in the three Royal Colleges of Physicians in the UK. I would hope that recent events will help to dispel any fears about our relationship with these ancient institutions.

Distinctive roles

We should not confuse the distinctive roles of the specialist societies and the Colleges. Clearly, we have shared philosophy in terms of promoting standards of care and postgraduate medical education, continuing professional development and clinical governance. The Colleges have major responsibilities for postgraduate examinations and the appointment of consultants in all medical specialities. The BGS has unique, special aims to promote high standards of health for older people, wherever they may be, to promote

optimal rehabilitation, to combat elder abuse and other forms of ageism, and to support and encourage education in the elderly health care for trainees in all of the health professions. The Society's mission statement also includes our expressed duty to provide guidance to older people and their carers. Therein lie our strengths as specialists, rather than partialists, and we should perhaps pause and recognise that physicians tend to be judged by public, patients and peers on the basis of specialist practice rather than any generalist role which they may fulfil.

Strong links

Over the last few decades, geriatricians have played important roles in the Royal Colleges. They have served as council members, censors, advisory committee members and membership or diploma examiners. We have provided at least one President, two senior Vice Presidents and one Honorary Secretary. All of the three UK-based Colleges of Physicians have had active standing advisory committees on geriatric medicine and over the years they have provided authoritative advice to their respective councils and College office bearers. I have been informed that the Geriatric Medical Advisory Committee of the RCP of Edinburgh has ceased to exist. The Edinburgh College does not traditionally have standing advisory committees in the major medical specialities but Edinburgh fellows in the

BGS might like to explore avenues to advise the College appropriately.

Joint working

The BGS now hosts biannual meetings of geriatric medical representatives of the three Colleges and the BGS. The meetings are chaired by our President. To date, the most promising initiative stimulated by these meetings has been the BGS document on clinical governance.

The RCP London recently reviewed its administrative structure and functions and part of this

process included a re-look at the relationship between the RCP Speciality Advisory Committees and the specialist societies, including the BGS. We are currently responding to a College suggestion that genuine joint liaison committees, with Scottish College representation, could be the way forward. This partnership principle is desirable and should obviate duplication of effort. This innovative step could better promote the shared aims of the College and the BGS and perhaps also the special aims of the BGS and its membership.

Brian Williams

Consultant physicians working for patients

A word of explanation on the document published in June by the Royal College of Physicians London is deemed necessary.

Many members of the Society will now have read the document, entitled '*Consultant Physicians Working for Patients*'. Some have written in questioning certain sections in it. It is, therefore, appropriate to explain how the document came about and to address areas giving rise to concern.

The need for the document

The College have been anxious to issue an authoritative statement in order to influence the thinking of the present government administration while their health care policy is still in the making, and to establish in the corridors of power that there is a need for consultant expansion across the whole medical profession if it is to meet the demands being placed on it.

This document is far more supportive to geriatric medicine than the original draft passed to the Society for comment at the end of 1998. However, as in any document covering over 20

specialties, there are some statements which the Society would have wished to see expressed differently. Nevertheless, the thrust of the document is correct and successful in making its main point - **we need more consultants!**

We are advised that it is the first time that a document has been issued by the College compiling the work pattern of all specialties on a comparative basis and no doubt future editions will refine this initial process.

The following are areas which have given rise to concern in the document.

Workforce requirements (page 8)

The statement that *geriatric medicine appears to be well staffed* has caused a degree of anxiety. However, the emphasis of the statement is on the word "appears", followed by the recommendation that the likely requirement is going to be accepted as one geriatrician per 50,000 population. It is this figure which the Society has consistently been campaigning for in its correspondence with the College and other statutory organisations.

The GIM/GER '*Statement of Principles*', issued by the College Geriatrics Committee and endorsed

by the Society last year (see November 1998 Newsletter, page 21) recommends *one consultant per 4,000 population aged over 75 years by 1 January 2003. This approximates to 1:50,000 where the percentage of the population over 75 is 7.5% of the total i.e. around 10 consultants for a population of 500,000.* We are hoping for the endorsement of this figure by the National Service Framework when it reports back to the Department of Health.

The College document, in the same paragraph, further states that in taking account of the work of geriatricians *it seems likely that the number of geriatricians will need to be almost doubled over the next 10 years*, which, whilst more conservative, is nevertheless supportive of the BGS Manpower Committee's submission last year that an expansion from 764 consultants at present to 1332 by 2005 would be required.

Job Plans; Geriatric Medicine: example of work programme

Regrettably, this part of the document contains ambiguities. The table on page 70 of the document is being interpreted as meaning that a consultant should in one NHD be seeing 6-7 new patients and 15-20 follow-up patients, which is patently impossible. The introduction to this section on job plans states that *'in most specialties the assessment is of the amount of work that an individual consultant is able to deliver'*. Possibly, in the case of geriatrics, the data as to what a consultant, assisted by a registrar and a team of paramedical staff, can effect is being confused with what a consultant can effect working single handedly.

However, the same introduction also states that *'the specialty committees have been asked to make more accurate calculations of the numbers of physicians needed in future. Knowledge of the prevalence of specific disease and the recommendations on the number of patients who can be seen in each session allocated to patient care should allow a more realistic estimate of the numbers of consultants required to provide adequate levels of high quality care'*. Dr Black, the Chairman of the Geriatrics Committee, has already taken up the issue with the College.

The Society carried out a survey of members in July 1998 to obtain data on outpatient clinic practice (see the 'Editorial' on page 3 of this Newsletter).

Summary of 1998 questionnaire

Based on the inter quartile ranges reported, the survey suggests that in an average outpatient clinic it would be reasonable for a consultant, with assistant medical and paramedical support, to see in a NHD session a mix of 2-4 new patients and 6-15 follow-up patients. This allows for the fact that 30-40 minutes may be needed for each new patient and 10-15 minutes for each follow-up patient. Alternatively, where only new patients are seen, a consultant-led multidisciplinary team could expect to see 4-8 patients in a session.

Each actual caseload will vary significantly depending on the complexity each patient presents with, on the extent to which the consultant is supported by a registrar or staff grade physician, and the availability of paramedical staff. The availability of trainee staff may assist the process, but their presence may also detract from consultant time to allow for supervision and teaching.

At the behest of members concerned about this, the Society would be happy to write to any Trust manager as necessary, to put matters into a clearer perspective.

Future liaison with the College

Clearly, the existence of ambiguities in a document issued by the College is unfortunate; given the pressures to release the document, neither the Society nor the College Geriatrics Committee had an opportunity to see the final draft before it went to print with the result that the ambiguities could not be identified and rectified.

