BGS NEWSLETTER
British Geriatrics Society
Improving healthcare for older people
Issue 60 | February 2017

Hospital at home

Looking at best practise and how we can care for the frailest members of our community.

Also in this issue

The Autumn meeting report
An indepth look at what was discussed at our Autumn meeting.

Get up, get dressed, keep moving!
We look at the newly launched Deconditioning Awareness campaign for staff and patients across some of our hospitals.

Re-imagining care homes
An innovative vision for care homes for the future.

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In this issue

Editorial

Welcome to our first newsletter of 2017, following a year of many ups and downs!

Most of us faced financial challenges and despite rising demand for our services we find ourselves ever more stretched. I say this as one who recently lost a local service; there is no doubt that even tougher times are ahead. The BGS continues to advocate for older people in this climate: take a look at the first press release (page 7) from President Eileen Burns, on delayed transfers of care. The person at the centre of this situation must not be blamed and Dr Burns calls on the government to understand this and ensure that social care is adequately funded.

With the pressure to reduce costs, comes an increasing drive to keep people out of the acute hospital. There is opportunity here to develop new community services such as Hospital at Home, but do these really work and if so, how?

This was the focus of the first ever UK-wide Hospital at Home forum at the BGS Autumn Meeting in Glasgow in November. Delegates heard about many new services that provided real patient-centred care in their own home. One of these, the REACT service, receives an in-depth introduction in this issue. See page 4 for a fascinating insight by Scotland's first community geriatrician, Dr Sureshini Sanders from West Lothian.

Sarcopenia Special Interest Group

In another first, the BGS announced the formation of a new special interest group (SIG) for frailty and sarcopenia at the autumn meeting. Those who were lucky enough to attend this session received a comprehensive update; if you missed out you can find out more about the SIG and joining it, on our website.

Dealing with the sensitive topic of substance abuse, Dr Anita Howard and Dr Sharmi Bhattacharrya, editors of the RCPsych's newsletter, report on the growing prevalence of older patients presenting with signs of alcohol or substance addiction (see page 8). They identify the different patterns of misuse and point to the dearth of research into substance misuse in older people. This represents a potentially rich vein for some enterprising researchers to tap.

If you've visited the blog recently, you'll see our new logo adorning the top; there was lot of positive feedback in Glasgow when the smart new visual appeared. There remains a certain fondness for the old logo in some quarters but I'm sure that a fresh new visual identity should help to enhance the image of the BGS.

Improving the image of nursing homes is an area that Jo Hockley writes about on page 29, describing the idea of a care home innovation centre of excellence. In reflecting on what a dream care home would look like, her group has uncovered several intriguing ideas. For example, did you know that one care home organisation in the Netherlands provides free accommodation for students in return for working with the care home residents? More can be found in their commentary piece in *Age and Ageing*.

Another article from the journal describes a large population analysis which notes that people with dementia have a higher number of co-morbid conditions. The authors call for holistic care, as opposed to focusing on single organs. This message is echoed by Dr David Paynton in his comments on a new report written in collaboration with the Royal College of General Practitioners. As he puts it, "Multi-morbidity is here to stay – the rest of the NHS needs to catch up." (page 36)

Those who make a difference

Another theme that runs through this issue of the newsletter is the recognition of individuals who have made and continue to make a difference to the lives of older people. Apart from three members of the BGS who were recognised in the Queen's Honours List recently (page 44), the Society acknowledges the work of Susan Stefiuk, a co-ordinator of Age UK's Friendship and Wellbeing Service (page 22), and Northern Ireland's Pat McCaffrey (page 24).

But on a sad note, we report the passing of two great geriatricians, namely Dr Jim George and, from the southern hemisphere, Professor John Campbell (pages 40 and 41).

Shane O'Hanlon
BGS Honorary Secretary and Editor

Community geriatrics and hospital at home

NHS Scotland's vision for 2020 is that we will "live longer healthier lives at home".

With continuing advances in technology and medicine, and a greater understanding of how diet and good social care affects quality of life, it is anticipated that by 2037 there will be an 83 per cent increase in the 75+ population to 779, 000. Today this stands at 425,000 and already poses challenges to our health services and social services, owing to the fact that people living longer often have complex health problems and multiple co-morbidities. It is hard to imagine that at the beginning of the last century, people often died before 50 years of age. We have become victims of our own success and the budget for the NHS has been described as a bottomless pit!

The NHS is one of the largest employers in the world, second only to the Chinese army and Indian rail company. Currently NHS Scotland has approximately 150,000 employees. To address the ever increasing demand on services integrated social care and health care organisations, such as REACT (Rapid Elderly Access Care Team), have been created to optimise care at home.

REACT currently operates in West Lothian, but similar services will be rolled out all over the country in due course. It is funded by the Scottish Government's "the change fund," hoping to address some of the challenges arising from a growing older population.

We have run REACT in West Lothian for the last two years. It is unique in that many GPs and Consultants work together. The benefits of this practice were recognised by Brotherston in 1965, leading to GPs and consultants manning hospital clinics collaboratively. It was on this model that the REACT team is based.

It significantly enhances communication between primary and secondary care, improves consistency and forward planning, while optimising disease management.

Our aim is to keep the frail older patient at home, if appropriate. We have the ability to administer fluids and IV medication and can access investigations from home or on an urgent outpatient basis if needed. We are able to give expert end-of-life care and support to patients and families. Our doctors also have input to the community hospital and day hospital. We therefore represent an excellent example of continuity of care, which is vital for older people and it has the further benefit of reducing unnecessary admissions. We liaise well with our local GPs and many work for the service.

I have worked as a General Practitioner in West Lothian for 21 years. West Lothian is unusual as many General Practitioners are dual-qualified and work in local practices as well as covering sessions in the District General Hospital.

In 2013 I became the first Community Geriatrician in Scotland. This involves input to REACT, where we aim to care for and treat older patients with frailty at home, with the support of consultants, GP's, nurse practitioners, physiotherapists, occupational therapists and social work colleagues.

On admission, patients require a "passport" which includes admission details of past medical history and a full medical and nursing assessment. Medications are rationalised, family contacts noted, mental function, depression scores, falls risk, assessment of hearing and vision, discussion on capacity issues and resuscitation status, if appropriate, are recorded.

In the home setting, we are able to administer IV medication and antibiotics, fluids and/or oxygen at home if needed and can optimise mobility with the help of our physiotherapy and occupational therapy colleagues. Advice is given on home safety and equipment supplied, if this assists safe mobility and improves independence.

We are also involved in the running of our local day hospital and some of our patients can be investigated there on an outpatient basis. We can perform Xrays, ECG's, ECHO's, 24 hour tapes, CT scans and most of the investigations which are usually done as an inpatient.

If all of the above options are unsuccessful, I run a 30-bedded interim care Community Hospital in Linlithgow, into which I can admit patients. This is basically if patients are unsafe at home and do not improve after a one week input from REACT. The hospital has 24-hour nursing cover and I visit daily, with remote backup cover from my GP colleagues at other times.

If patients are so ill that they require 24 hour medical presence, they are not suitable for admission to our community hospital.

The nursing staff often deal with frail individuals who need nutritional, fluid support, skin care and assistance to mobilise. Their tolerance and patience with some very complex patients is humbling to witness. As the population ages, many of our patients, as well as having medical problems, have cognitive impairment or dementia. The nurses take the time to reassure these patients and encourage them to do as much as possible for themselves, working closely with their families. Many of these patients are frightened by change and their loss of independence. This sometimes results in behavioural challenges, which the staff take in their stride. The nurses here are also experts in end-of-life care, dealing with cancer and end-organ disease with a holistic approach.

Our tea lady and domestic staff have been with us for years and their astute observations on who ate what or did what can be very informative. We are a close-knit little team and each individual is valued for what they offer to the service.

We can have contact with patients and relatives at all stages of care: home, Day Hospital and Community Hospital.

Consequently, we have the opportunity to develop a good relationship and understanding of the patients' conditions and families' views.

Continuity of care is essential and often results in stopping unnecessary investigations and treatments, once a relationship and trust is established.

It is often worth considering what an admission into an acute care ward will achieve.

Older people with frailty can do badly in this noisy setting, getting little sleep, being frightened to mobilise in an alien environment and eating less than normal. Medical problems, hearing and visual impairment as well as infections acquired in acute hospital, resulting in prolonged admissions and delayed discharge,

We routinely check whether patients would like to attend our day center, wish for spiritual support, or to benefit from pet therapy, hand massage, music therapy or a range of services from the lovely volunteers at St Michael's church. We are very grateful for our contact and long standing relationship with Linlithgow parish, without which many of our patients would have a much poorer experience at what is a very challenging time in their lives. Reverend Cheryl Mckellar-Young has been like the good fairy, coordinating all of the above.

We have extensively surveyed patients, carers and GPs and have had a 90 per cent satisfaction rating.

We believe that this approach to care in the frailest members of our community will soon be rolled out all over the country and that West Lothian has been at the forefront of these pioneering changes with REACT, and its enhanced use of our Day Hospital and Community Hospital. In November 2014 we won the health board award for Celebrating Success Team of The Year. It has been a privilege for me to be given this unique opportunity to help our frailest citizens.

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by Sureshini Sanders
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President's column

This is my first column as President of the British Geriatrics Society, so I want to start by saying how honoured and thrilled I am to take on the office.

I start in the role, conscious of the great work done by previous presidents (most recently, of course, the indefatigable David Oliver) and with an awareness of the size of the shoes I have to fill! I promise that I'll learn from my predecessors and take forward the work of the Society to the absolute best of my ability. David, as those who know him would expect, has not retired to a spot of gardening or relaxation at home, he's now clinical Vice president at the Royal College of Physicians of London. Whilst his role there is clearly multi-specialty, we rely on him to continue keeping our interests close to his heart! David's enormous knowledge of those in the Health and Social care policy world was of great benefit to the Society, and we trust that he will continue to be a valued resource.

I am especially honoured to be only the second woman president of our Society. Although most (if not all) of our members know that the founder of our Society was a woman (Marjory Warren), she was never president. The great Marion Hildick-Smith was my female predecessor, who I recall as president when I was a research registrar.

The issue of the crisis in social care funding remains the most pressing one for all of us, as the number of people delayed in hospital grows. As an organisation we continue to use every opportunity to press government to review their current stance. As the Nuffield Trust, the King's Fund, CQC, the National Audit office and everyone who has looked at the problem agree, the current situation is untenable.

Age UK publish a review of trends and changes in demography and health and social care issues which demonstrates a 25 per cent reduction in government spending on social care over the last five years, in real funding terms. This is without considering the impact of the growing older population. Little wonder then, that our patients remain the victims of underfunding.

It's great to hear of members raising the awareness of the risks to older people from hospitalisation and trying to mitigate these by keeping people moving in hospital to avoid the impact of deconditioning. Some are fortunate to work in services benefiting from volunteers who help at mealtimes to mitigate poor nutrition and to keep people occupied. The core problem is clear, and our Policy and Communications staff will continue to try to get the message across.

by Eileen Burns
President of the BGS

Older people are victims of underfunding

Dr Eileen Burns, who took office as President of the British Geriatrics Society at our autumn meeting last November, has called for public recognition that older people facing delays in discharge from hospital are the victims of underfunding of social care and are not 'the problem'.

She declared that members of the public and media should reject pejorative terms like 'bed blockers' and should urge the Government to give social care the priority it deserves.

Accessible social care is a key factor in reducing hospital admissions and delayed discharges for older people. According to research published earlier this month by Age UK, the number of older people in England who do not get the social care they need has soared to a new high of 1.2 million – up by a staggering 48 per cent since 2010. There is a direct correlation between these statistics and the latest data from NHS England which found that delayed discharges are at their highest level since records began in 2010, with the number of delayed days in September reaching 196,246. It is this lack of support for older people in their homes and communities, rather than patient or physician choice, which has led to such high numbers of hospital admissions and delayed discharges and which has, in turn, put tremendous pressure on an already overburdened acute sector.

"The vast majority of older patients would prefer to be in the comfort of their own home when they feel well enough, and some are actively distressed at having to stay in hospital. The term 'bed blocker' in no way conveys the true situation and lack of choice these patients are facing. As physicians our hands are also tied as we are unable and unwilling to send patients home without the certainty that they will be safe and receive the care they need. Patients who experience delayed discharge are not the problem; they are the victims of underfunded social services and deserve our understanding and respect. Without adequate funding we will continue to have high numbers of delayed discharges and I would urge both the Government, and the general public, to understand this vital connection between health and social care."

BGS Communications and PR press release

Substance misuse in older adults

Substance misuse is on the rise in older adults due to an ageing population and 'the baby boomers"[9] approaching older adulthood. It is estimated that substance misuse will double between 2001 and 2020 in adults over 65 and is related to increased mortality and morbidity. [1, 3]

Substances misuse ranges from the harmful use of alcohol, tobacco, and illicit drugs to prescribed and over the counter medication. Older people are more vulnerable to harmful effects of substance misuse due to the physiological changes associated with ageing, polypharmacy and co-morbid illnesses as well as the direct impact on physical health due to poor diet, isolation and poverty.[1] Healthcare professionals may be uncomfortable asking about substance misuse in older people and the information may not be disclosed by patients or carers but certain symptoms should trigger screening for substance misuse especially as they can be easily attributed to ageing or an early dementia[1] (see box 1). Risk factors for substance misuse can include loneliness, retirement, isolation, bereavement or an underlying depression, anxiety or cognitive disorder.

Box 1: Symptoms suggestive of substance misuse[1]

Altered sleep patterns	Unexplained weight loss
Impaired coordination	Unexplained chronic pain
Confusion	Unexplained falls
Poor hygiene/self-neglect	Short term memory difficulties
Tremors	

Box 2: Acute presentations of alcohol misuse

Acute presentations of alcohol misuse
Alcohol intoxication; Alcohol Withdrawal
Wernickes encephalopathy; Delirium tremens

Physical problems associated with alcohol
Falls/head injury; Hepatic disorders
Gastric damage/oesophageal varices or Mallory Weiss

Chronic presentations
Alcohol related Brain damage
Dementia
Korsakoff's psychosis

Psychiatric Presentations
Confusion; Anxiety
Agitation; Alcoholic hallucinosis

Vignette 1

Joe, 77, presents with blackouts, falls and some short term memory difficulties. During the interview he admits to drinking one bottle of wine a day and two shots of brandy a night (approx. 84 units/week). He was a social drinker until his wife died 18 months ago.

