# Geriatricians, the BGS & our influence on health policy

**David Oliver**

Consultant Geriatrician & General Physician

Ex BGS President & Hon Sec.

Ex RCP Vice President

Ex DH National Clinical Director

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Trustee, Nuffield Trust

BMJ Columnist

Visiting Professor, City University

**Joint BGS SW/SE Meeting 16th October**

# How mainstream journalism tells news stories

- Short “story in itself” intro
- **Who?**
- **What?**
- **When?**
- **Where?**
- **Why?**
- **How?**
- Illustrated with some human interest
- **“Inverted triangle”** approach (different from clinical research papers/abstracts)

- Bear that in mind as we consider this issue.
- “Policy” and “Comms” are bedfellows


# Dancing Chorley flasher 'balanced pie on head' before exposing himself at road junction


Gaskell was seen outside the pub by people in the opticians on Babylon Lane

Trending

1 Preston man, 46, arrested on suspicion of sexually grooming children in...

2 PNE v Man City: Gallery of fan pictures

3 City of Preston 10k CANCELLED after heavy downpours cause adverse...

4 Police hunt Preston sex attacker after teenager is seriously assaulted near...

5 Camelot Theme Park: 53 pictures show the attraction in its heyday

Boston 90-Minute Historic Sightseeing...

£28.37



- "Stunned customers in an opticians watched in horror as a flasher exposed himself outside a pub"
- "Preston Magistrates' Court was told two women were stood in the Susan Hilton opticians on Babylon Lane, in Adlington, Chorley, when the incident unfolded at around 10am on July 5"

# Strong policy-influencing narrative

- backed by data, evidence, guidance
- good practice resources & succinctly summarised examples
- told by effective individuals or organisation
- *our best bet….*

- Our brand as credible professionals with a commitment to evidence, objectivity, patient care, advocacy is key
- Must badge our “asks” as solutions to patient/public/provider/policy makers’, politicians’ problems
- Not just “empire building” or “self interests” (“they *would* say that”)
- “Policy” goes well beyond Whitehall, Westminster

# To cover: *with illustrative examples)*

- I: Some **history**
- II: **Why** try?
- III: **Who** we target?
  - Who else has influence? How is policy formed? Competing agendas? Value of alliances?
- IV: **What** we target or engage with?
- V: **Where**?
- VI: **How** we do it? (Not all public or visible, and some "soft") and don't win em all (that isn't failure)
- VII: **When** (Past, present, timing and horizon scanning)
  - The concrete examples and history to make it real
- VIII: **Futurology**?
- IX: How **you** could play your part?

# I: Some **history**

**Billy Joel**

- “We didn't start the fire
  It was always burning
  Since the world's been turning
  We didn't start the fire
  No we didn't light it
  But we tried to fight it”

**Isaac Newton**

- “If I have seen further, it is by standing on the shoulders of giants”

# Marjory Warren

- Medical director, West Middlesex Hospital
- Inherited 714 bed poor law infirmary
- Long-term patients
- *“Incontinent, with seizures, dementia, bedridden, elderly and sick with unmoved muscles”*
- *“For full recovery, they require the full facilities of the general hospital”*
- Created specialised assessment unit
- Systematically assessed patients’ capacity for improvement
- Most were re-mobilised, many discharged
- Turnover increased 300% . Beds reduced to 240


- *Warren, MW. 1946. Care of the chronic aged sick. Lancet. i:841–3.*
- *Warren, MW. 1943. Care of chronic sick. A case for treating chronic sick in blocks in a general hospital. BMJ. ii:822–3.*

# MH Nesbitt MD thesis

- *Dr Warren's routine was carefully studied, the method of admission, examination, diagnosis and treatment, the return home or transfer to home or hostel, the careful follow-up, the close contact maintained with the relatives, the help obtained from almoner, physiotherapists, OTs and chiropodist. The metamorphosis of an utterly hopeless helpless patient into an active, energetic and everlastingly grateful one was observed again and again'.*

# We now call this “Comprehensive Geriatric Assessment”

- ‘*a multi-dimensional, interdisciplinary, diagnostic process to determine the medical, psychological and functional capabilities of a frail older person in order to develop a coordinated and integrated plan for treatment and long term follow up*’.

- Stuck A.
- Ellis G et al.
- Cochrane

# Roots of the BGS

- Dr Trevor Howell
- GP and medical director of Chelsea Pensioners' Home
- Convened "Medical Society for Care of the Elderly"
- Initially 9 doctors
- *the relief of suffering and distress amongst the aged and infirm by the improvement of standards of medical care for such persons, the holding of meetings and the publication and distribution of the results of research*'
- *Barton, A. and Mulley, G. 2003. History of the development of geriatric medicine in the UK. Postgraduate Medical Journal. 79: 229-234.*

# In our first 30-odd years

- Early role models, pioneers and famous names
- Community geriatrics
- Care homes & long-stay care
- Day hospitals
- Orthogeriatrics
- Surgical-geriatrics
- Old-age psychiatry
- Frailty & “Geriatric Giants”
- Focus on age-related syndromes & harms
- Move towards closer integration with GiM and move to general hospital mainstream
- Establishment as academic discipline several new chairs
- Definitive textbooks

# Many other substantial figures in first 30 years of NHS  some pictured here e.g.

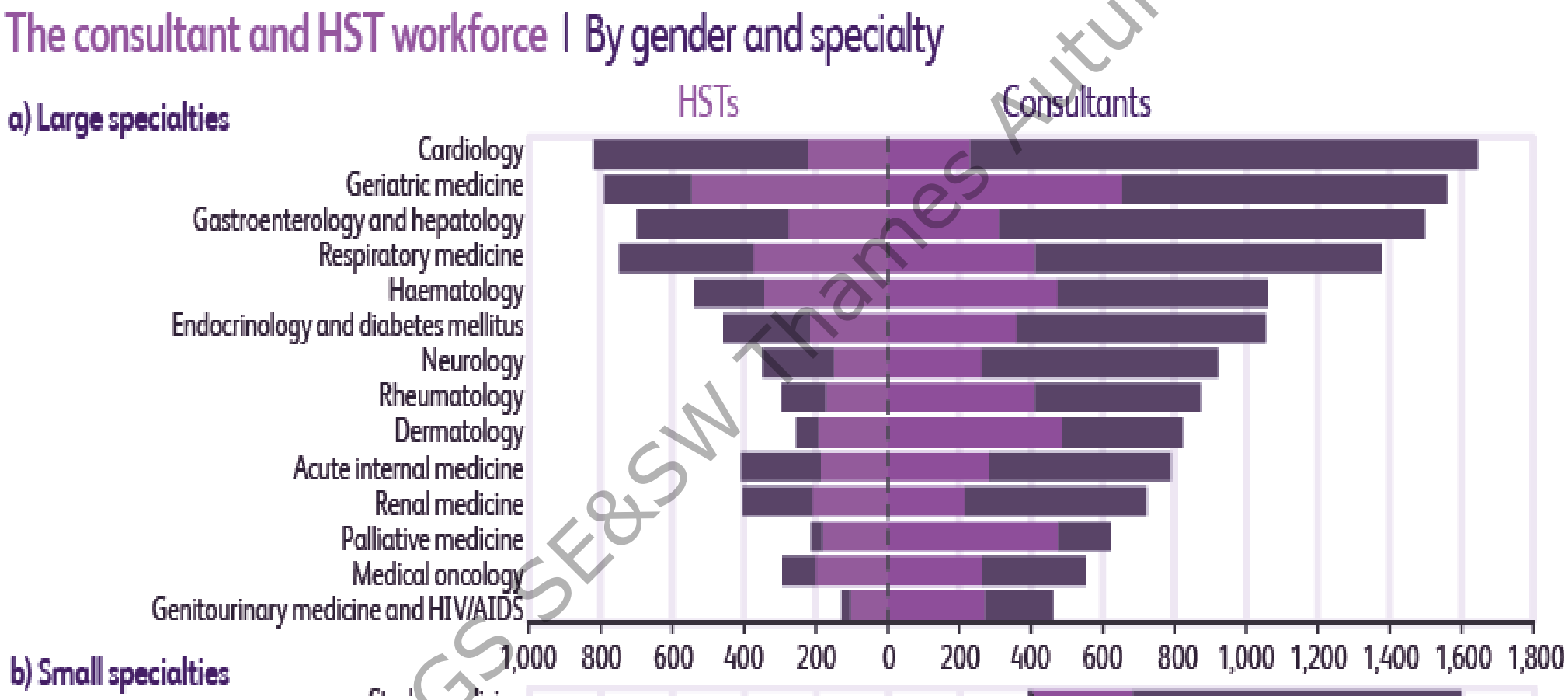
- Norman Exton-Smith (UCLH)
- Prof Ferguson Anderson (Edinburgh)
- Prof George Adams (Belfast)
- Prof Bernard Isaacs (geriatric giants)
- Dr Lionel Cosin (day hospital)
- Dr Bobby Irvine (ortho-geriatrics)
- Dr Joseph Sheldon (community)
- Prof Tom Arie (old age psych)
- John Brocklehurst (key textbook)
- **Lord Amulree (BGS Pres/HealthMinister)**