For the future, the College plans to change the system for liaising with specialist societies. From this autumn there will be just one joint committee for each specialty, providing, in our case, just one reference point and one single authoritative view on specialist geriatric medicine. This will provide for a more expedient method of processing business and avoid the type of error that inadvertently crept into the Consultant Physician Working document.

**Brian Williams
and David Black**

“Abbeyfield” article continued from page 1

This will remove uncertainty about the future by providing a safe, secure, friendly ‘home from home’. The intention is to give older people a renewed lease of life through support that values the individual, promotes independence and helps maintain active involvement in the community. Crucially, there is a promise to care for people for the rest of their lives, including appropriate support to meet the challenges of increasing frailty and dementia.

Although the Abbeyfield Society’s impressive track record of caring for older people stretches back more than 40 years, it is not complacent about the next 40. People are living longer than ever before and the UK population is ageing rapidly. Forty years from now the number of people aged over 85 is expected to double. The number of those over 90 will treble. That’s why, for Abbeyfield, delivering integrated care takes the highest priority.



The Society’s history

So what exactly is Abbeyfield? It all began in 1956 when a Coldstream Guardsman named Richard Carr-Gomm was haunted by the number of sad, elderly faces staring out at him from behind windows as he walked through the streets of Bermondsey. He resigned his commission, moved from Chelsea Barracks to a bed-sit in Abbeyfield Road, and became a home help. Soon realising that loneliness was the key problem, he spent his army gratuity on a house and invited four lonely old people to join him. By Christmas 1956 he had become the very first Abbeyfield housekeeper.

Within a couple of years six further houses - all in Bermondsey - followed. Then Abbeyfield began to develop elsewhere in London. By 1960 there were Abbeyfield Societies in eight London boroughs and 15 additional locations outside London. The parent society was incorporated to provide a nucleus for the movement as a whole.

Approaching the millennium, there are now around 600 local Abbeyfield Societies throughout the UK. Many run just a single

house. The largest, in Nottingham, runs nine. Altogether, there are about 1,000 Abbeyfield houses providing accommodation for some 9,000 residents.

International spirit

The Abbeyfield movement relies heavily on volunteers and paid staff working together at national and local level. The UK office in St Albans steers policy, develops strategy and helps with fundraising, organising seminars and conferences and producing a range of publications. It also has an international arm liaising with Abbeyfield societies in Australia, Belgium, Canada, Italy, Jersey, the Netherlands, New Zealand the Republic of Ireland, South Africa and the USA.

Accommodation

Abbeyfield houses come large and small and range from converted houses in semi-detached suburbia to purpose-built accommodation in the heart of a city or out in the countryside. They fall into different categories, providing, for example, assisted living, very sheltered care, registered residential care or nursing care. The concept of integrated care brings all these types of care together on a single site. It introduces operational flexibility and, importantly for the individual, a ‘home for life’ whatever the resident’s needs.

Provision of care is not all ‘one-way traffic’. Some Abbeyfield houses are very proactive in the community, organising events in which many non-residents are involved: bingo, garden parties, art classes, lunch clubs, keep fit sessions and so on. Integrated care will raise this profile even more - to the extent that the Abbeyfield house may become as much a part of the fabric of the local community as pub, church, library and post office.

Not that every local Abbeyfield society will be able to introduce integrated care. Many simply do not have the resources or an appropriate site. But even the most modest still perform a crucial role.

Changing needs and expectations

One thing that all Abbeyfield societies share is an awareness of the changing needs and expectations of older people. This comes from net-

working with each other and links with the UK office, whose initiatives enable local experience to be considered in a broader context.

Research

Sometimes the UK office comes up with something that really helps to set the agenda. One such initiative was a study* by Stephen Abbott and Malcolm Fisk that cannot fail to inform good practice for one splendidly simple reason – that the research was designed to listen to the ‘customers’.

It was carried out in three different areas of England and Wales. One hundred and forty six people aged 74 or over were interviewed. Two-thirds of them were 85 or over and the oldest

105. Sixty-six were Abbeyfield residents and 56 residents of other sheltered housing or residential care homes. The others lived in ‘ordinary’ accommodation without any in-house support services.

The purpose was to find out what

those interviewed thought about independence and involvement. And to what degree they themselves felt independent and involved – to what extent they were able to live their daily lives according to their values.

Abbott and Fisk, in a note about terminology, reveal that the term ‘very old’ proved contentious in initial discussions. Some service providers took exception to it on the grounds that age is often viewed negatively in the UK. To underline the point, the authors point out: *“Such views and attitudes have been instrumental in the perpetuation of patterns of accommodation and care that have served to foster dependency rather than enhance independence.”*

But given the lack of consensus regarding an alternative, the term ‘very old’ was adhered to. Abbott and Fisk declare: *“We firmly hope...that our research will show that to be very old should have many positive associations.”*

Abbeyfield was not looking for a glowing endorsement of the way they do things. As providers of residential care, they clearly want to improve their service. The study was a bold attempt to establish a valid basis for embarking on a change process. And integrated care is certainly part of that change process.

It’s going to be a huge task, however. The study reveals a wide spectrum of opinion. Tellingly, the report does not conclude with a set of recommendations, but with a list of issues. And there are three over-arching questions:

- u how can staff and committee members find out what each individual customer really wants?
- u how can services be more responsive to the whole range of individual needs and references?
- u how can housekeepers, committee members and residents support each other in finding the best ways of delivering services?

Being client responsive

The desire to be client responsive is to be applauded. However, Abbeyfield must guard against becoming ‘oh-so’ client responsive in the style of several big companies who standardise their offer and then tell us that it’s the standard offer we want.

If independence and involvement means anything, it’s individuality. Old and very old people don’t want a standard offer. And they’d like to have a say in the design of the offer, too.

The report has already started to serve Abbeyfield well in terms of future direction. And the words of the Archbishop of Canterbury, from his 1997 Abbeyfield lecture, serve as a clarion call for the whole Abbeyfield movement. Said the Archbishop: *“The Abbeyfield House is not an isolated enclave separated from the wider community. On the contrary, it can become a focal point in the wider community and may even serve to strengthen it.”*

Abbeyfield Society

**Independence and involvement: older people speaking.*
S. Abbott (Health and Community Care Research Unit, University of Liverpool) and M. Fisk (Liverpool John Moores University).
Published by the Abbeyfield Society, 53 Victoria Street, St Albans, Herts AL1 3UW. Price £6.50.

Update on long-term care



The BGS has now received over 90 replies from MPs and ministers in response to its letter urging full open discussion and Government action on the main findings of the Royal Commission's report on long-term care.

The House of Commons Health Committee has produced its own report, entitled *'The Long Term Care of the Elderly'* (see July 1999 Newsletter), which strongly supports the main findings of the Royal Commission. The final sentence of this report states that: *"The Government might not agree with every word of the report, indeed two of the commissioners themselves offered minority reviews which will be taken seriously as part of the debate but there is a consensus that the status quo is unacceptable. Failure by the Government to act urgently would be a serious dereliction of duty"*.

