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The traditional role of the Society

For "...the relief of suffering and distress amongst the aged and infirm by the improvement of standards of care for such persons..." (an extract from the Society’s Memorandum of Association).

Old people have changed. When I first began training as a geriatrician, it was generally agreed that old people then exhibited ‘high toleration and low expectation.’ This may still be true of the over-80’s but, of course, when you and I are in our 80’s, we shall have high expectations and will not put up with any nonsense.

A frail-friendly service is...expert at recognising and alleviating fear, anxiety and pain, impaired function and immobility, and atypical cognition and affect. All this with the important proviso that older adults are a heterogeneous group: ‘one size does not fit all.’

Marjory Warren’s contribution updated:
- Adequate assessment
- Accurate diagnosis
- Appropriate treatment
- Aftercare
- Advocacy: for patient and specialty
- Alliance
- Accountability

Marjory Warren may have started with a view to serving all old people, but we now focus our attention on the frail, older adult.


STATUTORY INFORMATION

Registered Office
British Geriatrics Society
Marjory Warren House
31 St John’s Square
London
EC1M 4DN

Bankers
The Royal Bank of Scotland

Company Number
1189776 (England & Wales)

Charity Number
268762

Auditors
Sargent & Co
Chartered Accountants & Registered Auditors
194B Addington Road
Selsdon
South Croydon
Surrey CR2 8LD
Report from the UKMC
Professor Graham Mulley, President of the BGS

The Trustees of the United Kingdom Management Committee are pleased to present this report to you, which once again demonstrates the strength and talent of so many Society members in furtherance of our charitable objectives.

Our Charitable Work – A Year of Considerable Activity
The commitment to increasing our spending on a range of clinical research and training initiatives has seen a full year’s funding to support our prestigious Fellowships, through to increased funding for trainees in the form of Specialist Registrar / Specialist Trainee grants; indeed, our charitable expenditure now accounts for 86% of the Society’s total.

The Society was one of the first whose Trainees have undertaken the new Specialist Certificate Examination (formerly Knowledge Based Assessment), which has called for substantial input both in terms of expertise from a range of members and financial outlay; we consider this to be central to our charitable commitments towards our younger members.

Trustees have agreed that the CME Journal of Geriatric Medicine is worthy of long term support, to assist more senior members in their quest to keep up to date in our specialty.

You will find more details on the financial contributions to the Society’s objectives within the Treasurer’s report (which can be found on page 26.), together with the varied activities of the many committees, regions and national councils during the past year, details of which appear later in this report. Members should feel assured that the Society has enjoyed a most productive year.

Responses to Government and Others
We have once again been very active in ensuring that we respond to requests for assistance, and we remain grateful to the many members who have devoted their time and expertise to ensuring that the Society’s views are taken into account. We have responded to:

- Departement of Health:
  - Medical Profession (Miscellaneous Amendments) Order 2008;
  - Future regulation of health and adult social care; NHS Next Stage Review – our vision for primary and community care;
  - A review of the consequences of additional private drugs for NHS care;
  - Transforming the quality of dementia care – consultation on the National Dementia Strategy;
  - The NHS Constitution;
  - Changes to arrangements for regulating NHS bodies in relation to healthcare associated infections for 2009/10;
  - The case for change – why England needs a new care and support system;
  - Safeguarding Adults – No Secrets Guidance;
  - Developing the Quality and Outcomes Framework – proposals for a new, independent process;
  - End of Life Care Strategy – Quality Markers Consultation;
  - Review of prescription of Anti-Psychotic drugs to people with Dementia;
  - New Medical Specialty – Acute Internal Medicine;

- Royal College of Physicians (London):
  - Physicians and the Pharmaceutical Industry; Clinical Quality Indicators;

- Welsh Assembly Government:
  - The National Framework for Continuing NHS Health Care; Changes to NHS Structures across Wales; The Care Standards Act 2000 – proposed changes to the adult placement scheme regulatory framework and national minimum standards;

- General Medical Council:
  - Confidentiality; Eligibility for inclusion in the specialist register; Tomorrows Doctors;

- Care Quality Commission:
  - Enforcement Policy; Reviews in 2009/10; Statement of Involvement;

- All Party Parliamentary Group:
  - Access to PD Services; Dementia Care Skills;

- HM Government:
  - Preparing for our ageing society;

- House of Commons Health Select Committee:
  - NHS Next Stage Review;

- Nuffield Bioethics:
  - Dementia – Ethical Issues;

- NHS Security Management Service:
  - Marking the electronic records of violent patients;
Royal College of General Practitioners: Primary Care Federations – putting patients first;

NHS Information Centre: Clinical Quality Indicators;

NHS Clinical Knowledge Summaries Service: Stroke and TIA.

Standing Committees, Special Interest Groups and Sections

The past year has seen the valued addition of the Clinical Practice Evaluation Committee to our group of Standing Committees, a worthy recognition of their input to our work on clinical guidelines. The other Standing Committees of Academic and Research, Editorial, Education and Training, Finance and Policy have continued their respective areas of activity which you will read more of in the pages that follow. We must also recognise the activities of our Special Interest Groups and Sections, who contribute most ably to the work we carry out.

The National Councils

The respective Councils for England, Wales, Northern Ireland and Scotland continue to play an influential role as the NHS policies evolve, and we are grateful for their input into national policies.

Relationships with Other Organisations

We continue to work with a wide range of both medical and non-medical organisations across the UK. You will find references to these various collaborations throughout the report. We will continue to forge new alliances as the opportunities arise.

The Society’s Strategic Review

The beginning of 2009 saw Trustees approve the review carried out through the latter part of 2008; there are many new initiatives in the pipeline which we feel will strengthen the Society in the years ahead. The full document can be accessed via the following link: www.bgs.org.uk/PDF%20Downloads/08BGS_Strategic_Review.pdf

Secretariat

We are most grateful to the staff who have once again demonstrated their dedication and professionalism in assisting the membership achieve so much.

The Future

Trustees are very aware of the current economic climate, which is already having an impact on the Society. Members can rest assured that all parts of the organisation are working hard to ensure that we come through this period with the minimum level of impact on our charitable activities. We hope you will take time to read the individual reports which follow; the Trustees fully commend its contents to the members.

It is always worth reminding politicians in every democratic jurisdiction, that old people both remember and vote. For us in geriatric medicine, old people are our potential political allies (as are their children - ‘the boomers’). We must encourage non-frail elders to say to our universities: ‘Why don’t you produce professionals who know how to care for us?’ and to various ministers of he alth: ‘Why don’t you employ people who know how to care for us?’
Celebrating the NHS’ sixtieth anniversary last year, the Health Service Journal published a list of “NHS Heroes – the 100 most influential figures in the NHS”. The founder of our specialty in the UK, Marjory Warren, was 18th in the charts, but one of the highest placed doctors. She was credited for “highlighting the needs of older people”, “beginning to improve services for them” and “inventing the specialty of geriatric medicine”.

A good deal of public discourse on the ageing population today, is coloured by so-called apocalyptic demography. Highly variable demographic forecasts are cited; there is an over reliance on homogenisation of populations of older people and there is a failure to appreciate that despite considerable increases in the numbers of older people, the “dependency” ratios in the developed world are likely to be relatively stable from 1997 to 2015. At our scientific meeting in October, Steve Illife, professor of primary care for older people at University College London, said: “It’s true that illness increases with age, but people are ageing more slowly now and illness and age are disconnecting. Most gains in life expectancy are occurring without disability”.

So, who is old? Who should be under the care of a geriatrician? Sixty years ago, our specialty’s founders concerned themselves with addressing functional disability arising from illness under the heading of so called “giants of geriatrics” including incontinence, instability, immobility and impairment. Systems were set up to identify those who needed geriatric care based on a guide of 65 years of age, but as older people live longer and have better expectation of good health, this has shifted upwards to 70, 75 or higher. At the same time, there are some younger patients who may benefit from care by geriatricians.

The year under review continues to see geriatric medicine swept along on the tides of various Government initiatives. Greater personal choice for patients and a drive to take quality care to the patient in his/her home vises constantly with a need for greater economies, and no doubt the latter will play an even greater part in policy making as the financial crisis bites deeper in years to come. Geriatric Medicine continues to adapt with a range of local initiatives, driven by individual geriatricians.

But however fragmented national policy may be, and however reliant older people’s care is on the dedication and the ingenuity of individual geriatricians, the fundamental principles of good care remain universal. Wherever care is delivered, be it hospital, care home, or private home; the principles of comprehensive assessment, holistic treatment with good follow up, monitoring and adjustment to any changes in the patient’s condition, all delivered in such a way as to allow the patient his/her dignity and all with a view to enabling the patient to live as independent and active a life as his/her health will allow - these aspirations cannot be changed.

A recently published report by the US Census bureau states that within 10 years, for the first time in history, older people will outnumber younger people throughout the world. Referring in particular to the rise in numbers of the “oldest old” (over 80’s), the report claims that this is a “massive human success story: life expectancy increases because of better education, greater wealth, lower infant mortality, better healthcare, less disease, the reduction of armed conflict, and the development of technology and its application in pursuit of good. While an ageing population brings its economic challenges, we should celebrate the phenomenon. Why do we even have a concept of public health, of co-operation, of sharing knowledge, if not to extend life, wherever we find it?