# By 1977 – 335 consultant geriatricians UK

- <u>RCP Working Party on medical care of older people</u>
- *Geriatrics should be part of undergraduate and postgraduate training for every doctor and incorporated into the MRCP syllabus... GPs should become more involved in delivering specialist geriatric care. There should be multidisciplinary care for frail older people in every hospital and a review of elderly mental health services. And there should be more posts for doctors fully trained in both general internal medicine and geriatrics and integration of geriatrics into general medical units'*.

# From RCP London Census 2017-18.

## We are now 2nd biggest GIM speciality & deliver most GIM apart from Acute Med. BGS Is largest (non-college) society



# And if you want to explore the modern history


- Oliver D BSG Newsletter Jan 2008 *The BGS at 60*
- Barton A, Mulley G. *History of the development of geriatric medicine in the UK.* Postgraduate medical journal 2003; 79: 229-234
- Powell C. *Whither geriatrics? Do we need another Marjory Warren?* Age Ageing 2007:607-10
- St John P, Hogan D. *Relevance of Marjory Warren's writings today* J Gerontology 2014

# Philip Larkin: *Annus Mirabilis*

- Sexual intercourse began
- In nineteen sixty-three
- (which was rather late for me) -
- Between the end of the "Chatterley" ban
- And the Beatles' first LP.

# Just a sample of many **modern day** (& future)policy influencers


# II: **Why** try?

## Charitable objects

The Society was established in 1947 to serve the frail, older person - a large and increasing sector of the UK and world population. The Society's objects, as set out in the Memorandum of Association, are 'the relief of suffering and distress amongst the aged and infirm by the improvement of standards of care for such persons'.

## Charitable mission

In line with Objects, the Society's charitable mission is to promote better health in old age.

We pursue our Objects and mission through the objectives and activities set out in the section below.

## OBJECTIVES AND ACTIVITIES, INCLUDING PUBLIC BENEFIT

Our objectives, which we refer to as our 'specific aims' are to

- Inspire students and trainees to specialise in the care of older people, and to support their education, training, clinical effectiveness and career development;
- Promote high standards of clinical quality through conferences, meetings, information, good practice guidance, and educational and training opportunities;
- Encourage the sharing of learning and best practice, both within and across relevant disciplines;
- Promote research into the healthcare of older people, facilitating access to research and opportunities to generate research;
- Act as the informed policy voice regarding educational curricula; clinical standards; research; effective commissioning practice and health policy regarding the treatment and care of older people across the UK;
- Raise awareness among healthcare professionals of the role of 'living well' in preventing disease in old age.

# **Why** try? (e.g.)

- Improve care for our patients and their families
- Improve the reach/influence/prestige of our own speciality
- And other professional groups/orgs we are closely aligned with
- Influence policy, systems and services for older people who we *don't* look after
- Increase impact of our research, guidance and local/national good practice
- To get greater attention for our work
- Influence research, education, training, agendas
- Lobby for investment and funding
- **Because it's great fun and we can learn from doing it**

# III: **Who** to influence?

# **Who** to influence?

- General public
- Especially those with related interest, electoral influence
- Media (specialist/general/national/local)
- Health charities/campaigning groups
- Professional membership bodies
  - E.g. NHS Providers, NHS Confed, LGA, ADASS
- Local government
- Local MPs
- National clinical leaders (e.g. NCD, GIRFT, NHS Med Director/CMO, Chief Scientific Officer)
- Influential healthcare think tanks
  - E.g. King's Fund, Nuffield, Health Foundation
- Policy teams in political parties
- Government ministers
- Number 10
- Senior Civil Servants
- Non-departmental (arm's length) national NHS Bodies
- Regulators/improvement agencies
- Medical and other royal colleges
- Other specialist clinical societies
- Research funders
- Educational bodies (national/local)
- Medical schools

# IV: **What** we target or engage with?

# **What** we target or engage with

- Build on what our distinct brand is as a group of clinicians and researchers and service leaders with a strong focus on
  - Improving care quality, care systems, evidence base, education/training, workforce, research
  - Specifically for older people with age related health needs
  - Wider advocacy around prevention/healthy ageing
  - Evidence-based practice
- ***Where other organisations/charities are better placed or more uniquely influential we should collaborate as equals***
- Or  let them take the lead
- Although BGS is nearly 4,000 strong, we have a small in-house team and a small number of doctors doing work in spare time

# Health for Care

*08/02/2019 10:48:35*

Health for Care is a coalition of 15 organisations representing the entire breadth of the NHS joining forces to make the case for a sustainable, long-term settlement for social care.

Finding a long-term, sustainable solution to how we pay for and provide care and support to people in England is among the greatest challenges our country faces. The impact on the public has been profound, with record numbers of people now left to struggle each day without the care and support they need. We believe it is the time to put this right.

- Read the newly launched Health for Care coalition's letter to the Prime Minister

## 3 recommendations critical to achieving a new, long-term settlement

Our Health for Care coalition has developed a set of principles upon which we believe a sustainable social care system should be based. We hope they will be a useful contribution to the debate ahead of the publication of the adult social care Green Paper. Alongside the principles, we have three recommendations that we believe are critical to achieving a long-term settlement for social care:

## CONTACT

**Victoria Fowler**
Victoria.Fowler@nhsconfed.org

## EXTERNAL LINKS

Visit the Health For Care Facebook page

Read the Early Day Motion: Lo term social care settlement

Sign the 38 Degrees petition

## RELATED LINKS

# QUALITY CARE FOR OLDER PEOPLE WITH URGENT & EMERGENCY CARE NEEDS

Royal College of Physicians
Royal College of Nursing
ageUK Improving later life
RC PSYCH Royal College of Psychiatrists
ENCA
ASSOCIATION OF AMBULANCE CHIEF EXECUTIVES
College of Occupational Therapists
Directors of adass adults social services
CHARTERED SOCIETY OF PHYSIOTHERAPY

RCGP Royal College of General Practitioners

BGS British Geriatrics Society Improving healthcare for older people

## Integrated care for older people with frailty

Innovative approaches in practice

British Geriatrics Society
Improving healthcare for older people

## Fit for Frailty

Consensus Best Practice Guidance for the care of older people living with frailty in community and outpatient settings - published by the British Geriatrics Society and the Royal College of Nursing in association with the Royal College of General Practitioners and Age UK

Part 1: Recognition and management of frailty in individuals in community and outpatient settings

How to use this guide

Why is frailty important?