The Department of Health (DOH) presented its response to the Health Committee in Parliament during July. In this, it put the Royal Commission's proposals in the context of the general policy thrust which the Government has pursued in the last couple of years, including those covered by the White Paper, *'Modernising Social Services'*, the discussion document, *'Partnership in Action'*, and the executive letter, *'Better Services for Vulnerable People'*. It supports the general thrust for more rehabilitation, better assessment and the development of more variable models of care for older people, learning from international experience. It falls short, however, of giving any commitment to resolving the present state of uncertainty and confusion regarding responsibilities for long-term care.

Age Concern has published a briefing (Ref: 1799, available from Age Concern England). This provides a useful summary of the main issues in the Royal Commission's report and illustrates Age Concern's general support for the recommendations, specifically calling on the Government

to act swiftly to resolve the fundamental question of *"who pays?"*.

The case of Pamela Coughlan v North & East Devon Health Authority

You may have seen media reports of this vital case. Pamela Coughlan has severe physical disabilities, following an RTA, and lives in a purpose-built NHS nursing home in Devon. When she moved there some years ago, the predecessor of the current North & East Devon Health Authority (HA) made a promise that this was a home for life.

Recently, the HA has attempted to close the home and move the residents to nursing homes in the independent sector. Pamela Coughlan has appealed against this closure. In December 1998, the High Court ruled that nursing care is the responsibility of the NHS wherever it is provided. Although the case was complicated by Miss Coughlan's promise of a home for life, the fundamental principles of responsibility for the provision of nursing home care (or similar) is a central issue within the ruling. Mr Justice Hidden had found that *"nothing in either the NHS and Community Care Act (1990) or HSG (95)8 altered the statutory responsibility of health authorities to provide health services including nursing care, including long-term general nursing care"*. He further found that the HA's eligibility criteria were wholly misconceived because they were based on misleading government guidelines, *HSG (95)8*, and in fact were specifically unlawful in excluding the right for certain types of nursing care based on the idiosyncratic distinction between specialist and general nursing.

North & East Devon HA, with the DOH, appealed to the Court of Appeal, whilst the Royal College of Nursing (RCN) supported Pamela Coughlan. The Appeal found in favour of the general ruling but gave further detailed consideration to the statutory responsibilities of the NHS in the provision of nursing care. The position is essentially that the *National Health Service Act 1997* (and previous Acts) does allow

the exclusion of some nursing services from the NHS, and these can be provided or purchased by local social services as a social or care service as long as the nursing care is consistent with the provision set out in the *National Assistance Act 1948* and subsequent relevant guidance issued in April 1993. It clarified that nursing care given as an intrinsic part of the provision of accommodation, rather than as an additional nursing activity, was within the *National Assistance Act*. On the other hand, it ruled that where the need for accommodation is predominantly for health care, then the nursing care is considered to be a component of this and therefore remains the obligation of the NHS. The Court of Appeal upheld the judgement that the eligibility criteria used by North & East Devon were unlawful.

Examination of eligibility criteria

The RCN's solicitors are currently examining eligibility criteria from 30 other HAs to see whether this is a common situation. The RCN, its solicitors and advising barristers view this victory for Miss Coughlan as likely to open the floodgates so that the great majority of resi-

dents in nursing homes would now be found eligible for free NHS care. There are differing views, however, and indeed Frank Dobson publicly welcomed the findings which suggests that the Department of Health does not necessarily agree with the RCN's opinion. Thus, some uncertainty continues but the specific ruling of the Court of Appeal suggests that eligibility criteria for free NHS care must be based on both the quantity and the quality of nursing care provision. As we go to press, further guidance from the Department of Health is expected to clarify what is now becoming murkier by the day.

Rapid action on the Royal Commission report would seem to be the best way forward. The media and BGS are working with the RCN and several other organisations, including Help the Aged, the Alzheimer's Society and Age Concern in pursuing the campaign along these lines. (For those wanting a more erudite summary, refer to *'The Times'* law report of 20 July 1999.

Finbarr Martin

Millennium appeal update - we're on the move!!!

(See July 1999
Newsletter for
further details.)



Manpower planning

- current state of play



The recent debacle in Obstetrics & Gynaecology of large numbers of specialist registrars (SpRs) with completed CCSTs but small numbers of consultant vacancies can potentially affect all specialties and sub-specialties.

The reason lies in the link (or lack of it) between the 'supply' and the 'demand' sides of the equation. Understanding the link is important to both national and local manpower planning. It helps us anticipate and influence demand for consultants. This article refers primarily to the situation in England and Wales. The processes in Scotland and Northern Ireland are dealt with separately under the respective governmental arrangements.

The supply side

Several factors determine the number of SpRs in training.

u *What the specialty thinks.* The BGS currently recommends one consultant for every 4,000 people over 75 years of age. This gives a total for England and Wales of 1012, compared to the present 763. The BGS Manpower Subcommittee recommends that by 2006 the figure should be 1332 (approximately one consultant per 3,000 population over 75).

u *What the Royal College says.* In the recently issued 'Consultant Physicians Working for Patients' (see page 5), the Royal College of Physicians (RCP) London estimated the requirement for the specialty to be one consultant per 50,000 of the population, equating to one per 4,000 over 75 years of age - the present BGS recommendation.

u *Specialist Workforce Advisory Group (SWAG).* This collates information from the above and other sources and recommends annually to the NHS Executive (NHSE) the number of SpRs required to achieve a target number of consultants five to seven years hence. It does this calculation using a computer programme of apparently Byzantine complexity, which is

viewed with great and increasing suspicion by all specialty representatives.

The demand side

The number of consultant vacancies arising at any one time is determined by the following.

1 *The number of retirements occurring in the specialty.* This is currently estimated at 20 per year based on historical data. In the future it will increase, probably unpredictably, as the overall number of consultants increases, as the age profile of the consultant body changes and if earlier retirements are precipitated by clinical governance and reappraisal.

2 *The number of new consultant posts created.*

Logically one would expect there to be a link between this and the target number of consultants determined five to seven years earlier by the discussions between SWAG and the NHSE. There is no such link. The NHSE has very little influence on consultant numbers: they are decided by NHS Trusts and health authorities (HAs), with current priorities being driven by the political imperatives of the day - waiting lists and waiting times. SWAG is presently asking Trusts, HAs and regional offices to give details of their plans for consultant expansion for the next seven years. This seems unrealistic in the sense that the availability of funding over such a period of time is uncertain and Government may change, leading to a totally different series of priorities.

