AGENDA

British Geriatrics Society
Improving healthcare for older people

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BGS NEW LOOK NEWSLETTER

The future of ageing?

Geriatrics for the next generation

PLUS

- Autumn Meeting report
- **50 years of *Age and Ageing***
- Shaping your BGS

AGENDA
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On the
AGENDA

President's *Message*

Happy New Year to all our BGS members and I do hope you are enjoying the new look of *Agenda* as we keep you up to date with various BGS activities. The energy and enthusiasm of our members is an inspiration to me as we tackle this difficult start to 2022, both within healthcare and the NHS and on a global and political scale.

I am acutely aware of the relentless nature of clinical work throughout the NHS. These problems existed before the pandemic but have been magnified with issues of staff sickness absence and increased infection levels in hospital and community settings.

We have also been keeping a watchful eye on the burden of serious illness related to COVID and asking for older people to continue to be regarded as clinically extremely vulnerable to the consequences of infection. I have written to the four Chief Medical Officers asking if the policy on use of antivirals and monoclonal antibodies can be reviewed to include age or frailty as a marker, and to allow access to medicines outwith clinical trials. We will continue to advocate for this.

BGS has been speaking up about the need to invest in the workforce across health and social care. We signpost to models of care that have the best outcomes for patients - and as we all know, good care for older people is best for the overall healthcare system too. Marion McMurdo, Emeritus Professor in Ageing and Health at Dundee University, always reminds her audiences of the need to design hospitals to promote excellence in older people's care, with comprehensive geriatric assessment (CGA) as an embedded expectation. This reduces mortality, morbidity and length of hospital stay.

We recently had the Hospital at Home study report in *Age and Ageing*[1] demonstrating that high quality healthcare at home in acute crisis was also cost-effective. We need to ensure our members are given time in their job plans to develop models of care to support older people beyond acute hospital hubs. In the past, this was always core to the work of a geriatrician, but acute pressures have very much dominated over the last couple of years and some outpatient and rehabilitative services have been diminished as a result. Investment in primary and community services is vital for older people's healthcare.

‘We continue to press government to invest in the social care workforce and to be innovative in trying to attract and retain staff.’

Our patients often struggle to access good quality social support to allow them to thrive at home, and BGS members are reporting concerns from across England that discharges from hospital are delayed and patients are diverted to placements in intermediate care units which lack the required rehabilitative support to allow them to recover and go home. This is happening in a Health Board area close to me in Scotland too, as they have no home care packages to offer patients. It highlights the difficulties created by pressure on hospital capacity, and also the workforce shortages in care homes and domiciliary care.

We continue to press government to invest in the social care workforce and to be innovative in trying to attract and retain staff. I would like to highlight proposals from the Health Foundation, the King’s Fund, and the Nuffield Trust. Their report, *Closing the gap: Key areas for action on the Health and Care Workforce*[2] sets out clear recommendations on increasing training numbers, improving terms and conditions for the workforce and supporting primary care. As former BGS President David Oliver said in his recent *BMJ* column, “we need a relentless focus on implementing and resourcing solutions.”[3]

Thanks too for all you are doing in your own workplaces to reinforce good practice and support innovation. We love to hear about these examples and are very happy to spread the word on the work you are doing in BGS blogs and summaries in this magazine.

I do hope you enjoyed the virtual Autumn Meeting in November as much as I did. The quality of the IT infrastructure has maximised the experience for our members. I thanked all the participants for fantastic content too. We had hoped to resume face-to-face conferencing from 2022 but we have made the difficult decision to delay the return to full face-to-face meetings until later this year. This means we will not be seeing one another in Manchester for the Spring Meeting,but will continue with our successful virtual meeting format from 6-8 April. Over the spring months, the conference team will trial some one-day SIG and national/regional meetings in a ‘hybrid’ (physical and virtual) model, and once we’ve learnt the lessons from this, we will be better positioned to host a full three-day Autumn conference.

I want to welcome our newly appointed officers to the BGS. We are delighted to announce the appointment of Dr Amit Arora, Consultant Geriatrician in the North Midlands,

‘Our patients often struggle to access good quality social support to allow them to thrive at home, and BGS members are reporting concerns.’

Get involved!

This is your member magazine and we'd love to hear stories and feedback from BGS members.

Upcoming themes for *Agenda* include leadership and the multidisciplinary team, education and training, international geriatrics, and care homes - so if you have a particular interest in any of these topics, or something else you'd like to share, please do get in touch.

Email editor@bgs.org.uk to discuss you ideas or to find out how you can get involved.

as Vice President for Workforce. This role is key to the policy and influencing work of the BGS in developing the workforce for the future of ageing and I am delighted Amit has taken this on. He has a broad background including many insights from his time as a service innovator that will give us fresh ideas and help us focus on improving patient pathways.

Dr Tom Downes, Clinical Lead for Quality Improvement, Sheffield Teaching Hospitals NHS Foundation Trust, has been appointed as Vice President for Clinical Quality. His expertise in quality improvement is renowned and we are very fortunate to have such an experienced geriatrician involved in this vital area of BGS work. He has a hard act to follow, as Dr Jugdeep Dhesi has committed endless time and energy to this role over the last two years and I would like to personally thank her for her support to me as President. It is a great asset to have someone with good judgement and positivity to support the BGS mission.

One of the joys of this role has been meeting (mainly virtually) so many individuals motivated to go above and beyond to contribute to the work and mission of the BGS. Thanks to you all and keep spreading the word!

Dr Jennifer MA Burns
President, BGS
@Burns61Jenny

References

1. Singh S, Gray A, Shepperd S, Stott D, Ellis G, Hemsley A et al. Is comprehensive geriatric assessment hospital at home a cost-effective alternative to hospital admission for older people?. Age and Ageing. 2021;51(1).
2. King’s Fund, Health Foundation and Nuffield Trust (2021). Closing the gap: Key areas for action on the Health and Care Workforce. Available at: www.kingsfund.org.uk/publications/closing-gap-health-care-workforce
3. David Oliver: Solutions for the workforce crisis exist, so let’s act now. BMJ 2022;376 (12 January 2022) doi: https://doi.org/10.1136/bmj.o23

Older people, new beginnings

In her first editorial as BGS Honorary Secretary, Professor Anne Hendry sets out her hopes for a new chapter in the health and care of older people, what BGS is doing to help ensure positive change.

The start of the year is traditionally a time for the annual 'must do' note to self - more steps, less screen time, better work-life balance, take up a new hobby.

At our January meeting, BGS Board members considered our collective goals and the actions and outcomes we want to achieve in the next year - to grow as a thriving multidisciplinary community that promotes high quality healthcare for older people; enhances relevant curricula, education and training; convenes research opportunities, skills and supports evidence into practice; and is an informed and influential advocate for policy, commissioning and practice attuned to the needs of older people.

That's a pretty ambitious agenda at a time when we continue to deal with pressures from the pandemic. But with the wholehearted support of our members I am confident BGS can achieve these goals. Many of you are already involved in this work through our Councils, committees and SIGs. Amit Arora, our new Vice President for Workforce, has just established a new multidisciplinary group to help take forward the workforce agenda.

'...2022 is a great time to reflect and imagine a better future for our older patients, a future where we work together across disciplines and with our partners from other sectors to prevent and manage frailty.'

One aspect will be campaigning for the long awaited and vital strategic planning required to build a workforce with the right skills to deliver the right care for older people in the right place. Workforce planning is complex - a careful balance between challenging staffing constraints in key disciplines and the desire to move further and faster towards the right clinical and service model, both now and for the future. To make progress we need to be clear about our strengths as specialists in the care of older people, understand our workforce gaps, and embrace the potential for new roles and ways of working.