# V: **Where** we influence?

# **Where** we influence follows from whom?

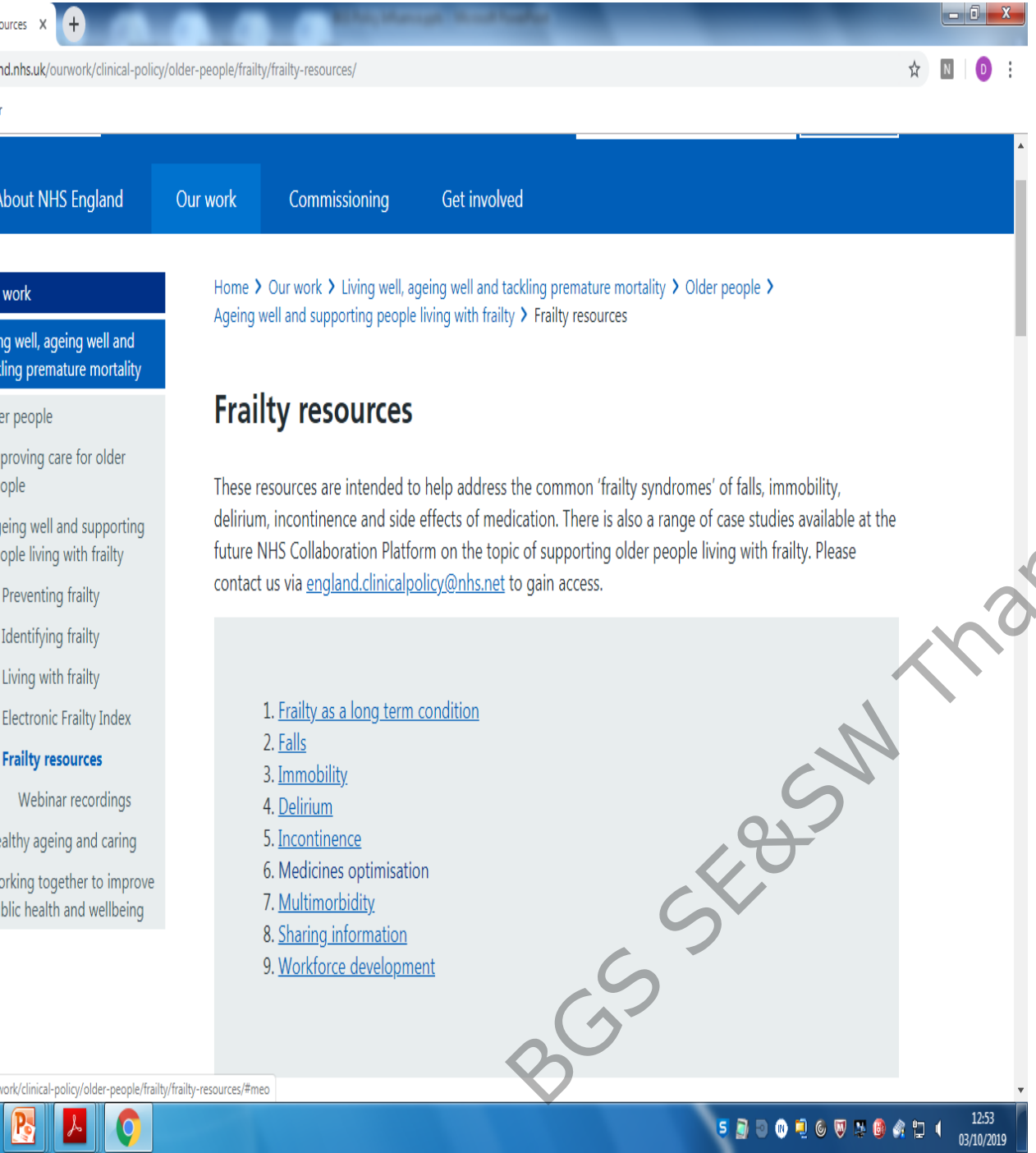
- Most importantly own **members** and **clinical colleagues**
- **Clinicians and managers** we work alongside but in **other disciplines** (e.g. GP)
- **National plans**, frameworks, incentives and strategies by government and arms length bodies
- National **audit** programmes
- National **data driven initiatives** like GIRFT (Getting it Right First Time) and "Right Care" atlas
- **National** clinical directors and other **clinical leaders**
- **Local NHS managers**, commissioners care system leaders, local government
- **Education** bodies
- By **raising awareness** and pressure from patients, public, carers, other charities
- Via **media** campaigns
- Other **professional bodies & societies**