The recommended number of units of alcohol is 14 units a week but drinking more than 13 units a week in the over 65s can lead to impaired ADLs[1,3]. There were 1.1 million hospital admissions related to alcohol consumption in 2014 to 2015, with older people tending to have increased stays in hospital.[2,4] Alcohol misuse can be missed in acute hospital admission due to non-specific and subtle signs and symptoms but is a common cause for delirium in older people admitted to inpatients.[5,6] An accurate assessment of alcohol consumption can be difficult in patients with cognitive impairment but an informant's history could be useful. Screening tools such as the CAGE, AUDIT (Alcohol Use Disorders Identification Test) can be used but the Short Michigan Alcoholism Screening Test- Geriatric Version (S-MAST-G) has been validated for use in older inpatients.[1,7] There are no specific blood tests to detect alcohol misuse - a raised Gamma GT or macrocytic anaemia performed routinely when patients are admitted could suggest an underlying problem.

Early onset or long term misusers have had alcohol related issues for many years and have simply grown older while late onset drinkers tend to start misusing alcohol in their 50's or 60's. Late onset misuse can be associated with stress, life events and bereavements.

Joe gradually reduced his consumption of alcohol to approximately 20 units a week and started to attend bereavement counselling as a result of his sessions with

local alcohol services. His memory improved and he had no further blackouts and falls.

Vignette 2

Rose, 84, was admitted to the short stay ward following an overdose of codeine due to persistent headaches not responding to codeine, despite her GP increasing this to 30mg qds. Her daughter reported to the admitting doctor she had been buying codeine for her mother from a pharmacy and Rose may have been taking up to 90mg qds.

Illicit drug use is still uncommon in older people but is likely to increase as the ageing population changes.[8] Long term prescription or poor adherence prescribing advice for benzodiazepines or hypnotics can lead to inadvertent or intentional misuse. This can cause tolerance, withdrawal or compulsive use and in the case of analgesics poor pain control.[1,9] Older people who are more likely to develop problems tend to be female, socially isolated or have a previous history of substance misuse or mental health disorder.[8]

During her hospital admission Rose had her codeine gradually reduced to 15mg qds. A discussion was had with her and her daughter about the safe use of medication. During her admission it became evident she had a number of depressive symptoms and was referred to the mental health liaison team.

Management of Substance abuse in older adults

There has been little research into substance misuse in older people, particularly the management despite the impact this will have in the future. There is no current guidance from NICE for the management of substance misuse for older people. There are also far too few services providing dedicated services to older people with substance misuse.

Guidance on the management of illicit and prescribed drug misuse in younger adults is widely available and may need to be adapted to older people taking into account co-morbidity, polypharmacy and the physiological differences.

The management of alcohol misuse will depend on whether the person is in the community or on a inpatient unit. Alcohol withdrawal may be more severe and prolonged in older inpatients[1] but respond to the same interventions as younger people. Patients with alcohol withdrawal may present with agitation as well sweating, tremors, tachycardia and insomnia, and in more severe cases, seizures. Long acting benzodiazepines are useful in alcohol withdrawal but at lower doses for older adults especially if there is hepatic dysfunction.

Intravenous thiamine should be considered in patients with Wernicke's encephalopathy as left untreated it could lead to Korasakoff' s psychosis which can result in permanent cognitive impairment. Low dose anti–psychotics may be needed in patients with marked agitation or hallucinations. Pharmacological interventions (e.g. Acamprosate, Disulfrum and Nalmefene for the long term management of alcohol misuse is used in conjunction with psychosocial interventions in younger people but the evidence of effectiveness in their use for older people is limited).

Substance misuse in older people is becoming increasingly common and detecting this problem during an inpatient admission could help reduce morbidity.

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Co morbidity and polypharmacy in dementia – time for action?

Reflections on a recently published article in *Age and Ageing* by Clague et al. (2016)

The context

Populations are ageing across the world, leading to growing numbers of people surviving to develop dementia, many of whom will have complex care needs.

"Today, 47 million people live with dementia worldwide, more than the population of Spain. This number is projected to increase to more than 131 million by 2050, as populations age. Dementia also has a huge economic impact. The total estimated worldwide cost of dementia is US$818 billion, and it will become a trillion dollar disease by 2018."

World Alzheimer Report 2016
Alzheimer's Disease International

Previous studies have had mixed findings as to whether people with dementia have more health conditions or use more medications than others of the same age, although such studies have often been small or have been based on highly selected samples. Our study analysed numbers of co-morbid health conditions and medications in a sample drawn from 314 Scottish general practices of 291,169 people over 65, of whom 10,258 (3.5 per cent) had a dementia diagnosis recorded, making this one of the largest population analyses carried out to date.

What did we find?

People with dementia had higher numbers of co-morbid conditions. After adjustment for age and sex, people with dementia were more likely to have five or more physical conditions (not including dementia) and to be on five or more repeat prescriptions. Parkinson's disease, epilepsy and constipation had the highest relative prevalence among people with dementia, compared to controls. Our results rely on the recording of "diagnosed" dementia and may underestimate comorbidity, for example among residents in long term care with "known" but not formally diagnosed dementia.

People with dementia were also prescribed larger numbers of medications than age and sex matched controls. Over half of those with dementia were on five or more repeat prescriptions with 43.2 per cent on five to nine repeat prescriptions compared to 32.4 per cent of controls and 14 per cent on ten or more compared to 8.4 per cent of controls.

Others have found that increased comorbidity and polypharmacy are both associated with increased cognitive and functional decline, in addition to possible associations between higher levels of medication use and increased mortality. A study of US claims data indicated that, when illness burden is controlled for, the care costs of patients with dementia may be up to 34 per cent higher than those of aged matched controls, where medication is the main reason for cost difference. Previous work using our Scottish dataset has shown that people with dementia are seventeen times more likely to be prescribed an antipsychotic and twice as likely to be prescribed an antidepressant or a hypnotic/anxiolytic than older people without dementia.

Implications

These findings highlight the importance of effective multidisciplinary integration between specialist and non-specialist services. People with dementia have many other care needs, making it important that their other care needs are accounted for by specialist dementia services, and that their dementia is accounted for by other services. Supporting primary care is a key role for specialist services, both by providing specialist care on referral, and to provide advice and education.

The findings support growing international consensus about the care needs of people with dementia.

Healthcare for people with dementia needs to be:

- Continuous: treatment options, care plans and needs for support must be monitored and reviewed as the condition evolves and progresses.
- Holistic: treating the whole person, not single conditions, organs or systems and mindful of that person's unique context, values and preferences.
- Integrated: across providers, levels of care, and health and social care systems"

World Alzheimer Report 2016
Alzheimer's Disease International

Polypharmacy in particular, needs careful review, since people with dementia will often (but not always) have lower expected benefit from preventive medications and are usually at higher risk of harm, making it important to minimise over-medication in this frail population.

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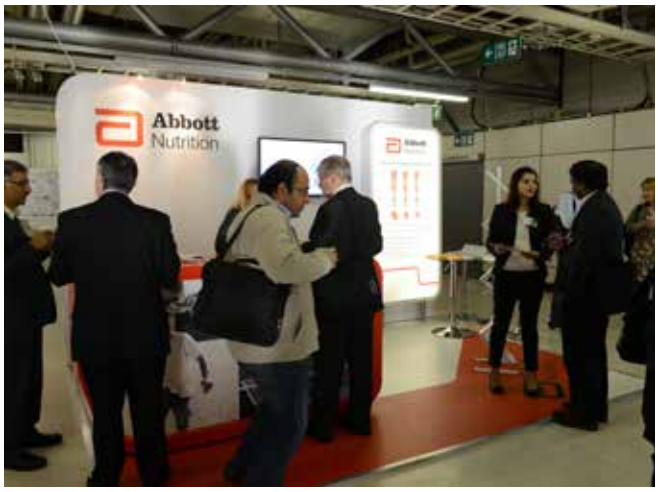
by Fiona Clague, Perth Area Psychological Therapies Service, NHS Tayside,
Bruce Guthrie, School of Medicine, Dundee
The fully referenced paper was published in *Age and Ageing*. See http://**tinyurl.com/z6asnzw.**

BGS Autumn Meeting Report



Twenty first century specialist medical care for older people will not be confined within the walls of a hospital: much of it will be delivered in or close to the patient's home.

This glimpse into the future – with examples of how it is already happening in the present – was the major theme of the first day of the BGS Autumn meeting in Glasgow. The Hospital At Home Forum – the first ever UK wide one – was run by the Society's Community Geriatrics Special Interest Group and focused both on the push factors – increasing demand, stretched resources and the unsuitability of many aspects of hospitalisation for frail older people – and the pull ones – innovative technology, clinical effectiveness and patient satisfaction.

"I felt like the queen getting all that attention" one woman had told Dr Graham Ellis, associate medical director for older people's services in Lanarkshire. Another had said: "it felt like the cavalry coming over the hill." A third had commented, "just being in your own surroundings makes you feel happier and more confident and able to cope."

They were all talking about their experiences of their local Hospital At Home system. This had been started five years ago and now covered over half a million people. It dealt with 250 referrals a month, of which three quarters could be managed in their own homes.

Such innovations are urgently needed elsewhere, Dr Ellis told the meeting. "We can't carry on as we are. There has been a huge growth in demand but our resources have not expanded to match." Moreover, hospitals could actually be dangerous places for older people. There were increased risks of infection, delirium, drug errors, functional decline and acquired immobility: according to some estimates ten days' bed rest could equal ten years of ageing.

There could be problems with discharge planning and there was often great strain on carers.

What *we* want may not be what *they* want

Increasingly sophisticated equipment for testing and treating, much of it now portable, plus technological developments like video conferencing, electronic records and remote monitoring were offering new opportunities in the field.

It was also important, he added, to consider what patients themselves wanted –"which isn't necessarily what we want for them." Dr Ellis had realised this early on in his career when he had visited the home of an old man who regularly presented with respiratory problems and who was regularly told to get rid of his 300 pigeons.

> "But when I was invited to go into his back room I saw every inch was covered with trophies and pictures and pigeon memorabilia. He had been a champion racer in his day and he would rather live a shorter life with his pigeons than a longer one without them."

Opening the session Prof. Sasha Shepperd, professor of health services research at the Nuffield Department of Population Health, had defined the new approach as a geriatrician led acute service which provided a direct alternative to admission to hospital or the opportunity for hospitals to discharge patients early because a high level of care could be offered at home.

Studies so far had suggested encouraging trends in cost savings and reduced admissions and length of stay, but there had been too few to date to be able to draw statistically conclusive evidence and he appealed to his audience to participate in the research his department was currently undertaking.

Some individual schemes, however, have been able to take some measurements. Describing the REACT – Rapid Elderly Assessment Care Team - project in Lothian, consultant geriatrician Dr Scott Ramsay said that over the past three years it had dealt with 1,697 acute patients with an average age of 81 and provided a total of 10,444 care days which might otherwise have been spent in hospital.

Breaking down empires

Although some patients had still to be admitted, most could be given the same investigations and treatment where they lived – in their own homes, in sheltered housing or in a residential or nursing home – as they would have received as an inpatient. "The aim is to shift the balance, focus and location of care but to give the equivalent or even better."

He told those considering setting up a similar scheme: "You need to recruit a great team and be prepared to blur roles so you can all work together for the benefit of the patient – I change beds and pads, the occupational therapist takes urine samples.

You also need to find a home for your HQ, sort out your shopping list for all your equipment, define your identity and keep electronic records. My message is – just do it and you'll quickly learn what you can and can't do."

Another system in Fife was proving safe and cost effective according to its consultant geriatrician, Dr Angie Wilkinson. Most cases involved acute exacerbations of chronic conditions: the scheme excluded such problems as stroke, cardiac arrest, gastro-intestinal bleeds and head injury with loss of consciousness. "You can pick up clues in someone's house which you don't get in a hospital bed. You also get additional information from the family."

One of the main problems, she said, had been changing attitudes and getting both hospitals and the community to understand the new concept, a sentiment echoed by other speakers.

"We have to let go of the paternalistic culture in health and social care and find new ways of working," said Dr Bruce Willoughby, a GP and clinical lead for the Harrogate and District New Care Model.

"Some GPs saw us as a threat, they thought we'd be increasing their workload at a time when they're already overstretched so we rolled it all out slowly in a pilot study to show them there were no adverse effects."

Another GP, Dr Chris Preece from Boroughbridge, added, "It is difficult to change people when they're all walled off in their own empires. So you need good communication and information sharing. You need to keep all your stakeholders up to date. And you need to be clear on your core values and aims, and work out what's actually needed, not just what's currently in fashion. We reviewed all roles and tasks and asked, could a job be done by someone else, the voluntary sector for example."

Other challenges included recruiting staff prepared to work beyond the traditional professional boundaries, and ensuring staff safety. In the Guy's and St. Thomas's scheme practitioners always went in pairs for a first visit. Another difficulty in London was dealing with traffic and finding parking spaces.

Otherwise, said consultant geriatrician, Dr Rebekah Schiff, 'bringing the ward to the patient' for acute or semi acute care in their own home had already enabled the Trust to close one hospital ward.

"It takes time to embed the concept into practice because a lot of health professionals are risk averse and prefer to keep patients in hospital. And that's where some patients want to be. Other patients like it so much they self-refer."

Tele-consultation

An example of how technological developments can enable community care advances was given by Rachel Binks, nurse consultant for Digital and Acute Care in Airedale.

Their clinician-led service offers face to face advice via video to residents and staff in care homes. It now covers 500 homes around the UK with 18,000 residents. Its aim is to avoid unnecessary trips to A&E, distressing in themselves but often exacerbated by long waiting times.

A tele-consultation involves looking at a patient with a high definition camera so you can see if they are clammy, sweaty or if their face is collapsing from a stroke, or count their respiration rate just as if you were at their bedside or sitting beside them on the settee.

"We aren't just a call centre following pathways like 111. We have a pro-forma but we're staffed by senior nurses. Our aim is to enhance services, not be a substitute for them. They can call us back as many times as they want and we also call them back to see if the patient has taken the pain relief, for example, or the necessary fluids. We can also act as a triage process for GPs."

The hub offers its Gold Line service for end of life care and the session concluded with a moving video of a husband telling how much its support had meant in his wife's final days.

The meeting had its own technological innovation which allowed members of the audience to submit questions electronically during a talk which the speaker could then address afterwards, along with the usual method of questions from the floor.

How difficult is it to carry shopping?

The conference also saw the launch of a new Special Interest Group for Sarcopenia and Frailty, described by the first speaker, Prof Avan Sayer, director of the Newcastle Biomedical research Centre, as a 'core business' for geriatricians.

Sarcopenia, literally 'poverty of flesh', is the loss of skeletal muscle mass, function and strength with age. It may be indicated by slow gait and poor grip strength and responses to such questions as, 'how much difficulty do you have carrying shopping, walking across a room or climbing stairs?'

Frailty is a multi-system impairment associated with increased vulnerability to stressors and a consequence of cumulative decline in physiological systems over a lifetime.