Remobilisation, Recovery and Reform are the current policy buzz words. NHS 'lifers' like me know that if you missed the last reorganisation, there's always another one on its way! But I believe the introduction of Integrated Care Systems in England from July and the proposed reform of Integration Joint Boards in Scotland are timely opportunities to reshape the way we deliver health and care for, and with, older people.

This issue of *Agenda* takes a peek at the future of ageing and health. Throughout 2022, in this 50th anniversary year, *Age and Ageing* journal will publish a series of commentaries from international experts on ageing and healthcare for older people. So 2022 is a great time to reflect and imagine a better future for our older patients, a future where we work together across disciplines and with our partners from other sectors to prevent and manage frailty. And where we do this right along the continuum of care through:

- Stronger alliances with local government, community partners and citizens for healthy ageing and wellbeing in later life.
- Creative contracts, job plans and workforce plans that enable practitioners to embrace multidisciplinary practice and share skills through cross sectoral working.
- Proactive anticipatory primary care and community services that ensure early intervention for exacerbations of chronic disease and minimise deconditioning.
- Integrated teams that deliver urgent assessment, treatment, rehabilitation and support at home, or closer to home, through well-coordinated transitional and intermediate care alternatives to the emergency department and hospital stay.
- High quality ambulatory and inpatient care that enhances the experience of patients and professionals and can be accessed without delay.
- Long-term health and social care that enables people to live their best lives in the place they call home and to experience a good death in their preferred place of care.
- Greater choice, control and coordination of care enabled through safe and effective information sharing and accessible personalised technology enabled care solution.

We have most of these building blocks in place, but too often these services are fragmented, difficult to access, and patchily implemented within and across regions. Some of our members are leading cutting edge research and contributing to national and international guidance in these fields. BGS has already published many excellent resources about what works – for example our Frailty and Delirium Hubs and publications on healthcare in care homes and urgent community-based care. Hard to believe but it's now seven years since BGS published *Fit for Frailty 2*! This year we want to look beyond community services and take a whole system and population health approach.

BGS is well placed to develop a 'what good looks like' blueprint to support commissioners of services for older people to create integrated systems that are frailty-attuned. If you are involved in planning services for older people in your area, you can share your insights via a new reference group that will support this piece of work, to be led jointly by the BGS Policy and Communications Committee and the Clinical Quality Committee in the months ahead. Check our e-bulletin for an invitation to register interest or get in touch with me directly at **anne.hendry@lanarkshire.scot.nhs.uk**.

Related BGS resources

- **Delirium Hub**
  www.bgs.org.uk/deliriumhub
- **Frailty Hub**
  www.bgs.org.uk/frailtyhub
- **Ambitions for change: Improving healthcare in care homes**
  www.bgs.org.uk/ambitionsforchange
- **Right time, right place: Urgent community-based care for older people**
  www.bgs.org.uk/righttimerightplace
- **Fit for frailty 2**
  www.bgs.org.uk/resources/introduction-to-frailty

Getting to know Professor Anne Hendry

Professor Anne Hendry became BGS Honorary Secretary in November 2021. She gives us the rundown on her priorities and goals for her time in the post.

About Anne

A geriatrician and former national clinical lead for integrated care in Scotland, I continue to promote effective health and care for older people through honorary positions with NHS Lanarkshire's research and development team, with the University of the West of Scotland, and as trustee Director of Kilbryde Hospice. I am a Senior Associate of the International Foundation for Integrated Care and Director of their hub in Scotland, serve on the Editorial Board of the Journal of Integrated Care and am pleased to contribute to WHO Europe's forum on Long-Term Care.

Main priorities as Honorary Secretary

This is a hugely challenging time for those who work with older people but there has never been a better time for creative and innovative approaches to workforce planning and service design. I will support BGS to influence the current policy landscape across the UK so emerging governance arrangements create the conditions to deliver the best possible experience and outcomes for older people across the continuum of care. I hope our influence and advocacy encourages commissioners to develop integrated primary care, community and hospital services that are fit for frailty and supported by investment to build an interdisciplinary workforce with the right skills and networks.

How can members get involved?

The Policy and Communications Committee aims to identify and respond to policy issues in each of the four nations. We want our informed voice to influence the narrative and decision-making on healthcare for older people across the UK. In framing our policy statements, we are supported by members from different disciplines who are involved in our SIGs and councils. You can contribute to our collective policy influence through these BGS communities. If you want to raise a particular issue with me directly you can also email me at anne.hendry@lanarskhire.scot.nhs.uk

Professor Anne Hendry
BGS Honorary Secretary
@AnneIFICScot

EuGMS LONDON 2022

18TH INTERNATIONAL CONGRESS

SEPTEMBER 28-30

Better together: Multidisciplinary team working

EuGMS
European Geriatric Medicine Society
Fostering geriatric medicine across Europe

BGS
British Geriatrics Society
Improving healthcare for older people

Annual General Meeting

Every year in November, the BGS holds an Annual General Meeting for its members. This is an important opportunity for BGS members to exercise their democratic rights and vote on strategic issues. The BGS is required to give you at last 14 days' notice of the AGM and ensure you have access to all the papers, which we do via the website.

After agreeing that the minutes of the last year's AGM are a correct record, typically members are asked to approve the Trustees' Annual Report and Audited Accounts for the financial year that ended the previous March. As a charity, the BGS is required to produce these documents and have them approved by the membership before they are lodged at the Charity Commission, with the accounts also uploaded to the Companies House website. The Trustees' Report gives a good overview of the charity's objectives and activities. The accompanying Accounts have been signed off by the BGS's auditors and provide a record of income and expenditure, investments and assets, showing in a transparent way the overall financial position of the Society.

Members are also asked each year to approve the new proposal for membership subscriptions for the following calendar year. For the last two years, fees have been held at the same rate as agreed in 2019, and so this resolution has been passed with little debate.

We also invite members to ratify new officer appointments. Our trustee posts and senior officer roles tend to be for a duration of two years, but the term of office for Vice-Presidents and the Honorary Treasurer is three years.

At the recent AGM in November 2021, we said goodbye and thank you to the officers who completed their term of office at the AGM or earlier in the year:

- **David Attwood**, demitting Honorary Secretary
- **Lucy Lewis**, demitting Chair of the Nurses & AHPs Council
- **Carly Welch**, demitting Chair of the Trainees' Council
- **Alan McKenzie**, demitting Chair of BGS Scotland
- **Tarun Solanki**, demitting Chair of the England Council
- **Sandip Raha**, demitting Chair of BGS Wales
- **Clare Copeland**, demitting Vice President Workforce

We welcomed the following new post-holders:

- **Anne Hendry** as the new Hononary Secretary
- **Esther Clift** as the new Chair of the Nurses & AHPs Council
- **Sangam Malani** as the new Chair of the Trainees' Council
- **Rowan Wallace** as the new Chair BGS Scotland
- **Sam Abraham** as the new Chair of BGS Wales
- **Mike Azad** as the new Chair of the England Council
- **Amit Arora** as the new Vice President Workforce
- **Ruth Law** as the new Deputy Honorary Secretary

BGS President Dr Jenny Burns thanked the demitting officers for all they had done in support of the BGS's aims during their time in office, and welcomed the new batch of trustees and other office-holders.

Charity governance rules also required us to seek membership approval for the re-appointment of the Society's auditors (currently Sayer Vincent) and to agree that the CEO should set their remuneration.

Beyond this standard set of resolutions, there is scope for additional resolutions to be brought to the membership. At the AGM in November 2022, we will be asking for member approval of a new BGS Strategic Plan for the three-year period 2023-26.

During the course of 2022 we will be consulting the membership on strategic priorities and how the Society needs to evolve to meet the challenges and opportunities to improve healthcare for older people. We also intend to modernise some of the out-of-date aspects of our founding documents, our Memorandum and Articles of Association.