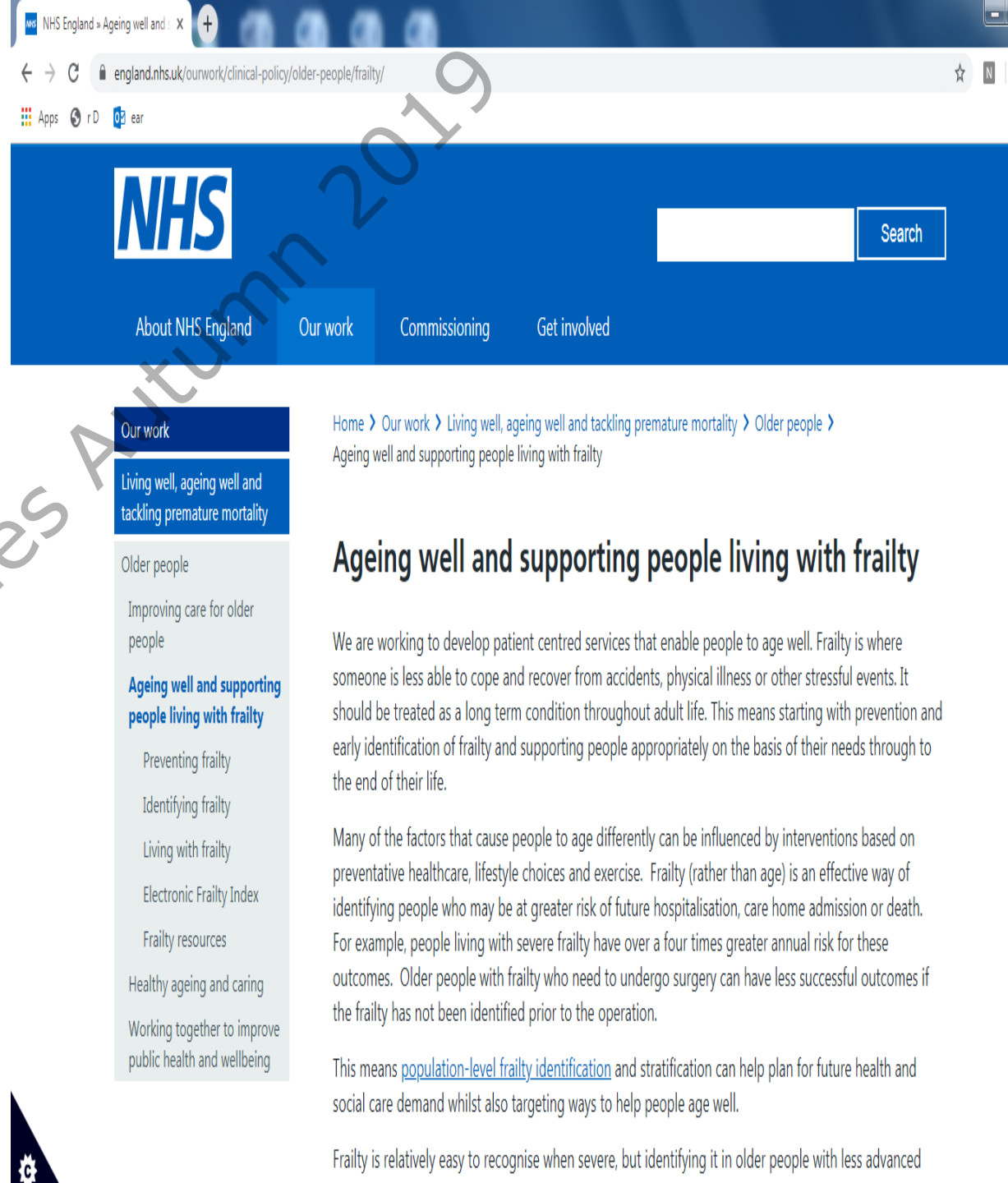
Modern Standards and Service Models

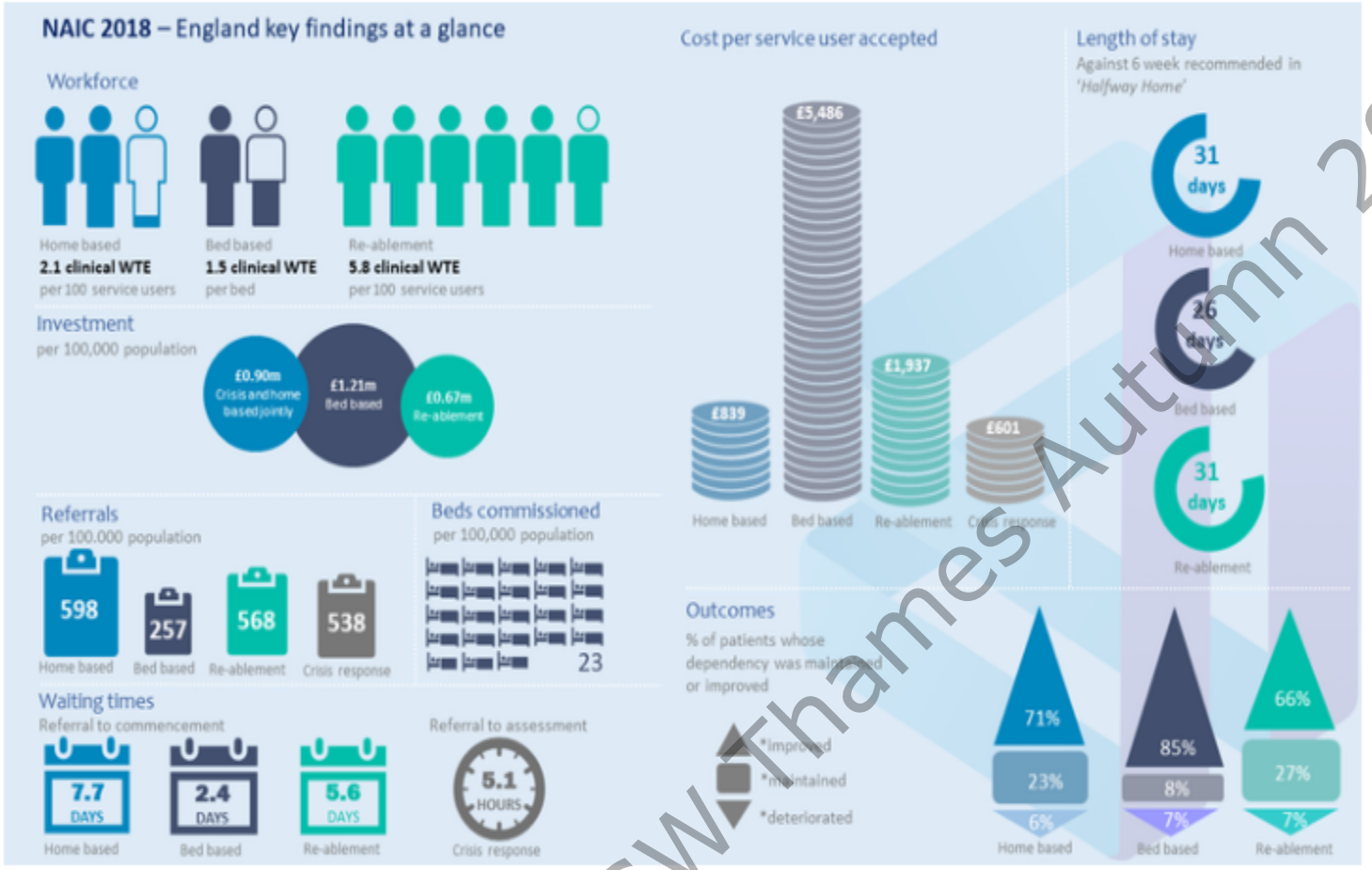
# Older People

national service framework

## National Service Framework for Older People






## Background to the NAIC

The National Audit of Intermediate Care was launched in November 2011 as a partnership project between the British Geriatrics Society, the Association of Directors of Adult Social Services, AGILE, the Royal College of Occupational Therapists, the Royal College of Physicians (London), the Royal College of Nursing and the NHS Benchmarking Network. The Patient's Association and The Royal College of Speech and Language Therapists became

We can confirm that the National Audit of Intermediate Care (NAIC) 2019 will not be running in England and Wales. Discussions are ongoing about running the audit again in 2020.

The audit content will be reviewed inlign with the NHS Long Term Plan.

## NICE quality standard

The NHS Benchmarking Network are pleased to support the publication of the new National Institute for Care and Excellence Intermediate care including reablement NICE quality standard.