It can be measured by the frailty index which lists 36 conditions or situations; the more that apply to a patient, the higher the frailty score.

Dr Helen Roberts, associate professor in geriatric medicine at the University of Southampton, pointed out that Shakespeare recognised sarcopenia in the sixth age of man with his 'shrunk shank', but that in practice it was not always easy to spot. "You can be obese and still be at risk. People can look better than they are."

There is a growing interest in the lifelong approach: some research suggests childhood influences, even birth weight, can play a part in the development of sarcopenia and frailty in later life and it was important to preserve the peak muscle strength reached in adult life for as long as possible. For older people already enduring the condition there were various approaches including resistance training and nutritional supplements. Intervention was important, stressed Dr. Roberts, because sarcopenia and frailty were associated with a range of adverse outcomes.

"You can reach a point where an older person can't actually stand up, which impacts on their independence."

Dr Miles Witham, clinical reader in ageing and health at the University of Dundee, listed some of the possibilities being explored in what has become a fast moving field in both practice and research. These included, with their attendant advantages and disadvantages, Vitamin D, ACE inhibitors, testosterone, leucine, multi-component nutrition and myostatin inhibitors.

"What does work is resistance training. There's good evidence for this. What is less known is how we can actually make this work in clinical practice."

Horrible and bad for you

Another major subject highlighted at Glasgow was delirium, summed up by Dr Elizabeth Teale as 'horrible and bad for you.' Symptoms included visual hallucinations, misinterpretation of sensory experiences, fear, anxiety, delusions, disorientation, time distortion and a reduced ability to direct, focus, sustain or shift attention.

The most common subtype, the hypoactive, which affected around 39 per cent of patients, was also the most difficult to diagnose. Sufferers might be withdrawn, sleepy, difficult to rouse, have poor oral intake, slurred or incoherent speech and abnormal hand movements such as plucking at the air or at bedding. Patients might have poor eye contact, seem vague and be easily distracted. A good test of inattention was to ask them to say the months of the year backwards. They should also be asked if they were frightened by anyone or anything, or concerned about what was going on.

The hyperactive subtype was less common at 21 per cent, but easier to spot with its symptoms of agitation, wandering and behavioural disturbances. Other patients fluctuated between the subtypes and some showed no motor symptoms at all. Delirium, added Dr Teale, clinical senior lecturer in geriatric medicine at Bradford Teaching Hospitals, was the most common complication of hospitalisation in older people affecting around one in five patients. Triggers included medication, pre-existing dementia, dehydration, pain, acute illness, infection, noise and other environmental factors. Sometimes something as simple as moving wards in the middle of the night could provoke an attack.

Treating the underlying causes and paying close attention to such basics as bowel movements, sleep disturbances, nutrition and hydration – even just checking that hearing aids worked and spectacles were clean - could prevent or significantly shorten perhaps a third of all episodes.

Doing so was crucial, she stressed, because delirium could persist after discharge and could have longer term implications including acceleration of cognitive decline, incident dementia, institutionalisation and mortality.

Around half of all patients could recall their experiences and some suffered flashbacks.

"Those with more severe delirium or underlying cognitive impairment are less likely to recall but that doesn't mean their distress was any less at the time," she added.

We're not superfluous yet

Comprehensive geriatric assessments are now a standard part of our speciality's armoury but they have had to be fought for over the years, as a guest lecturer from America reminded the meeting. Prof Laurence Rubenstein, chairman of the Donald W Reynold Department of Geriatric Medicine at the University of Oklahoma, outlined three stages in their development.

The first between 1935 and 1975 saw the early concepts and models - and the subsequent setting up of the BGS – which arose out of the work of Marjory Warren and her colleagues, particularly in UK workhouses.

The second stage from 1975 to 1995 involved refinement and testing: controlled trials and meta-analyses, conferences in Britain and overseas, the introduction of home visit teams, Geriatric Evaluation and Management units and Acute Care of the Elderly units

The third stage from then until the present day was about integrating CGAs into mainstream care as well as further multi-site trials and analyses, and creating uniform databases.

He reminded his audience of what a comprehensive geriatric assessment actually meant: it was a multi-dimensional interdisciplinary diagnostic process to identify and then plan for the care needs of frail older people. Its purpose was to get better diagnostic accuracy, optimise medical treatment, improve outcomes, function and quality of life, optimise living locations, minimise unnecessary service use and arrange effective care management.

The measurable dimensions of a patient's physical health should involve taking a traditional history, giving a physical exam, examining relevant lab data, listing the problems, using disease specific severity indictors and implementing prevention practices such as exercise or vaccination. There were scales, like the Activities of Daily Living scale, which could also be used to measure function, mobility

and quality of life, and scales to measure cognition and psychological health. Other factors to be considered included social networks and support systems, economic adequacy and environmental safety.

Geriatric assessment should be targeted according to risk: dependent or higher risk older people should have tailored CGAs and follow up programmes; over 75s at medium risk should have preventative home visits; over 65s at low risks should have general appraisals. But all CGAs had to be part of a bigger picture.

Over the years CGAs had contributed significantly to better outcomes for older people, improving physical function, cognition and morale, reducing unnecessary medication and hospitalisation, avoiding premature admission to nursing or care homes and reducing costs.

"But big questions remain. What are the most effective models; which outcomes can we now most improve; what are the key elements of a programme; who benefits the most; how can it be best integrated into the care system?"

He compared health care systems in the US and the UK. The advantages of the former were good resources, high technology, active research, choice of provider, provider flexibility, relatively high provider income. The disadvantages were that it was too expensive, could be too high tech, there was often duplication and inefficiency, there were gaps in coverage, it was not well planned and it was unequal.

"Geriatrics now has a major place in your health care system but in the US it is still confined to major health centres. And we haven't yet achieved critical mass. There aren't enough geriatricians to go round. We are very envious of your system."

"When I started 35 years ago the goal was to teach every young doctor so much about the subject that in the end we wouldn't be needed as a separate speciality. But we're not superfluous yet."

Sod seventy

The other guest lecturer at Glasgow was Sir Muir Gray, director of Better Value Healthcare and professor of knowledge management at Oxford University. In a talk entitled, 'how to stay young and get younger', Sir Muir, who has just written a health and lifestyle book called *Sod Seventy*, told the audience, "There are only two phases of life: growth and development and decline. The turning point between them is what we need to postpone. That generally tends to be in your late thirties though you could say for a lot of people, it's all downhill from when you get your first job because the most dangerous activity is sitting.

I always want to ask Bear Grylls to commute to work every day and then see how healthy he is after six months."

"The key issue is loss of fitness marked by decrease in ability. The gap between the best possible rate of decline and the actual rate of decline tends to open up as you get older but actually without a great deal of effort most people can move themselves back to where they were ten years before so the fittest 50 year-old can be like the average 40 year old."

Disease accelerated the rate of decline and some disease was caused by environmental factors rather than lifestyle. He himself often suffered from breathlessness because he was born before the Clean Air Act and had measles as a child. The impact of illness though, could be reduced by developing positive attitudes as well as improving strength, stamina and suppleness.

Geriatricians had a role to play in prevention as well as cure, in fighting to ensure resources were allocated to all those in need while also striving to cut waste and increase efficiency. "We need to develop a culture of stewardship to ensure the NHS is still here in ten or twenty years. We need some big debates. You can give the leadership. You can make the difference."

Shrinking brain inside a fixed cranium

Other subjects at the meeting included sessions on stroke, polypharmacy and prescribing, molecular biology, orthogeriatrics, peri-operative care, thyroid disease and head injury. In the latter, Dr Roddy O'Kane, consultant neurosurgeon at the Institute of Neurological Sciences in Glasgow, explained that head injury presentation could include mental deterioration, headache, drowsiness, coma, seizure, collapse, visual disturbance, gait disturbance and limb weakness.

There could be chronic subdural haematoma or other causes. A trauma like a bang on the head could, in itself, be negligible but the older brain did not repair itself as efficiently as the younger brain. "Older people have less neuronal reserve and less plasticity. In old age we have a shrinking brain inside the fixed space of a cranium so there is more room for it to shake."

He gave a brief overview of both surgical and medical approaches. The brain had huge metabolic demands and an injured one would take what it needed to prevent secondary problems at the expense of every other organ. Focusing on the cerebral meant an assault on the lungs, heart, kidneys.

"We are treating more but we are getting better at doing so, partly through better anaesthesia, rehab and geriatrics. It's a rapidly evolving science with increasing choices of interventions and drugs. As geriatricians you should never hesitate to call us if you are concerned about a patient. We can help each other."

He was followed by a colleague at the Institute, consultant clinical neurophysiologist Dr Veronica Leach who spoke about the use of EEG in epilepsy, seizures and attack disorders, states of altered consciousness like coma and delirium and in the diagnosis of specific neurological disorders in the elderly.

Electroencephalography, which records cortical activity usually for about 20 to 30 minutes, could be a very useful test in the correct context but all recordings should be interpreted with detailed and accurate clinical information and patient history.

There must not be over reliance on the test which was not always helpful and could sometimes be counterproductive.

As in previous years the meeting drew visitors from overseas including a group of trainees from Canada who, with a group of their UK peers, shared their experiences of persuading other young doctors to go into geriatrics. An ageing population in both countries meant the need was growing but there was still a shortfall.

Those who were put off the speciality had cited the on-call duties of medical registrars, not wanting to deal with patients with cognitive impairment or chronic illness and a feeling of therapeutic nihilism, a belief that nothing could be done. Some thought the speciality lacked prestige and had more to do with social issues.

Those who were attracted liked the intellectual challenge of dealing with complexity, the focus on the whole patient and the chance to work in an interdisciplinary team.

To promote interest in the UK, Geriatrics for Juniors conferences had been launched in 2013 to bring together like-minded individuals. "If you find others who share your enthusiasm, that's empowering," said Peter Brock, an ST5 geriatrics and general medicine with the Northumbria NHS Foundation Trust and one of the founders of the scheme. Speakers were chosen to project a positive image, give practical advice, counter negative ideas and deal with issues fundamental to juniors. The year the scheme began 14 per cent of geriatric registrar posts were unfilled; in 2016 the figure had dropped to 6.9 per cent. "This is amazing, a huge change", he added, "and the quality of applicants is very high. There are a lot of rising stars."

Dr Marisa Wan, a consultant geriatrician at Mount Saint Joseph Hospital in Vancouver, described the efforts of the National Geriatrics Interest Group which now involved medical students, to promote the speciality. These included publications, lectures, skills programmes, community outreach and mentoring. There was also a project involving retired police officers, judges and members of the armed forces to advocate for health literacy and promote a positive image of older people.

The rest of the feast

In the falls session, Prof Dawn Skelton, professor of ageing and health at Glasgow Caledonian began her talk by asking her audience if they had fallen for whatever reason during the past 12 months.

When the majority rose to their feet she told them, "Falls are part of life. Why should all falls be bad? We can stop falls by not moving at all. But what effect does this have on mental health, isolation, loneliness and depression?"

Older people who were fearful often avoided activity to reduce their exposure to hazards, a response that some professionals used as well, she added. But risk aversion could also have serious physical consequences. Sedentary behaviour in the over 60s was associated with higher plasma glucose, higher BMI, higher cholesterol and reduced bone density. Sitting still in a hot room could raise blood pressure, increase postural hypotension and reduce stamina; in a cold room it could result in less muscle strength, slower walking speed and lower sit to stand velocity.

"In hospital it's normal not to move so people are coming out frailer than when they went in. Or patients might do rehab for a bit and then sit for the rest of the day. Are we allowing deconditioning of patients to reach epidemic proportions? We must talk about moving more, maybe getting patients to stand for a minute every hour, for example, and geriatricians have a role to play in this."

"We must send out a consistent message to older people: sit less, move more and we must encourage all professions to regularly mobilise patients. It's important to encourage an active lifestyle beyond rehab so we must help patients aim towards self-directed exercise and effective doses of highly challenging strength and balance exercise to reduce frailty and falls. We need to work strategically with the fitness and exercise industry to ensure training frameworks meet our standards of effectiveness and safety."

BGS meetings also consider topics related to the law and ethics and an example of this was the talk on the Court of Protection and Best Interests given by Jane Buswell, an independent consultant nurse and best interests assessor. Her role, she explained, was to provide independent reports for the Court which dealt with health and welfare cases for children and adults lacking capacity.

Issues might include resuscitation, serious medical treatments, restrictive practices and restraint, where someone lived and what care they needed.

The Official Solicitor representing the individual would ask a BIA for their opinion of that individual's care needs and how these could be met and the advantages, and disadvantages of residing in a care home or their own home.

They would also be asked whether they had specific recommendations about any arrangements and what they thought were the wishes and feelings of the person concerned.

Recent cases had seen interesting rulings from judges. The most well-known was that of the woman who refused medical treatment after taking an overdose because she did not want to live if she could no longer enjoy her 'bling' lifestyle.

Her decision might be unwise, even fatal, and one that other members of society might consider unreasonable, illogical or even immoral, but it was not in itself, the judge decided, evidence of lack of capacity, provided she was able to weigh the relevant information. Even where someone did lack capacity their belief and values must not be undervalued, according to a judge in another case.

Ms Buswell had trained to be a BIA, she said, because she wanted to be the voice of the older person and help stop arguments between doctors and social services. She had produced seven reports to date, the findings of which had all been accepted by the judges.

Being a nurse had helped with this 'serious and fascinating' job because she already had a knowledge of medical conditions and specialist language, an understanding of the pressures on clinical staff and also of the impact of complex, life limiting health problems on patients' mental and emotional states.

It was often important though, to question the paternalistic, risk averse culture of the NHS. "Sometimes capacity only becomes an issue on discharge when the patient disagrees with the team."

As a BIA she felt she had perhaps had more impact on people's lives than in all her years as a nurse.

"You can be an advocate for the vulnerable and you can challenge poor practice and discriminatory attitudes."

She advocated five principles: "assume initially that everyone has capacity; talk to the patient and their family; accept that an unwise decision does not necessarily mean someone lacks capacity; always act in their best interests; and when there has to be intervention make sure it is the least restrictive."

Don't prescribe before doing the basics

There were three sponsored symposia: one by Bial on the role of COMT inhibitors in Parkinson's Disease, another by Internis Pharmaceuticals on the problem of adherence with alendronate tablets and a third by Astellas Pharma on the treatment of over active bladder in older people.

In the latter, Dr Susie Orme, consultant geriatrician at Barnsley Hospital, spoke of the link between incontinence and falls, urinary tract infections, falls, fractures, pressure ulcers and depression. Frequency and urgency meant older people were often fearful to leave their homes.