The AGM is one moment in the year when the membership holds the Society to account. We encourage you to get involved in this and the many other ways you can be active in the Society - taking up an officer role, writing a blog, speaking in a conference session, submitting an abstract or championing policy action. Thank you for your engagement!

Sarah Mistry
BGS Chief Executive
@SarahMistryBGS

For more information about the Annual General Meeting please visit www.bgs.org.uk/AGM

Workforce *for* change

This is my first column as the incoming BGS Vice President Workforce with a key role in influencing what may be the most important challenge facing the NHS as a whole: ensuring it has the right workforce in place, appropriately skilled, trained and supported.

I would like to start by paying tribute to our fellow members who sadly lost their lives during the pandemic. I would also like to thank all our colleagues who, on a daily basis continue to carry on their excellent work in challenging circumstances. The BGS has a vital role in ensuring that the workforce caring for older people is supported. Recruitment, retention, training and support of the workforce are crucial if we are to deal with the current challenges and prepare for the demographic reality of an ageing society. I would like to thank my predecessor Dr Clare Copeland for all she achieved in this role, including her work on the two BGS Through the Visor reports on workforce wellbeing, which I very much hope we can build on.

In my view, at the very heart of our workforce is a multidisciplinary culture which includes doctors, nurses, therapists, social care colleagues, domiciliary care workers and all others who have a role to play in care of older people across the four nations of the UK. With the ongoing challenges we face in the NHS, whether in policy, quality, recruitment, retention, research, or other aspects of care: the theme of workforce is overarching.

As clinicians, we cannot improve care and support the workforce without working with clinical and non-clinical colleagues, including decision-makers and health and care leaders. I feel that the BGS has an important role to play in helping to develop a collaborative strategy, working alongside various national bodies, colleges and professional bodies like NHS England and Health Education England and their devolved counterparts; various Royal Colleges, social care and other influential stakeholder.

'We cannot provide the best care for older people without sufficient staff, who have the necessary skills, development opportunities and support to do their jobs.'

We have established a new BGS workforce subcommittee, following a call out to members through our e-bulletins and website, with representation from nurses, therapists, medical students, junior doctors and social care colleagues. Watch this space for more information about the group, and for opportunities to get involved.

We do want to understand the priorities of our membership and how we can help. For example, my Specialty Doctors and Associate Specialist (SAS) doctor colleagues tell me that support and guidance in career progression to a specialty grade or CCT via CESR route is important to them. There are likely to be similar aspirations for other colleagues like therapists, nurses, consultants, GPs, social care colleagues, student and trainee members and others. They may want information and support in career progression, less than full time working, portfolio careers, or pre and post retirement working. I am really keen to hear your views and wish to do what is important for you. To help us understand what matters to you and how we should prioritise our efforts, we will be developing a survey during 2022 and your views will be very welcome.

There is no doubt that our workforce has been under pressure for some time due to imbalance between demand and supply, resulting in higher workload, stress, burnout, moral distress and early retirement for some. The pandemic has increased these pressures further. The specific needs of our staff from ethnic minority backgrounds have been particularly highlighted during the pandemic. The high proportion of deaths in BAME colleagues, and also the fact that many of our members may have family overseas who they have been unable to see only compounds these struggles.

We are aware of the challenges in recruitment, retention, training and development of colleagues. The NHS and social care each have over 100,000 unfilled vacancies. These vacancies exist in consultants, GPs, nursing, district nursing, social care and across most staff groups. The Nuffield Trust, King's Fund and The Health Foundation have issued key reports and have made suggestions on how to address these

‘How a country looks after its older people is a good indicator of its culture and responsibility towards its citizens.’

shortages. Themes have included better pay and rewards, being a good employer, international recruitment, workforce redesign and others. I hope that the BGS will be able to increase its influence on this front and help develop a national strategy on workforce for all the four nations. There are other steps that local organisations and leaders could consider. These include new roles, full use of multidisciplinary work force, senior clinicians working more in advisory capacity, developmental opportunities for other experienced staff, training for non-specialists, challenging the traditional working and many other innovative ways. Solutions do exist, we will need to think differently and develop different models.

How a country looks after its older people is a good indicator of its culture and responsibility towards its citizens. We cannot provide the best care for older people without sufficient staff, who have the necessary skills, development opportunities and support to do their jobs. Colleagues may have noted that the NHS Operating Plan 2022-23 mentions workforce as a key priority, but how this will be addressed remains unclear. We appreciate that it is a complex issue and there are no easy solutions or short term fixes. At the same time, we also know that NHS staff are extremely dedicated, resilient and will want to do the best for their patients. They do need to feel that help is on its way, and that the promise of help is supported by action. This needs a collaborative and strategic approach that looks ahead and builds a sustainable solution for the long term.

As a Society, we will continue our work to address and influence workforce decisions. The BGS and I remain ready, willing and able to do this on your behalf, with your support and help.

Older people deserve no less.

Dr Amit Arora
Consultant Geriatrician and BGS Vice President, Workforce
@betterageing

Workforce: Further reading

- **Closing the gap: Key areas for action on the health and care workforce**
  The Health Foundation, The King's Fund and Nuffield Trust
  www.nuffieldtrust.org.uk/research/closing-the-gap-key-areas-for-action-on-the-health-and-care-workforce

- **The state of health care and adult social care in England 2020/21**
  Care Quality Commission
  www.cqc.org.uk/sites/default/files/20211021_stateofcare2021_print.pdf

- **The state of medical education and practice in the UK**
  General Medical Council
  www.gmc-uk.org/about/what-we-do-and-why/data-and-research/the-state-of-medical-education-and-practice-in-the-uk

- **Facing the Facts, Shaping the Future: A draft health and care workforce strategy for England to 2027**
  Health Education England
  www.hee.nhs.uk/our-work/workforce-strategy

- **The state of the adult social care sector and workforce in England 2021**
  Skills for Care and Workforce Intelligence
  www.skillsforcare.org.uk/stateof

Community *and* Primary Care Group

The majority of interactions older people have in relation to their health take place in primary and community care. The BGS Community and Primary Care Group is being formed in response to an increasingly strong emphasis on care closer to home for older people, with the aim of reducing avoidable hospital admission and the associated risk of potential harms such as deconditioning and delayed discharge.

The Community and Primary Care Group is initially being created by merging two existing and well-established BGS groups - the GeriGPs group, and the Community Geriatrics Special Interest Group (SIG). These two groups have long shared a common goal to improve the quality of care for older people beyond acute settings.

Community and primary care provision for older people covers a broad spectrum of services and care settings, from care homes to primary care networks to emerging models of community care such as Hospital at Home and Urgent Care responses.

Why have the groups been merged?

In addition to the reasons outlined above, there are some other benefits to combining the two groups to form one single group.

The groups will have a larger number of members when combined and therefore a stronger single voice, which will help to influence policy and practice across different care settings in the UK.

A multidisciplinary perspective is vital to influence how community and primary care are delivered. The GeriGPs group and Community Geriatrics SIG have not typically attracted members from across the whole multidisciplinary team, and this new group will help encourage members from the allied health professions and beyond.

Integration is becoming an increasingly important priority for the NHS, and reinforcing community care and primary care silos within the BGS does not align with these wider objectives. The BGS will benefit from having a strong body of professionals who can feed in experience from the frontline, offer examples of innovation and comment on new guidance and plans.

By combining these groups and appointing an officer to sit on the BGS Board, the Society can benefit from greater representation from community and primary care to balance the strong acute care focus of much of our Board.

The BGS consulted members on these proposals in November 2022. You can read the full rationale for this decision by reading the information that was provided during the consultation by visiting **www.bgs.org.uk/CPCGmerger.**

Who can join?

Membership of the Community and Primary Care Group is open to healthcare professionals from all professions within the membership of the BGS with an interest in community and primary care. Any GP or trainee GP who joins the BGS is automatically a member of the Community and Primary Care Group. BGS non-members can also join the group but they will not be eligble to run for any officer positions.