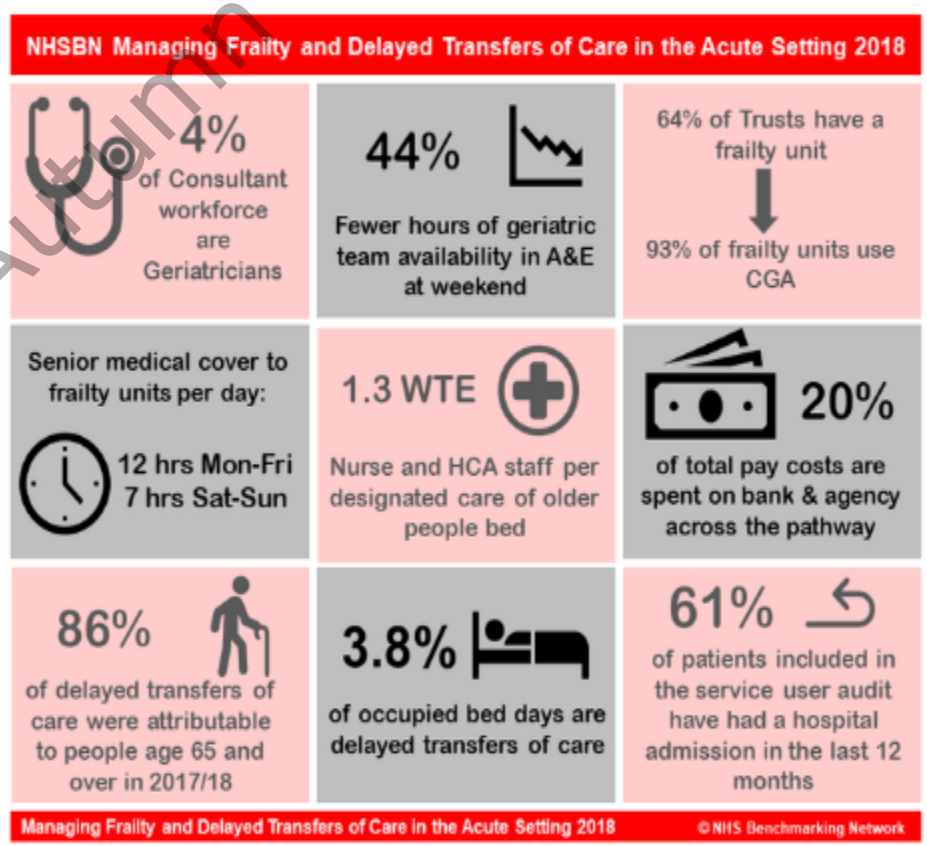
## NAIC 2019

NAIC 2019 Northern Ireland Audit Scope

# Managing Frailty and Delayed Transfers of Care in the Acute Setting



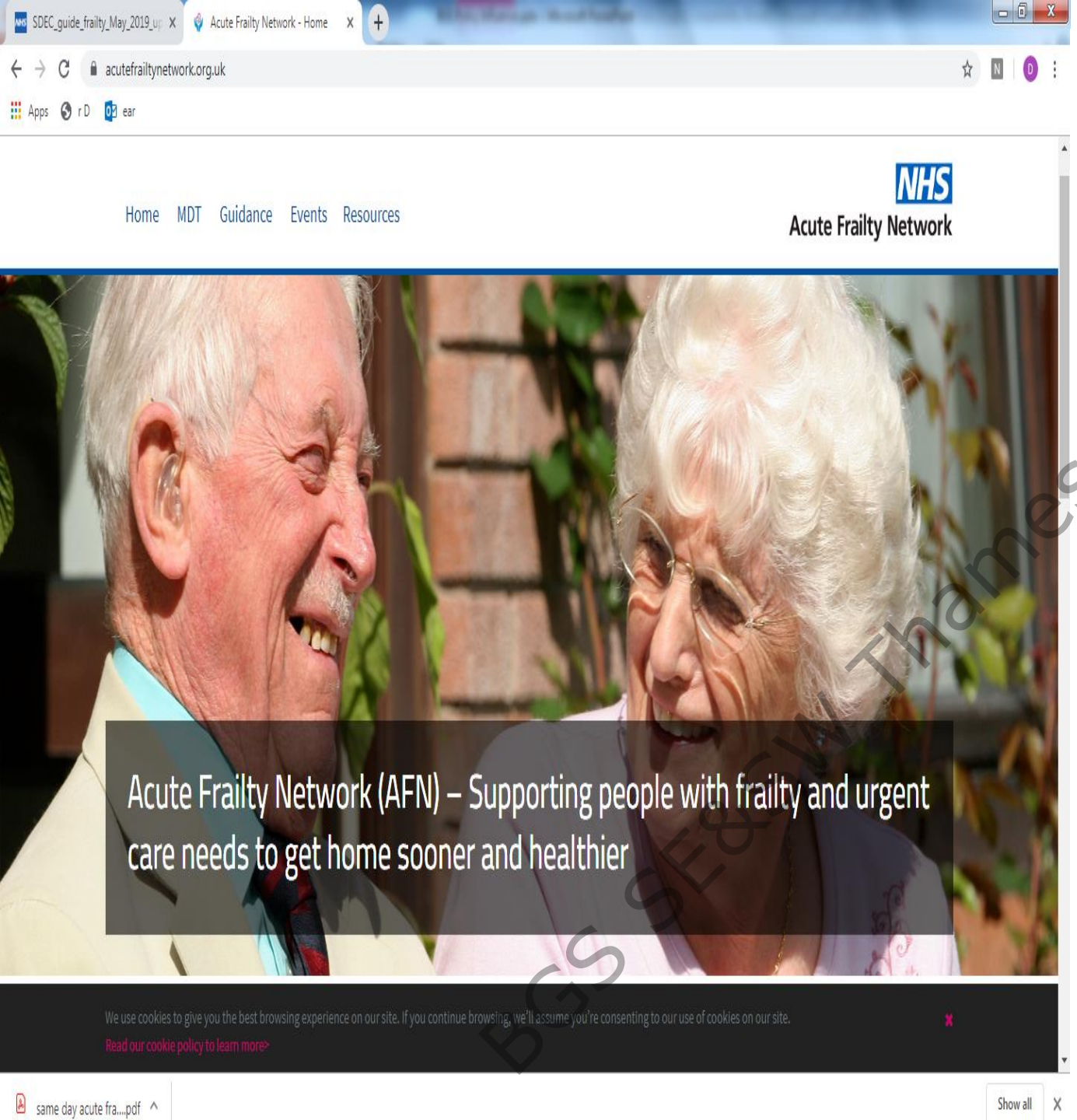
The NHS is faced with the demands of an ageing population and increasing numbers of people with multiple long-term conditions. Whilst much can be done to keep people as independent as possible and keep them safely at home, at some point in their journey of care, many people living with frailty and older people will need to be admitted to hospital for a period of acute care. In addition, older people, often living with frailty, can be subject to delayed transfers of care (DToC).




The Managing Frailty and Delayed Transfers of Care in the Acute Setting project focuses on the pathway of frail older people through secondary care, from assessment in A&E, assessment units inpatient wards and supported discharge. The project also takes a deeper dive into the management of delayed transfers of care and reviews protocols, processes, local reporting and onward routes out of the hospital. The British Geriatrics Society (BGS) has also worked with the NHS Benchmarking Network to develop a short service user audit which will be included in the project.

This project is for all providers of acute care where older people access their services. Subscribing members will receive:

- An interactive online toolkit, allowing you to benchmark your service across hundreds of metrics






NHS

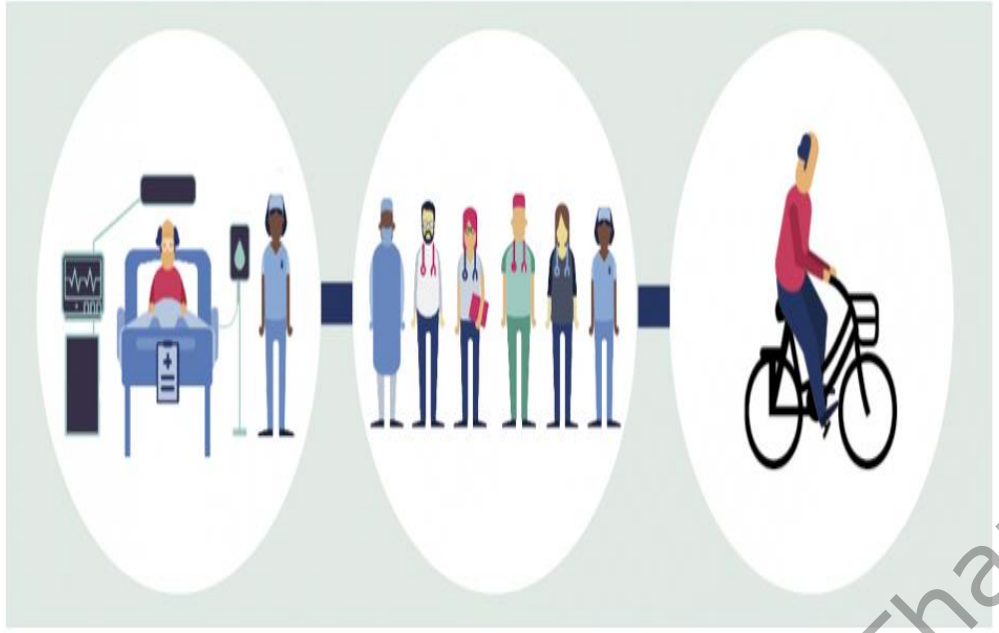
# Same-day acute frailty services

Published by NHS Improvement, NHS England, the Ambulatory Emergency Care Network and the Acute Frailty Network

May 2019

Anaesthetists

PERIOPERATIVE MEDICINE



- Home
- Vision Document
- RCoA Perioperative Medicine Programme
- Perioperative Medicine Leads
- Animated Film
- Case Studies

# RCoA Perioperative Medicine Programme

## The challenge

Surgery is an important treatment option for a wide range of acute and chronic diseases, with around 10 million patients having procedures annually; a number which will continue to rise. For most patients surgery is a success, both in terms of the procedure itself and the care before and afterwards. However, the population is changing and so must our services. There are 250,000 patients at higher risk from surgery and this number is set to rise. So with increasing demand and the increasing complexity of surgical procedures, come new challenges that we must address.

## The solution

We believe that collaborative and efficient perioperative care is the route to effective and sustainable surgery. Many components of the perioperative medicine pathway already exist within the NHS. We have produced a vision document, Perioperative Medicine: The Pathway to Better Surgical Care and have commissioned a film to

SHARE

Register online via AAA site

# AAA Scientific Meeting & BGS POPS Conference

Date(s)

Thu 14 - Fri 15 May 2020

Location

Bristol Marriott

Social Media

#BGSConf

@GeriSoc

The Age Anaesthesia Association and Perioperative medicine for Older People undergoing Surgery (POPS Specialist interest Group look forward to welcoming you to Bristol for the 2020 Annual Scientific Meeting which will take place at the Bristol Royal Marriott Hotel on Thursday 14th to Friday 15th May 2020. This joint event is intended to bring together different specialities and disciplines involved in the care of older surgical patients to facilitate cross-boundary education and training and help to improve quality of care for this complex group of patients. The 2 days will include keynote presentations from experts in the field, workshops and plenary sessions demonstrating best practice approaches available. We hope you will make contacts and start collaborations which will continue on from this meeting.

## Who should attend:

# VI: **How** we influence?

# **How** we influence? (Local)

- By having enough “boots on the ground” and local allies in services around the country
- If we are crucial to service delivery and leadership
- And expertise/leadership in local systems
- If we are sufficiently strong/influential to advocate/inform
- And demonstrate local service improvements
- And engage with local media, 3rd sector, community services etc
- And offer solutions to problems affecting whole organisation/systems
- And useful local system expertise

# How national leadership can help local influence?

- Train more clinicians in policy, media, comms, develop their confidence/effectiveness
- National campaigns & alliances locally applicable
- National good practice resources & best practice examples
- Including workforce/training resources
- National literature reviews, guidelines, quality standards
- National/regional peer/learning networks
- National audits
- National datasets

# Also…

- Effective influence over government policy
- Or plans/priorities of arms length bodies, regulators, improvement agencies
- Workforce planning
- Research priorities
- National News Media (proactive placement and reactive to stories)
- Responses to policy consultations
- Proactive national campaigns
- Input to national working groups
- By having some of our people in national/regional policy roles

*BMJ* 2019;364:l707 doi: 10.1136/bmj.l707 (Published 18 February 2019)



FEATURE

# "We're on the same side, really": medical profession turns to soft power to influence policy

Doctors' leaders are starting to take a different approach to winning people round to their way of thinking, **Tom Moberly** finds

Tom Moberly *UK editor, The BMJ, London, UK*

tmoberly@bmj.com

# Terry Kemple BMJ rapid responses 2019

- “If we want to improve our healthcare services we must equip our leaders better to influence our policymakers and get the outcomes we need. The adversarial approach may be seen as aggressive by policymakers and be ineffective”.
- “The amicable approach may be seen by followers as appeasing and also be ineffective”.
- “We need medical leaders who are assertive, have command of high quality information, understand the policy processes, the competing influences and the context for the policymaker, but who are flexible in their approach, and can build the constructive ‘honest broker’ relationships that result in the best outcomes for the health service.”
- We need more successful influencers more than we need soft influencers”.