"It really impacts on someone's quality of life. There are big care costs to society – the pad budget is enormous - but there is no need for nihilism, we now have treatments." Outlining the use of Mirabegron in patients who might be at risk of an anticholinergic overload with its possible effects on cognition, Andrew Sinclair, consultant urologist at Stepping Hill Hospital in Stockport, told the symposium that it was important to use other approaches first.

These included lifestyle advice – stopping smoking, losing weight and reducing caffeine intake - bladder retraining and pelvic floor physiotherapy. "There's no point in giving drugs if you haven't done the basics.

The meeting was dedicated to the memory of Dr Kate Granger, the young geriatrician who started the 'hello my name is' staff and patient communications social media campaign, after being diagnosed with cancer and who died earlier this year at the age of 34.

There were 701 attendees including nurses and other health professionals as well as doctors. There were 108 abstracts, 88 posters and a social agenda: a drinks evening with the Lord Provost and representatives from Glasgow City Council on the Wednesday evening and a dinner the following night at the Grand Central Hotel, followed by a lively ceilidh with the Reel Time band.

2016 Autumn meeting prize winners

Elizabeth Woodford Williams Prize
for best platform presentation:
Namali Samarasekara for her presentation titled:
Overtreatment of Type 2 Diabetes in Older People Living in Care Homes in United Kingdom.

John Brocklehurst Prize
for the best clinical effectiveness poster:
Hanni Wolfenden for a poster titled:
A Post-operative Proforma to Improve Sepsis Identification Following Hip Fracture Surgery.

Norman Exton-Smith Prize
for the best scientific research poster titled:
A Granic for a poster entitled: Initial Level and Rate of Change in Grip Strength Predict All-cause Mortality in Very Old Adults.

The Eva Huggins Prize
for best poster by a nurse or allied health professional:
Yvonne Murphy for a poster titled: *The Integrated Community Ageing Team (ICAT) Pharmacy Service: Comprehensive Medication Reviews in the Community*
and
Geraldine Rogers for a poster titled: *A quality improvement project to create a climate of care resulting in a reduction of the prescription of anti-psychotics on the ward.*

by Liz Gill
Freelance Journalist

Differences in diagnostic process, treatment and social support for Alzheimer's dementia between primary and specialist care: results from the Swedish Dementia Registry

An ageing population has led to an increasing prevalence of dementia disorders, putting pressure on health care systems to develop efficient strategies for diagnosis and care. In many care systems, this has meant shifting some of the diagnostic burden onto primary care physicians.

The Swedish Dementia Registry, *SveDem*, is a nationwide quality registry founded in 2007 with a view to improving quality and equality of dementia care throughout the country. Patients are registered with *SveDem* at the time of dementia diagnosis, together with information on demographic background, living situation, cognitive level and medication.

The Swedish Board of Health and Welfare published guidelines in 2010 defining the requirements for a dementia diagnosis and giving recommendations on treatment and care. One of the aims of *SveDem* is to evaluate compliance with these guidelines.

Diagnosis of dementia in primary care is well established in Sweden. The aim of our study was to compare diagnostic process, treatment and access to social support between patients with Alzheimer's dementia diagnosed in memory clinics (specialised care) and those diagnosed by primary care. We also wanted to check how primary and specialist care complied with the national guidelines.

We included in our study, 9,625 patients with Alzheimer's dementia diagnosed between 2011 and 2014. Sixty per cent (5734) were from specialised care and forty per cent (3,891) from primary care. Patients diagnosed in primary care were on average older, and had lower cognitive level at the time of diagnosis. They were also more likely to receive home-care or day care and were diagnosed faster. Fewer diagnostic tests were performed in primary care and some tests were less likely to be performed. The greatest differences were found in neuro-imaging—usually computer tomography (CT) of the brain (83 per cent completed in primary care compared to 98 per cent in secondary care) and clock test (84 per cent in primary care versus 93 per cent in specialist care). After adjusting for background factors, prescription of antipsychotics was lower in primary care, while prescription cholinesterase inhibitors (specific dementia medication) did not differ between primary and specialist care.

We concluded from this study that the background characteristics of patients diagnosed in primary and specialist care are different, and this may lead to different testing required to reach a diagnosis. Primary care excelled in restriction of antipsychotics while the use of head CT and clock test are areas for improvement.

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by Sara Garcia-Ptacek
Division of Clinical Geriatrics, Department of Neurobiology, Care Sciences and Society, Center for Alzheimer Research, Karolinska Institutet, Stockholm, Sweden

BGS Policy update Autumn 2016

During autumn there were some good opportunities to promote BGS's work and key messages to a range of opinion formers and decision makers. I am also very much enjoying working with BGS officers and colleagues, and getting to know BGS members, as well as policy colleagues in some of the other organisations that we work with.

Key policy developments and current programme of work

BGS's written submission to the House of Lords Select Committee Inquiry on the long-term sustainability of the NHS.

BGS submitted written evidence to the House of Lords Committee Inquiry. A copy of our full response has been published on the Committee's website and is also available at **www.bgs.org.uk/index.php/policy-digest-m/5151-policy-sustainability-of-nhs**.

Our submission highlighted the need for a re-modelling of services through a person-centre approach to care, to include a review of social care and its funding. The select committee held its final oral evidence sessions on 20 December.

The committee will have begun drafting its report in January with a view to it being published by 31 March at the latest, and Government will then need to provide a response.

In the meantime, on 30 November the House of Lords held a debate on the need to reform social care. Lord Patel, who is chairing the Select Committee Inquiry, made clear that the debate had been called as a consequence of the submissions the Inquiry had received many of which, including BGS's, pointed to the urgent need to address the crisis in social care. You can read a full transcript of the debate here: **www.parliament.uk/business/news/2016/november/lords-debates-social-care-reform/.**

BGS/RCGP report on integrated care. In November, to coincide with our Autumn conference we published our joint report on Integrated care for older people with frailty: innovative approaches in practice **www.bgs.org.uk/press-3/press-and-pr/bgs-press-releases/rcgp-bgs-integrated-care.**

The report was developed collaboratively with the RCGP and provides thirteen case studies of innovative approaches which showcase geriatricians and GPs working together with other health professionals to improve the provision of health care for older people with frailty. The case studies cover the whole frailty trajectory from supporting older people with frailty to stay healthy and independent through to supporting them in hospital. The report also provides an analysis of the common themes which contribute to success.

The initial reaction to the report has been very positive and we will continue to promote it as widely as possible. We hope that you will find it helpful. Please share with your colleagues and others who you think would find it useful. We will be carrying out an evaluation of the report in the second half of 2017 and would welcome feedback on its usefulness.

Guidance on commissioning and providing healthcare for older people living in care homes. On 6 December, to coincide with the King's Fund conference on Enhanced Care in Care Homes, we published our updated guidance on healthcare in care homes. It is short accessible guidance aimed at commissioners, policy makers and service providers and anyone with an interest in ensuring that older people living in care homes have access to healthcare that meets their needs.

We want to promote this good practice guidance as widely as we can and will continue to communicate and disseminate it in the coming weeks. We would also welcome your feedback on the guidance which you can send directly to me at **policy@bgs.org.uk.**

Attendance at meetings, conferences and report launches

This autumn I attended a number of events and conferences which have been useful for networking, building policy contacts, and helping to raise the profile of BGS.

These include:

- the parliamentary launch of the College of Occupational Therapist report, Reducing the Pressure on Hospitals, which is part of their ongoing Improving Lives, Saving Money campaign. The report makes recommendations for the provision of OTs in all rapid response and emergency care services, more occupational therapy in primary care to prevent frailty and falls-related hospital admissions and out of hours service provision **www.cot.co.uk/news/occupational-therapy-proves-crucial-reducing-hospital-admissions-england**
- a round-table hosted by the BMA on Growing Older in the UK which Eileen Burns and I both attended. The discussion focused on a series of briefing papers on ageing and health which have been published as a report **www.bgs.org.uk/pdfs/2016bma_growing_older_in_uk.pdf**
- the launch of a report by the Royal Pharmaceutical Society, Frontline pharmacists: making a difference for people with long term conditions held at the House of Commons on 30 November. **www.rpharms.com/news-story-downloads/34.-long-term-conditions-report---web-version.pdf**.

I have also attended meetings of the BGS in Wales and Northern Ireland, and the autumn conference in Glasgow. This has been very useful in helping bring me up to speed with the work of BGS members across the UK and I am grateful for the warm welcome.

Caroline Cooke
Policy Manager

Time to move: Get up, Get Dressed, Keep moving...

Many years ago I suffered restricted mobility following an emergency appendectomy. It took me a surprisingly long time to regain my strength and function, despite the fact that I was young and motivated. My muscles were weak and it took a while to return to normal!

I can understand, then, that for the frail older people that I see in hospitals, some of whom were able to function well before they came to hospital, it can take substantially longer to regain their pre-admission mobility. Prolonged hospital stay, bed rest, risk of infection, fear of falling – all these may lead to loss of muscle power, strength and abilities. By mitigating against these risks, we might achieve shorter length of stay in hospital, better outcomes for patients and better ability at discharge.

Older people in hospitals have an increased risk of reduced bone mass and muscle strength, problems with blood pressure control, reduced mobility, increased dependence, confusion and demotivation. These problems can be attributed to deconditioning which affects well-being as well as physical function. Possible outcomes include falls, constipation, incontinence, depression, swallowing problems, pneumonia and demotivation. Put simply, long stays in hospital may cause older people to lose their abilityto go about their daily lives. The longer the period of deconditioning, the greater the risk of losing the ability to return to normal life in a downward spiral toward increasing frailty and disability.

Preventing deconditioning in hospitals requires a multi-pronged strategy of physical therapy, good nutrition, medical management, and psychological support. Activity and independence should be promoted from the time of admission.

But, are all health care staff and patients aware of the phenomenon of deconditioning? Are we doing enough to prevent deconditioning? Do we care? Of course, we care! We are caring professionals! But are we over-caring to the point that we do everything for our patients, without trying to encourage them to do what they can do themselves and supporting their attempts only where necessary.

So, how can we help? Simple things first. We could ensure that glasses and hearing aids are readily available, ensure that patients sit in chairs during the day, preferably in their own clothes; ensure that meals are consumed whilst sitting in chairs, as opposed to spoon-feeding them in bed (unless circumstances dictate that this should be done).

We could encourage patients to wash and dress independently, walk to the toilet where possible, provide appropriate mobility aids earlier on and encourage patients to keep their arms and legs moving in bed or chair. Even moving arms, legs and encouraging them to sit up in bed when we are examining the chest offers a small degree of physiotherapy of its own kind. Removing catheters can help them regain confidence. Removing restrictions on visiting hours and social interactions to encourage normalcy will also help them to maintain function and regain independence.

Patients need to be supported and encouraged to get moving as soon as they are able. As leaders it is our role to encourage our staff to encourage our patients to do what they can. We also have a duty to educate families and carers, in what they might do to prevent deconditioning.

Reconditioning can take twice as long as deconditioning. It is often said that in people aged 80 or more, for every ten days of bed rest in hospital, the equivalent of 10 years of muscle ageing occurs. If we want the best outcomes for our patients, it is necessary to design effective programmes for reconditioning. We need to get our patients up as quickly as possible, while being careful not to overload them. In terms of frequency of sessions, it is more beneficial for patients to do several smaller sessions than one long session. Our strategy needs to be appropriate for the growing population of older people - an "elder-friendly" hospital environment and an exercise program. This will have to be thought out clearly and may cost more in the short term, but with major long term societal health gains.

On Older People's day, we launched a deconditioning awareness campaign for staff and patients across some of our hospitals. There are banners, posters, screensavers, information leaflets, exercise programs and live demonstrations to raise awareness. These will soon be

available for download from the BGS website.

Get up, Get Dressed, Keep moving….
Your muscles, Your strengths, Your abilities: use them or lose them!

Amit Arora
Consultant Physician and Geriatrician
University Hospital of North Staffordshire

BMA Medical Book Awards 2016

Oncology – First Prize
BMA Medical Book Awards 2016

Problem Solving in Older Cancer Patients

Alistair Ring, Danielle Harari, Tania Kalsi, Janine Mansi and Peter Selby

Clinical Publishing 2015
ISBN: 9781846921100 £39.95

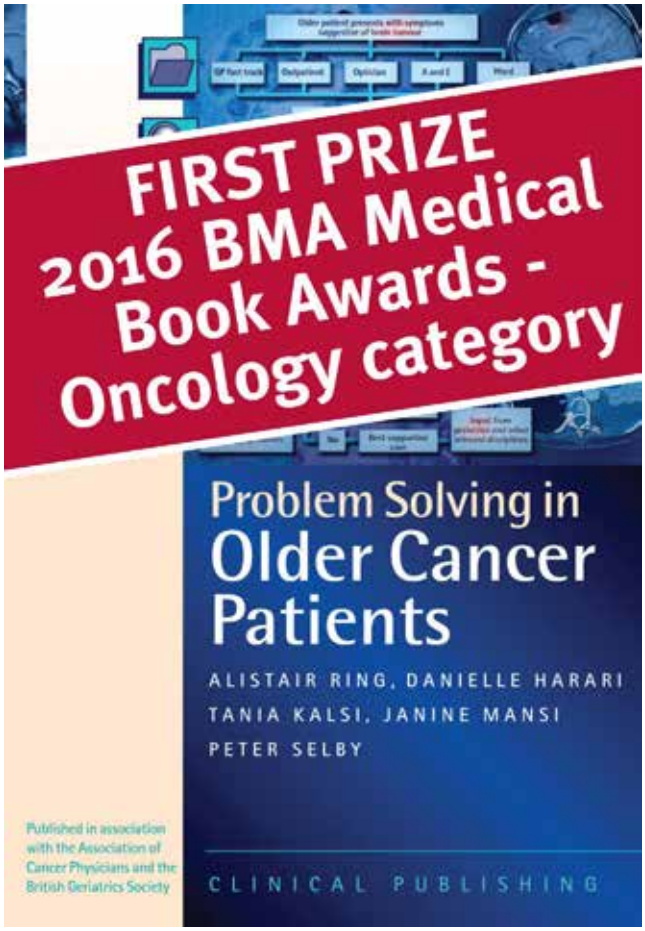
Reviewer's comments / citation:

"The management of elderly patients with a malignancy is such a relevant and hot topic now, as the amount of patients with a diagnosis of cancer that live longer is increasing and the practising physician needs to become aware of how to manage such potential complex patients.

This book comes at a great time to address these concerns and provide advice for such patients. The authors here show an excellent technique of addressing the current issues in geriatric oncology in such an ingenious way by using clinical cases and examples but also discussing the epidemiology of cancer in the elderly and also providing the view of how the same issues are dealt with by different oncologists and elderly physicians in the rest of Europe.