How can I become a member of the new group?
Anyone who is currently a member of the GeriGPs group or the Community Geriatrics SIG will be automatically transferred to become members of this new group in March 2022. We will send you an email closer to the time confirming

the change. If you are a member of either or both of these groups and do not wish to join the new group, please update your preferences as soon as possible by logging into the BGS website - you can do this at any time before or after the change.

If you are not currently a member of either of the old groups but wish to join the new one, please email j.gough@bgs.org.uk and we will add you to the new group when this becomes live.

How else can I get involved?

We will shortly be advertising positions for officers for this new group, which will include:

- Co-Chair (healthcare professional working in community care)
- Co-Chair (GP, ideally working in primary care)
- Committee Secretary
- Research lead
- Ageing Well/Anticipatory Care lead
- Ageing Well/Urgent Community Response lead
- Care homes/Enhanced Health in Care Homes sub-group lead
- GP sub-group lead
- Nurse/AHP representative
- Scotland representative
- Northern Ireland representative
- Wales representative
- England regions representative
- Communications lead.

Details of these roles and current vacancies are being added to the CPCG page at **www.bgs.org.uk/CPCGinfo** as they become available. If the role you are interested in is not currently advertised, please email **j.gough@bgs.org.uk** with an expression of interest.

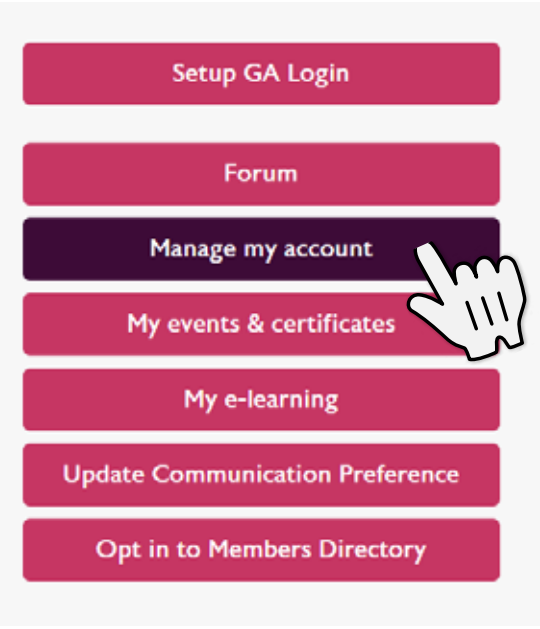
Join a BGS *Special Interest Group*

The BGS currently has 16 active Special Interest Groups (SIGs).

These include Peri-operarative care of Older People undergoing Surgey (POPS), Falls and Bone Health, End of Life Care, Dementia and Related Disorders, and many more besides.

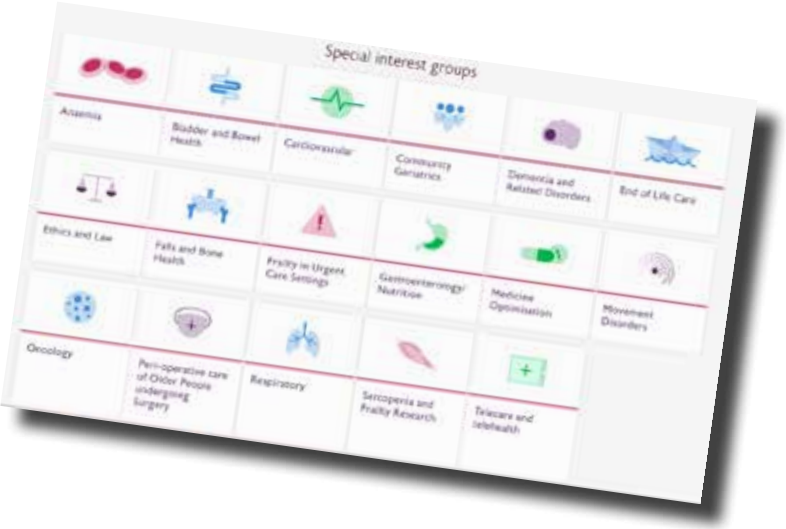
You can join a SIG via the BGS website in a few simple steps!

To join a SIG, log into your account at **www.bgs.org.uk** and navigate to '**My Acccount**' in the top right hand corner. Select '**Manage my Account**' and then find the '**Update personal details and SIG membership**' tab in the top row.



From here you can view all available SIGs and add or remove them from your account using the tick boxes. Click 'save' to confirm.

For more information or queries about getting involves with our SIGs, please contact Joanna Gough at j.gough@bgs.org.uk.



Ageing *without* children

One in 12 older adults have never been parents, a number which is set to double over the next decade. With more than 90% of unpaid care delivered by family members, Jenny Collieson from the charity Ageing Without Children (AWOT) explains how this might shape how health and social care should be delivered as this generation grows older.

"Not everyone has a network of friends and organisations, not everyone is proactive and able to seek help. Lots of people are falling through the net."
– York AWOC Group member, June 2020

COVID-19 has highlighted health and care inequalities in the UK and elsewhere, and demonstrated the real limitations of care systems that are predicated on the assumption of family care for older people.

This reinforces the importance of recognising the diversity of our ageing populations, of raising awareness of how later life may be experienced very differently by those without children or grandchildren, and of campaigning to ensure that these needs are acknowledged and met.

In 2020 I wrote a report summarising the views and experiences of members of the York Ageing Without Children (AWOC) group during the early stages of the pandemic.[1] This local group, set up in 2016, provides peer support, advice and social contact to 50+ people who identify as AWOC - this means they either do not have

'The informal care provided by many adult children to their parents as they age provides not only practical and emotional support, but also contributes a strong preventative element in terms of continued independence, wellbeing and quality of life.'

children, or their children have died, are estranged, live far away or are unable to support them.

Alongside significant practical challenges, the pandemic also heightened longstanding fears and anxieties that many people ageing without children have - feeling invisible and socially marginalised, losing independence, not being able to access appropriate or timely care support, becoming ill or dying alone, or having to move unwillingly into residential care.

For members of the York group and others surveyed in 2021,[2] daily life under lockdown made them more aware of the potential fragility of their personal support networks and their invisibility in the media coverage of the pandemic. The dominant narrative focused on family separation, which did not address the realities of life for many older people ageing without family support, living alone, unwell, possibly shielding or caring for a spouse/ partner with a disability or long-term condition. Their stories did not feature.

Despite evidence of more mutual aid and positive community spirit (at least initially), our respondents recognised that the support of neighbours and community was unlikely to be sustainable nor was available to everyone. The alternative networks of friends or 'families of choice' which many people ageing without children develop over their lifetime often become more difficult to maintain as people age, retire, move home or develop poor health.

Why AWOC deserves more attention

Ageing without children was raised as an issue of growing concern by Kirsty Woodard in an article in *The Guardian* in 2014.[3] After working on ageing issues for over 20 years, Woodard had become increasingly aware of how the assumption of family support was hard-baked into health and care practice, while demographic changes showed many older people had no children.

'The prospect of developing dementia or other cognitive impairment with no close family to tell your story or advocate on your behalf is particularly difficult.'

There are a multitude of reasons why people age without children and also many myths and assumptions made about being childless or childfree which can lead to prejudice, stigma and social exclusion. In the UK the continuing crisis in the funding and delivery of social care means high numbers of people experiencing unmet care needs, which significantly impact on daily life and have become more acute since the pandemic. Well-documented recruitment problems in the care sector have also worsened making it harder to find good quality care home places or homecare support even if you are a self-funder.