In geriatric medicine, we know from the surveys carried out by Dr Brian Moore-Smith that it is possible to predict future consultant expansion fairly accurately over periods of about two years; for longer intervals the figures become increasingly inaccurate. The cycle of specialist training does not match the political planning cycle in the NHS and its associated funding.

The balance in geriatric medicine

The calculations are bedevilled by disagreements in data, which are currently unresolved. The

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“Manpower planning” article continued from page 10

Joint Committee on Higher Medical Training (JCHMT) estimates that 195 SpRs will have obtained the CCSTs in Geriatric Medicine by the end of the year 2001. SWAG estimates the number for the same period to be 155. Other medical sub-specialties also have such discrepancies though the differences are smaller. For the same period, the number of consultant vacancies will comprise about 60 created through retirement and 97 new posts (based on a historic rate of increase of 4.1 % per annum), giving a total of 157 vacancies.

The figures for vacancies and SpRs with CCSTs is uncomfortably close if the SWAG estimate is right. If the JCHMT figures are correct then there will be an excess of 40 candidates over the number of consultant posts.

The SpRs currently in training provide enough candidates to give 1056 consultants by 2005 - very similar to the total required by England and Wales using present BGS guidelines - but will enough new posts have been created to absorb those with CCSTs? The answer is probably no, not at the present rate of expansion.

What can be done?

Reducing the numbers of SpRs in training and using released resources to create more consultant posts to absorb the clinical work previously undertaken by SpRs is a possibility. There is a potential paradox here since more consultants than SpRs may be needed, and this would necessitate creating additional SpR posts to provide those extra consultants! A soft landing will require some careful flying!

The alternative is to “go for growth” on the

demand side, but what are the potential drivers that will make this possible? They have to link to political agendas. The best bets are as follows.

- u *Clinical governance (CG)*. The RCP recommends a 10% increase in consultants in all sub-specialties to provide time for the demands of CG. Ensuring CG is the responsibility of Trust chief executives, which may not be discharged if there is inadequate consultant time available.

- u *National Framework for Care of the Elderly* (see May 1999 Newsletter, page 13). The implementation of this is likely to require additional consultant input. Hopefully, the report will consider the manpower implications of implementation.

- u *The European Directive on Working Hours*. The implementation in respect of consultants has been agreed between the NHSE and the BMA. Local implementation will be by Trusts, and Local Negotiating Committees (LNCS) will play an important role in enacting this Health and Safety Legislation which places particular responsibilities on employers.

The future

It is apparent that future manpower planning will require a much more objective basis than is currently the case for most specialties. The RCP is asking its individual sub-specialties to produce manpower projections based on ‘procedures’ needed per head of population. This will be much easier for procedure-driven specialties such as cardiology or gastroenterology than it will be for specialties like geriatric medicine which are more eclectic in approach and which do not wield a particular ‘scope’ or investigative catheter! It is a task that will require close collaboration between the BGS Manpower Sub-committee and the RCP Geriatrics Sub-committee.

John Bendall

Chairman, BGS Manpower Sub-committee

MEMBERS CONTRIBUTING TO CONSULTATION DOCUMENTS

Further to the report in the July Newsletter on members’ activities in contributing to the Society’s replies to consultation documents, it has been pointed out that we omitted to mention one significant contributor. Dr David Kennie on behalf of the Health Promotion & Preventative

Care SIG, provided the core of the response to the Green Paper, ‘*Our Healthier Nation*’, which with further input from the Policy Committee was then submitted to the DOH. The text of the response was published as a supplement to the BGS Newsletter in June 1998. The

invaluable support and professional advice offered by Dr Kennie and the SIG was much appreciated.

We would also like to apologise to Dr Adrian Wagg for not attributing his name to the *Review of Policy on Continence Services* in the same article.

Clinical Indicators

and High Level Performance Indicators



In June the Government continued its drive to improve quality and performance in the NHS with the publication of the first sets of Clinical Indicators (CIs) and High Level Performance Indicators (HLPis).

These are derived from routinely available data on hospital activity and are intended to support both the Performance Assessment Framework and the National Service Framework programme (see Newsletter May 1999, pages 10 and 13). They are considered a starting point and will be improved over time.

The accompanying *Health Service Circular (HSC 1999/139)* made clear that CIs and HLPis were for action by Health Authorities (HAs), Primary Care Groups and NHS Trusts: to review the performance of local services; to compare local performance with that of similar HAs and Trusts; to share good practice and take forward work on benchmarking; to assist clinical governance; and to secure improvements in the quality and accuracy of data collected routinely within the NHS.

Clinical Indicators - which ones?

Six CIs have been developed from the 15 proposed by the NHS Executive in 1997:

- 1 *Indicator 1*: rates of death in hospital within 30 days of surgery by method of admission (emergency or non-emergency);
- 2 *Indicator 2*: rates of death in hospital within 30 days of emergency admission with a hip fracture (neck of femur), for patients aged 65 and over;
- 3 *Indicator 3*: rates of deaths in hospital within 30 days of emergency admission with a heart attack (myocardial infarction), for patients aged 50 and over;
- 4 *Indicator 4*: rates of emergency readmission to hospital within 28 days of discharge from

hospital;

5 *Indicator 5*: rates of discharge to usual place of residence within 56 days of emergency admission from there with stroke, for patients aged 50 and over; and

6 *Indicator 6*: rates of discharge to usual place of residence within 28 days of emergency admission from there with a hip fracture (neck of femur), for patients over 65 years old.

Two other indicators in the 1997 consultation, namely surgery for hernia recurrence and frequency of curettage of uterus in women under 40 years, have been incorporated into composite indicators in the HLPis. Six on medical and surgical complications after surgery may be published after further work. One on adverse drug related events in hospital will need new data collection based on agreed definitions before it could be used.

How are data presented and CIs calculated?

(This is a summary only.)

w Presentation

Data are presented for 100 HAs and up to 389 NHS hospital Trusts in England largely based on data supplied to the Department of Health by the NHS for the 1997/98 financial year. Indicators for 1995/96 and 1996/97 are included to enable trends to be analysed. The HA data relate to resident populations and not place of treatment.

w Base data

The analysis was based on 11 million patient episode records collected annually in England. Hospital Episode Statistics data relate to episodes, a period of care under one consultant within one provider unit. There can be several episodes during the entire stay of a patient in hospital (a spell). To account for this, episodes for the same patient during one spell, including transfers between different hospitals, were linked according to date of birth, sex and postcode to form a continuous inpatient spell.