References:
1. Desmond O’Neill, BGS Newsletter Oct 2008 Issue 18 ISSN 1748-6343 18
2. David Oliver, BGS Newsletter August 2008 Issue 17 ISSN 1748-6343 17
Older People's Specialist Society Forum (OPSF)
The English Council has coordinated aspects of its work with the OPSF. This is a national, multi-professional group currently hosted and administered by the BGS. The forum aims to maximise its influence on emerging policy for older people in England by producing joint responses on behalf of the participating specialist societies. We have produced joint responses to the National Dementia Strategy Consultation, Darzi Review and the Department of Health “Prevention Package for Older People.”

National Audit of Intermediate Care
We have made significant progress towards a national audit of intermediate care. The audit format and question content have been developed. Pilot work is underway and these provisional findings will be reported at a workshop during the BGS Autumn Meeting.

Engaging the Regions
There has been a concern that work needs to be done to improve opportunities for the BGS membership to have a stronger voice in the Society’s affairs. Several new initiatives are now underway:

- To clarify the role of regional officers;
- To develop a process to validate regional e-mail lists and thereby improve communication with members;
- To conduct a debate in the regions about a possible expansion of the BGS membership to non-medical practitioners;
- To consider how we can develop regional networks for elderly care medicine with a core aim of supporting service commissioning.

Acknowledgement
The English Council wish to thank Duncan Forsyth in his role as chairman. He led the Council with tireless commitment and considerable skill.

English Council Consultation Responses

Department of Health
Future regulation of health and adult social care;
NHS Next Stage Review: our vision for primary and community care;
The NHS Constitution;
Changes to arrangements for regulating NHS bodies in relation to healthcare associated infections for 2009/10;
Responsible officers and their duties relating to the medical profession;
The case for change - why England needs a new care and support system;
Developing the Quality and Outcomes Framework: Proposals for a new, independent process;

House of Commons Health Select Committee
NHS Next Stage Review;

NHS Security Management Service
Marking the electronic care records of violent patients;

NHS Information Centre
Clinical Quality Indicators (Quality Metrics);

RCP London
Clinical Quality Indicators (Quality Metrics);

Care Quality Commission:
Enforcement Policy Reviews in 2009/10
Statement of Involvement.

In a frail-friendly organisation, particular attention is given to communication with patients and their families, to a physical environment which does not aggravate disability, to staff behaviours which facilitate rather than frustrate, and to a pro-active dynamic which anticipates and predicts problems.
We have had a busy year in Northern Ireland.

**Governance**
The implementation of the Review of Public Administration (RPA) continued apace. The five new integrated Health and Social Care Trusts (HSCT) which had replaced eighteen previous Health and Social Services Trusts continued to establish and consolidate their structures against a background of financial insecurity. The latter was due to the imposition of an exacting Comprehensive Spending Review on top of a recurring underlying deficit inherited from the previous Trusts. The resulting shortfalls have resulted in rapid and in some cases radical changes in service provision. Many BGS members in all of the new HSCTs are of the view that the brunt of the change has fallen on services for older people. During this year, we have seen significant reductions in existing (usually hospital based) provision, together with development of Intermediate Care (IC), a relatively recent phenomenon for us. The NI Branch is currently carrying out an audit of services, taking into consideration both prior provision and new Intermediate Care provision. This is proving somewhat problematic, due to the rather sketchy information about the latter, and the very patchy involvement of geriatricians in its planning and delivery.

**Commissioning**
At the same time, the development of the local Commissioning process, also subject to RPA attention, was delayed due to a last minute rethink. Three new commissioning and support bodies were finally to be established on 1 April 2009 to replace four previous Health and Social Service Boards. The relative role of these bodies and that of the pre-existing Local Commissioning Groups will no doubt become clear in time.

**Intermediate care**
Geriatricians are used to working in “interesting times” (in the Confucian sense), and this time of challenge is also a time of opportunity. The existing extensive knowledge base within the BGS Intermediate Care has proved an invaluable asset to a number of local members who have been able to use this as an opportunity to get involved in planning and strategic development of services, as well as in delivery. We were very pleased when Professor John Gladman was able to join us for our scientific meeting in October 2008. John was able to give us a clear and sometimes humorous description of the development of IC in England and Wales. This was followed by a spirited debate on the motion “This House Believes that Intermediate Care will Save the NHS”. Anyone interested in the outcome of the debate is advised to contact the writer on a direct and confidential basis!

This year also saw an extremely useful scientific meeting, held jointly with the NI Branch of the Royal College of Psychiatrists. This meeting was attended by the Master of the Office of Care and Protection and the Official Solicitor from the Office. In Northern Ireland these officials carry responsibility for the proper management of the financial affairs of those no longer competent to do so themselves. We also had useful talks on mental capacity assessment and the emerging role of PET-CT scanning in dementia.

**Recognising old friends**
The year was marked by occasions of sadness and encouragement. We were sad to learn of the deaths of longstanding BGS members Nessie Maybin and Campbell Ball. They had both worked alongside George Adams (a BGS Founder Member) in developing his groundbreaking service based at Belfast City Hospital.

We were encouraged to mark the contribution of a non-member, Professor Faith Gibson, when we presented her with the Society’s Relief of Suffering medal in token of a lifetime’s contribution to services for older people, particularly those with dementia. We were also encouraged by the appointment of Dr Joan Harbinson as Older Person’s Advocate in the Office of the First Minister and Deputy First Minister, preparing the way for the appointment of a Commissioner for Older People. Also, following lobbying by BGS and others, the local Minister of Health announced his intention to proceed with a Service Framework for Older People.

We have been approached during the year for views on several local strategic documents. We are determined to ensure that BGS becomes the leading professional voice in relation to older people’s health and social care services.

We anticipate an even more “interesting” year in 2009/2010.

It seems appropriate to end with a quotation from Henry Louis Mencken, a famous US figure of the 1920s. His assertion that “Old age ain’t no place for sissies” seems relevant, particularly when referring to specialists working in the area.
Important areas from the BGS Cymru Wales Programme over the last year have been:

**Community Work, Frailty and Intermediate Care**
There has been continued work on the frailty model and in particular, its use as a commissioning tool. Much of this was summarised in the recent article in the Newsletter. It may be appropriate to base the method of commissioning health care in this group on care pathways derived from the frailty concept.

**Links with Age Concern Cymru**
Partnership working with Age Concern Cymru (ACCymru) has continued. This will develop further now that Age Concern Cymru and Help the Aged have merged. This occasion was recently marked by a breakfast meeting in Cardiff. The importance attached to older people in Wales was emphasised by the fact that the First Minister and the Deputy Minister for Health and Social Services attended and spoke.

**Stroke**
Despite controversy generated by a recent programme on Welsh television, improvements in Welsh Stroke Services continue and are led by the Welsh Stroke Alliance. Recent correspondence with the Minister of Health and Social Services has produced a positive response.

**Meetings**
We had very successful regional meetings in Swansea (Organised by Dr Abhaya Gupta) and Aberystwyth (Organised by Dr Phil Jones). We were particularly pleased to welcome Dr Jerry Playfer (Past President BGS) to the Swansea meeting, where he spoke and equally delighted that Professor Graham Mulley was able to attend the meeting in Aberystwyth, where he gave a keynote address. This, I think is an excellent marker of the close and constructive relation between BGS Cymru Wales and BGS UK.
Responses to Consultative Documents
We have provided written response and comment concerning:

- Proposals to Change the Structure of the NHS in Wales
- National framework for continuing NHS Health Care
- The Care Standards Act 2000.
- Anti-platelet Therapy in Wales - Consultation

Personalia
We were much saddened by the death of Professor John Pathy. His contribution to Elderly Care in Wales is unique. Many consultants currently practicing in Wales were trained by him and thus his influence will persist.

Professor Bim Bhowmick was recently awarded the Bupa Foundation Care Award 2008 for his work in Gwent on a new community-based service which aims to ensure that older people receive the care and treatment they need in the comfort of their own homes. This initiative is helping to reduce the huge burden on the NHS as a result of unnecessary admissions.

Pradeep Khanna, Consultant Physician, Care of the Elderly and Chief of Staff for Community Services, Gwent Healthcare NHS Trust, has been appointed Professor in the Department of Health & Science at the University of Glamorgan. This is a consequence of his interest and work in Community Services and Intermediate Care. This is a remarkable achievement and I offer Pradeep our sincere congratulations on this well deserved recognition.

Training tomorrow’s geriatricians
Chairman: Prof Tahir Masud
Tahir.Masud@nuh.nhs.uk

The Education and Training Committee (ETC) is committed to developing and promoting high quality undergraduate and postgraduate training in geriatric medicine across the UK. Dr Rhian Morse completed her time as chair of the ETC in June 2008 and I’d like to thank her for her hard work and leadership over the previous 2 years. The ECT has been heavily engaged in many issues over the course of the 2008/9.

SAC – Joint Working
The ETC continues to work closely with the Geriatric Medicine Specialist Advisory Committee (SAC) in matters relating to higher specialist training. A major cause for concern for trainees and trainers in 2008 was that the JRCPTB and PMETB had announced that the 2007 and 2008 starting cohort of SITRs would not get full accreditation in General Internal Medicine, but instead would be accredited as a “level 2” in Acute Medicine which would allow them to take part in acute rotas. Conversely, trainees starting in 2009 would be able to receive dual accreditation in both Geriatric and General Internal Medicine. Both the ETC and the SAC felt very strongly that this was unfair to the 2007 and 2008 cohorts and lobbied both JRCPTB and PMETB with the trainees. This effort proved very productive because it led to a special meeting where this decision was reversed and it now means the 2007 and 2008 cohort of trainees can gain dual accreditation CCTs.