The experiences of people who are AWOC intersect with those of other minority populations, particularly LGBT older people (who are much more likely to live alone and without children or a partner), and older people with lifelong disabilities who have not had children. AWOC individuals are disproportionately represented in other groups too for example, those on low incomes, in poor health, and lacking support networks.

Specific concerns

The reality of growing older with increasing health and care needs but no family support means that people who are AWOC may be more anxious, depressed and socially isolated; more vulnerable to poor treatment or even abuse; can experience higher rates of self-neglect and poor nutrition; are more likely to visit their GP frequently and call A&E services, and have to move prematurely into residential care. There is also a link with life expectancy with studies suggesting that people with children

Ageing without children: The facts

Of the 12 million people aged 65+ in the UK **over a million** have never been parents

92% of informal, unpaid care is provided by family

20% of people over 85 **rely solely on their adult children** and do not receive informal care from anyone else

By 2030, 1 in 5 of the UK population will be over 65 and **2 million** of these will be ageing without children

Older people without children are **25% more likely** to go into residential care

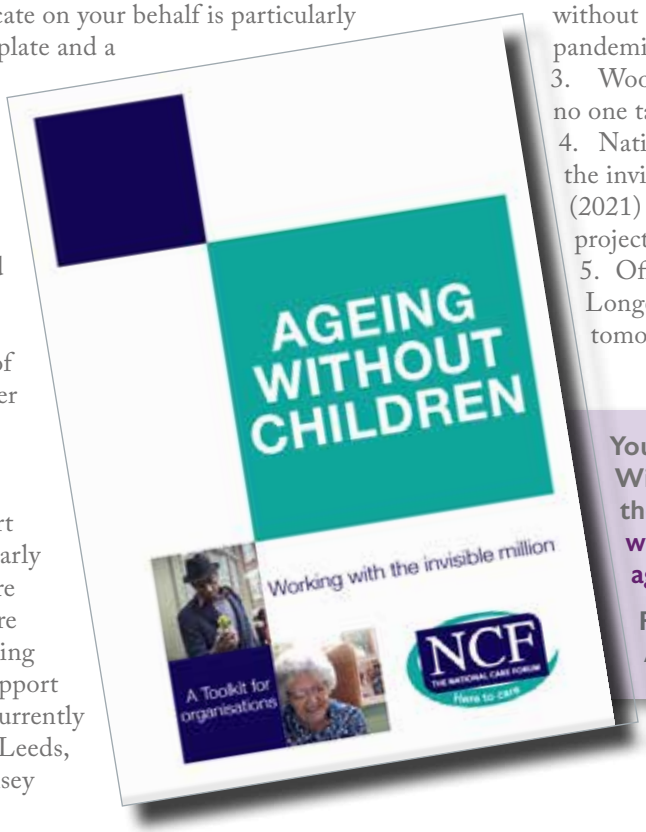
(including adoptive parents) live longer than those without. It is clear that the informal care provided by many adult children to their parents as they age provides not only practical and emotional support but also contributes a strong preventative element in terms of continued independence, wellbeing and quality of life.

Many who identify as AWOC have been carers for their own ageing parents or have arranged care on their behalf. Often their experience of navigating the system has acted as a trigger for thinking about their own future ageing and what needs to be put in place. This includes low level support such as help at home, getting online, arranging and getting to appointments, preparing for hospital admission, being supported when discharged back home, financial and later life planning, researching, sourcing and paying for care, welfare checks and making complaints if necessary.

Even the apparently simple request to name a 'Next of Kin' can present a challenge particularly for those who are AWOC and single. The prospect of developing dementia or other cognitive impairment with no close family to tell your story or advocate on your behalf is particularly difficult to contemplate and a major concern.

What AWOC is doing

As a small and currently unfunded charity we are campaigning and raising awareness of the growing number of older people without children and highlighting where more support is required particularly in health, social care and housing. We are facilitating the setting up of more peer support groups like those currently operating in York, Leeds, Bradford, East Linsey and Gloucester which bring people together to share experiences, information and positive action. Last year together with the National Care Forum, AWOC published a toolkit for organisations providing older people's services to support them in becoming 'AWOC confident' by explaining the impact ageing without children can have and making recommendations to mitigate this.[4] We firmly believe that improving systems and services so that they work for people ageing without children will benefit the lives of all older people.



You can view and download the Ageing Without Children toolkit, developed with the National Care Forum, at www.nationalcareforum.org.uk/projects/ageing-without-children-awoc.

For more information and resources on AWOC, visit www.awwoc.org

Jenny Collieson
Information professional, AWOC Board member and member of AWOC York group
@tottenhamtopcat

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BGS Retired Member's Group

Are you retiring from active practice, or have you retired? There is no need to end your relationship with the British Geriatrics Society. There are favourable membership rates for retired members and annual activities and regular meetings for retired BGS members.

The main purpose of the Retired Members Group is to ensure that retired members can stay in touch with and contribute to the work of the Society, to provide a number of volunteering opportunities for retired members and support social networking on both a regional and national basis.

For more information or to get involved, please contact Mark Stewart at **M.Stewart@bgs.org.uk** or by phone on 020 7608 8575.

A new generation of older people living with Down's Syndrome

The Down's Syndrome Association is in the process of marking its 50th anniversary, which has been an opportunity to reflect on the experiences of individuals who have Down's syndrome born 50 years ago or more. The charity's Services Development Manager, Julian Hallett, explains some of the specific challenges and changes experienced by older people living with Down's syndrome.

As part of our 50th anniversary, the Down's Syndrome Association have produced a special Oral Histories[1] project celebrating the lives of people over 50, offering them and their families the chance to tell their stories in their own words. The contrast between the rich and full lives of these older adults, set against the expectations expressed by an array of professionals involved with their families when they were first born, is marked.

It is this generation of people who have Down's syndrome who became trailblazers for others who followed. They were the first generation to attend mainstream schools, the first to achieve greater levels of independence by moving into homes of their own, take on employment, and embark on relationships of their choosing.

'For someone who had Down's syndrome born in the 1970s, their life expectancy was perhaps 30. By 2013, this had increased to 58 years.'

They have defied the limitations that society seemed to place upon them, and nowhere is this more stark than if we look at life expectancy. For someone who has Down's syndrome born in the 1970s, typical life expectancy was perhaps 30. By 2013, this had increased to 58 years.[2]

Greater understanding of the health needs of people who have Down's syndrome, especially advances in paediatric cardiology, have meant there is so much more we can do now to ensure people who have Down's syndrome live healthy lives.

The fact that institutional care, so prevalent in the period up to the 1970s, has largely been consigned to history, means children and adults who have Down's syndrome have benefited from all of the opportunities that inclusion within their local community can bring.

While we will naturally want to celebrate these welcome improvements, we must not become complacent. A quick read of any recent LeDeR programme (learning from lives and death of people with a learning disability and autistic people) annual report[3] will tell us that individuals who have a learning disability are still likely to die between 20 and 25 years younger than the general population, and some of these deaths are avoidable.

The recent experience of COVID-19 has highlighted many of the clinical vulnerabilities of adults who have Down's syndrome, with data from the first wave of the pandemic showing that adults who have Down's syndrome were nearly 12 times more likely to die from COVID-19, before the protection of vaccination and availability of new antiviral medication.[4]

Adults who have Down's syndrome are now likely to outlive their parents – a shift in the dynamics from when the Down's Syndrome Association was first established. As welcome as this improvement in life expectancy is, this poses a challenge for services that provide support to adults who have a learning disability. The changes that have taken place to accommodate young people who have a learning disability within mainstream education settings have yet to take place in some adult settings. Services are now catering for a population who are ageing. It is commonplace for supported living settings to have residents who have Down's syndrome aged in their 60s and 70s, and the needs of these older individuals differ from a younger population.