Records have not been linked across years or with data from the Office for National Statistics (ONS) to include deaths occurring after discharge from hospital.

w **Validation of data**

The data are imperfect and so each NHS Trust's data have been assessed for both coverage and record quality for each of the three years, and assigned a quality code. Of the 389 NHS Trusts in 1997/98: 67% have indicator values based on 'adequate' quality data; 11% based on 'mediocre' data; 15% have 'low' quality data; and 6% were ineligible for analysis either because they do no inpatient work or as a result of erroneous instructions gender fields were miscoded.

w **Rates and degrees of confidence**

Rates are calculated using direct standardisation, with the European Standard Population as the standard, and the values given with 95% confidence intervals.

w **Comparing 'like' with 'like'**

1 The indicators have been adjusted for differences in age structure of local populations but not for gender or social and economic characteristics.

2 HAs have been grouped according to an area classification system developed by the ONS which assigns areas to 11 different 'types' e.g. growth, resort and retirement, inner London, and manufacturing, based on census data relating to a wide range of social, economic and demographic characteristics of their populations.

3 NHS hospitals have been grouped according to a hospital classification system that groups hospitals into nine different types, e.g. large acute and very large acute.

4 In some sections, HAs and hospitals are grouped according to NHS Executive Regional Office (1999 boundaries) (see January 1999 Newsletter, page 23).

5 There is likely to be less variation in factors such as case-mix between resident populations of HAs than between smaller hospital populations. Therefore, comparisons between HAs are more robust.

w **Further work**

Development of the CIs is in the following areas:

- 1** operation-specific death rates;
- 2** linkage with ONS deaths data;

3 new indicators as part of the National Service Frameworks; and

4 National Data Quality Indicators.

How are CIs to be used?

They are not direct measures of quality but should be used to draw attention to issues that may need further investigation or action. Trusts and HAs whose data, including the confidence interval, either do not overlap at all or only overlap marginally with like Trusts and HAs could examine the number of cases making up the rates, examine the data to see if there are obvious anomalies, or whether there seems to be real potential for improvement relative to the best and make contact with Trusts and HAs with better values to explore differences in practice.

A toolkit to help NHS organisations interpret and use the indicators will be available later on this year.

High Level Performance Indicators

These look at the performance of the NHS across the six areas of the Performance Assessment Framework at HA level. The document gives details of the 41 HLPs that were summarised when the Framework was launched in April (see Newsletter May 1999). In general, the reservations expressed by the Society as part of the consultation exercise last spring still stand and my comments in the May Newsletter remain valid.

Conclusion

CIs and HLPs are with us for the foreseeable future. Those for the 1998/99 financial year should be published this winter and those for 1999/00 in 2000. Geriatricians are going to have to learn to interpret them if they are to be used appropriately to improve the quality of geriatric services.

Rebecca Dunn

Hon Deputy Secretary

Copies of *Quality and Performance in the NHS: Clinical Indicators, June 1999*, *Quality and Performance in the NHS: Clinical Indicators, Technical Supplement, June 1999* and *Quality and Performance in the NHS: High Level Performance Indicators, June 1999*, can be obtained from Prolog, PO Box 777, London SE1 6XH, or fax: 01623 724524.

Ageing in the 21st century

- the need for a balanced approach



The following is a brief summary of the Secretary General, Council of Europe's report on the Sixth Conference of European Health Ministers, which took place in Athens in April 1999.

The theme of the conference was inspired by the right to health promotion and disease prevention written into the European Social Charter, as well as by the right to equitable access to health care guaranteed by the Convention on Human Rights and Biomedicine, adopted in 1996.

The Ministers discussed several subjects and particularly: the economic and social environment promoting human dignity and independence; the policies aimed at reducing need for hospital/institutional care; and the means of optimising the efficiency of care.

Equal access

The policy declaration adopted at the end of the debate stresses the importance of ensuring equal access to care and cure, irrespective of age and calls for the elimination of discrimina-

tory age-related criteria.

The Ministers agreed on the need to develop a comprehensive and coherent policy framework, which ensures the appropriate balance between "adding years to life" and "adding quality of life to years". They also agreed to give top priority to maintaining the autonomy of older persons, particularly by providing them with 'meaningful missions' and helping them to remain in their home environment.

Commitment to healthy ageing

Attention was drawn particularly to the commitment of the Ministers to reflect the issue of healthy ageing in the Council of Europe work programme by developing and monitoring coherent policies for older people, and by developing a website concerning the science base of health and social issues of older people.

In addition, Ministers expressed great concern about the impact of the crisis in south-east Europe on the life and health of refugees, displaced persons and all persons living in the area, as well as on health and social services in countries directly affected.

BGS COUNCIL MEETING, 7 OCTOBER 1999, RCP LONDON

- AGENDA

- | | | |
|--|--|---|
| <p>1 Apologies for absence.</p> <p>2 Minutes of the meeting held on 1 July 1999.</p> <p>3 Matters arising.</p> <p>4 Chairman's report</p> <p>5 Executive Committee and Standing Committee minutes, draft minutes, verbal reports.</p> <p>6 Honorary Secretary's report - to include outpatient clinics/consultant workload.</p> <p>7 Honorary Treasurer's report</p> | <p>and report on the premises campaign.</p> <p>8 Election of England Representative on Executive Committee - England members of Council only to vote.</p> <p>9 Appointment of additional Standing Committee members.</p> <p>10 Referrals from: the Regions; representatives on outside bodies; and Trainee Group.</p> <p>11 Special Interest Group</p> | <p>business.</p> <p>12 Any other business.</p> <p>13 Dates of future meetings:</p> <ul style="list-style-type: none"> u Spring Council meeting and Study Day - Birmingham, February 2000; u Summer Council meeting and Study Day - London, July 2000; and u Autumn Council meeting - London, evening of 18 October 2000. |
|--|--|---|

LOW VISION SERVICES - RECOMMENDATION FOR FUTURE SERVICE DELIVERY

The report of the Low Vision Services Consensus Group has recently been published (available from B. Ryan, RNIB, 224 Great Portland St, London W1N 6AA). It is the result of an initiative to address the fragmentation and disparate provision of Low Vision Services in different areas. A large number of organisations, including the BGS, were represented and have endorsed the report.

Summary

1 Low vision (LV) is defined as visual impairment where full remediation is not possible and there is resultant restriction of everyday life.

2 Where LV is present, functioning may be improved by LV aids (optical, electronic), environmental adjustments, physical aids and/or training.

3 Low vision as defined is not necessarily limited to registered blind and partially sighted but where appropriate registration as blind or partially sighted should be offered to access local social service and voluntary support and financial benefits and concessions.

4 Initial GP involvement and specialist assessment is required to diagnose treatable disease, and annual eye tests subsequently to monitor any changes.