This book is unique and will be very warmly welcomed not just from oncologists, but also from general physicians, geriatricians, and GPs. We all need to adjust our practice with an increasingly large aging population and publications like these facilitate the training of doctors in dealing with more complex patients like elderly patients with malignancy among other co-morbidities."

It is a definitive must-buy for every geriatrician, oncologist, GP and general physician. The main strengths include the fact that the authors have come to address a very topical issue in a very clear, structured and succinct manner, providing perspectives on different issues commonly seen in the management of geriatric patients but also by using clinical case examples. This is such a good book, and I have thoroughly enjoyed reading it!"



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Interview with BGS Special Medal Winner, Susan Stefiuk

Marina Mello, BGS Communications Manager spoke to Susan Stefiuk, who was recently awarded the BGS Special Medal for 'work to promote the health and wellbeing of older people throughout society'. Susan is a Senior Coordinator for *Well Being and Friendship Services* at Age UK. She has been the lead in developing Age UK's well-being services for over seven years. During that time she developed a wide variety of new services and activities to keep older people fit and active.

Last year older people in Shropshire took part in over 5,000 activities that Susan had organised and coordinated. We asked her about her role at Age UK. She said:

I am the Wellbeing and Friendship Services Senior Coordinator at Age UK in Shropshire, Telford and Wrekin - part of a team with three co-ordinators and an administrative assistant, and we have a central office in Shrewsbury. *Wellbeing and Friendship Services* are made up of living well activities such as dance, fitness classes and social activities. There are a variety of dance classes available, including Zumba Gold and Latin Steps, which is a mix of Cha Cha Cha, Salsa - anything that is a bit Latin. From a social perspective we do afternoon teas, occasional tea dances, lunch clubs, which are very popular, and reading groups. We also do walking football, seated exercise and

walking groups. An important aspect of my role is managing the volunteers and instructors. I take one of the exercise classes myself, once a week, and I will often go and help run one of the afternoon teas. I will also go to one of the other sessions each week, for instance the reading group. Living well is only part of the overall service, we also do a befriending service where we have visitors that visit older people who are isolated in their own homes.

We also do a telephone buddy service where we have volunteers that come into the office on a Monday and ring people that have generally been on their own all weekend and probably not spoken to anyone, maybe not even all week.

My general day will involve taking referrals and helping out volunteers but every day is different!

We have probably around 180 to190 volunteers in the Shrewsbury area. We have more women volunteers than

men but both are equally important. Older men can find it challenging to go out and socialise on their own, we find that activities like walking football can be particularly helpful.

In rural communities like ours, a big challenge for older people is public transport. We don't have buses on a Sunday and for people living on their own the weekend is the loneliest time. They want to go out on a Sunday and they can't. We have tried to hold events on a Sunday to address the issue but the lack of transport hampers this.

Our Monday phone calls help, and of course also function as a welfare check. If someone isn't answering the phone, who usually does, we will pursue it and make sure they are okay by contacting a member of the family or someone else in the area.

Asked what achievement she was most proud of, Susan responded: It has been building up the service. We started off with some exercise classes, and then we added a book group and it has just grown from there.

The feedback has been incredibly positive. One retired lady who regularly uses our services said, "This group is a lifeline for me. If I didn't come here I wouldn't hear laughter". Often when people leave work they leave their colleagues and their regular social circles. We can help address this.

We then asked her what the main areas of concern are for older people living in the community. She said: Mobility and, of course, the growing number of older people with dementia. Although dementia support is a more specialist service we do cater to older people in the early stages of dementia. They come to our activities and we have befrienders coming in. Sometimes a family member comes with them but often they come alone while they are still able. Another big issue is loneliness and isolation which can lead to a whole raft of other problems, including depression.

We are currently developing a short term befriending service where volunteers go into older people's homes and have a coffee or play chess. Our short term befrienders can then take them out to an exercise class or social event. Many of the older people we see have lost their confidence and once they get it back they can go on their own. Quite often it is just a matter of getting them through the door that first time.

A message to BGS members

I would encourage BGS members to refer older people they are treating to our service, or an equivalent Age UK service in their area. They can find out more about what is available from the Age UK website. We try to put as much information as we can in doctors surgeries so hopefully patients can find out more there as well. Please encourage your patients to get in touch, especially if they have fitness requirements or social issues we can address. We have Age UK care navigators based in GP surgeries that are also there to help.

Asked what being awarded the BGS Special Medal meant to her, Susan said, 'The voluntary sector are under constant pressure from funding cuts so winning this award is a wonderful recognition of the work we do in the community'.

Marina Mello
BGS Communications Manager

Interview with Marjory Warren Lifetime Achievement Award Winner, Pat McCaffrey

Dr Pat McCaffrey is the Clinical Director for Older People and Stroke Medicine within the Southern Trust in Northern Ireland. She is an active member of the British Geriatrics Society and is currently the Northern Ireland representative on the BGS Policy and Communications Committee. She sits on the steering group for the stroke improvement program and has continuously sought to improve the care for older people within Northern Ireland.

We interviewed Pat on her being awarded the Marjory Warren Lifetime Achievement Award in 2016. We asked her what first attracted her to geriatric medicine.

"I found the challenge of making a diagnosis in frail older people with multimorbity intellectually stimulating. I could also see there was a big need to improve services, it was very much the 'Cinderella speciality'.

"When I took up post, I was appalled seeing the treatment of stroke patients. The people were allocated spaces at the back of the ward and sometimes the ward round consultant would stop the ward round before getting to them. There was a very nihilistic attitude towards stroke patients. I could see a need to improve care for stroke patients and for frail older patients.

"Completing my undergraduate and postgraduate training in the late 70's and early 80's in Northern Ireland was challenging and a very different experience from the experience of our students now.

"I commenced my undergraduate training in Queens in 1974, just at the height of the troubles. Our social life was very much confined to the students union. Going to clubs and bars was high risk. And when working in the Emergency Department, one saw victims of the bombings, gunshot wounds and so called punishment shootings, - young people shot through their knees. These were punishments carried out by paramilitaries.

"So while the teaching was very good, the troubles definitely had an impact on our overall university experience. With regard to our older patients, many of them came from areas where there was a high level of paramilitary activity, and also from very deprived areas. One met many older people who had relatives who were either victims or involved in the paramilitary activity and this had a negative effect upon their overall wellbeing and health."

We asked Pat to define the biggest change she had seen in the health care landscape during her career - what had not changed enough in her opinion.

"When I started as a consultant at Lurgan Hospital in 1989 we had no dedicated beds on the acute hospital site and we were providing care for our patients in a former work house.

"There were also a huge number of patients but low staffing levels. Patients stayed in hospital for months, very literally three or four months. It was considered quite normal."

Marjory Warren at work. The 'mother' of geriatric medicine in the United Kingdom and the innovator of rehabilitation techniques for previously 'incurable' chronic conditions

"We didn't have a sufficient number of physios and occupational therapists. We didn't have properly resourced

multi-disciplinary teams. Over the years the number of elderly beds have reduced, we now have a frailty unit on the acute site, geriatricians are more involved with the acute care of frail older people and obviously the stroke service has developed as well."

Thrombolysis - it changed everything

"The introduction of thrombolysis influenced this and now stroke has also become a highly sought after specialty, as has geriatric medicine. The teaching has improved and there is a bigger emphasis on geriatric medicine in the curriculum. I think we have been able to attract some young, very bright doctors into the speciality."

"We still need to work on how we treat frail older patients in acute hospital. I believe the majority of our acute hospitals are still geared towards patients with single organ pathology. I don't think we are geared towards conducting proper holistic assessments of frail older people. Quite often the approach isn't quite right."

"What I have been impressed by is 'hospital at home' and how quickly frail older patients recover in their own homes. They recover their independence, they are not getting confused, not falling the same way they do in hospital. I think there is some learning to be had there. It is about treating the patient as an individual, communicating with the patient and their families and ensuring rapid access to Comprehensive Geriatrics Assessments. We don't always do that well in hospital, there is a lot of work to be done for frail older patients."

Asked to expand on her impressions of hospital at home, Pat went on, "It is very stimulating, I get a high degree of job satisfaction, and I am really impressed how quickly patients recover. One of the challenges is we still have some work to do to convince the majority of geriatricians that this is the right way to go. I also think our workforce planning has been problematic. We have been able, at least where I work, to persuade our commissioners that this is the right way to treat older people. We are getting funding but have difficulty recruiting more specialised doctors and nurses for a variety of complex reasons. Also in rural areas, like where I work, the logistics of seeing our patients is another challenge."

We then asked Pat where she would like to see the BGS in ten years. She responded that while we should continue in the direction that we have been going, she would like the Society to become more political and forceful in influencing policy.

"Sometimes I think that geriatricians are too nice. There are problems in acute hospital so we need to be a bit more vocal."

Asked what she felt about winning the Marjory Warren Lifetime Achievement Award. She said, "I see it as a wonderful honour, I am humbled by it. I see it as a tribute not necessarily to me personally but to the wonderful teams I have worked with, and indeed to the lovely patients from whom I have learned so much.'

Marina Mello
BGS Communications Manager

BGS Communications in action

Since the last newsletter there have been a number of positive developments including the adaptation of our new identity to BGS communications channels, unprecedented online engagement during the Autumn Meeting and our first steps towards a new BGS website.

The new BGS website... Have your say!

We sent out a survey to help us find out more about what our members, and other site visitors, are looking for from the new BGS website. This feedback will be very useful. Included in the survey is the option for respondents to join the website consultation group and/or panel of medical professionals which will help us review and update existing materials. There is still time to join both the group and the panel, visit the survey **www.surveymonkey.co.uk/r/BGSwebsite** to sign up. We will be developing the site throughout 2017, with a view to launching it at the end of 2017 or very early in 2018.

Adapting our new look and feel to the Society's communications

The new BGS logo and identity received final approval from the Board of Trustees last October. So far the identity has been adapted to a number of BGS communications channels including the BGS blog, Twitter, the BGS e-bulletin and, of course, this newsletter. The feedback from members has been highly positive.

Twitter and the BGS Autumn Meeting

Social media engagement during the BGS Autumn Meeting was an unqualified success. 1,986 tweeters from around the world participated via the hashtag #bgsconf. In total there were 11,558 tweets using the hashtag, which led to 34 million impressions globally (potential audience reached via their twitter account). Our twitter account @gerisoc led the pack with 1,546 tweets during Autumn Meeting, 2,047 mentions and 14.6 million impressions globally. @gerisoc continues to perform well with over 9,750 followers and an average of seven new followers a day.

The BGS blog is now having its best performing year since its creation in 2013 with total views of 105,093 and 68,804 unique visitors. Since September more than 50 blogs have been published on topics as varied as 'A daughter's perspective on dementia' to 'Getting to grips with multimorbidity and polypharmacy for older people'.

BGS in the Press

Media relations continue to be a high priority and BGS has featured in 66 different publications since September, including the *National Care Forum, Canadian Family Physician, Ambulance Today* and the *Health Medicine Network.* A major PR focus related to the launch of our two reports 'Guidance on commissioning and providing healthcare services across the UK; Effective healthcare for older people living in care homes' and 'Integrated care for older people with frailty: innovative approaches in practice'. Both reports have received significant coverage and been warmly received by their intended audiences. In addition to supporting BGS policy objectives, when Dr Eileen Burns took office as President an announcement was made for public recognition that older people facing delays in discharge from hospital are the victims of underfunding of social care and not 'the problem'. In total six press releases were sent out between September and December including two *Age and Ageing* press releases '*A poor work life balance in midlife may affect health and quality of life decades later'* and *'Raising the profile of Sarcopenia and Frailty in older people'*, both of which received coverage in number of different counties including China, Japan, The United States and Finland.

Recruiting new members to our Society

Finally, the communications campaign to recruit medical students and foundation year doctors continues. BGS had a stand at the Royal Society for Medicine Speciality Careers Fair which received substantial traffic and interest, and at Imperial College London's School of Medicine Careers Fair on 20 February. This year we will be extending our communications campaign to include other membership categories such as GPs and retired consultants.

Marina Mello
Communications PR & Media Manager

Professor Paul Knight appointed to Council of the GMC

At the start of 2016 there were a few things that I wasn't expecting, including, Brexit and Donald Trump winning the US Presidential election. But, from a personal point of view I wasn't anticipating a letter from the Privy Council telling me that I had been appointed to the Council of the GMC or, more specifically as Registrant Council Member (Scotland).

I had seen an email about vacancies on the Council in the early summer and out of curiosity had gone onto the search agency web site to have a look at the further particulars. The head-hunters were a firm that I had previously had some dealings with and they happened to have a copy of my CV. This proved to be fortuitous because without that I possibly would never have gone down the road of application. Having looked at the details I had concluded that whilst I had many of the requisite skills it would be a tremendously popular position and an application likely a lot of work without much benefit. However, the following day I received an email from the lead of the search and then a follow up phone call to encourage me to apply.

I updated my CV and sent it with a note to detail when I would be out of the country on vacation. The selection process has a number of stages. An initial document screen, a preliminary 40-50 minute interview by the search agents, a meeting with the CEO, an interview with an independent panel, a recommendation initially vetted by the Professional Standards Agency and then an onwards recommendation to the Privy Council, although, I am not absolutely certain whether the Queen has now heard my name!

Because of my vacation dates, my preliminary interview was conducted via Skype whilst I was in a hotel room in the USA and my wife felt compelled to absent herself for fear of embarrassment - not sure if that was hers or mine. In any event, I must have been fairly relaxed even if not that well prepared. The formal parts of the process were conducted over two days and I did wonder to myself as I was killing time in the vicinity of Liverpool Street Station, why I had put myself through this ordeal. The panel were experienced at appointing high court judges amongst others and I felt that I had done ok in what was quite a searching process.

Then I just had to wait. Bizarrely enough, two weeks later, as I was exiting the loo at the EUGMS conference in Lisbon, I received a phone call asking me if I would allow my name to be put forward to the Privy Council. I am sure the person at the other end must have wondered about the echo and background noise. That wasn't the end of it though, as I had to agree to giving up my post as Director of Medical Education and then negotiate that with my medical director without actually knowing if the Privy Council would offer me the gig. Then I had to wait some weeks again whilst the Privy Council deliberated. Apparently they only meet standing up so I'm not sure if that delayed things. As it happened I received my confirmatory email whilst I was at the BGS meeting in Glasgow. It is funny how these things turn out.

So, what do I think? Well, I am really quite chuffed to have been appointed. It has been quite a gruelling process but I am now looking forward to sitting on Council. As a Council Member one guides the strategy and policy of the GMC and hold the executive officers to account. Fitness to practice is conducted at arms length by the Medical Practitioners Tribunal Service. This is a bit like being a non-executive on a commercial board. The Council consists of twelve people including the Chair. Six are medical and six are lay. I think I may be the first geriatrician to be on the GMC and certainly am in the new era of appointed rather than elected members.