It is widely understood that adults who have Down's syndrome are more likely to develop dementia and at a younger age than the general population. A study by Strydom in 2007 established that the majority of individuals with Down's syndrome who are diagnosed with dementia presented in their 50s, with a mean age at diagnosis of approximately 55.[5] Survival varied considerably, but did not appear to be much shorter than the general population, with a mean survival time of four years following diagnosis.

Good practice guidance about dementia baseline assessments have existed for more than 20 years. For example Turk *et al.*, in 2001, recommended that every service for people with intellectual disabilities should set up a register of adults with Down's syndrome and conduct a baseline assessment of cognitive and adaptive functioning by the age of 30 years.[6] However, the availability of assessment and treatment across the UK remains variable, with a growing number of services offering baselines and prospective screening to adults who have Down's syndrome.

Having trained professionals in many settings, it is my experience that two things come into play: missing a timely diagnosis of dementia (diagnostic overshadowing) or, conversely, over-eagerness to assume a change is due to dementia. Sometimes, a general awareness that adults who have Down's syndrome are more likely to develop dementia leads to an assumption that any change in cognition or behaviour is dementia, when there could be a number of other causes.

There is a need to carry out a differential diagnosis, which looks at other possible causes of a change. An acceleration in an existing sensory impairment, an untreated thyroid condition, a psychological response which develops following a life stress, or an understandable grief response to a bereavement, are just a few examples. All of these causes might warrant some form of intervention, but would involve a differentiated approach from someone who was developing dementia. It is important to note that these issues may exist alongside an individual developing dementia and remain an important area of consideration after a diagnosis of dementia has been made, too.

Ageing for people who have Down's syndrome is the subject of a great deal of research interest and the UK leads the way. Teams working in Cambridge under the banner of Defeat Dementia in Down's syndrome[7] and the team led by Professor Andre Strydom at University College London[8] mean that we understand far more now about this process and ways to improve support for individuals and their families.

The Down's Syndrome Association works with partners across all relevant fields and aims to collaborate with research, develop information resources, provide support and training on all aspects of living with Down's syndrome. We have a confidential helpline, facilitate webinars and run a closed Facebook group for anyone with an interest in Down's syndrome and dementia.

For more information visit the Down's Syndrome Association website at www. downs-syndrome.org.uk

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Julian Hallett
Services Development Manager, Down's Syndrome Association

Disease, illness or what?
Where should geriatricians focus their attention?

To mark its 50th anniversary in 2022, *Age and Ageing* has commissioned a series of commentaries from leading international thinkers, exploring major issues in geriatric medicine. The journal's Editor-in-Chief, Professor Rowan Harwood, introduces the first of these fascinating pieces which examines our perceptions of illness.

In the first special anniversary commentary, Marcel Olde Rikkert from Nijmegen and three Canadian colleagues discuss how geriatricians can think better about ill-health. Clinical reasoning prioritises seeking out disease, but the disease concept is less helpful in chronic or progressive conditions, poorly-explained syndromes such delirium, or multi-morbidity. Disease-focus suggests seeking a cure, which is often not possible. Instead, older patients prioritise improved function and wellbeing as treatment goals. Olde Rikkert and colleagues propose methods used to analyse complex systems and computer modelling to create individualised 'dynamic symptom networks' leading to different, more appropriate and less burdensome treatment. Maybe think of it like a constantly-updated, quantified and interacting problem list.

Diagnosis is at the heart of medical teaching. Diagnoses provide explanations for problems, suggest possible treatments and indicate prognosis. But the medical model alone is inadequate when managing ill older people. Multi-morbidity complicates matters and diagnosis alone tells us little about the consequences of ill-health. As an alternative, comprehensive geriatric assessment extends the medical model by considering function, mental health and human relationships. Person-centred dementia care and palliative care emphasise the experience of illness, the psycho-social and individualised decision-making.

Others have attempted to define alternatives to diagnosis. In 1980, the WHO published its International Classifications of Impairments, Disabilities and Handicap. Impairments are abnormalities of body structure or function, basically symptoms and signs like pain, weakness or forgetfulness.

Disabilities are inabilities to perform tasks, such as walking or maintaining continence. Handicaps are restrictions in function in a physical environment and social context, leading to dependency or lack of occupation. These were useful ideas, especially in rehabilitation, but some argued that they made ill-health a 'personal tragedy' while neglecting the role of social context in enabling participation. The 2001 update, the International Classification of Functioning, Disability and Health resolved some of these issues but arguably lost conceptual clarity and clinical usefulness in the process.

Tinetti defined the 'geriatric syndromes' of falls, incontinence, delirium, functional decline and pressure sores, which tend to group together and have common predisposing factors. Fried and Rockwood operationalised measurement of frailty, the vulnerability to decline and adverse outcomes. Frailty has a close relationship to multimorbidity and disability, but captures more than these alone, emphasising the propensity to crises. Crises may be preventable and are potentially resolvable with careful multi-professional assessment and management.

All these ideas inform our approach to clinical intervention. We deal in each of prevention, cure, rehabilitation and palliation. Navigating them requires especial attention to treatment-burden, relationships with patients and families, preferences, overt shared decision-making and end-of-life planning. Strong forces within healthcare try to oversimplify ill-health in older people and our response to it. Geriatricians must advocate when more is needed. Olde Rikkert and colleagues may be showing us a glimpse of the future. Their commentary is well worth reading.

Professor Rowan H Harwood
University of Nottingham, Editor-in-Chief *Age and Ageing*
@RowanHarwood

The *Age and Ageing* 50th Anniversary commentaries are being published online throughout the anniversary year. Access them all for free at www.bgs.org.uk/AAA50

50th Anniversary of Age and Ageing

As *Age and Ageing* journal reaches its milestone 50th anniversary, BGS Digital Media Editor Charlotte Squires takes a look back at the first ever issue, published in February 1972, and reflects on what has - or hasn't - changed in geriatric medicine over the last half a century.

What was happening in the world 50 years ago, back in February 1972? In America, NASA had just launched its space shuttle programme. In Sapporo, Japan, the Winter Olympics would have been starting. In the UK, Edward Heath was in Number 10, and had recently declared a national emergency following the miners' strikes. On the radio, Don Maclean was singing American Pie, and in the Toby Jug pub in Tolworth, David Bowie, as Ziggy Stardust, had just opened his new tour. I suspect many of these things might have been on the radar of the readers of the very first edition of *Age and Ageing*, published in February 1972.

Reading back over the first issue of Age and Ageing has been insightful. Many of the themes covered still commonly feature today, with articles on bone health, urinary tract infections, and iron deficiency; the geriatric giants, it seems, have continued to age well. Other included topics, such as salivary gland infections, seem to be less common now though this might relate to changes in prescribing practices as atropine, for example, had been highlighted as a common precipitating factor.

Over the last fifty years, a key development has been improved therapeutics and in some areas, this has caused a sea change in management. Peptic ulcer disease, which features in this paper considering men with this condition residing in York, was mainly managed surgically in the early 1970s when intervention was thought to be necessary. Cimitidine did not enter use until the late 1970s, and it was not until 1988 that omeprazole was commercially available. The seminal work on H Pylori, which won Marshall and Warren the Nobel Prize in 2005, was still a decade away when this issue was published. These days proton pump inhibitors are one of the most widely prescribed medications in use and surgical management for stable peptic ulcer disease has become effectively obsolete.

Similarly, the article on osteoporosis was written before the advent of bisphosphonates and other forms of bone protection. Much of the decision making within bone health now relates to weighing up the relative benefits of established therapeutics for patients with metabolic bone disease, which as ever in geriatric medicine requires knowledge of where research has included, but also excluded, frail patient cohorts. Fifty years ago, the focus of this paper was around how to identify and classify bone disease, rather than how to treat it as the drugs were not yet developed. We still however have a number of geriatric syndromes without effective therapeutics, delirium being a prime example. I hope it does not take another fifty years to make similar progress within these fields.