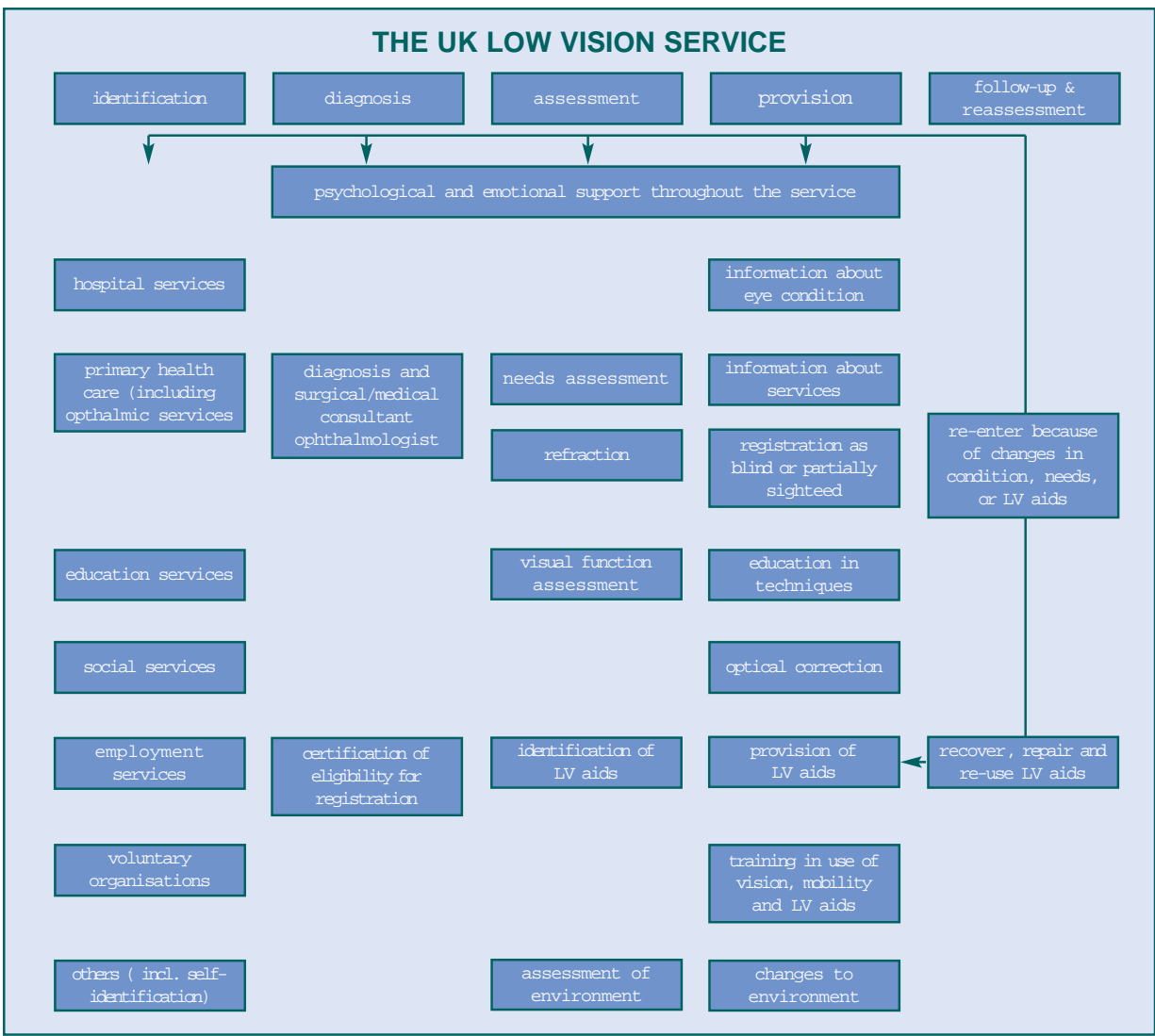
5 Since delivery of low vision services require multi-agency involve-

ment, the need for a Local Low Vision Services Committee is required to coordinate and ensure delivery.

6 The composition of the Committee could include representatives of Health Authority, hospital Trust, Primary Care Groups, Social Services, GPs, voluntary organisations, lay members and professionals (e.g. optometrists, ophthalmologists, and others).

7 Disseminating information on means of access and services available to users, and psycho-social support, are an integral part of the service.

A flow diagram of a blue-print for the service is provided below.



In Memoriam



DR ALISON JANE GRAHAM BELL (1963 - 12 AUGUST 1999)

Dr Bell trained at St Bartholomew's Hospital, qualifying in 1987.

After qualifying, she continued her training in London and subsequently specialised in geriatric medicine, joining the South West Thames rotation in 1994. Dr Bell obtained an MA in medical ethics and law from Kings College in 1998 and took up her post at the Royal Surrey County Hospital as consultant in geriatric medicine.

Alison had a delightful personality. She was calm, gentle, softly spoken

yet firm, decisive and fair-minded.

She was full of enthusiasm and had many innovative ideas. Although she had only been at Guildford for nine months, she had already left her mark and her tragic and untimely death will leave a huge void. She will be greatly missed by friends and

colleagues and everyone who knew

her. She is survived by her mother, two brothers and two sisters.



There are plans for a memorial service to be held at Guildford Cathedral at the end of September. Contact The Royal Surrey County Hospital for further

information. Tel: 01483 571122.

FROM THE CHAIRMAN OF THE POLICY COMMITTEE

“Withdrawing or withholding life prolonging treatment”

The attention of members is drawn to this BMA document providing guidance for decision making. (Published by BMJ books London 1999). Stephen Luttrell has provided an editorial for the BMJ, June 26th 1999. The BGS Medical Ethics Special Interest Group considers the guidance to be consistent with its own *“Guidance on Artificial Hydration and Nutrition in Elderly Patients”*, which is in the current compendium. BMJ guidance can be supplemented by the “overview” article published by Professor Lennard-Jones on behalf of BAPEN in the Royal College of Physicians of London Journal (volume 3, No 1, January 1999).

On the advice of the Medical Ethics SIG, we are not publishing a summary of the guidance as it is considered that the document is better read as a whole document since it is the approach to decision making which is the key issue, and selected extracts maybe misleading.

The BGS and service accreditation

We are aware of a variety of organisations becoming involved in this area, sometimes for commercial reasons. The BGS is a co-founder and sponsor (this might need changing) of HAS 2000 although it is clearly a separate organisation and not a BGS function. The BGS members have and still do contribute to the work of Health Services Accreditation (HSA). This involvement by no means suggest BGS commendation or approval of either the content or the methods that this organisation may use now or in the future. Other accreditation bodies may also involve BGS members locally or nationally in discussions about appropriate standards and their implementation. It is important that the BGS identity is not used to give such organisations or their documents the authority of having a BGS imprimatur.

Dr F C Martin
Chairman, BGS Policy Committee

THE 1989/99 RESEARCH INTO AGEING
EDGAR PALAMOUNTAIN PRIZE FOR PUBLISHED RESEARCH

Calling all research active members of the BGS!