I am sure the next four years will be very interesting as the GMC has a big portfolio of work around standards and education as well as a likely government consultation on the future of healthcare professions regulation. Hopefully my background will help me to steer the GMC on a pragmatic and practical course.

Paul Knight
Past President of the BGS

BGS Falls and Postural Instability Meeting Report

In September, Edinburgh hosted the 17th International Falls and Postural Instability Meeting of the BGS's Falls Special Interest Group.

The meeting opened with an intriguing review of the role of technology in falls research and its potential clinical applications. From this, we learned about the challenging field of medication use, withdrawal and drug effects on falls risk. One difficulty is getting buy-in from doctors and patients to stop the worst culprits, often benzodiazepines. However, it may be that some are genetically more susceptible to their effects. Additionally, switching to more selective beta-blockers improved falls risk regardless of genetics, an easy practice point.

Exercise

The first session concluded with a presentation about the FINALEX study looking at use of exercise programmes to prevent falls in a cohort with Alzheimer's dementia, an understudied area. This RCT compared a weekly home-based physiotherapist led exercise programme to a group-based programme and usual care. One of the challenges is the decline in function due to neurodegeneration. However, this was reduced in the exercise groups, with home-based doing best. Although the largest impact on functional decline was in mild dementia, those with more advanced dementia benefited most in terms of falls. This emphasises that despite the challenges, we must strive to involve all patients with dementia in falls prevention programmes.

After coffee we were treated to a Scandinavian *tour de force* as Teppo Järvinen and Peter Nordström squared up for The Great Debate: This house believes the resources should be diverted from osteoporosis to falls services. Teppo Järvinen opened his persuasive argument for the motion by highlighting that many low trauma fractures are non-osteoporotic.

He argued that osteoporosis treatments are not a panacea, citing high numbers needed to treat, poor compliance, lack of applicable evidence and atypical fracture risk. In response, Peter Nordström stressed the impact of severe osteoporosis and the lack of good data for falls prevention strategies. Swedish population data suggests that treating osteoporosis lessened the chances of further fractures, despite constant falls rate. Finally, even if osteoporosis services closed, costly falls prevention interventions still could not be funded. The President-Elect, Tahir Masud, closed the debate with the declaration that we need both falls prevention and osteoporosis treatment, and the debate was declared a draw.

Care Homes

The afternoon session opened with Juliet Harvey's prize-winning presentation of the pilot SOS Study, which aimed to reduce sedentary behaviour in frailer older adults using real-time feedback from activity monitor devices. Similarly, the successful Up and About in Care Homes Improvement Project, aimed to empower care homes to provide person-centred falls prevention strategies. We learned that many Fracture Liaison Services are still missing opportunities to prevent falls through multifactorial falls risk assessment. One option to improve this might be online resources such as the Falls Assistant Tool: an easy-access resource with information, self-screening, signposting and exercise programmes. Finally the VIP2UK feasibility study highlighted the importance of targeted interventions for older people with sight impairment, who fall.

The penultimate talk was an overview of the role of health economics in falls research, stressing the importance of economic evaluation in research to increase the impact of the findings, particularly for managers and commissioners. This is especially pertinent when studying more costly falls prevention strategies.

Delirium

Finally, Edinburgh's Alasdair Maclullich impressed upon the conference the key role that we must play in identifying and treating patients who present with delirium. Delirium is not only now a nationally recognised falls risk factor, but it causes great psychological distress. His solution: screen for delirium and treat it with good comprehensive geriatric assessment and person-centred care.

This last statement sums up much of the conference. There is no panacea for falls in older people. The key is in attention to detail and high quality person-centred care that takes into consideration individual factors, giving older people choices as to how to access falls prevention. It is vital that we include potentially marginalised groups such as those with cognitive or sensory impairments and find ways to optimise falls prevention for all.

Jenny Harrison
ST6, South East Scotland

Re-imagining care homes: our care home innovation centre

The significant problems we face cannot be solved at the same level of thinking we were at when we created them

Einstein

Many of us may end up being cared for in a care home. Whilst there are some excellent care homes providing exceptional care, the public and professional perception of care homes is poor and needs addressing. It is time to create an innovative vision for care homes that delivers consistently excellent evidence-based care and offers a desirable career pathway for a range of professions in the future.

Background

Over the last 25 years, the care home industry has grown. Currently, it has three times the number of all NHS acute-beds. Unlike the 1980s when people admitted themselves for companionship, care homes (as opposed to hospitals) are now the main providers of long-term care for frail older people. Eighty percent of residents have a dementia, and multi-morbidity is the norm. A fifth of the UK population die in care homes with over half of residents dying within a year of admission.

The dread of going into a care home is reminiscent, in some ways, of the dread people felt when receiving a terminal cancer diagnosis back in the 1960s when there was little hope for good symptom control and holistic care. Inspired by what the hospice movement has achieved for people with advanced cancer, we believe there is similar potential for change within the UK care home sector in relation to a teaching/research-based care home. In our recent *Age and Ageing* commentary, Fixing the broken image of care homes, could a 'care home innovation centre' be the answer? we present our vision for the future. We want to raise the profile of people in care homes across a region – residents and staff alike – in order for them to feel valued members of the community, being helped by skilled and knowledgeable practitioners who see a future in care-home work.

The vision for our care home innovation centre of excellence Our vision is to create a centre of excellence linked to the three local universities. With residents, families and care home staff at the heart, it will require a cohesive multi-partnership model involving hospitals, hospices, community, nurses, doctors, allied health professionals, social work, social care, and local community engagement.

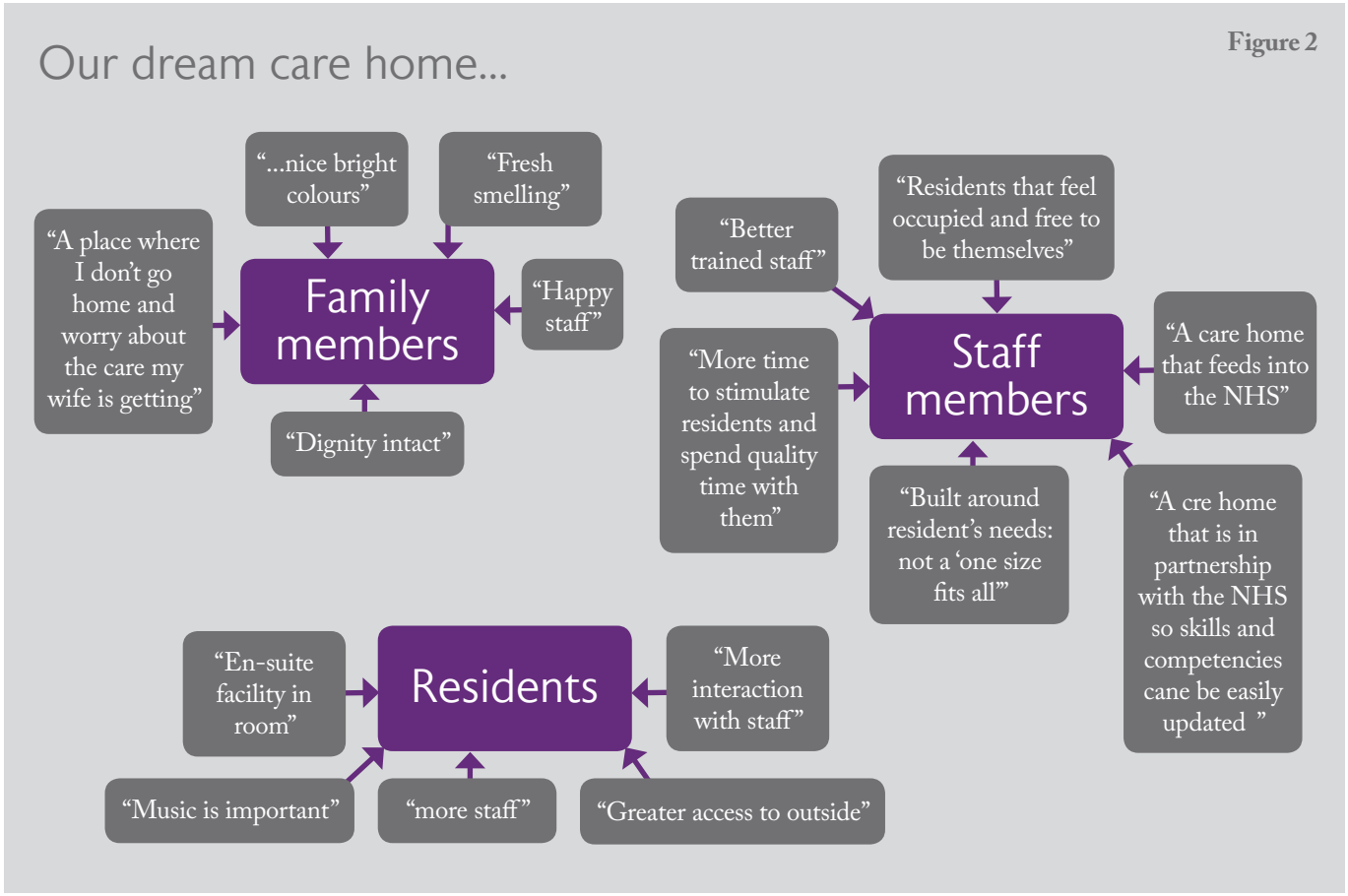
We have been conducting an in-depth feasibility study for the initiative and have been encouraged by the levels of enthusiasm and engagement from across health, social care and academia. In addition to exploring logistical and financial considerations we have sought the views of care home residents, families and staff about 'What is currently good about their care home?' 'What would they change?' and 'What would their dream care home look like?' (see Figure 1).

Figure 1

A prime role of the Centre, once established, will be to reach out to care homes across the region in a 'hub and spoke' model. Each health and social care partnership (represented by the bold grey stripes) will have one or more "satellite" care homes (represented by the purple stripes) closely associated with the Centre. The satellite care homes will help to lead innovations/training locally.

The other thinner stripes represent independent and council care homes.

The Centre will not be an 'isolated ivory tower'



Innovative ideas

Staffing levels in care homes have been problematic for many years now. It is recognised that people residing in care homes nowadays are increasingly dependent and medically complex. It is essential that the role of care staff is valued and that they are supported to provide the necessary care. With increasing demands on staff across health and social care and recognition of the need for greater person-centred care, how can we get 'more hands on deck'? In relation to this particular issue, the innovations planned for the Centre are:

- **Student placements:**
  - A care home organisation in Adelaide, Australia has 3000+ student placement requests/year from a myriad of undergraduate programmes such as medicine, nursing, physiotherapy, occupational therapy, dentistry, dietetics, social work and dental hygiene. We will engage students with the workforce during their placements so they can experience direct care and learn to form relationships with residents
- **Student accommodation:**
  - A care home organisation in the Netherlands (**www.pbs.org/newshour/rundown/dutch-retirement-home-offers-rent-free-housing-students-one-condition/**) have created student accommodation where students are given 'free' rent in return to working 30hrs per month in the Centre – we will propose such an initiative but accommodation is likely to be offered to students from poorer backgrounds
- **Volunteers:**
  - Many UK hospices are supported by between 500 – 1500 volunteers. We will follow the hospice model with well organised training and support for volunteers at the Centre.

Outward looking:

Above all, the Centre will be a rich resource for quality improvement, research and innovation. It will work towards a 'hub and spoke' model working with care homes across the region, some of which will become specific satellite care homes working in close cooperation with the Centre (see Figure 2).

Our vision document for the care home innovation centre, shaped by the engagement of a much wider team of practitioners, researchers and individuals, is now available and we are happy to provide electronic copies to those who wish to find out more.

In conclusion, we want to see a new generation of visionary professional carers for frail older people in care homes who can challenge and change current perceptions of long-term care to ensure excellence for all.

Please email Jo at **jo.hockley@ed.ac.uk** for any further information

by Jo Hockley, Jenni Harrison, Julie Watson and Scott Murray

Inaugural BGS Eastern region geriatric SpR research and audit presentation day

Katie Honney obtained her MBBS BSc (Hons) at University College London. She completed her foundation and core training in the eastern deanery and is currently working at the Queen Elizabeth Hospital, King's Lynn, as a specialty registrar in geriatric medicine.

On the 24th June 2016 the inaugural BGS Eastern Region Geriatric SpR Research and Audit Presentation Day took place at NAPP Pharmaceuticals, Cambridge Science Park. The wealth of excellent research and audit work conducted by trainees within the region prompted the need for an opportunity in which this work could be shared among colleagues.

The day commenced with an informative presentation from Prof John Potter relating to blood pressure control and cognitive function. Prof. Potter told the audience about the rising prevalence of hypertension with age, as well as discussing how cognitive impairment is associated with the extremes of blood pressure. Dr Sarah Hopkins (Geriatric Medicine SpR, Addenbrooke's Hospital) followed with a thought provoking presentation of her audit considering the importance of DNACPR discussions and the factors affecting whether they were had in a timely manner (predominantly lack of time!). Three Cambridge Medical School students presented Quality Improvement Projects pertaining to stroke research that they had completed under the guidance of Dr Nick Evans (Clinical Research Fellow in Stroke Medicine). Their work highlighted how long term cardiac monitoring with implantable loop recorders has helped aid AF detection in cryptogenic stroke and has identified age as being a factor independently associated with developing AF.

After lunch Dr Max Yates (Arthritis Research UK Clinical Research Fellow, Rheumatology SpR) delivered a stimulating presentation on retinal vascular morphology in giant cell arteritis and gave some very helpful clinical guidance for managing older patients presenting with the condition. Dr Isuru Induruwa (ST4 Geriatrics/ACF Stroke Medicine) followed Dr Yates with a topical discussion and presentation of his work on optimising stroke prevention in AF and frailty. His talk highlighted that anticoagulation prescription rates are around 55 per cent within the eastern region and that being judged to be frail negatively impacts on anticoagulation prescribing. Dr Induruwa emphasised the need for further work determining whether explicit frailty measurements can add another dimension to making anticoagulation decisions in older people.

The day ended with another topical and thought provoking research presentation from Dr Nick Evans (Clinical Research Fellow) relating to the multimodal imaging of carotid atheroma in stroke. His work established how non-invasive metabolic vascular imaging using PET can identify important pathological mechanisms in atheroma destabilisation in vivo and how detection of these different components of the atherosclerotic process has provided fresh insight into how inflammation influences stroke severity and subsequent recovery.

The day was very well attended by consultant geriatricians, consultant stroke physicians and geriatric medicine registrars from around the region. The feedback was extremely positive and we hope to make this an annual event open to those both within and beyond the borders of East Anglia!