The ETC has continued to work with the SAC on developing and evaluating the work based assessments, and also in making sure that the developments in stroke medicine mean that the training in stroke to our trainees is improved without compromising the rest of geriatric medicine training.

Consultations
The ETC took a number of opportunities to contribute to the various inquiries emphasising issues relevant to the care of older people. We produced four responses on behalf of the President/Society.

- Department of Health - Medical Profession (Miscellaneous Amendments) Order 2008;

Training Website
2008/9 has seen further development and refinement of the BGS website dedicated to education and training, thanks to several members of the ETC who have helped with the excellent development work done by Recia Atkins, Chris Turnbull and Sarah Allport. These pages continue to be modified and updated. It is hoped that the website will provide guidance to both trainees and trainers at a time of great change in postgraduate education, including the development of e-portfolio and the mandatory use of work based assessments.

Speciality Certificate Examination
Formerly called the Knowledge Based Assessment (KBA), the Speciality Certificate Examination (SCE) has now firmly established as a mandatory assessment for all trainees in Geriatric Medicine who started on a numbered post from August 2007 onwards. The SCE was developed as a partnership arrangement between the Federation of the Royal Colleges and the specialist societies, utilising the expertise of the MRCP (UK) Office to develop the examinations. There has been justified concern among the trainees regarding the cost of this examination (around £800) and the ETC lobbied the JRCPTB regarding this issue and continues to argue that the costs to the trainees should be kept to a minimum. We were also concerned that trainees who failed the SCE may have to pay again to retake the SCE. The ETC is working towards developing a “hardship” fund for the few trainees who, due to special circumstances, may need financial help to take the SCE.

The first Geriatric Medicine SCE took place on the 4th March 2009. Fifteen candidates took the exam and all passed (the only speciality where everyone passed). The online examination consisted of 2 papers of 100
questions each (based on the best of 5 possible answer format). A big thanks goes to Dr Oliver Corrado, Specialty Lead for the SCE and the many members of the society involved in the question setting and standard setting groups.

Training in Continence Care
Dr Rhian Morse and her team from Cardiff conducted a national survey, on behalf of the ETC, of the depth of training in continence care received by trainees. This was an important survey which has highlighted important gaps in training in this subject. The ETC is naturally concerned that the training in one of the “Geriatric Giant” areas is becoming sub-standard, and is actively looking at ways to improve this. One idea being pursued is the development of training days which will provide comprehensive education on the subject and fill in any gaps for the trainees.

Undergraduate Teaching and Training in Geriatric Medicine
The ETC is keen to ensure that all medical students have good exposure and training in the biological, social and clinical aspects of gerontology and that the speciality of Geriatric Medicine should try and attract students early in their careers. On behalf of the ETC, two SpRs in Geriatric Medicine (Adam Gordon and Adrian Blundell) have been surveying all UK medical schools to see how they perform against a “gold standard” undergraduate curriculum in geriatric medicine. The first results are due to be reported later in 2009.

BGS Study Grants awarded over last year
The BGS gives out a number of study grants every year, which the ETC helps to adjudicate. For this year the following numbers were awarded: Nurses (32), Therapists (17), Medical Students Elective and Vacation Projects (11), and Young Doctors Education Grant (20). Medical students undertook projects as far afield as Samoa, India and the USA.

CME Journal Geriatric Medicine
This journal has now been adopted as the Society’s official CME Journal. The ETC has worked with Professor Sinclair to develop an evaluation strategy and continues to provide input to the editor to help continual improvement in the content and format so that the journal meets the needs of the BGS member readership. The initial feedback on the journal has been generally positive. The ETC also provides a member for the editorial board.

PACES
The MRCP PACES examination is due to have a format change in the later 2009 examinations. Station 5 format will be changed from four 5 minute stations to two 10 minute stations. The Royal colleges are keen to incorporate more geriatric medicine in this station and asked the Society to help in this process. At the start of 2009, a subgroup of the ETC formed to start working on this project with a view to developing scenarios to forward to the Royal Colleges later in the year.

Workforce Planning
The ETC does a regular survey of Trainees to help with future workforce planning. I’d like to thank Dr Nelson Lo, the lead for this role who puts together the reports, and to all the members of the ETC who help to provide the data in a timely way.

BGS Reading Lists
The ETC regularly updates the compendium reading lists as well as the Diploma reading list and again thanks to Drs David Heseltine and Rhian Morse who led on these projects this year and to the members of the committee who contributed.

National Headroom Interviews
Several members of the ETC helped with the national SIR headroom posts interviews in 2008 held in London. This was a time consuming process, organised by the Kent Deanery. There were important lessons learnt during this process which the ETC has fed back which will improve any future similar national interviews.

Liaison with the Academic and Research Committee (ARC)
The ETC has had discussions with the ARC regarding the issue of improving academic training and research for our trainees. The ETC is supportive of initiatives by the ARC to improve these aspects. Some members have expressed concern about difficulties in getting LAT cover if too many people in a programme take out of programme experience to do research. Nevertheless the ETC feels that trainees should be encouraged and supported to do good quality research projects and will continue to work with the ARC to help with the process.

Summary
The ETC continues to be active in trying to improve education and training in geriatric medicine. I’d like to thank the members of the committee who give up a lot of their valuable personal time to help with the activities of the ETC. A particular note of thanks goes to the trainees representatives Dr Zoe Wyrko, Dr Adam Gordon, Dr Claire Steves and Dr Peter Burbridge who were very active in bringing the views of their colleagues to the ETC. Also, I’d like to say a big thanks to Alex Mair, Sarah Allport, Recia Atkins and the team at Marjory Warren House for their help and support over the last year.
Trainees - tomorrow's consultants / Staff grade physicians and specialist associates

Specialist Trainees Group
Chairman: Dr Zoe Wycko
zwyrko@tiscali.co.uk

Objectives of the Trainees Committee
The Trainees Committee was constituted to represent the ideas and opinions of trainees within the BGS and to encourage junior doctors to be involved with the work of the Society. We represent qualified doctors who have chosen to undertake their specialist training within the field of Geriatric Medicine. Our role includes the dissemination of ideas and information throughout our group; our meetings at the twice yearly scientific conferences provide a forum for discussion of relevant issues predominantly related to training. We also aim to promote and encourage high quality research by trainees, whether as part of a taught degree or full time research programme.

Summary of the Committee activities
Trainee representatives sit on the majority of the Society’s committees. We hold three positions on the Education and Training Committee and Specially Advisory Committee in Geriatric Medicine; these have been the most active posts over the past year, with involvement in negotiations regarding training qualifications, re-writing of the geriatric medicine curriculum and discussions regarding the new Specialty Certificate Exam. We are also represented on the Finance Committee, Academic and Research Committee, CPEC and Policy Committees and there is trainee representation on all the national Councils.

The Chair of the Trainees committee is a trustee of the Society and also represents Geriatric Medicine trainees in various British Medical Association groups.

A new post of Meetings Secretary has been created to increase our involvement in organising the Scientific conferences and also to work towards establishing regular Trainees’ Educational meetings.

Individual Items
Members of the Committee carried out a survey of funding of Postgraduate Degrees among Geriatric Medicine trainees, and the results of this were published as a poster at the Spring Scientific Meeting. As a result of this research, a new ‘Masters Fellowship’ scheme is currently being established. Application will be via a competitive process but successful applicants will be able to have a taught Masters degree in a relevant subject fully funded by the BGS.

Further plans
Work will continue to ensure fairness and parity in ongoing training, and qualifications obtained at its completion.

We plan to continue to build on the communication links that have been recently established, to ensure that all trainees in Geriatric Medicine are as well informed as possible about the training issues that may affect them, and the work of the Society in general.

Staff Grade Physicians and Specialist Associates
Chairman: Dr Sue Morgan
suemorgan@doctors.org.uk

The objectives for the Staff Grade Physicians and Specialist Associates (SAS) Group are:

- To maintain an up-to-date register of all SAS doctors working within elderly care medicine.
- To provide support and assistance to members to fulfill their Continuing Professional Development.
- To act as a link to other specialist groups in order to facilitate involvement in audit and research.
- To maintain links with and offer support to the BMA and RCP for other matters such as revalidation, remuneration, working conditions, entry to the specialist register and career progression.

Activities this year
One subgroup meeting was held at the Autumn meeting, this had a disappointingly low attendance. A second subgroup meeting will be held by the Secretary at the Spring meeting.

Communication
The column for SAS doctors in the BGS newsletter unfortunately has not met with the objective of raising more interest from SAS doctors, so was been discontinued. Events of particular interest to SAS doctors will be announced by this means however, such as the forthcoming educational day.

Educational Day
A joint educational day funded by the London Deanery and supported by the BGS was advertised in the newsletter. The day is being organised by the BGS subgroup Chair.

Mentoring
The Chair has taken up the London Deanery’s mentoring scheme and is now involved with the Deanery promoting the scheme to other SAS doctors in teach-ins organised by the Deanery.