Award: £500 annually

Closing date: 12 November 1999

Have you published a paper in a refereed journal of which you are particularly proud or which you believe to be of importance to our field during the period June 1998 to July 1999?

If the answer to this question is 'yes', then you are eligible to apply for the Research into Ageing (RIA)/ BGS publication prize, the **Palamountain Prize**, generously endowed through RIA and now increased in value to **£500** each year. For 1999 applications will be considered up to and including Friday 12 November, with the award of the prize to be made at the December Millennium ("Autumn") Meeting - so now is the time to act! The newly enhanced prize will, thereafter, normally be presented each year to the winner at the Autumn Meeting of the Society, with adjudication normally occurring after a deadline of the end of August.

How to apply

Submit a copy of your paper to the BGS office not later than the above date, together with a maximum one side of A4 indicating what you believe to be the paper's particular merits. There are no application forms. Priority will be given to original research, but cutting edge leading or review articles in refereed journals may also be submitted. If you wish to make a nomination on behalf of an author (with the author's agreement), that will also be acceptable, using the same format. *The prize will be awarded to the first named author, but all other named authors will be awarded a certificate in recognition of the achievement.*

The purpose of the prize award, for which the Society is indebted to RIA, is to enable the charity to support and encourage research excellence specifically amongst

BGS members in a highly tangible way (alongside its existing research grants programme).

BGS members have published a large volume of high impact work over the relevant period. If you are one such contributor, or you know of one, you are strongly encouraged to take this opportunity of applying to have the work's merit openly recognised through this mechanism. The adjudication committee anticipate reviewing a highly competitive field of publications, but you have nothing to lose by submitting an application!

Please would **Regional Branch Secretaries and Heads of Academic Departments** ensure that all members of the Society are fully aware of this opportunity.

Cameron Swift
Chairman, Scientific Committee

MANY THANKS TO MPs FOR THE SUPPORT GIVEN

The Society has had an encouraging response from Westminster MPs asking for their support for the Royal Commission's recommendations (see page 5 of this Newsletter). We would like to thank the following MPs in particular who were extremely helpful and are obviously committed to the welfare of their elderly constituents and look forward to their continued support on this vital matter.

Betty Williams
John Hutton
Paul Flynn
Frank Field
Nigel Waterson
Eddie O'Hara
Vincent Cable

Archy Kirkwood
Malcolm Wicks
Paul Burstow
Ted Rowlands
Doug Naysmith
Lynne Jones

REVIEW SYLLABUS IN GERIATRICS

The American Geriatrics Society (AGS) and Novartis Foundation for Gerontology have recently launched a website on an **International Review Syllabus in Geriatrics** at www.healthandage.com/fphysi.htm based on the 4th edition of the *AGS Geriatric Review Syllabus*. Its objectives are, for example, to facilitate access to comprehensive educational material in geriatrics.

Contact: info@healthandage.com or the Novartis Foundation for Gerontology, Postfach 4002, Basel, Switzerland, for more information.

HIPFEST 3

“Audit and Guidelines in Hip Fracture Care”

Queen Mother Conference Centre, RCP Edinburgh

1 October 1999

Topics include: hip fracture - the challenge; improving care - the goal of audit; audit data collection - new approaches; STARS Trial - the story so far; and rehabilitation.

Fee: £40 including lunch.

Contact: Lee Ross, RCPE, 9 Queen Street, Edinburgh EH2 1JQ. Tel: 0131 225 7324. Fax: 0131 220 4393. Email: l.ross@rcpe.ac.uk.

PULSE WAVE ANALYSIS

2nd European Meeting on Pulse Wave Analysis

Royal Society of Medicine, London

4 October 1999

The scientific programme includes oral presentations by guest lecturers, discussion sessions and poster presentations. Topics will include:

- u methodology and validation of pulse wave analysis;
- u clinical evaluation and emerging applications; and
- u application to cardiovascular and pharmacological research.

Fee: £195.

CME credits: 6 hours (only for UK physicians).

Registration forms and information on remaining sponsorship opportunities from the Secretariat: Hampton Medical Conferences Ltd, 127 High Street, Teddington, TW11 8HH. Tel: 0181 977 0011.

DRUGS & PRESCRIBING SECTION

DPS meeting

The Hilton, Kensington, London

6 October 1999, 11.30am - 4pm

Sessions on the basic science of pain and evidence based pain relief.

Fees: £40/(£50) (DPS members); £50/(£70) (non-members) (cost for residential delegates in brackets).

.....
SpR training afternoon in Clinical Pharmacology & Therapeutics and Spring Meeting of the DPS

Belfry Hotel, Warwickshire

9 to 10 March 2000

Aspects of drugs and therapeutics relevant to ageing will be covered, followed on the second day by the DPS Spring Meeting.

Fee: £80 (includes training, dinner, accommodation and DPS meeting).

Registration: Cal Communications (for both above). Tel: 01273 623630.

AGM AND COUNCIL STUDY DAY

**AGM, 12.15 pm, Council Study Day, 9 am- 12 pm
7 October 1999**

RCP London

The AGM of the British Geriatrics Society will be held in October to transact statutory business.

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

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

STROKE MANAGEMENT

The Science and Art of Stroke Management

The Postgraduate Centre, Clatterbridge Hospital, Wirral

14 to 15 October 1999

This further and updated two-day stroke management event will cover topics such as: organised stroke care; medical management of acute stroke; dysphagia and nutrition; stroke rehabilitation research; and higher cerebral function - cognition and speech.

Fees: one day £80; two days £150.

Registration: by 28 September.

Contact: Ruth Plant, Research Nurse, c/o DME Secretariat, Wirral Hospitals NHS Trust, Clatterbridge Hospital, Bebington, Wirral L63 4JY. Tel: 0151 604 7434. Fax: 0151 482 7691.

CHALLENGE OF HOSPITAL NUTRITION

Royal Society for the Promotion of Health/Canterbury Christ Church University conference on “The Challenge of Hospital Nutrition”

Kensington Town Hall, London

20 October 1999

Topics include: medical and nursing perspectives on hospital nutrition; nutrition supply chain; dietetic view; drug-nutrient interactions; nutrition and cancer; and the elderly perspective.

Contact: Brenda Didmon, Canterbury Christ Church University College, North Holmes Road, Canterbury, Kent CT1 1QU. Tel: 01227 782838. Email: nutriconf@canterbury.ac.uk.

**COST EFFECTIVE FREE
LONG-TERM CARE**

“Why is it cost effective to make long-term health care free?”

Royal Society of Medicine,
London

26 October 1999

Topic include the findings of the Royal Commission on Long Term Care, *‘With Respect to Old Age’*, and the implications of both ignoring and accepting its proposals.