# It is important to measure **impact**

- Refine/abandon/adopt new approaches accordingly
- e.g. in BGS members services review 2015
- e.g. in:
  - Media mentions.
  - Citations in policy consultations or final responses
  - Social media shares/mentions etc.
  - Citations or use in national or local policy/service development
  - Through data (e.g. audit)
  - Perceptions/awareness from other organisations
  - Use by/influence on NHS national bodies, professional bodies, colleges, improvement networks
  - However well we influence policy (e.g. on Ageism/Age-Discrimination, Dementia Strategy) need to measure impact on services

National Audit of Dementia (NAD

rcpsych.ac.uk/improving-care/ccqi/national-clinical-audits/national-audit-of-dementia

Apps r D ear

ROYAL COLLEGE OF PSYCHIATRISTS

Home › Improving care › College Centre for Quality Improvement (CCQI) › National Clinical Audits › National Audit of Dementia (NAD)

# National Audit of Dementia (NAD)

The National Audit of Dementia (NAD) is a clinical audit programme commissioned by the Healthcare Quality Improvement Partnership on behalf of NHS England and the Welsh Government looking at quality of care received by people with dementia in general hospitals.

NAD
NATIONAL AUDIT OF DEMENTIA

- “Since the policy process tends to be very fast, papers must be timely. An 80 % right paper before a policy decision is made it is worth ten 95 % right papers afterwards, provided the methodological limitations imposed by doing it fast are made clear”

# Advancing rapid evaluation: challenges and opportunities

The Nuffield Trust in collaboration with three national Rapid Evaluation Centres – RSET, BRACE and the Improvement Analytics Unit - held an event to explore the growing use of rapid evaluation in the health service as a mechanism to drive improvement.



**Conference/Seminar**

**Start date:** 29/01/2019 | 9:15

**End date:** 29/01/2019 | 16:30

Hallam Conference Centre
44 Hallam Street, London, W1W 6JJ

**For more information on this conference contact:**

events@nuffieldtrust.org.uk
020 7631 8450

What qualifies as a rapid evaluation? What challenges do they present – and how are they overcome?

**Share this page**

# BGS Commissioning Guidance

## High Quality Health Care for Older Care Home Residents

### Introduction

Nearly 400,000 older people live in care homes in the UK, nearly 20% of those aged 85+. Their health and social care needs are complex. All have some disability, many have dementia, and collectively they have high rates of both necessary and avoidable hospital admissions. Standard healthcare provision meets their needs poorly, but well-tailored services can make a significant difference.

The British Geriatrics Society (BGS) report Quest for Quality describes current NHS support for care homes and makes recommendations as to how care home residents' quality of care can be improved. This guide describes the clinical and service priorities for meeting care home residents' needs. It details the outcomes needed from commissioned services and suggests how these can be achieved.

A more detailed version of this guide is available on the BGS website along with reference material and links to useful resources.

### Why specialist commissioning for older people in care homes?

**Health needs are different:** Most residents have a mix of comorbidities affecting both physical and mental health. Dementia is prevalent, the majority of residents in most care homes being affected to some degree, and depression is common.

**Managing disability:** The physical aspects of conditions which are common in care home residents (such as late stage neurodegenerative conditions including Parkinsonism and dementia, and severe stroke disease) are complicated. Care home staff need support from specialist health services to identify, understand and respond to the everyday impact of providing essential care. This includes appropriate provision of food and drink, preserving residents' skin integrity and preventing contractures. Medical treatment remains an important part of the response but requires a systematic approach and attention to detail, which GPs may find difficult to deliver with existing time and resource constraints. Some medical treatment may need specialist support from geriatricians.

**Disease based models are insufficient:** Single condition based programmes don't work for people with co-existing late stage diseases. An individualised approach is needed; shorter term

### What are the outcomes needed from commissioned services?

**For residents themselves?**

- Improved experience through high quality essential care – reducing distress from depression, disorientation, agitation, pressures sores, contractures, constipation, pain and sleeplessness.
- Minimisation of predictable acute events - urinary infections, aspiration and pneumonia.
- Avoidance of unnecessary progression of long term conditions coupled with a reduction in adverse drug events and the unnecessary burdens of irrelevant treatments.
- Reduced risks of falls, fractures and other injuries.
- Enhanced autonomy and involvement in decisions about care, place of care and place of dying.
- Reduced fear of dying and enhanced experience of dying for residents and their families.

**For the local NHS?**

- Enhanced equity in care (bearing in mind the Equality Act 2010) and health related quality of life – by shaping services to suit patients.
- More efficient use of local resources – reductions in



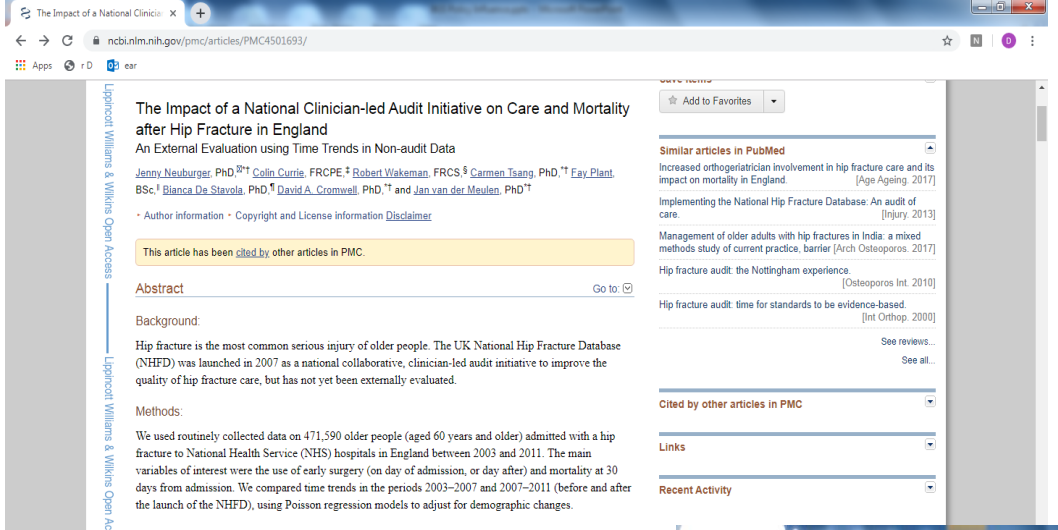
- Has influenced
- NHS 5 year view
- New Models Vanguards
- GP Contract
- 10 Year Plan
- Development of community geriatrics
- And new clinical roles for nurses?AHPs
- King's Fund Events/Papers
- Local service innovation/evaluation
- We made all the initial running and had a "niche"

# British Orthopaedic Association

PATRON: H.R.H. THE PRINCE OF WALES



# THE CARE OF PATIENTS WITH FRAGILITY FRACTURE



The Impact of a National Clinician-led Audit Initiative on Care and Mortality after Hip Fracture in England

An External Evaluation using Time Trends in Non-audit Data

Jenny Neuburger, PhD,[a][*†] Colin Currie, FRCPE,[‡] Robert Wakeman, FRCS,[§] Carmen Tsang, PhD,[*†] Fay Plant, BSc,[‖] Bianca De Stavola, PhD,[¶] David A. Cromwell, PhD,[*†] and Jan van der Meulen, PhD[*†]



Abstract

Background:

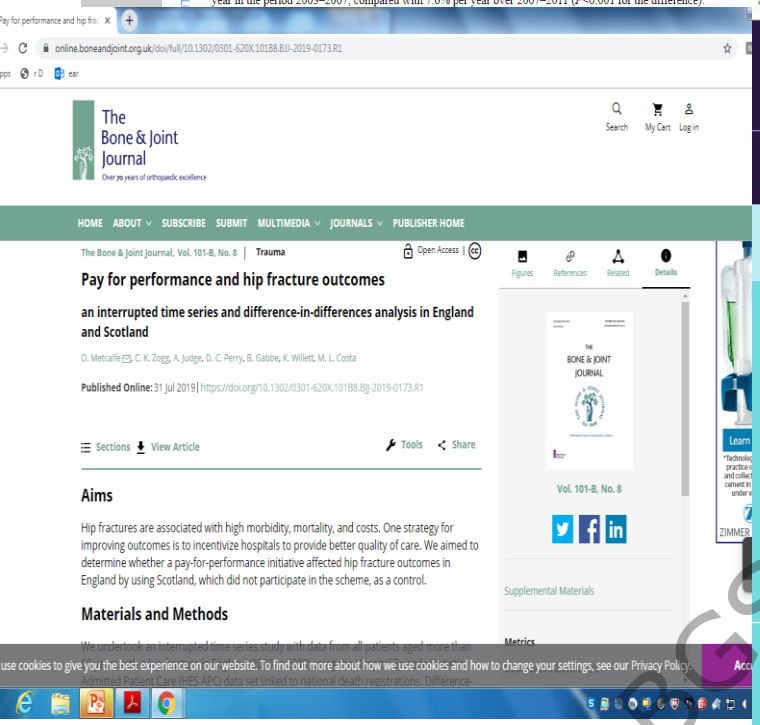
Hip fracture is the most common serious injury of older people. The UK National Hip Fracture Database (NHFD) was launched in 2007 as a national collaborative, clinician-led audit initiative to improve the quality of hip fracture care, but has not yet been externally evaluated.

Methods:

We used routinely collected data on 471,590 older people (aged 60 years and older) admitted with a hip fracture to National Health Service (NHS) hospitals in England between 2003 and 2011. The main variables of interest were the use of early surgery (on day of admission, or day after) and mortality at 30 days from admission. We compared time trends in the periods 2003–2007 and 2007–2011 (before and after the launch of the NHFD), using Poisson regression models to adjust for demographic changes.

Findings:

The number of hospitals participating in the NHFD increased from 11 in 2007 to 175 in 2011. From 2007 to 2011, the rate of early surgery increased from 54.5% to 71.3%, whereas the rate had remained stable over the period 2003–2007. Thirty-day mortality fell from 10.9% to 8.5%, compared with a small reduction from 11.5% to 10.9% previously. The annual relative reduction in adjusted 30-day mortality was 1.8% per year in the period 2003–2007, compared with 7.6% per year over 2007–2011 ($P$<0.001 for the difference).



The Bone & Joint Journal

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The Bone & Joint Journal, Vol. 101-B, No. 8 | Trauma

Pay for performance and hip fracture outcomes

an interrupted time series and difference-in-differences analysis in England and Scotland

D. Metcalfe, C. K. Zogg, A. Judge, D. C. Perry, B. Gabbe, K. Willett, M. L. Costa

Published Online: 31 Jul 2019 | https://doi.org/10.1302/0301-620X.10188.BJJ-2019-0173.R1

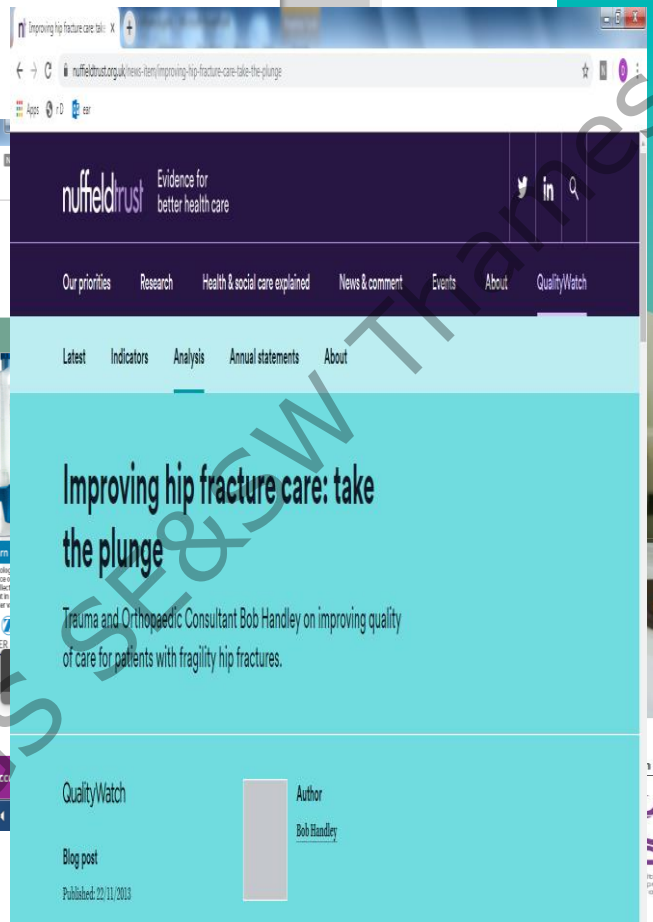
Aims

Hip fractures are associated with high morbidity, mortality, and costs. One strategy for improving outcomes is to incentivize hospitals to provide better quality of care. We aimed to determine whether a pay-for-performance initiative affected hip fracture outcomes in England by using Scotland, which did not participate in the scheme, as a control.

Materials and Methods

We undertook an interrupted time series study with data from all patients aged more than





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Improving hip fracture care: take the plunge

Trauma and Orthopaedic Consultant Bob Handley on improving quality of care for patients with fragility hip fractures.

QualityWatch

Author

Bob Handley

Blog post

Published: 22/11/2013

Royal College of Physicians | Falls and Fragility Fracture Audit Programme (FFAP)

# National Hip Fracture Database (NHFD)

## Annual report September 2018 (Data from January to December 2017)

In association with:

British Geriatrics Society

National Osteoporosis Society

Public Health England

Commissioned by:

HQIP

# VII: When?

Creating Opportunities. Seizing Opportunities.

# **When** to influence?

- We can be proactive and make the running in a particular area
  - e.g. Nursing Homes, Frailty, Acute Frailty, Safety/QI
- And develop the evidence base and good practice examples
- We can engage with and respond to policy consultations and working groups
  - e.g. social care, ageing well,  dignity, end of life
- We can plan for the medium term future (e.g. workforce roles/numbers/skills)
- We can be constructive or outspoken critics
  - E.g. health tech/digital, workforce crisis, funding, integration
- We can seize the day to help provide solutions to pressing wicked problems
  - e.g rising admissions, delayed transfers or care, stranded patients, readmissions, admissions from care homes,

# VIII: Horizon Scanning and **Futurology?**

# Emerging policy consensus/orthodoxy

*(but should be challenged here and there)*

- Geared to acute
- Hospital-centric
- Dr-dependent
- Episodic
- Disjointed
- Reactive
- System/disease
- Patient passive
- Self-care rare
- Carers undervalued
- Low-tech

- Geared to LTCs
- Community/whole systems-centric
- Team-based
- Continuous
- Co-ordinated
- Preventive
- Person-centred
- Patient partner
- Self-care supported
- Supported as partners
- High-tech

Prevention now becoming ideological turf war between broad social policy/wider determinants inequality/pricing etc and individual responsibility, genomics etc

# The kind of issues that might count (loads more besides)

- Tech/Digital
- Precision/predictive medicine
- Carers and changing population pyramid
- Prevention and non clinical, whole community based approaches to care
- Shift of expertise outside hospital walls
- Improving end of life care for all
- Dementia prevalence
- Growing focus on teams and other workforce groups with right skills

ARTICLES | VOLUME 390, ISSUE 10103, P1676-1684, OCTOBER 07, 2017

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# Is late-life dependency increasing or not? A comparison of the Cognitive Function and Ageing Studies (CFAS)

Andrew Kingston, PhD • Pia Wohland, PhD • Raphael Wittenberg, MSc • Prof Louise Robinson, MD • Prof Carol Brayne, MD • Prof Fiona E Matthews, PhD • et al. Show all authors • Show footnotes

Open Access • Published: August 15, 2017 • DOI: https://doi.org/10.1016/S0140-6736(17)31575-1 •

Check for updates

Summary
Introduction
Methods
Results

## Summary

### Background

Little is known about how the proportions of dependency states have changed between generational cohorts of older people. We aimed to estimate years lived in different dependency states at age

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Volume 47, Issue 3
May 2018

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Strengths and limitations
Comparisons with other studies
Policy implications
Supplementary data

EDITOR'S CHOICE

# Projections of multi-morbidity in the older population in England to 2035: estimates from the Population Ageing and Care Simulation (PACSim) model

Andrew Kingston, Louise Robinson, Heather Booth, Martin Knapp, Carol Jagger ✉, for the MODEM project

*Age and Ageing*, Volume 47, Issue 3, May 2018, Pages 374-380, https://doi.org/10.1093/ageing/afx201
**Published:** 24 January 2018 **Article history** ▾

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## Abstract

### Background

models projecting future disease burden have focussed on one or two diseases. Little is known on how risk factors of younger cohorts will play out in the future burden of multi-morbidity (two or more concurrent long-term conditions).