Katie Honney
ST4 Geriatric Medicine, Queen Elizabeth Hospital, King's Lynn

BGS Vacancies

See the BGS website for more details and full job descriptions of these senior officer roles. Select Resources/Vacancies

England Council Deputy Chair

The BGS invites expressions of interest in the role of Deputy Chair of the England Council.

The term of office as Deputy Chair is for two years, at which point the Deputy Chair will succeed Dr Aung as Chair.

England Council meets 3 times a year.

The BGS Trustee Board meets 4 times a year and the Chair of England Council is required to attend each meeting; the deputy Chair may be called upon to attend these meeting if the Chair is unable to do so.

If you are interested in applying for the Deputy Chair role, please contact the BGS Business and Office Manager, Mark Stewart on 020 7608 8575, committees@bgs.org.uk Expressions of interest should be accompanied by a short career summary and a brief indication of how the candidate would approach the requirements of the role.

If you are not already a regional office bearer and are interested in the Deputy Chair post you are strongly advised to discuss the role with your regional Chair or Secretary in the first instance. Ideally anyone applying for the role of Deputy Chair should have experience as a regional office holder in the capacity of regional Chair, Secretary or Treasurer.

The closing date for expressions of interest is midnight on the 30 March 2017.

Vice President Clinical Quality

Following the sad death of Dr Jim George, the Society is now seeking to appoint a new Vice President for Clinical Quality.

Vice President roles at the BGS, including the post of Vice President for Clinical Quality, are appointed rather than elected.

The appointment process is that expressions of interest, in the form of a letter and CV, are invited in the first instance. Short listed candidates are then interviewed by the BGS President, President-Elect and the Chief Executive.

The Vice President for Clinical Quality is responsible for leading the Clinical Quality agenda for the BGS. This involves work aimed at raising standards of health care for older people through standard setting, development of quality assurance tools and quality improvement activities. This is a voluntary, unpaid role, though travel costs and other expenses will be covered.

The anticipated time commitment is one day a week, depending on the demands of the role at any given time. The term of office is three years.

Those interested in discussing the purpose and activities in more detail are invited to contact the BGS Chief Executive, Colin Nee, via ceo@bgs.org.uk. Those interested in applying for the post are asked to contact Mark Stewart, Business and Office Manager on 0207 608 8575, committees@bgs.org.uk. **The closing date for the receipt of applications in the form of a short expression of interest (a letter and CV) is midnight on the 30 April 2017.**

Deputy Honorary Secretary

The Deputy Honorary Secretary will serve until the Honorary Secretary demits, on which date s/he will automatically take over as Honorary Secretary, and serve in that role for two years.

The Deputy will support the Honorary Secretary, Dr Shane O'Hanlon, and take on a share of his responsibilities, to be mutually agreed. The duties of the Honorary Secretary include (see website for more detail):

- Act as one of the most senior officers of, and ambassadors for, the society
- Serve as a member of the BGS Trustee Board.
- Commission articles and edit the BGS Newsletter (6 issues a year)
- Act as one of the commissioners of BGS blogs
- Act as one of the Society's tweeters in chief
- Approve press releases, blogs and policy submissions to government etc.
- Liaison with external organisations; NHS, Royal Colleges, other specialist medical societies, voluntary organisations and allied professional groups.
- With the other senior officers, the Honorary Secretary will have a key role in strategic planning. Both the Honorary Secretary and Deputy Honorary Secretary can expect to be involved in key projects during their term of office

If you are interested in applying for the Deputy role please contact the BGS Committees Manager, Mark Stewart on 020 7608 8575, committees@bgs.org.uk

The closing date for expressions of interest is midnight on the 30 April 2017.

Notices

BGS EVENTS REGIONS AND SPECIAL INTEREST GROUP

BGS Wales
9 - 10 March 2017, Wrexham

Optimising the older surgical patient (POPS)
15 - 16 March 2017, London

BGS South West
23 March 2017, Taunton

BGS West Midlands
16 March 2017, Solihull

BGS Mersey
22 March 2017, Whiston

BGS Yorkshre
29 March 2017, Pinderfields

BGS South East Thames
6 April 2017, London

BGS Spring Meeting
26-28 April 2017, Newcastle

BGS North West
11 May 2017, Bury

BGS Falls and Postural Stability
15 September 2017, Birmingham

BGS/RCN Joint Conference
20 September 2017, London

Geriatrics for Juniors
4 November 2017, Newcastle

BGS Autumn Meeting
22-24 November 2017, London

Online registration and programmes may be found on www.bgs.org.uk (Select Conferences andEvents)

Geriatrics for Juniors

4 November 2017, Newcastle

Updates in Elderly Medicine for Foundation Year and Core Medical Trainee Doctors

- Front Door Geriatrics – how to be a medical detective
- Frailty and the ageing body
- Dizziness – the dos and don'ts
- Stroke medicine essentials
- Common-sense continence care Community geriatrics – life outside the hospital...
  and much more.

www.bgs.org.uk
See Conferences and events

Prehabilitation and Perioperative Care

Joint RCoA and RCSEd meeting

3 March 2017

The Royal College of Surgeons of Edinburgh

The programme comprises a range of cutting-edge topics, delivered in a lecture-based format by international and high profile speakers from a range of specialties.

www.rcoa.ac.uk/education-and-events/joint-rcoa-and-rcsed-meeting-prehabilitation-and-perioperative-care

Call for abstracts

RCN and BGS 'Older People's Services: clinicians leading together', 20 September, London
The RCN Older People's Forum & British Geriatrics Society invite abstracts relating to innovating services led by nurses and medics relating to the care of older people, the interface between medicine and nursing, multi-disciplinary team working and leading teams. We would like to request that the abstracts are presented by nurses and other disciplines or AHPs to reflect the work between medicine and nursing
Deadline: 16th March 2017
https://www.rcn.org.uk/news-and-events/events/older-peoples-conference

BGS Autumn Meeting, 22 - 24 November, ExCel, London
The submission of abstracts is invited for presentation at the British Geriatrics Society Autumn Meeting under the categories of either Clinical Effectiveness or Scientific Presentation.
All accepted abstracts will be published, subject to a review process, as a supplement to *Age & Ageing*. This is published online only. Deadline 1st June 2017
18 CPD Hours
http://bit.ly/BGSAut17Abstracts

18th Falls and Postural Stability Meeting, 15th September, Birmingham
Abstracts are encouraged and will be accepted as platforms or posters to be displayed at the meeting.
Deadline: 1st July 2017.
6 CPD Hours
http://bit.ly/BGSFalls17Abstracts

If you would like to display a poster presented at another meeting or be a poster assessor at any BGS Meeting please notify Joanna Gough scientificofficer@bgs.org.uk

Other vacancies on the Trainees' Council

Prospective candidates who want to join the BGS Trainees' Council are welcome to self-nominate and invited to submit expressions of interests to for one of the five available voting positions.

Deadline: Friday, 21 April 2017

These positions are:

Chair of trainees council (Applicant must be ST3+ and member of the BGS)

Research and Academic development representative (Applicant must be ST3+ and member of the BGS)

Educational events representative (Applicant must be ST3+ and member of the BGS)

Clinical Quality representative (Applicant must be ST3+ and member of the BGS)

Junior member representative (Applicant must be a Foundation year or core medical trainee and member of the BGS)

If elected, posts are for 2 years in duration (2017-2019 session). The deadline for applications is 5pm on 21st April 2017.

Should there be more than one nomination per position, a ballot will be held. Online voting will open in the week preceding the BGS Spring conference and close during the trainees' meeting (28 April 2017) where the results will be announced.

If you are keen to know what the roles involve please check out the BGS Trainee Council page or contact the current representatives individually.

All expressions of interest must be emailed to the chair of the trainees council at . Expressions of interest should be no longer than 1-2 paragraphs and outlining why you wish to take on the role.

BGS Trainees' Council Profiles - Philip Thomas

I am the trainee representative on the BGS Research and Academic Development committee. This group is responsible for delivering the BGS Research Strategy that aims to increase the quantity and quality of research being undertaken in older persons.

During my time in post, I have been working on revamping and updating the Research section of the BGS website to make it more user friendly. Earlier this year we undertook a survey of BGS members working in active research units. This information will facilitate the creation of an interactive map of current research centres around the UK, their research interests and the key contacts within each department. This will help to signpost aspiring researchers to others with similar interests in the hope of facilitating collaboration.

We are reviewing the current series of resources while also making a series of resources to act as a 'How to' guide. The aim of these is to aid navigation of the research process. This will cover all areas from developing an idea, securing ethics and funding for projects all the way through to disseminating the results of the study.

The BGS is keen to understand what barriers members face in undertaking research and shortly I will be conducting a survey about the challenges they've experienced. This will assist the BGS in helping to overcome these difficulties.

Finally, my tenure in this post ends at the 2017 Spring Meeting. If anyone would be interested in succeeding me and would like more information about the post, please contact me on pst365@googlemail.com.

Growing the evidence-base: Thomas Jackson

As part of its strategy to promote high-quality research, the BGS Research and Academic Committee (RADC) encourages researchers to tell readers about their research journey - how they were drawn to research (or fell into it!); the obstacles they encountered on their journey; the effect of the journey on their self- and career development, and the lessons that they believe might help those following the same path.

In this article, we feature Thomas Jackson. He is a Clinician Scientist in the Institute of Inflammation and Ageing, University of Birmingham and an Honorary Consultant at Queen Elizabeth Hospitals Birmingham. He was a Fellow in Ageing Research from 2012 to 2015, funded by the British Geriatrics Society and Research into Ageing at Age UK. He was awarded a PhD in 2016. He tweets at @delirious_dr

I started my research 'journey' an interested, slightly naïve, but enthusiastic registrar who wanted to 'do research'. However, I was going to 'do it properly' so I'd have some idea if this was a career for me. I now work in a University post, spending half my time on research and teaching. I hope to share 'how I made it' but am very conscious I am only 'making it' and am certainly not there yet.

Despite some initial setbacks (apparently I should have stayed in London!), the key was mentorship and supervision. I had fantastic initial help from Dr Bart Sheehan, a psychiatrist, who steered a nub of an idea about what happens to people we discharge with delirium, into a small pilot project I could fit around my training. Inspiration via a distance learning course on methods in cognitive ageing from Edinburgh led to me making research fellowship applications with Alasdair MacLullich, and tapping into the fundamental science at my home University, Birmingham, through Professor Janet Lord. A very near miss fellowship with the Alzheimer's society then brought me in touch with Professor John Gladman in Nottingham. This is not an exercise in name dropping, just an illustration of the need to get the team right. Bringing together such a group was hard work and required persistence, but enabled me to win a fellowship from Age UK and the BGS to start my PhD project investigating delirium and unrecognised dementia in general hospitals. I owe them an awful lot.

It may seem a path less travelled compared to other specialities where perhaps research degrees are done because they are needed to secure consultant jobs, as opposed to being motivated by genuine intellectual curiousity. For me,

I was genuinely interested in the answer to the question, and it was my research, not someone else's.

World class research in ageing and clinical gerontology has to be multidisciplinary, which mirrors our clinical roles. Engaging with fundamental scientists is mutually mind- broadening and the opportunity to acquire new knowledge and skills (isolating neutrophils anyone?! Thanks @teamneutrophil) are refreshing and challenging.

There are two key themes through my whole journey; hard work, and frank, wise supervisors. Despite the quiet constant murmur that research is a 'doss', anyone who has done it will tell you otherwise. It is littered with disappointments, hurdles and frustrating late nights. These are however, strongly counterbalanced with the good times. Seeing your work published, presenting on scientific platforms, engaging with your research 'heroes', and feeling you may have genuinely made a difference to lots of patients is very exciting. Persistence is key though, as no-one will give this to you on a plate. The next hurdle for me is a personal fellowship and the nirvana of 'tenure'.

Juggling the two roles can be difficult, and the bars set by universities can seem very high. We've had a tendency to see ourselves as 'small fry' who will struggle with REF submission. We must challenge this, and aim to produce consistent collaborative world-class research to try and answer the key unknowns in our discipline; rise to the challenge, not shy away from it.

I now derive considerable satisfaction from trying to offer the same degree of support and encouragement to the current crop of three NIHR academic clinical fellows we now have here, as they start their journeys.

The future's bright, and we must nurture it to make it even brighter.

Read more about Thomas' research on the BGS blog and on the BGS website: [Select Groups/Research/Researcher Profiles]

Multi-morbidity – the case for change

Generalists are the solution

For too long policy makers have ignored what clinicians on the front line have been telling them, people with multiple conditions not only exist but are the mainstream.
It is our failure to recognise this fact that has put pressure in the system as the NHS struggles to keep its head above water especially when one adds social factors, depression and mental health into the mix of complexity.

The RCGP "responding to the needs of patient with multi-morbidity" has created a powerful case for change with the need to substitute ever-increasing investment into super specialism by a call for the generalist to support those with multi-morbidity in the community.

Poly-pharmacy, multiple single disease specific clinics and individual QOF targets will have to be incrementally replaced by multidisciplinary team meetings (MDT), proactive care planning, changes in training and adaptation of IT systems.

Evidence based medicine dominated by trials that remove confounding factors will need to be reset.

Continuity of care will be valued not just as a "nice to have" but crucial in supporting those with a combination of physical, social and mental health problems.

Nowhere is this more important than in supporting older people in the community where frailty is being increasingly recognise as an entity in its own right and with GP systems automatically using algorithms to record frailty.
We need a new paradigm.

But what does this mean for those of us working in the community?

Care and Support Planning for those with long term conditions, complexity and multi-morbidity will become the norm as we try to shift towards a more proactive approach.

Wider teams based around neighbourhoods (circa 50,000 population) will support core general practice and the registered list. This will include enhanced community support teams for older vulnerable patients with geriatricians, Allied Health Professionals, specialist nurses and social services.

GP surgeries and their respective MDTs will remain the main unit of responsibility and accountability, often supported by non-statutory agencies such as Age UK. Community geriatricians, who, as generalists with an expertise in frailty, have been so valuable in helping us support more complex people in the community, are already having to support those in their fifties, especially in the more deprived populations where mortality occurs ten years earlier.

Hospital care will have to become less precious about protecting clinical fiefdoms and become more streamlined as community geriatrics "reach into" the hospital rather than the other way round.

Multi-morbidity is here to stay – the rest of the NHS needs to catch up.

David Paynton
GP in an inner city surgery and
Clinical Lead for Commissioning for the RCGP

The Quest to become a Geriatrician

The Older Person Whisperer says: I use comics to understand and analyse the qualitative data I collect. I was investigating how people learn to be geriatricians as part of a masters in medical education. This comic uses a plot structure the "Quest" (the classic example is Homer's Odyssey) to think about the journey to becoming a geriatrician. Sometimes I find it useful to look for overarching narratives in qualitative research to give structure and make sense of the findings.