Fees: £15 (Fellows); and £25 (non-Fellows).

CME credits: 2 points.

Registration: Debbie Smith, Academic Dept, RSM, 1 Wimpole St, London W1M 8AE, tel: 0171 290 2984, fax: 0171 290 2989, email: Debbie.smith@roysocmed.ac.uk.

QUALITY OF CARE

Measuring Quality of Care for Older People

RCP London

20 November 1999

See insert in this Newsletter for details or contact Luna Islam on 0171 935 1174.

ACTIVE AGEING

The Geriatrics Society of India Conference on “Active Ageing”

Hotel Ashok, New Delhi

12 to 14 November 1999

There is now a website with details of this conference on www.geriatricsindia.com/conference.html. For further details on the ASI, see May 1999 Newsletter, page 22.

Abstracts deadline: 30.09.99.

Contact: Conference Secretariat, K-49, Green Park, New Delhi 110016, email: opsharma@geriatricsindia.com.

**AUTUMN MEETING 1999
- REMINDER**

British Geriatrics Society
Autumn Meeting

Novotel, Hammersmith,
London

15 to 17 December 1999

The provisional programme with registration forms and accommodation details are included in this issue of the Newsletter.

Abstracts: the deadline for receipt of abstracts has now passed. Notification of the Scientific Committee’s decision on the acceptance of abstracts will be go out after the Committee meets on 21 October 1999.

For conference details contact: BHM, 1 Arun house, River Way, Uckfield, East Sussex TN22 1SL. Tel: 01825 768 902. Fax: 01825 768 864. Email: contact@bhm.co.uk.

**UPDATE IN
GERIATRIC MEDICINE**

5th Annual Conference
“Update in Geriatric Medicine”

Imperial Hotel, The Promenade,
Llandudno, North Wales

4 to 5 November 1999

This conference is aimed at SpRs, staff grades and clinical assistants in geriatric medicine. Its aim is the diagnosis, assessment and clinically effective management of common disorders in elderly people.

CME/PGEA: applied for.

Contact: Marlene Maddock, Dept Secretary, University of Wales College of Medicine, Dept of Geriatric Medicine (North Wales), Glan Clwyd District General Hospital, Rhyl LL18 5UJ. Tel: 01745 534847. Fax: 01745 534668. Email: Marlene_maddock@hotmail.com.

**SpRs TRAINING
WEEKEND**

Training Weekend for SpRs in
North West Region

Low Wood Hotel, Windermere

19 to 21 November 1999

This training weekend for SpRs will start in the early evening on Friday 19 November. Topics covered are to be confirmed at a later date.

Contact: Dr Paul Baker, Consultant Geriatrician, Royal Bolton Hospital, Miverva Road, Farnworth, Bolton BL4 0JR. Tel: 01204 390991. Fax: 01204 390933. Email: paulbaker@drivehard.demon.co.uk.

**FUTURE BGS
SPRING MEETINGS**

The Society’s next scientific meetings will be held in:

London	15-17 December 1999
Warwick	5-8 April 2000
London	19-20 October 2000
Cardiff	5-7 April 2001.

The venue and date for the Spring Meeting in 2001 has been changed due to unforeseen circumstances. We are grateful to Prof Woodhouse, Dr Freeman and Dr Sastry for offering Cardiff as a venue at short notice.

The Cardiff team had originally planned to host a Spring Meeting later in the new decade, after the new Assembly Building had been completed. Notwithstanding the absence of this edifice, we are sure the welcome in Cardiff will be just as warm.

BGS NORTHWEST

Forthcoming meetings for SpRs

Please refer to July 1999 Newsletter for dates of forthcoming meetings which are mandatory for SpRs in the Northwest Region.

Contact: Dr Paul Baker on 01257 427571, fax: 0870 056 9670, email: paulbaker@drivehard.demon.co.uk for any further details.

NEUROBIOLOGY

5th International Symposium on Neurobiology and Neuroendocrinology of Ageing

Mehrerau Monstery, Bregenz, Austria

23 to 28 July 2000

Topics include: interrelationships between the different types of pathologies contributing to cognitive decline and dementia; brain glucose and energy metabolism in sporadic Alzheimer; genetics of Alzheimer's disease; behavioural changes during ageing; cell cycle regulation in ageing; and estrogens and ageing.

Contact: Richard Falvo/Andrzej Bartke, Dept of Physiology, LSII 245, Southern Illinois University School of Medicine, Carbondale, Illinois, USA 62901-6512. Fax: 618 453-1517. Email: rfalvo@som.siu.edu or email: abartke@som.siu.edu. Website: <http://www.som.siu.edu/physiology/bregenz.html>.

GERIATRIC MEDICINE IN AUSTRALIA

Australian Society for Geriatric Medicine

Office Bearers for 1999/2000

President: Dr Robert (Bob) Penhall
Immediate Past President: Prof Robert Helme
Honorary Secretary: Dr James Tulloch
Honorary Treasurer: Dr Roger Clarnette.

All correspondence should be directed to the Hon Secretary at: ASGM Inc, 145 Macquarie Street, Sydney, NSW 2000. Tel: (61-2)9256 5460. Fax: (61-2) 9241 3458. Email: asgm@racp.edu.au. Website: www.racp.edu.au/asgm.

REMINDER OF NEW EMAIL ADDRESSES

New BGS administrative office email addresses

Richard-Lynham@bgs.org.uk - for all general management enquiries.

Recia-Atkins@bgs.org.uk - for Policy Committee, financial matters and Compendium enquiries.

Rawia-Habiby@bgs.org.uk - for Newsletter and Annual Report enquiries.

Caroline-Houston@bgs.org.uk - for Training Committee, Handbook, grants/awards, membership and CME enquiries.

PAPOFF SOCIETY

The Society for Physical Activity for the Prevention of Osteoporosis, Falls and Fractures

This Society was formed earlier this year in China at the International Conference on Osteoporosis. Its aim is to encourage physical activity at all ages of life, particularly with a view to improving bone strength, muscle function and postural stability, and with the ultimate goals of reducing the risks for falls and fractures. This is a multidisciplinary scientific society which encourages further research in the field and promotes education to the public and health care professionals alike.

For further details contact: Dr T Masud, Secretary, PAPOFF, Nottingham City Hospital, Nottingham NG5 1PB (email: tm@nchhce.demon.co.uk) or Dr Ole Simonsen, President, PAPOFF, Email: simonsen@comvision.dk).

MEMBERS ON EMAIL - CONTACT US!

We know you are out there. We just don't know your email addresses! The BGS office would be grateful if you could send an email to: Caroline-Houston@bgs.org.uk, so that we can add you to the email address book and future Handbooks. (And thanks go out to those who have already done so!)

published by

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