Representation
The Chair of the SAS group is now holding a seat on the RCP SAS doctors committee. This should improve links between the BGS group and the RCP group as well as the London Deanery.
The Society’s scientific meetings

AUTUMN MEETING (BIRMINGHAM)

Following a very successful Spring meeting in 2005 the Society returned to Birmingham for its Autumn 2008 meeting. It was hard to resist returning to Birmingham considering the excellent facilities at the International Conference Centre, travel connections and the vibrant city centre.

The programme covered most of the major areas of geriatrics and, judging from the feedback forms, the vast majority of the 500 delegates attending were not disappointed. The meeting followed the traditional format starting with a Wednesday afternoon symposium on the topical subject of Intermediate Care. The session covered various aspects of the subject including the role of the day hospital and organisation of services. The session was concluded with a Dutch perspective from Marcel Olde Rikkert.

The President’s welcome address paid tribute to some of Birmingham’s well known geriatricians including Bernard Isaacs and Jed Rowe. Delegates attending the "at the frontiers" session heard about some of the latest research originating from various departments in the UK. A number of parallel sessions were held on elder abuse, palliative care, education, falls and stroke High profile speakers presented in these sessions including John Ellershaw, who developed the Liverpool Care Pathway. The special interest groups of the Society play an important part in presenting interesting programmes relating to their area of expertise. This meeting was no exception with three very well received sessions from Cerebral ageing, Respiratory and Drugs and Prescribing sections. Steve Iliffe gave the Marjory Sutherland of Houndwood told the audience that the way of doing things.

Warren guest lecture. He gave an insight into catering for the future needs of elderly people. Chris Phillipson presented the Trevor Howell lecture. He outlined some of the dramatic developments that have happened over the past 50 years and called for sociological inputs into geriatric medicine to be truly effective. After the statutory Annual General Meeting the programme concluded with a plenary session on Managing Syncope. Considering it was a Friday afternoon, at the end of a busy meeting, a large number of delegates attended to hear popular speakers including Steve Parry and Rose Anne Kenny.

Delegates had the time to browse through 95 posters and had the opportunity to attend a dedicated session for scientific presentations. Sponsored symposia on hip fracture care, vaccination, Parkinson’s Disease, managing chronic pain and fracture prevention. All the symposia included speakers considered to be key opinion leaders in their respective fields and had programmes that complemented the main meeting.

This conference dinner was held in the impressive Council House located in Victoria square. Delegates attending the dinner would have found it difficult to avoid the Christmas spirit as they had to walk through a Christmas Market in the square. After a busy day delegates relaxed with friends and colleagues had a good meal and ended the day listening to a jazz quartet. Once again the Birmingham meeting proved to be a successful meeting both in terms of location and content of the programme. This augers well for a possible return in the future.

SPRING MEETING (GLASGOW)

In April 2008, the BGS returned to Scotland for its Spring scientific meeting. Once in decline after the closure of industries such as shipbuilding, Glasgow has been given a new lease of life. The conference was hosted in one such manifestation - the new Scottish Exhibition and Conference Centre on the banks of the Clyde.

Speaking as one of the keynote speakers, Lord Sutherland of Houndwood told the audience that the three major issues facing the western world were climate change, the provision of clean water, and ageing and demography.

Currently in the UK, for every three people of working age, one is pre-work or retired; within three or four decades the proportion will be two non–working to every three working members of society. In some G7 countries, such as Japan, the situation would be even worse.

Ageing is changing our culture and our civilization. “Unless we take it on seriously we’ll be in terrible difficulties. It’s good news in so many ways. As a 65 plus year-old man I think it’s marvellous, but we have to think about the implications for the economy and our way of doing things.”

The retirement age, for example, had to be reconsidered. One approach might be for people to take more time off when they had young families, on the understanding that they would then be active until the age of 70.

“The speed at which things are happening is incredible but we need a new vision of how society operates. We need to think of the talent and capacity of people now living into their 70s and 80s and how they can contribute to society. To do that though, you’ve got to meet their transport, housing and other needs. You’ve got to integrate health and social care.”
“You as geriatricians must contribute to this new vision. You have the expertise because of the profession you’ve chosen. You need to use your influence to make people in power think imaginatively and long term.”

Among the revolutionary strategies developing to change care of older people in the long term, is an increasing emphasis on telecare and e-health.

Richard Wootton, director of the Scottish Centre for Telehealth in Aberdeen, for example, described a scheme for online assessment and reporting which had been developed in Queensland.

The system had been set up as a way of tackling both the shortage of geriatricians in the area and the vast distances involved. The system’s effectiveness had been tested by asking geriatricians to diagnose dementia in 230 paired cases. One set was assessed by video link, the other by face to face consultation. Results were the same for both methods. Though further studies were under way, anecdotal evidence to date from over 1,200 assessments showed reduced length of stay and readmission rates. This is e-geriatrics of the 21st century in Australia.

Though the benefits of exercise were clear, actually getting older people to do it was more complex, and dependent on emotional, mental and societal factors, as Dr Nelson acknowledged in response to a question from the floor, on whether the doctors recommending it undertook exercise themselves.

Other themes featured in a varied programme included the perennial falls and bone health, and the so-called disability paradox (in which Professor Shah Ebrahim, professor of public health and policy at the London School of Hygiene and Tropical Medicine, described a fascinating study in Bristol which had traced 1,000 people from a pre-war nutrition and household income study and then timed them on a six minute walk. Those from a poorer household then, took longer to cover the distance now, suggesting that factors in infancy may have effects in later life.)

Unusually, there was a session on dentistry in which Petrina Sweeney, senior lecturer in adult special care dentistry at the University of Glasgow, described in her talk on dental health in the older patient the difficulties of oral care in old age, due to impaired dexterity as a result of arthritis.

Also in the area of telecare, are new devices, already in use or in development, included item locators, video and phone prompts and webcams linked to carers. Chris Nugent, reader in computer science at Ulster University said, “So, you can have messages saying ‘put your lunch in the microwave, take your medication or make sure the door is locked. People always say they would rather stay at home even if they’re at risk. The idea now is to tailor the support to the effects caused by the impairment so that they can experience greater autonomy and feelings of empowerment and thus an enhanced quality of life.

Another popular theme in more recent meetings is the value of physical training for older people.

Dr Miriam Nelson, director of the John Hancock Centre for Physical Activity and Nutrition at Tufts University in Boston, outlined some of the benefits of aerobic exercise including reduced risk of coronary heart disease, depression, osteoporosis, diabetes and hypertension. Muscle strength and metabolic rates could be boosted and bone health and balance improved. Studies suggested that the best effects came from moderately intensive exercise for 30 minutes, five days a week, or from vigorous exercise for 20 minutes three times a week. “This is relative intensity – what older people themselves see as intensive, not some super fit ideal.”

Also covered, were the issues of dignity, MRSA, and consumer issues. On the latter, Vikki Entwhistle, professor of value in health care at the Universities of Dundee and St Andrews said of older people’s services: “Satisfaction rates are often very high, especially among older people. But that can sometimes tell you more about patient characteristics than about the quality of the services. People often say things were OK despite poor experiences. They do this possibly because they ignore a few negatives if the overall experience was good”, once again, bearing out Colin Powell’s words that older people have high tolerance of inadequate service and low expectations of high quality service.
In collaboration with Rhian Morse, former Chair, and Tash Masud, current Chair of the E&TC, we canvassed the BGS membership to ascertain how the first few issues of the recently revamped CME Journal (edited by Duncan Forsyth) have been received. This review indicated satisfaction among many members as to the content and style of the journal and the journal has formally been adopted by the BGS as its official CME organ. This will be reviewed in two years.

We continued to represent the BGS at RCP Policy meetings and to evaluate the CPD merit of scientific and medical meetings that are being planned by geriatricians, for applications sent to the RCP website. Most of applications fulfill the standard CPD criteria but many lack evidence of sound educational principles to underpin the meetings. Most applicants fail to indicate precisely what the learning objectives are for the events.

Finally, working with Peter Belfield and Linda Patterson, I have been actively involved in discussions at the RCP (along with other society representatives) in the subject area of revalidation. At a meeting in June this year, we discussed the recertification pathway and how it links with the overall process of revalidation which is likely to affect us in 2010-11. It was stressed that revalidation is a 5-year process (and not a 5th year process (GMC)) and that the skills and competencies for BGS members with supporting CPD mechanisms.

Future CPD Activities
I am keen to ensure that other promising directions within CPD are explored. The following have been proposed as future CPD Initiatives within the BGS:

- Revising/enhancing the Rolling Programme 2009-12
- Ensuring that CPD initiatives are in line with Donaldson and other best practice including Revalidation
- Creating opportunities for new continuous collection of data relating to multisource feedback (MSF), audit, CPD, and teaching was essential. During the next 6 months we will be asking BGS members if they want to work towards specialty-specific standards in the framework document, what their views are on specialty indicators, and if they would like to have a specialty-specific MSF instrument.
Age & Ageing is the Society's scientific journal, published by Oxford University Press. It has seen its renown growing and we are very pleased to report that it has seen a significant rise in its impact factor to 3.052 for 2008.

We have made a small number of changes to the journal over the past two years, including the introduction of a short Editor’s View article in each issue, highlighting some of the key papers and their implications. These are now available as free access papers, which can be downloaded as HTML or pdf files. Hopefully, these articles serve not only as a ‘shop window’ for the journal contents, but may also encourage citation of some of the more important papers.