I greatly enjoyed an article entitled Locating the elderly at home which found that although health

records often contained inaccurate addresses for people over 65, in cases where documented addresses matched the electoral register, this inaccuracy was much reduced. I wondered whether the electoral register might still hold similar impact and was interested to read via the ONS that the over 65 age group have continued to be a reliable cohort of voters, with a higher proportion voting compared to younger counterparts. This is a phenomenon known as the 'grey vote' and is sometimes viewed negatively, particularly by the parties that are less favoured by older age groups in polls. In spite of this, records suggest that a lower proportion of older adults vote today, compared with the early 1970s. There might be multiple reasons for this, including for example, the increasing prevalence of dementia, or perhaps difficulty in accessing opportunities to vote. In any case, I think we can assume that our computerised records probably mean we can get away without relying on the electoral register as a second check.

Several articles concerned topics that remain a stalwart consideration in modern geriatric medical practice. A study aiming to assess the prevalence of thyroid disorder in older inpatients commented that in this population, there may be a lack of the hard clinical signs and symptoms present in younger patients, an observation that remains well established. Similarly, I enjoyed the article on the complexities of translating research around urinary tract infection diagnosis in younger women to the older cohort. I found that many of the included hypotheses remain true today and it made for an informative read. How many of us, after all, have found ourselves bemoaning that yet another older person has been diagnosed with a UTI in the absence of any clear supporting evidence?

Lastly, from its very first edition, Age and Ageing showed both an international and multidisciplinary focus. A pamphlet written by Canadian OT Mary Judd entitled Why bother, he's old and confused, was featured as one of several book reviews. This pamphlet aimed to inspire both clinicians, and crucially, members of the wider MDT, to consider older adults more holistically, and featured a variety of practical tips and tricks regarding assessment and rehabilitation. Reading this review was simultaneously a call to arms, and perhaps a cause for despair.

It seems we are still engaged in the same advocacy battles as we were fifty years ago; we are still bothered, and we are still trying to get everyone else to bother, too.

Charlotte Squires
BGS Digital Media Editor and Medical Registrar, Scotland
@CharSquires

Age and Ageing: Your fully online journal

***Age and Ageing* journal has come a long way from its teal-hued incarnation from the 1970s (left).**

Not only has it recorded its highest-ever impact factor - 10.668 - in the past year, placing it 3rd in the 'Si: Geriatrics and Gerontology' category of academic journals, it has also successfully transistioned to a monthly digital journal, fully accessible to BGS members. This means that every single issue, past, present and future, is archived and indexed and available to read online via the journal's publisher, Oxford University Press (OUP).

How do I access the digital journal?

There are several ways you can now access the journal.

- **Open Access articles**
  From the OUP *Age and Ageing* homepage, everyone is able to read a number of 'open access' articles. These are marked as 'Free' on the journal's page of contents. Simply visit **https://academic.oup.com/ageing** and click on the '**Lastest Issue**' icon for the most recent digital edition, or browse past issues and content.

- **Institutional access**
  Your university, Trust or other institution may be an *Age and Ageing* subscriber. This means that you will have access to all the content that forms part of their subscription. You will need to log in through Shibboleth or OpenAthens. For more information, speak to your library or learning resources department.

- **BGS Member access**
  You can also access the journal as part of your BGS membership, if your category of membership includes this. To access *Age and Ageing* through BGS, log in with your membership details at **www.bgs.org.uk**. Once logged in, you will be taken to your main account page. Scroll down this page and on the right hand side you will see an image of the journal with a pink button saying 'View journal'. Clicking this will take you to the OUP website and allow you to read the articles. Alternatively, you can log in via the OUP website (**https://academic.oup.com/ageing**) by scrolling to the bottom of a restricted article to where it says 'British Geriatrics Society members - sign in through society site.'

British Geriatrics Society
Improving healthcare for older people

Join us

Group membership

We are keen to strengthen our multidisciplinary ethos and to enable nurses and AHPs to take advantage of lower membership fees if they join as part of a group. Group membership is available to teams and organisational units, providing a cost-effective way to sample the majority of benefits available to individual members.

The key benefits are:

- Discounts on registration fees with accreditation for CPD at most of our events
- Access to e-learning modules or content-only courses (discounts available for CPD accreditation)
- Digital access to the BGS journal, *Age and Ageing*
- Networking opportunities with other specialists and experts in the care of older people by opting into the Members directory and accessing the Forum
- Opportunities to present and showcase research and quality improvement projects at our events
- A regular BGS Newsletter, e-bulletins and blogs
- Automatic membership of the Nurses and AHPs Council, and to the networking, peer support and informal mentoring opportunities it provides to assist nurses/AHPs in their professional development

Benefits **not** included in group membership:

- Voting rights
- Standing for officer roles (however you can volunteer and act on committees)
- Access to grants

Group membership package	Number of members in the group	Annual membership fee	Annual cost for individual membership for package size	Saving for the organisation
Package 1	<10 members	£500	£850	£350 compared to 10 individual members
Package 2	11-20 members	£1,000	£1,700	£700 compared to 20 individual members
Package 3	21-30 members	£1,500	£2,550	£1,050 compared to 10 individual members

How to join?

If you are interested in finding out about a Group membership for your team or workplace, or have any questions please contact: **membership@bgs.org.uk**

"Does delirium cause dementia?"

Dhole-Eddlestone Prize 2022

This year's winner of the Dhole-Eddleston prize, awarded for the best paper published in in *Age and Ageing* in the previous year, looks at the impact of delirium on cognitive decline. Here, the journal's Editor-in-Chief, Professor Rowan Harwood, introduces the three outstanding papers from this years' shortlist.

It is always a pleasure to read through the highlights of *Age and Ageing* and a disappointment that we only have one Dhole-Eddleston prize to award.

This years' winner was the paper from Sarah Richardson and colleagues on the impact of delirium on chronic cognitive decline. We are all aware of the clinical overlap between delirium and dementia, and the times when clinically convincing delirium does not appear to recover. Does delirium cause dementia?

There are many possible alternative explanations. Previously undiagnosed or 'subclinical' dementia can become manifest as a result of the challenges of acute illness and relocation to hospital. A 'step' in the stepwise decline of vascular dementia can also mimic delirium.

Richardson *et al* tracked hospital admissions among patients who had previously been part of the Newcastle Cognitive Function and Ageing Study. They had the advantage of having had a thorough cognitive assessment just a few years before, and so were known to be 'cognitively normal'. They were assessed daily for delirium when in hospital, including re-admissions, and followed up a year later. Episodes of delirium, especially multiple or prolonged episodes, reduced cognition by a mean 2.2 MMSE points, and increased the chances of a dementia diagnosis nine-fold, independent of illness severity, frailty or co-morbidity. Delirium damages the brain, providing further incentive to try to prevent it. In a second paper, the same team established that hospitalisation without delirium is not associated with later cognitive decline.

'Delirium damages the brain, providing further incentive to try to prevent it.'

The judges were also very impressed by a paper by Gahee Oh and colleagues from Korea. The potential to prevent or reverse frailty is an important question. This study was a cohort, rather than a randomised controlled trial, in which vulnerable older rural dwellers were assessed and opted to undertake a health improvement intervention (n=187) or not (n=196).

The intervention was intensive, lasting 24 weeks, and comprised group exercise, dietary protein supplements, comprehensive depression management, medication review and deprescribing, and assessment for home hazards. Adherence was remarkably good. Blinded follow-up was undertaken after 6, 18 and 30 months using a battery of measures. Propensity matching was used to balance characteristics between the groups who did and did not do the intervention. There was a substantial benefit for the intervention on Short Physical Performance Battery scores, which persisted at 30 months. The proportion who were frail on the Fried Frailty Phenotype reduced over the 6 months intervention period, but the advantage waned after that.