British Society for Heart Failure Autumn meeting

The British Society for Heart Failure recently held its 19th annual meeting in London, attracting over 700 delegates for the two-day conference. Entitled 'Heart Failure: the multisystem problem', the meeting covered a wide range of topics including cardio-renal interactions, diagnostic dilemmas, devices in heart failure and a key-note lecture on 'counting the cost of comorbidities in heart failure'(Michael Bohm, University of the Saarland, Germany).

Guidelines and trials update

Of particular note at this event were updates on latest guidelines/ clinical trials and the management of myocarditis.

Prof John McMurray (University of Glasgow, UK) discussed recent breaking trials. The most prominent of which was ATMOSPHERE which studied the direct renin inhibitor Aliskiren either as monotherapy or in combination with Enalapril[1]. Over 7,000 patients were enrolled. Overall, there was no additional benefit of Aliskiren but additional risk of hypotension, renal decline and hyperkalaemia was identified.

One of many other exciting trials discussed was the DANISH trial[2]. This study investigated the real world risk of death in non-ischaemic systolic heart failure (LVEF <35% and NT-proBNP >200 pg/ml). There was no significant difference in the primary outcome of death from all causes but importantly outlines that not all patients with severe systolic heart failure should necessarily be implanted with an ICD. Going forward careful thought is required to identify those with non-ischaemic cardiomyopathy that will clearly benefit from ICD therapy.

Amongst other trials discussed were two looking at the effect of Glycogen-like peptide-1 (GLP-1) agonists. Incretin mimetics, although felt to be promising and improve glycaemic indices, do not reduce and may increase the risk of cardiovascular events and worsening HF[3]. Both LEADER[4] and SUSTAIN-6[5] demonstrated no statistical benefit in heart failure outcomes.

Looking forward, things look bright with plentiful new phase III trials underway. Driven by the success of sacubitril/ valsartan and the PARADIGM-HF trial we eagerly await the results of two further studies. Of interest will be Entresto in the HFpEF population and in the setting of acute myocardial infarction with PARAGON-HF and PARADISE-MI respectively.

Difficult devices

One of the highlights of the conference was Dr Archie Rao's (Liverpool Heart and Chest Hospital) take on the approach to device therapy in younger patients with heart failure. Refreshingly Dr Rao made it clear that we must work towards providing tailored therapy for the individual. In an effort to reduce hardware burden, complications, potential infection and the need for extraction procedures we must consider all aspects of device therapy carefully. The need for the device in the first instance should be questioned alongside the psychological impact followed by choice of generator, lead selection and appropriate programming.

Falls, Frailty and palliative care in Heart Failure

Dr Andrew Davies (Sunderland Royal Hospital) presented a thought-provoking and entertaining overview of the assessment of falls, dizziness and basic movement problems hammering home the need for careful evaluation of the multitude of patient problems with attention to avoiding polypharmacy.

It is important to consider the application of a multi-disciplinary team approach for frail older patients with heart failure. Frailty should be assessed by utilising a scoring system such as the FRAIL score recommended by the 2016 ESC guidelines[6]. Frailty is clearly linked to falls and worsening cognitive function, worsening functional condition and then confidence and independence[7].
The provision of specialist input when coming towards the end of life is a major unsolved issue. Recent research presented by Dr Ross Campbell (BHF Glasgow Cardiovascular Research Centre) outlined that over 25% of patients admitted to hospital have palliative care requirements but most patients with heart failure did not access specialist palliative care services.

Kidney disease, anaemia and iron replacement in Heart Failure

We have long debated the impact of anaemia and erythropoietin deficiency and the need for iron replacement therapy in heart failure. Questions have also been raised around the best method of replacement.
Iron deficiency is a common comorbidity in HF associated with a worse prognosis[8]. Professor Sunil Bhandari (Hull

and East Yorkshire Hospitals NHS Trust) provided an overview of the relationship between iron deficiency, impaired mitochondrial function, activation of pro-apoptotic pathways and impaired contractile function of cardiomyocytes with exceptional clarity.

Overall, the evidence supports the use of iron replacement therapy and it is clear that intravenous administration provides benefit leading to sustained improvement in functional capacity, symptoms and hence quality of life scores[6,9].

Conclusion

The British Society for Heart Failure annual meeting, as always, provided a number of entertaining and outstanding presentations which were both informative and reassuring. Sessions were designed to cover common presentations but also provide an interactive platform to discuss challenging management issues. There are few meetings with access to such a number of internationally renowned experts not only in cardiology but other medical specialities and allied health professions. The meeting itself reflects the collaborative spirit and multidisciplinary approach that is present in modern day heart failure centres and is an opportunity to meet like-minded HF enthusiasts in a supportive and welcoming environment.

Ewan J McKay
North West Heart Centre,
University Hospital South Manchester

Footnotes

Future meetings include the Heart Failure Day for Revalidation and Training on 2nd March 2017, the Heart Failure Nurse and Healthcare Professional Study Day on 3rd March 2017 and the 20th Annual Autumn Meeting on 23-24th November 2017.
Website: www.bsh.org.uk
Twitter: @BSHeartFailure
Email: info@bsh.org.uk

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In memoriam

Dr Jim George 1953-2017

On 2nd January, Dr James George (known as Jim to his friends and colleagues) and the BGS's Vice President for Clinical Quality, passed away.

Jim came from a very unusual family dedicated to personal service. He was one of three brothers – his oldest brother, Henry, was a soil scientist; his middle brother, William, was an eminent lawyer, barrister and judge. They owned a 70 acre estate in Derbyshire and involved themselves in many environmental issues. They were always a very ambitious family and finishing second was never considered satisfactory. In his youth he was head boy at his school, long jump champion and a talented rugby player. Watching rugby remained one of his passions in later life.

Jim qualified from Liverpool University in 1977. He made lifetime university friends, including the 'Bootle Seven' – Nick, Brian, Mike, Steve, Tony, Bartley and himself – who always kept in touch. He met the love of his life, Angela, at Broadgreen Hospital, and settled in his early career in Liverpool. Angela and Jim married in January 1978 and he was always very proud of their daughter, Jennifer – particularly because of her Masters Degree in Philosophy in Glasgow and New Zealand, and he learned a lot from her about philosophy and ethics.

He later trained in Leeds and was appointed as a Consultant in Geriatrics in Carlisle in 1986. Although the main focus of his career was being a clinician on the front line, he also had keen interests in both education and research. He has been an Honorary Senior Clinical Lecturer for Newcastle University and a Lead for Specialist and Undergraduate training in Geriatrics. In 2002 he won a national BUPA care award for establishing a Joint Delirium/Dementia ward which facilitated a collaborative research sabbatical working with Professor Ken Rockwood in Halifax, Canada. He was an invited speaker at national meetings in the UK and also in Hong Kong, New Zealand and Canada. He was a lead author of the BGS/RCP National Guidelines on Delirium and also a member of the NICE guideline group that produced the 2010 Guidelines on Delirium. He was the lead clinician for research in his hospital Trust. He also set up the Parkinson's disease and falls services at Carlisle. More recently he held the post of Vice President of the BGS for Clinical Quality. He continued, even in ill health, to contribute to departmental teaching sessions.

Jim published a large amount for a DGH consultant across a range of subjects. His work includes academic papers, book chapters and he was co-author of a book designed to improve the care provided to older people in emergency settings.

He was a loving husband and a cherished father. By his colleagues he will be remembered as an excellent clinician, champion and innovator for the care of older people. He was a clever tactician who could spot an opportunity to make a change or development.

He had the gift of being able to give people time and never looked rushed or flustered. He would always listen and give sound advice. He brought unshakeable enthusiasm and a positive outlook.

Whatever was going on he would greet you with a smile and his characteristic, "oh hi hello". He has had a huge influence on his colleagues and the healthcare professionals he has trained over the years. He was an incredible man and will be greatly missed.

Henry Woodford

Prof John Campbell 1946-2016

Professor John Campbell died at Dunedin, New Zealand on August 22 at the age of 70 from complications related to dementia.

Professor Campbell was raised in Auckland, graduating MBChB at Otago in 1969 and subsequently achieved FRACP, FRCP and MD (University of Otago). Following post-graduate study in Canada and the United Kingdom he returned in 1977 as a general physician and geriatrician to Gisborne. In 1980 he was a joint appointee to the University of Otago and the Otago Hospital Board. His influence there resulted in the Geriatric Unit becoming a leader in geriatric care in New Zealand.

His contribution as a clinician was most evident at the bedside. He was interested in the person behind the illness knew how to make the patient feel valued.

His attention to the care of the whole individual, gave him the greatest pleasure. He was a razor-sharp diagnostician and analytical physician who enjoyed the teaching stimulus of undergraduate and postgraduate students.

Professor Campbell was awarded a Chair in Geriatric Medicine in 1984 and was later appointed Chair of the Medicine Department in Dunedin in 1988, then progressed to Dean, Faculty of Medicine in 1995 holding the post until 2005. He was a member of the Australian Medical Council Accreditation Committee and contributed to reviews of Australasian medical schools.

He published in excess of 100 refereed journal articles mainly relating to the epidemiology of illness in old age with particular emphasis on factors contributing to falls. His work led to the development of a falls prevention programme.

Professor Campbell was Chair of the Medical Council of New Zealand from 2003 to 2009. His clear views of the future shape of medicine guided the Council through implementation of changes embodied in the Health Practitioners Competence Assurance Act. He was appointed inaugural Chair of the Expert Panel on Veterans' Health in 2009 and to the Courts of Cambodia as an expert geriatrician. He served as an advisor to WHO between 1979 and 1995 and authored a number of technical reports for WHO meetings. He also served on many national advisory bodies and was a member of many international editorial boards.

Whenever possible he worked with Wendy, his wife, on managing their farms. Art collecting, especially porcelain, were among his interests. Professor Campbell derived great enjoyment from his three talented children and their families. He was interested in all sport and could be a fearsome competitor.

Professor Campbell will be fondly remembered by all who had the privilege of working with him. The specialty of Geriatric Medicine has been truly enriched by this talented researcher, erudite teacher, visionary leader and humanitarian clinician.

Stephen Chalcroft
Geriatrician and Executive member of ANZSGM

Older HIV-Infected Adults are Geriatricians' Business

'Frailty and physical function in older HIV-infected adults' is a published paper in the Age and Ageing Journal. This paper, written by the authors, and first published on the BGS blog, outlines a study to define the frailty phenotype in the older population infected with HIV.

The HIV-infected population is ageing due to the success of combination antiretroviral therapy, which prolongs survival, and also because of the growing number of newly diagnosed cases in older adults. Nowadays, over half of people infected with HIV are older than fifty years, which is the age cutoff accepted by the scientific community to consider someone an HIV-infected older adult.

Fifty is only their chronological age, but biologically they are older, as accelerated ageing in this population has been demonstrated. So, it seems that in the coming years, HIV care is going to be focused on a growing group of older adults and their specific problems.

This means more than only survival, infection control, or avoiding the adverse events caused by antiretroviral drugs; it also includes consideration of comorbidities, polypharmacy, functional decline, and geriatric syndromes.

We performed a study to define the frailty phenotype in the older population infected with HIV, because frailty is a syndrome that identifies those at risk of adverse health events being more vulnerable to stressors than others. We hypothesised that prevalence of frailty in this population would be at least as high as it has been described in the uninfected population, and we wanted to assess physical function in this population too. Our findings have been really interesting.

We evaluated 117 HIV-infected older adults and we found a prevalence of frailty of 15.4 per cent, twice as high as that of the most representative studies on frailty performed on the general population, who were at least ten years older. We found that depressive symptoms were associated with a 9.2-fold increase in the risk of frailty, and we found the CD4/CD8 ratio to be independently associated with the risk of frailty (OR 0.11 [0.02–0.61]). We also found a high prevalence of functional impairment with one in five older HIV-infected patients showing a slow gait (<0.8 m/s) and more than half having an SPPB (Short Physical Performance Battery) score of <9.

Consequently, the management of HIV-infected patients has to change, and we geriatricians have to be involved in HIV care for older adults, working together with our HIV-specialist colleagues in a collaborative way and providing our global approach and knowledge to their specific HIV assessments.

I'm sure that we're going to be talking about "HIV-geriatric clinics" very, very soon.

Fátima Brañas
Consultant geriatrician and the clinical lead for orthogeriatrics at the Infanta Leonor University Hospital in Madrid (Spain)

For articles off the beaten track

Read the BGS blog at https://britishgeriatricssociety.wordpress.com

The BGS welcomes blogs of interest to doctors, nurses and allied health professionals on any aspect - medical, social or environmental - affecting the health and wellbeing of older people.

Contact Marina Mello on pr@bgs.org.uk

Similarly, the BGS welcomes unsolicited articles for this newsletter, and for consideration for publication in the newsletter of the Royal College of Psychiatrists.

Contact the editor on editor@bgs.org.uk

BGS members recognised in The Queen's New Year's Honours List

Professor Paul Knight, Past President of both the BGS and European Union Geriatric Medicine Society and Associate Medical Director NHS Greater Glasgow and Clyde, was awarded the OBE in recognition of his services to geriatric healthcare.

Dr Vicki Goodwin, Senior Research Fellow at the University of Exeter, was awarded the made MBE in recognition of her services to physiotherapy.

Professor Deborah Sturdy, a Nurse Adviser Care England and member of the BGS Nurses Council, was awarded an OBE in the Queen's New Year's Honours List for services to older people, dementia care and nursing. Deborah has worked with older people throughout her career and has held a number of positions including posts in practice, research, management and policy. She is a passionate advocate for older people, and people with dementia, and has been instrumental in developing a number of initiatives to promote good care practices across the speciality. She was awarded the BGS President's Medal in 2011.

Dr Andrew Naylor, a GP on the Isle of Harris, was awarded an MBE for services to healthcare in the Western Isles in The Queen's Birthday Honours List. Andrew is the permanent doctor at a single-handed GP practice based in Leverburgh that was featured in the BBC Alba documentary 'An Island Practice/Slàinte na Sgìre'. The award recognises his commitment to medical services for approximately 600 patients, a third of whom are over the age of 65, in the South Harris community.

Commenting on the awards, BGS Chief Executive Colin Nee said:

"The recognition given to these splendid role models in the care of older people is extremely welcome – and what a great way for the BGS to start its 70th anniversary year. We would like to congratulate Vicki, Paul, Deborah and Andrew upon receiving these exceptional awards. We are delighted that four BGS members from different disciplines have been honoured in the same year. This is wonderful reflection of the multi-disciplinary nature of our Society and a testament to the vital work of our members."

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