The time taken to process a manuscript from submission to first editorial decision continues to improve, with a mean and median turnaround time of less than 30 days. This reflects not only the efficiency of the Manuscript Central system, Editorial Office, Associate Editors and Reviewers, but also the increase in papers which are rejected outright without being sent for peer review. Although rejection without formal peer review may be disappointing to the authors, it avoids placing an unnecessary burden on our Reviewers and Associate Editors. Furthermore, sending a poor quality paper for peer review does little to enhance the reputation of the journal. Nevertheless, we plan to provide more specific feedback on the reasons for outright rejection, as this may potentially enable authors to improve future papers. With the help of the Associate Editors, we hope to develop a list of potential problems with a submitted paper (such as poor study design, inadequate statistical power, lack of new data and language problems), which can be used to highlight the reasons for rejection.

The annual page budget for volume 38 has been increased from 648 to 768 pages. This has reduced the back-log of accepted papers awaiting publication in the printed version of the journal. We will continue to monitor the balance of accepted papers and available pages, so that further adjustments can be made if necessary. We have recently introduced a formal Author Statement which reflects best practice in addressing the legal and ethical requirements in medical publishing and clearly sets out the responsibilities of the authors. The statement is designed to be as simple as possible, and should make the submission process more efficient and further simplify the instructions to authors.

The last year has seen developments in our website functionality with the addition of the e-letters facility which is moderated by Frazer Anderson. This is an electronic ‘letter to the editor’ function allowing readers to respond online to any published article or submit an ‘out of the blue’ letter to the editor. This function offers more rapid feedback, encourages online debate and the promotion of ideas for future articles. We hope these facilities will be taken up by our readers and look forward to seeing more online contributions.

Our memberships with the Committee of Publication Ethics (COPE), the International Society of Managing and Technical Editors (ISMTE) and Oxford Journals Editorial Resources Online (OJERO) continue to support better working practices and help us to explore new initiatives. Oxford University Press invited us to the Journals Day in Oxford, which was a great opportunity to learn from publishers and other editors about journal development, peer review management and publication ethics.

We look forward to holding another Associate Editors’ meeting this year to discuss ideas arising from these contacts about the future of online publishing. In the next year we look forward to developing our peer review systems, conducting an ethics audit and producing a themed issue.
The primary areas within the remit of the Academic and Research Committee (A&R) are:

a) to promote research within geriatric medicine and to promote a high standard of research;
b) to oversee the programme of continuing professional development of geriatricians through the vehicle of the Society’s scientific meetings;
c) to oversee the disbursement of scholarships and grants to those pursuing research or continuing professional development in the care of older people.

Among the committee’s main concerns in the period under review, were those of falling number of abstract submissions to the Society’s bi-annual scientific meetings and the falling attendances which impacts on the Society’s income and the ability to spread relevant new knowledge about Geriatric medicine.

It was therefore proposed to include within the scientific meetings, presentations from recipients of BGS scholarships who can provide the “human interest” story behind a move into academic and research medicine. It is hoped that these sessions, together with the regular “Meet the Professor” clinics and a newly introduced series of presentations showcasing academic departments of geriatric medicine, will encourage young doctors, who would not otherwise consider academic geriatric medicine. The first of these sessions will be held at Bournemouth in April 2009.

It was also proposed to canvass members to ascertain reasons for falling attendances. While we can make educated guesses as to why attendances are falling (squeezed local budgets, staff cover problems), we need to ascertain what areas we can change as opposed to those outside our control.

Grants
The total disbursement of grants is outlined on page 25.

BGS Fellowships and NIHR Status
The Society has fellowships each totalling £250,000, to be disbursed over three years. We have applied for NIHR (National Institute for Health Research) Partner Organisation status for the Society’s Fellowships. The NIHR Clinical Research Network is part of the National Institute for Health Research (NIHR) and forms a key part of the NHS R&D Strategy set out in the “Best Research for Best Health” (January 2006). This is an initiative committed to establishing the NHS as an internationally recognised centre of research excellence. It is being established on a phased basis and will provide the framework through which the Department of Health hopes to position, manage and maintain the research, research staff and infrastructure of the NHS in England as a virtual national research facility. (see www.cmcc.nihr.ac.uk/index/about/partners.html)

Yuste
For the past two years the University of Salamanca has held an International Joint Meeting in Geriatrics Medicine and Gerontology with the BGS. Each year the A&R Committee has identified, through the regions, 10 pre NTN students to attend the meeting. The University of Salamanca offer them free registration and free accommodation at a beautiful monastery in Yuste Spain. Past participants have reported that the programme is excellent and very useful to them. Dr Sinead O’Mahony (A&R Committee Chair), Dr Anthony Bayer from Cardiff and Mrs Joanna Gough from the BGS office publicised the programme, recruited for it and co-ordinated travel and accommodation arrangements.

Future Activities
In collaboration with other affected committees (CPEC, Education and Training), the A&R will be undertaking surveys, in the light of which results, we will address those issues which we can, in an attempt to improve meeting attendances. We will be making our abstract submission rules simpler, in order to encourage more abstract submissions and investigate the incentives (or disincentives) regarding our current policy for publishing abstracts. We will also work with the CPD Director who, together with his apprentice CPD Director, to be appointed in 2009, will be reviewing the rolling CPD programme.

I wish to thank Joanna Gough for all her help this year. Without her guidance and gentle pestering the A&R committee would not have made the progress that it did.
Clinical Practice Evaluation Committee

The Clinical Practice Evaluation Committee (CPEC) has expanded its membership since last report, now including representatives of three SIGs on a rotational basis which broadens scope for discussion and actions.

Clinical effectiveness abstracts for scientific meetings
CPEC works hard in its adjudication role to achieve the delicate balance between promoting quality in clinical standards work, while not excluding abstracts of clinical interest. When abstracts under the clinical effectiveness category were first introduced a few years ago, there was a strong steer from both the new CPEC and A&R committee to set standards guiding authors on what is acceptable for a national meeting and for potential abstract publication in *Age & Ageing*. Initially submissions were invited as audit, guideline development or systematic review, but criteria have since grown organically in response to the broader scope of abstracts being submitted. ‘New Practice Development’ (a popular subcategory with AHPs) was introduced, and more recently, the Survey subcategory. CPEC provides guidance on appropriate methodology for these subcategories. With clinical audit, we have observed that by firmly sticking to guidance of including practice change strategy and reaudit cycles, the messages from abstract submissions have grown in strength and generalisability.

Audit

The CPEC audit tool website is moving forward to provide access to an easy-to-use system of audits (against national and good practice guidelines), with the overall aim of promoting standardised care and practice improvement. There have been a few technological challenges, but once up and running (by Autumn 2009) this initiative will allow users to compare their own audit cycle data, benchmark against other departments, and share information on effective practice change strategies. CPEC has also monitored and facilitated national audits this year on Urinary and Faecal Incontinence, Falls, Parkinson’s Disease, and COPD.

Guidelines
CPEC promotes guideline development in areas that are patient-focused and highly relevant to quality care of older people but which are unlikely to be covered by other national groups or societies. This year saw the publication of the RCP concise guidance on Advance Care Planning (lead author Simon Conroy), and the initiation of the Management of Pain in Older People guideline working group. BGS/CPEC supported the Dignity and Privacy in Continence Care study, from which has emerged a Privacy and Dignity in Continence Care toolkit - again pursuing CPEC’s remit to contribute, where possible, to standards in clinical areas where such standards may be harder to define and measure.

Policy Committee

The main function of the Policy Committee remains to develop, review and maintain a series of statements of best practice and promote expected standards of service provided to older people. These are all available from the website and are aimed at being a source of reference material to BGS members and the external world, e.g. the public, other professional groups and commissioners of services. This year we formally moved from a Compendium to a Best Practice Guide.

Secondly, the Policy Committee liaises with outside bodies regarding issues affecting the health of older people, providing comment, responses and information to a variety of agencies, including government, the Department of Health in each of the four counties of the United Kingdom and other professional bodies.

Policy Committee, uniquely for the BGS has two lay members, whose contributions continue to be very effective and thought provoking e.g. Roy Latham stimulated further discussion about our Society’s name. Critically, this Committee brings together key members of the Councils of the four Nations, allowing a UK wide perspective to be retained. We have also had insightful comments from our Trainee representative, particularly about how to communicate to our wider audience of younger doctors. Policy Committee also includes representatives from two key BGS Special Interest Groups (Primary & Continuing care and Cerebral Ageing and Mental Health) and in 2008/9 we have commissioned Best Practice Guidance from other Special Interest Groups (SIGs) such as the excellent new Guide from the Diabetes SIG.

Activities of the Committee
We continue to have thought provoking presentations on topics of interest and importance to the Policy Committee prior to the formal meeting. The following, among other issues, were discussed in the last year: End of Life Care – what is important for the BGS? led by Eileen Burns; Promoting cost effective system-wide care of older people: the role of CQC by Colin Currie and Finbar Martin; Patient Information by Graham Mulley

Over the last year the Committee has continued to review and update the Best Practice Guide. Work in 2008-9 has developed a standardised format for each Guide which makes them more accessible.