### Design

a dynamic microsimulation model, the Population Ageing and Care Simulation



The King's Fund

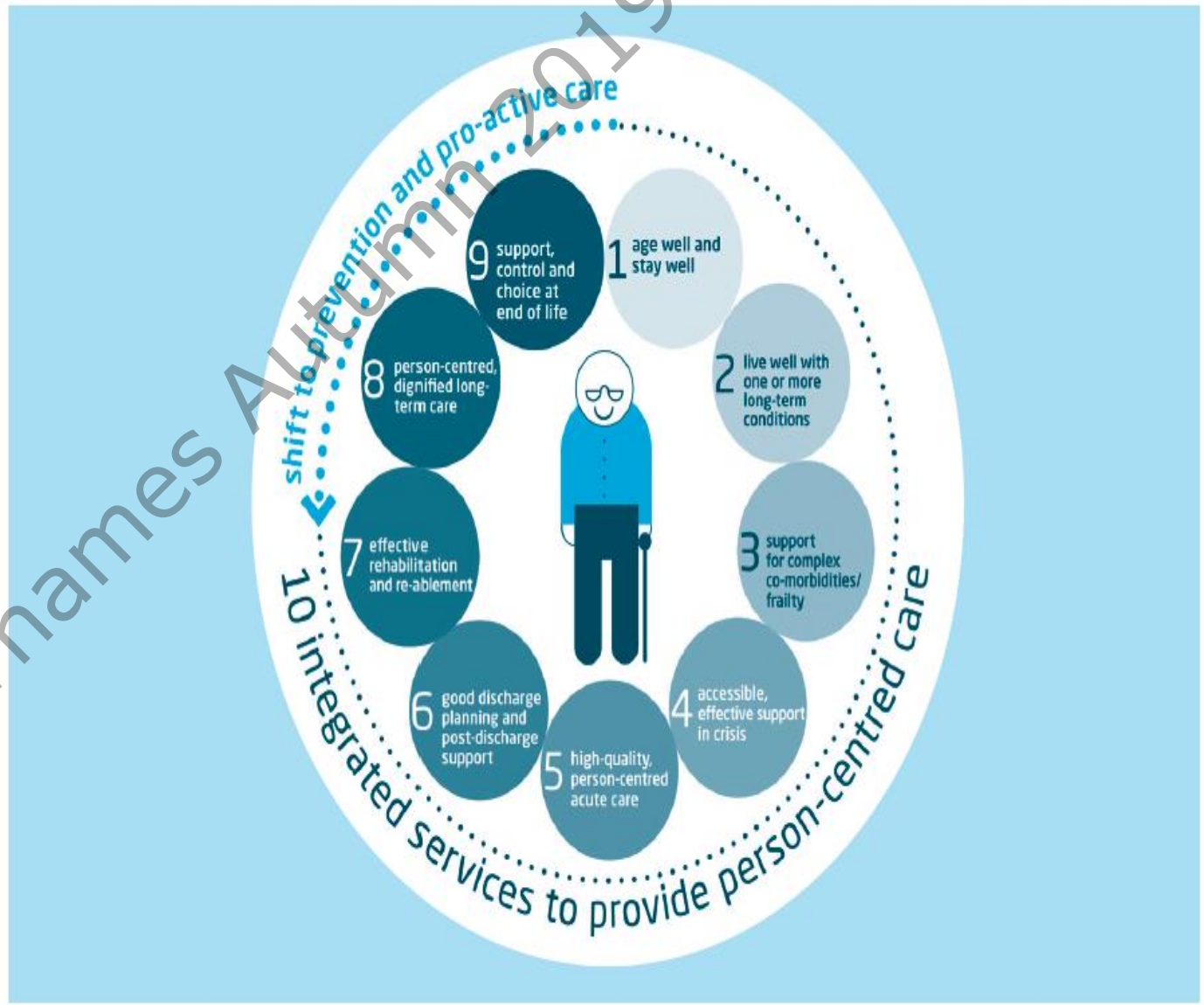
Ideas that change health care

# Making our health and care systems fit for an ageing population

Authors
**David Oliver**
**Catherine Foot**
**Richard Humphries**



**Figure 2** Ten components of care for older people



Future Hospital Journal 2016 Vol 3, No 1: 49–54





# Geriatric medicine and geriatricians in the UK. How they relate to acute and general internal medicine and what the future might hold?

**Authors:** David Oliver[A] and Eileen Burns[B]

ABSTRACT

**The Royal College of Physicians and its Future Hospitals Commission has a renewed focus on general internal medicine. But in 2015, most is in effect either acute medicine or geriatric medicine. Acute physicians and 'organ specialists' looking after inpatients on specialty wards or at the acute hospital 'front door' will need sufficient skills in geriatric medicine, rehabilitation, discharge planning and palliative care, as frailty, dementia and complex comorbidities may complicate the care of older patients with predominant speciality-defining complaints. In an era where we are urged to focus on patient-centred care, patients' preference for continuity and 'whole-stay', consultants must be recognised and respected. Ideally, this will require increasing numbers of geriatricians and acute physicians, more age attuned training for all; a shift in values and status. This should be backed by adequate capacity and rapid access to social and intermediate care services outside hospital, as well as adequate multidisciplinary staff and skills within the acute hospital to ensure that older patients' needs beyond the immediate complaints are not neglected. Meanwhile, geriatric medicine itself has diversified into specialised, community and interface roles, aligned with the integration agenda, and continues to contribute substantially to acute, general and stroke medicine. These developments are described here.**

**KEYWORDS:** Geriatrics, general, acute medicine and workforce

Medical specialities in those early post-war years tended to focus on short-lived, infectious or 'single-organ' diseases generally affecting people below retirement age. This has indirectly coloured the way our services, training and specialities are configured to this day.

UK geriatric medicine came to prominence in the 1940s with the pioneering work of Warren, Amulree, Howell and Exton-Smith among others, and with the founding of the British Geriatrics Society (BGS).[5] Its pioneers demonstrated the value of specialised and skilled assessment of older patients both to those individuals and to hospitals. Back then, geriatricians were far from the mainstream of acute adult medicine and centred in long-stay facilities.[6] We are now the largest UK internal medicine speciality with at least 1,350 consultants, with most consultants dually accredited in general internal medicine (GiM) and many also in stroke or acute medicine.[7]

The BGS has defined geriatric medicine thus: 'a branch of GiM that is concerned with the clinical, preventative, remedial and social aspects of illness in old age. The challenges of frailty, complex comorbidity, different patterns of disease presentation, slower response to treatment and requirements for rehabilitation or social support require special medical skills'.[8] This is explored in more detail in the Royal College of Physicians' *Consultant physicians working for patients* resource on the speciality.[9] A recent article in this journal[10] discussed how we identify older people with frailty and

# IX: How **you** could play your part

# How **you** could get involved?

- Participate in BGS work (or other professional bodies like RCP, HEE)
- Get involved in working groups at national or regional level (e.g. NICE, DHSC, NHSE, NHSI)
- Take on local system leadership roles
- Local QI/innovation and sharing the story, peer support for others, learning  networks
- Get some policy and media training and experience & maybe take it further
- Including some writing

# X: Limitations, realism, targeting of efforts

# Limitations and realism

- BGS team (even RCP team) is small
- Small number of clinicians able to get fully involved in supporting employed team at HQ
- Have to prioritise key areas and stick to those where we have strongest expertise and stake
- Even for collaborations/alliances/coalitions have to choose battles
- Need to realise lots of other groups/organisations also lobbying for their thing
- Through the eyes/ears of the people we are lobbying/engaging, we and our issues are one of many

# Limitations and Realism

- Only some (if any) of what you say will stick
- Only some of that will make an immediate and enduring difference
- Some will be ignored completely
- Lots of other agencies or groups have a different world view/ideology re ageing and health
- Not getting everything we want or having every message heard/believed is not a policy failure
- Even small victories are successes