Among the new and revised documents added are:
- Clinical Governance
- The Older Person in the A&E Department
- Palliative Care
Advance Care Planning
Diabetes

The committee has also responded to the following consultations:

Nuffield Bioethics
Dementia: Ethical Issues

General Medical Council
Confidentiality

Department of Health
End of Life Care Strategy: Quality Markers Consultation

Other activities:
Linda Patterson, Steve Hamilton, and Alan Sinclair have helped contribute to the development of work on revalidation for the BGS by attending workshops facilitated by the Royal College of Physicians (London). This will lead to further updates via the newsletter and Best Practice Guides; our aim for specialist standards is for them to be as straightforward and simple as possible while improving care of older people. Members of the Committee contributed to the discussion and comment on Clinical Quality Indicators.

Jackie Morris has unceasingly led the BGS Campaign on Dignity and we have continued work with Help the Aged via the Health Advisory Panel. The recent merger in April 2009 of Age Concern and Help the Aged, to become one bigger charity dedicated to improving the lives of older people, will provide new opportunities for our Society. Mike Cheshire has provided a very helpful perspective from the RCP (London) where he heads up Clinical Standards and interacts with many external key stakeholders.

Acknowledgements

A number of members demit office with me and I would like to thank them for all their hard work and particularly highlight the contribution of Brian Chapman despite a period of ill health and Nadia Chambers who has given an invaluable nursing perspective, and who was rightly recognised in the New Years Honours List with an OBE for the excellence of her work in services for older people. Thanks also to Alex Mair for his calm approach and wisdom and Recia Atkins for her patience and web master skills.

I would also like to thank all existing members of the Policy Committee for reading and commenting on the various papers, consultations and for making the Committee a lively and enjoyable forum that is at the heart of the BGS. I wish Ian Donald well when he takes over the Chair in late 2009 and I am confident Maeve Rea, recently elected as his Deputy, will keep the Society moving forward and ensure a consistent approach across the UK to care for older people.

Lastly, key thanks go to Sarah Allport, Committee Secretary for her efficient support, gentle reminders and attempts to organise me – without her the Committee would not function.

Here is a salutary warning from Rudolph Klein of the London School of Economics:

‘it is impossible to be sure a new model can ever be fully implemented, however seductive its logic may be in theory’. We must remember in all our plotting and planning that ‘old people have a lot of inside information about ageing’. Do we ask them? Do we listen to the m?
Meetings in 2009
The Cardiovascular Section has had an exciting 2008/09 year having organised two major educational days so far and a third event later this year.

The first of those meetings was our third annual specialist registrar meeting at the Church House Conference Centre in London, entitled, “Treating the oldest old”. The scientific presentations addressed management of hypertension in the very elderly in an excellent talk by Professor John Potter, and the HYVET-COG study and its implications in a presentation by Dr Ruth Peters. The day went on to cover “Cardiovascular surgery in the oldest old”, by Professor John Dark, “Lipids in the very elderly” by Dr Allan Gaw, “Managing heart failure in the very elderly”, by Dr Henry Purcell, “Contemporary treatments of stable coronary artery disease”, by Dr Ian Menown and “Revascularisation in the older patient”, by Dr Ian Purcell. The afternoon session was headed by Professor Alan Sinclair who gave a superb talk on the complexity of managing diabetes in the very elderly, with special consideration of residential and nursing home residents. The meeting ended with an overview of the “Mental Capacity Act”, presented by Dr Stephen Louw. The meeting was highly rated by the trainees in Elderly Care Medicine for its quality, organisation and venue.

The section will also have the honour of facilitating one the special interest group sessions at the British Geriatrics Society Spring meeting in Bournemouth in April 2009. Professor Chris Bulpitt and Dr Nigel Beckett will give an in depth analysis on the HYVET study and future directions for the study.

Planned activities
Another joint meeting is planned with the British Association of Stroke Physicians (BASP) to be held on 2nd and 3rd of July 2009 in Birmingham. The meeting will address the National Stroke Strategy policies and practicalities, topical issues in stroke management including thrombolysis, carotid stenting and carotid endarterectomy, recent advances in stem cell research and stroke rehabilitation, Neuroradiology of stroke for physicians, as well as the primary care link to TIA and stroke management. The meeting will have eminent speakers including Professor Roger Boyle, Professor Hugh Markus, and Dr Keith Muir, amongst others.

The Chris Bulpitt Travel Fellowship
The fellowship remains an attractive grant to medical students considering a career in Elderly Care Medicine.

New appointments
The section would like to thank Dr Nikhil Majmudar for his appreciated hard work over the last few years as a treasurer for the section, and welcome Dr John Baxter to this position.
The Cerebral Ageing and Mental Health Special Interest Group continues to pursue its aims of promoting excellent clinical care of older people with cognitive and other mental health disorders, supporting relevant learning and research. Professor Peter Passmore is now Chair and Dr John Holmes Secretary.

We would wish to thank Professor Starr and Dr Bullock for their efforts in continuing the good work of the SIG. Following on from 2007, the session at the Autumn Scientific meeting was very successful. The Spring meeting at Bournemouth is scheduled to have a very interesting afternoon on cognitive impairment and dementia. This has been organised in conjunction with the IAGG. There was no formal educational input into the Royal College of Psychiatry Old Age Section meeting this year.

**Dementia**
There have been considerable developments in the past year. We have seen the arrival of the **National Dementia Strategy for England**. The **Scottish Dementia Research Network** and **Northern Ireland Clinical Research Network (Dementia)** are now established, as is a formal Cross Network Agreement established. A Dementia Strategy is in development for Northern Ireland. Research activity has remained at high levels. The SIG has also produced responses to a number of national consultation exercises related to dementia for the BGS to submit.

The BGS’ largest section has gone from strength to strength in recent years.

We had a very successful and very interdisciplinary annual conference in York with excellent scientific and educational content and in September 2009 we hope for an even better attended meeting in Blackpool as well as a lively session at the Harrogate Autumn BGS conference, where we will be holding a workshop on the National Hip Fracture Database and a plenary session on the Falls and Fracture DH Commissioning Toolkit.

We have a memorandum of understanding with the British Orthopaedic Association and in addition to our earlier work on the “Blue Book” for hip fracture management, we have also collaborated to produce the BOAST guidelines. Members of our section (Jonathan Potter, Jon Treml and Finbarr Martin) have been protagonists in the 2008/9 round of the RCP Clinical Effectiveness Unit Falls and Bone Health Audit which has now produced detailed national data on assessments and treatments, received by individual patients to back up the earlier audits on organisational aspects of service delivery. The BGS, in conjunction with the BOA, is now leading on the National Hip Fracture Database – a fantastic resource to inform practice and commissioning. This database is now funded nationally, £1.4 million by the Health Quality Improvement Programme (HQIP) and hip fracture management has been identified as one of the key quality priorities in the Payment By Results Best Practice Tariffs.

The Section is also to provide input into the NICE Hip Fracture Guideline Group, due to be published in 2011 and our members have worked closely with the NHS Institute on its project on hip fracture management. Our members in Scotland, Wales and Northern Ireland have also been active in national audit and guideline development and in informing governmental policy.

The Department of Health (DH) in England is about to launch the ageing strategy and prevention package for older people and a major part of this is the “Falls and Bone Health Commissioning Toolkit” on which several members of the section have had considerable input and helped to present the toolkit to providers and commissioners around the country. The DH worked closely with organisations such as the NOS and RCGP on developing this toolkit.

In the *Age and Ageing* journal, the section receiving most submissions continues to be falls and bone health.

In 2008/9 the committee of the section changed, with Opinder Sahota and David Oliver taking over as co-chairs, Rob Morris as Treasurer and Jane Youde as Secretary. Adam Darowski as
Special Interest Groups

Web/Newsletter editor, with Tash Masud continuing as annual meetings secretary. We also co-opted several associate members onto the committee from orthogeriatrics, physiotherapy, psychology and occupational therapy and hope to recruit a nurse and a pharmacist with an interest in falls prevention.

The new committee is working on an action plan to re-invigorate the section. This includes:

- Updating the membership list and interests of the members
- Expanding the membership and aiming to recruit doctors in training and allied professionals (whether or not full BGS members)
- Providing continued funding for the PROFANE (Prevention of Falls Network Europe) with our own section, content and electronic newsletter
- Providing networks of regional experts to inform local commissioning, service development and speak to the media in their patch.

2009/10 may be an important time in the world of falls and bone health, especially in the wake of central governmental initiatives and we hope to make falls and fractures "the new stroke" – falls and fractures being just as costly, more numerous and accounting for many hospital bed days and long term care admissions. There are credible interventions – as recognised by NICE. We now need to play "catch up" but we also need to educate practitioners, share good practice models and showcase original research.

GASTROENTEROLOGY AND CLINICAL NUTRITION

Secretary: Dr J Newton
Julia.Newton@nuth.nhs.uk

The BGS SIG for Gastroenterology and Nutrition met for its annual meeting in June 2008 in Newport. Despite being a small, select gathering the meeting was extremely valuable and included a multidisciplinary audience. Topics covered included management of non-alcoholic fatty liver disease in older people and anaemia, preceded by a debate on coeliac disease in an older person. The decision has been made by the group that due to issues with funding, an annual meeting is not sustainable at the current time. So the plan is to arrange a biannual meeting.

PRIMARY AND CONTINUING CARE

Chairs: Dr Ian Donald and Professor John Gladman
Secretary: Dr Eileen Burns
Eileen.burns@leedsth.nhs.uk

The membership of this SIG continues to grow and currently stands at 54. Most of the members are community geriatricians but we are very pleased to have general practitioners, a care home specialist and acute medicine geriatricians within the group. The growth in new or replacement consultant posts with community sessions has led to an increase in newly appointed consultants in the SIG and this is an extremely welcome development. Members of the SIG currently involved in community work are regularly approached to advise colleagues in other areas aiming to commission similar developments.

There have been a number of key government publications in the last year which have significant relevance for community geriatricians, including the National Dementia Strategy and the End of Life Care Strategy. The SIG has led the BGS response to some of these strategies and members have been involved in discussions with local and national bodies regarding implementation.

After a small and successful conference in July 2008, held to provide a forum for geriatricians and care home staff to meet together, members of the SIG have planned a more substantial event focused on the same topic. The conference on Care Home Medicine will be held on June 30th 2009 at the Royal College of Physicians in London. Other work to raise the profile of care home medicine during the year included publications on the topic and an editorial in Age and Ageing.

Other members of the SIG are planning a meeting at the Royal College of Physicians (L) on the interface between the acute medical unit and the geriatrician (whether in the hospital or community) in March 2010.

Other work of the SIG includes influencing the work of the NHS Next Steps Review (aka the Darzi review), where some success has been achieved in ensuring that the needs of frail older patients are not overlooked - SIG members have had a role in long term conditions and end of life pathway groups.

During 2008/9 the SIG contributed to regular updates of BGS Best Practice Guidelines including ‘Advance Care Planning’ and ‘The Geriatrician and the Management of Long Term Conditions’.
The Movement Disorders Section:

identifies and coordinates expertise in Parkinson’s disease and related disorders amongst health care professionals, predominantly in older people.

provides a forum for the presentation and discussion of clinical innovation, service development, audit and research.

supports the coordination and development of research in these areas.

Life Long Learning

National Meeting:
The section ran a one hour meeting at the autumn BGS Scientific Meeting in Birmingham on developments over the previous year - 80 attended. The Section’s annual update for Parkinson’s specialists was held in Birmingham in January - 70 attended.

Allied Health Professionals Meeting:
The section inaugurated its professional partnerships in practice meetings (PPiP) in Glasgow in February 2009. This was for colleagues from the Allied Health Professions and 40 attended from physiotherapy, occupational therapy and speech & language therapy.

PD Academy:
This is in its 7th year and by the end of the reported year, 13 masterclasses, (with 264 attendees) were completed, with now a clearer separation of the curricula for Specialist Registrar and consultants. The MasterStrokes newsletter for graduates and mentors continues and past copies are now available in two compilation formats.

Audit
Masterclasses 10 and 12 have piloted an audit tool developed by the section with the Parkinson’s Disease Society and neurology colleagues. This was launched in March 2009. It uses locally entered data to (anonymously) populate a national pool which then becomes the national reference standard.

The Medical Ethics Special Interest Group seeks to provide a forum within the Society for constructive and informed debate on moral issues which relate to older people. The SIG seeks to encourage research into ethical issues, promote learning on applied ethics as it relates to geriatric medicine and inform BGS policy on issues with an ethical dimension. The SIG is a member of the UK Clinical Ethics Network.

The SIG has made important contributions in several areas over the past year:

Members of the SIG co authored the British Geriatrics Society /Royal College of Physicians concise evidence based guideline on advance care planning. The four authors reviewed over 130 papers to collate the evidence which was then discussed with the guideline group in order to formulate the recommendations.

Members of the SIG have contributed to BGS responses to consultations on private payment for drugs as part of NHS treatment and draft GMC guidance on ‘End of life treatment and care: Good practice in decision-making’.

A joint study day with the Royal College of Physicians (London) on ‘Ethical and legal dilemmas in old age’ was held on 30th September 2008. Speakers included: Baroness Greengross who talked about ‘The right to equitable health and social care in old age’, Dr Jackie Morris discussed the need for dignity and humane care for older people and Professor Penney Lewis used a real case scenario to illustrate the relevance of the Mental Capacity Act in medical practice.

Membership of the SIG is free and open to all interested members of the BGS. Our plans for next year are ambitious; we aim to raise the profile of the SIG and promote the importance of ethical reasoning as fundamental to the practice of holistic patient centred medical care in today’s highly technological and evidence based clinical environment.

Finally, the SIG wishes to thank our outgoing Chairman, Dr Martin Vernon for all his hard work and enthusiasm, particularly in putting together the excellent and varied programme for the RCP/BGS joint meeting.
The Nurse Consultant SIG was formed in 2006 in order to support the development of specialist nursing and therapy in the field of older people.

It provides a forum for Nurse Consultants and other senior clinicians, and those aspiring to specialise in the field of older peoples care, to share information and influence the future agenda.

The group have recruited new members over the last 12 months, and continues to promote the group to encourage new members from the wider nursing and therapy arena.

Over the past year we have met quarterly and have had representation from all four countries of the UK. The group membership encompasses people working across a range of specialities within older people’s care and support, such as mental health, community, acute rehabilitation, and safeguarding.

The group in turn has representatives on the following BGS groups; RCP Falls and Bone Health, CPEC, BGS Policy Committee. Individual members of the group also represent Older People’s issues within their regional forums, and at each meeting they update the wider membership on the work of the BGS, and other national projects they are involved.

The group also contributes regularly to the RCN publication ‘Nursing Older People’ where comments and views are debated and expressed in relation to current high profile issues pertaining to older people.

Our quarterly meetings comprise a mix of review of new policy and its impact, or potential impact on service, presentations from other individuals from organisations involved in research or policy affecting older people, as well as giving group members the opportunity to share their work and or experiences.

Over the year the group have met with representatives from the End of Life Strategy, Safeguarding Adults, and RCN Dignity Campaign. The Group will also host a session at the BGS Spring meeting in Bournemouth in 2009.
The promotion of professional education and training
- The Society's grants & awards

**Grants and Awards**

**Dunhill Medical Research Fellowships (Allied Health Professionals)**
This award is funded by the Dunhill Medical Trust to the amount of £400,000, and is topped up by the BGS. The first fellowships were awarded during 2007-08, and covers a projects spanning three years.

**Young Doctor's Education Grant**
The Society offers grants, originated through a bequest from Mrs Esther Hepher, a member of the public, to junior doctors to finance their attendance at BGS Scientific Meetings. Assistance of around £450 is provided if the health authority is unable to provide financial support. £7,177 was awarded in 2008-09.

**Amulree Essay Prize**
Since 1986 the Society has encouraged medical and dental undergraduates to take an early interest in medicine for older people. To this end, the Society promotes an annual essay competition on any subject pertinent to ageing from a medical, biological or sociological aspect. The Amulree Prize is now fiercely contested with many entries every year, each of a high standard. The prize is worth £500.

**Specialist Registrar Start-up Grant**
The Specialist Registrar Start-up and Travel Grant programme provides immediate financial assistance of up to £10,000 to support research projects, which may not yet be developed sufficiently to warrant support from research councils, or visits to centres of excellence which may otherwise not be funded. The programme provides grants to enable young geriatricians to follow through ideas at relatively short notice, to enable advantage to be taken of unique or rare opportunities, and to provide short-term assistance to speculative and innovative research that may be at an early stage. £62,253 was awarded in 2008-09.

**Medical Students' Elective and Vacation Grant**
This grant of up to £500 is designed to encourage medical students to develop an early interest in the health and care of older people. It provides undergraduates with an opportunity to study a relevant initiative in age research or in the provision of health care complementary to their taught curriculum. £5,591 was awarded in 2008-09 to support a wide range of projects.

**Therapists' Study Grant**
The Society provides funds of up to £300 to enable qualified physiotherapists, speech and language therapists, occupational therapists and therapists in training with an expressed special interest in older patients, to enjoy the same opportunities as nurses (see Nurses Study Grant). £4,041 was awarded last year.

**Nurses' Study Grant**
The Society offers a number of grants of up to £300 to trained nurses (and nurses in training), with an expressed special interest in the care of the elderly to attend conferences, seminars and meetings of an innovative nature which will enhance their understanding and appreciation of the needs of elderly patients. £6,198 was awarded last year.

**M A Kuck Research Fund**
This one-off award was funded by the estate of the late Dr M A Kuck, a former member of the Society. It provided a three year research fellowship, awarded in January 2008.

**Bernard Isaacs Research Fund**
This three year clinical fellowship was funded by the BGS and awarded in January 2008.
I am pleased to present this, my first report as Treasurer, to the membership

The fact that the accounts show an excess of expenditure over income requires some explanation, as the Society is in fact in a very strong financial state. During the previous financial year we received monies (most notably from the Dunhill Medical Trust) which, due to timings, had not been expended. The year ended 31 March 2009 has seen this reverse – with no fresh monies received from Dunhill but a range of grants approved and being financed, so a specific cash inflow has now become a specific cash outflow for the life of these grants. Expenditure on all grants and Fellowships alone accounts for some £300,000. Trustees also approved increased charitable spending on education and training activities with increases in Specialist Registrar/Trainee Start-Up Grants, the financing of the CME Journal of Geriatric Medicine, and the initial costs associated with the Specialist Certificate Examination for trainees. These three items have added a further £74,000 to cash outflows. The Society had, in fact, built up considerable reserves of income which quite rightly are now being used to fulfill a range of our charitable objectives; I would suggest this is good news, even when it results in what might appear to be a deficit.

That said, and fully in line with expectations, we have seen a marked drop in surpluses generated from our spring and autumn conferences, arising directly from the impact of the recession on our main sponsors. This will continue, and I can assure you that the Finance Committee are in close communication with the other Society Committees to ensure we react sensibly to the present economic situation. The Finance Committee, together with the secretariat, are looking closely at their obligations with regard to risk management and good corporate governance, and have already suggested proposed changes to current Society policy, particularly focussing on the conferences. These measures, whilst they will take some time to reach a consensus on and then action, will help the Society to remain financially stable.

On behalf of the Finance Committee I fully commend the summarised financial statements to you.

ACCOMPANYING STATEMENT BY THE UK MANAGEMENT COMMITTEE
OF THE BRITISH GERIATRICS SOCIETY

The summarised financial statements on pages 28 - 30. have been derived from the full statutory report of the UK Management Committee and financial statements for the year ended 31 March 2009 which have been audited by Sargent & Co who gave an unqualified audit opinion on 16 July 2009. The auditors have confirmed to the UK Management Committee that the summarised financial statements are consistent with the full financial statements for the year ended 31 March 2009.

The full statutory report of the UK Management Committee and financial statements were approved by the Council on 16 July 2009 and signed on their behalf by Professor G Mulley and Dr D Cohen. They will be submitted to the Charity Commission by 31 October 2009.

These summarised financial statements may not contain sufficient information to allow for a full understanding of the financial affairs of the Society. The full statutory report of the UK Management Committee and financial statements can be obtained from:

The British Geriatrics Society
31 St Johns Square
London
EC1M 4DN

On behalf of the UK Management Committee on 16 July 2009.

Dr David Cohen
Our thanks

The following companies contributed to the commercial exhibitions at the scientific meetings, sponsored satellite symposia and several parallel sessions:

- Astellas Pharma Ltd
- Bayer plc
- Biotronik UK Ltd
- Boehringer Ingelheim Ltd
- Eli Lilly & Co Ltd
- GE Healthcare Ltd
- Glaxo Smith Kline Ltd
- Grunenthal Ltd UK
- Kyphon UK
- Lundbeck Ltd
- Menarini Pharma UK SRL
- Merck Sharp & Dohme Ltd
- Napp Pharmaceuticals
- Norgine Pharmaceuticals Ltd
- Novacor UK Ltd
- Novartis Pharmaceuticals UK Ltd
- Omron Healthcare (UK) Ltd
- Orion Pharma Ltd
- Pfizer Ltd
- Proctor & Gamble Pharmaceuticals UK Ltd
- Prostrakan Ltd
- Rapiermedical Ltd
- Roche Products Ltd
- Rosemont Pharmaceuticals
- Sanofi Pasteur MSD
- Servier Laboratories Ltd
- Shire Pharmaceuticals Ltd
- TMMP Ltd
- UCB Pharma Ltd
- Vitaline Pharmaceuticals
- Wisepress
- Wyeth Pharmaceuticals

Donations and legacies

The Society gratefully acknowledges the donations and legacies received from the following generous benefactors to fund our grants programme:

- GM Morrison Trust
- Elizabeth and Prince Zaiger Trust
- Estate of Dr M A Sleightholm

Services

- Juliet Brereton, Caroline Copp, Bettina Hoffman, Joanna Prendergast, and colleagues (Hampton Medical Conferences Ltd)
- Liz Gill, Freelance Journalist
- Neil Walmsley and colleagues (Greene & Greene Solicitors)
- Helen Allchorn, Mike Strudwick, Mike Tutt and colleagues (Manor Creative)
- Sargent & Co (Auditors)
SUMMARISED FINANCIAL STATEMENTS
FOR THE YEAR ENDED 31 MARCH 2009
STATEMENT OF OTHER RECOGNISED GAINS

Permanent Endowment (£) | Restricted income (£) | Unrestricted income (£) | Total 2009 (£) | Total 2008 (£)
---|---|---|---|---
- | (137,809) | 72,756 | (65,053) | 505,108

STATEMENT OF OTHER RECOGNISED GAINS

NET MOVEMENT IN FUNDS FOR YEAR
- (137,809) | 72,756 | (65,053) | 505,108

UNREALISED INVESTMENT GAIN/(LOSS) FOR YEAR
717 | - | (81,648) | (80,931) | (49,676)

NET MOVEMENT IN FUNDS FOR THE YEAR
717 | (137,809) | (8,892) | (145,984) | 455,432

TOTAL FUNDS BROUGHT FORWARD
176,856 | 1,038,245 | 1,946,753 | 3,161,854 | 2,706,422

TOTAL FUNDS CARRIED FORWARD
177,573 | 900,436 | 1,937,861 | 3,015,870 | 3,161,854

Note to the summarised financial statements for the year ended 31 March 2009

<table>
<thead>
<tr>
<th>Costs directly allocated to activities</th>
<th>Basis of allocation</th>
<th>Cost of generating funds</th>
<th>Governance</th>
<th>Scientific meetings</th>
<th>Publications</th>
<th>Education and Research</th>
<th>Total 2009</th>
<th>Total 2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff Costs</td>
<td>Direct</td>
<td>108,710</td>
<td>9,808</td>
<td>45,603</td>
<td>55,278</td>
<td>17,964</td>
<td>237,563</td>
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<td>Conferences</td>
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<td>-</td>
<td>542,497</td>
<td>-</td>
<td>-</td>
<td>542,497</td>
<td>532,899</td>
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<tr>
<td>Journals</td>
<td>Direct</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>77,679</td>
<td>-</td>
<td>77,679</td>
<td>75,296</td>
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<td>Information &amp; Education</td>
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<td>1,331</td>
<td>-</td>
<td>7,332</td>
<td>57,902</td>
<td>450</td>
<td>67,015</td>
<td>51,580</td>
</tr>
<tr>
<td>Grants, Awards &amp; Prizes to individuals</td>
<td>Direct</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>355,118</td>
<td>355,118</td>
<td>128,837</td>
</tr>
<tr>
<td>Committee Expenses</td>
<td>Direct</td>
<td>19,163</td>
<td>-</td>
<td>2,840</td>
<td>5,702</td>
<td>20,324</td>
<td>43,459</td>
<td>43,145</td>
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<tr>
<td>Annual Report</td>
<td>Direct</td>
<td>4,196</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>4,196</td>
<td>3,754</td>
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<td>Audit Fee</td>
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<td>-</td>
<td>-</td>
<td>-</td>
<td>7,400</td>
<td>7,310</td>
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<td>Bank Charges</td>
<td>Direct</td>
<td>4,316</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>4,316</td>
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<td>Direct</td>
<td>-</td>
<td>756</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>756</td>
<td>45</td>
</tr>
</tbody>
</table>

Support costs allocated to activities

| Premises | Staff time | 6,828 | 607 | 2,580 | 3,945 | 1,214 | 15,174 | 15,561 |
| Depreciation | Staff time | 5,738 | 510 | 2,167 | 3,315 | 1,020 | 12,750 | 8,895 |
| Office Costs | Staff time | 12,806 | 1,138 | 4,838 | 7,399 | 2,277 | 28,458 | 20,006 |
| Other Costs | Staff time | 14,225 | 349 | 1,482 | 2,267 | 698 | 19,021 | 11,854 |

177,313 | 20,566 | 609,539 | 213,487 | 399,065 | 1,419,972 | 1,118,835
### Summarised Financial Statements

**For the Year Ended 31 March 2009**

<table>
<thead>
<tr>
<th>Asset Category</th>
<th>2009 (£)</th>
<th>2008 (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fixed Assets</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tangible Assets</td>
<td>728,643</td>
<td>722,905</td>
</tr>
<tr>
<td>Investments - Dhole Bequest</td>
<td>347,289</td>
<td>339,058</td>
</tr>
<tr>
<td>Investments - General</td>
<td>487,689</td>
<td>541,849</td>
</tr>
<tr>
<td>Investments - Restricted</td>
<td>45,537</td>
<td>43,537</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>1,609,158</td>
<td>1,647,349</td>
</tr>
<tr>
<td><strong>Current Assets</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Debtors</td>
<td>511,252</td>
<td>401,480</td>
</tr>
<tr>
<td>Bank Balances</td>
<td>1,559,396</td>
<td>1,674,093</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>2,070,648</td>
<td>2,075,573</td>
</tr>
<tr>
<td>Creditors: Amounts Falling Due Within One Year</td>
<td>(663,936)</td>
<td>(561,068)</td>
</tr>
<tr>
<td><strong>Net Current Assets</strong></td>
<td>1,406,712</td>
<td>1,514,505</td>
</tr>
<tr>
<td><strong>Net Assets</strong></td>
<td>3,015,870</td>
<td>3,161,854</td>
</tr>
<tr>
<td><strong>Accumulated Funds</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unrestricted Funds</td>
<td>907,412</td>
<td>757,474</td>
</tr>
<tr>
<td>Revaluation Reserve</td>
<td>(94,646)</td>
<td>(12,998)</td>
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<tr>
<td>Charitable Trading Fund</td>
<td>103</td>
<td>103</td>
</tr>
<tr>
<td>Designated Funds</td>
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<td>1,202,174</td>
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<tr>
<td>Permanent Endowment</td>
<td>177,573</td>
<td>176,856</td>
</tr>
<tr>
<td>Restricted Income Funds</td>
<td>900,436</td>
<td>1,038,245</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>3,015,870</td>
<td>3,161,854</td>
</tr>
</tbody>
</table>