Institutionalisation-free survival was 87% vs 65% after 30 months, a hazard ratio for institutionalisation or death of 0.31. Depression, polypharmacy and falls were not improved. Health status can be improved among people living with frailty, but it is hard work, and must be sustained over a long period. Investing to prevent frailty may be a better option.

Age and Ageing, now published in on-line format, is the leading international clinical geriatric medical journal. The past two years has seen a huge increase in the numbers of papers submitted, the numbers accepted, and the quality of papers judged by the Impact Factor, now 10.7. We publish practically-orientated commentaries, reviews and original research. *Age and Ageing* is an important part of the British Geriatrics Society's contribution to promoting scholarship on the care of older people.

We highly recommend reading the three papers highlighted by the Dhole-Eddlestone prize.

Professor Rowan H Harwood
University of Nottingham, Editor-in-Chief *Age and Ageing*
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Leaders *of the* future

The Royal College of Physicians Chief Registrar Programme is flagship leadership programme for higher specialty trainees, designed to develop the clinical leaders of the future. The programme enables protected time to develop and implement local initiatives in service improvement, staff engagement and morale, education and training, and workforce and sustainability.

Geriatric Medicine is well-represented on the programme and in 2020/21 had the highest number of trainees appointed of any specialty. This offers an important opportunity to promote geriatricians as leaders and managers of the future, as well as reflecting the contribution of geriatric medicine at the forefront of quality improvement and change management within the NHS, including as leaders during the COVID pandemic.

As they come to the end their term, members of this group of Chief Registrars reflect on their achievements and what they have gained from the experience.

Shalini Rajcoomar, Great Western NHS Foundation Trust

Shalini's projects looked to improve the management and flow of medical outliers, increase the response times to observation alerts and provide an office space for the team working on the COVID ward.

"This year has brought unexpected challenges but has been thoroughly enjoyable. The RCP programme has given me an invaluable insight into the challenges of an NHS leader and about my own personality, communication, resilience and leadership styles. I hope to build upon what I have learnt and utilise it to improve the care and service provided to geriatric patients in my future career."

Joe Hetherington, Croydon Health Services

Joe's main project has involved redesigning Hospital@Night processes to promote inter-disciplinary working and ensure patient safety out of hours.

"This year has been challenging, but rewarding. Through the RCP modules I have learnt about QI, leadership and management as well as my own personality and leadership style. Being able to put this into action through different projects has allowed me to develop these skills, which will stay with me as I progress through my career."

Jess Palmer, Royal Berkshire Hospital NHS Foundation Trust

Jess has focused on the Rapid Access Clinic for Older Patients service. She has worked on improving access to the clinic by creating information for local GPs and encouraging direct referrals from practitioners within the local ambulance trust. Funding has been secured to provide dedicated nursing and OT support to the clinic to allow a full CGA to take place for the patients seen there.

"I have loved the opportunity this year to work on making real change in a trust and speciality I am passionate about. The insight and knowledge provided by both real world experience and the excellent RCP programme has really helped me develop as a leader. As I look forward to my future in Geriatric Medicine I hope I can use these skills to develop excellent, patient centred services for Older People."

Sarah Packer, Worcestershire Acute Hospitals NHS Trust

Sarah has been improving GIM training via regular case based teaching and debriefing sessions, and working with Urgent Care and IT to develop systems to reduce the workload of medical registrars. Sarah also managed the redeployment of 25 junior doctors into medicine during the second Covid surge, and has been part of the Sepsis 6 working group.

"This role has been a fantastic opportunity. I have learned so much about leadership, the NHS and myself. I have developed a greater understanding of the roles of those who work alongside us but outside the clinical environment, and been a voice for medical trainees with management and high level leaders. I would definitely recommend a Chief Registrar year to Geriatric Medicine trainees."

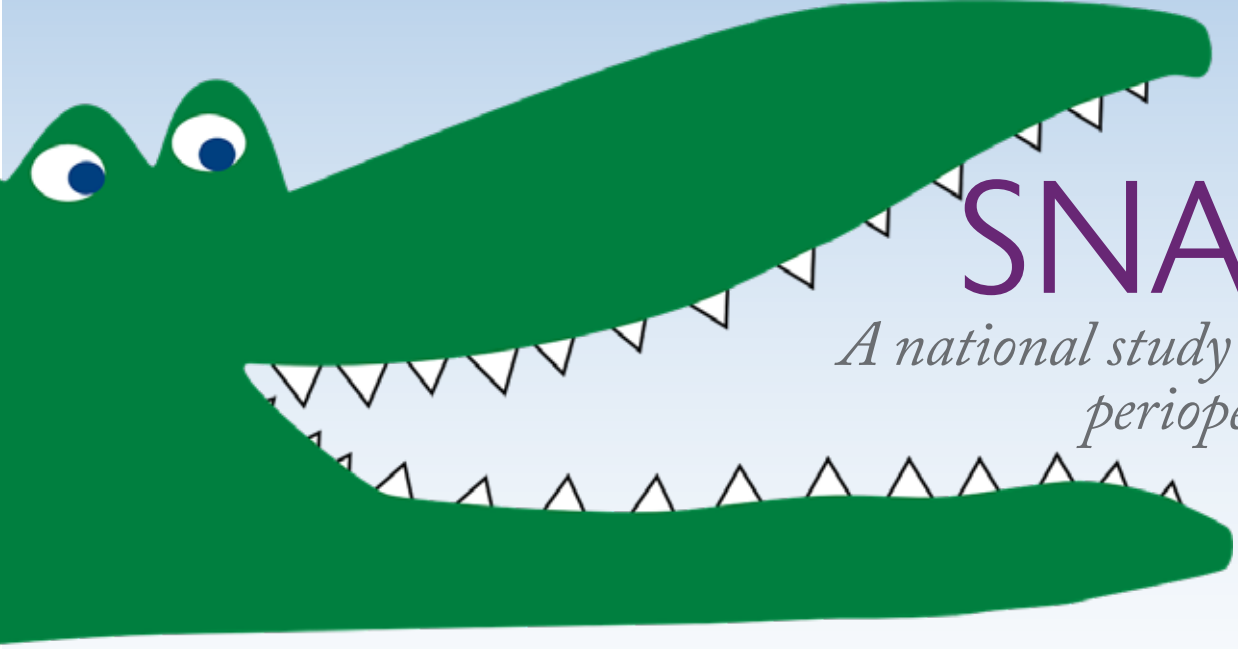
Bethan Davies, University Hospitals Sussex

Bethan has been working on developing sustainable healthcare as part of her trust's response to the Greener NHS programme, including setting up a green clinical workstream responsible for reducing the environmental impact of clinical care.

"This has been an incredibly rewarding year; I have been given the freedom to work on projects that I am passionate about and have learnt about how a large organisation works from collaborating with a wide range of colleagues across different departments. I have used the educational opportunities of the role to raise awareness of the vulnerability of older people to the health impacts of climate change."

To find out more about the RCP Chief Registrar programme, visit their website at: www.rcplondon.ac.uk/projects/chief-registrar-programme.

Bethan Davies
Chief Registrar, Brighton and Sussex University Hospitals NHS Trust



Make it SNAPPY

A national study to improve perioperative care

SNAP 3 is a collaborative, national project, investigating the care of older surgical patients. It is led by Dr Judith Partridge (Perioperative medicine for of Older People undergoing Surgery, Guys and St Thomas Hospital) and Professor Iain Moppett (Anaesthesia and Perioperative Medicine, Nottingham). The study will launch in Spring 2022 in over 190 sites in England, Northern Ireland, Scotland and Wales, and they are looking for local collaborators from the BGS.

The study aims to describe the impact of frailty, multimorbidity, delirium, and their management, on outcomes following surgery in older people. By furthering our understanding of the growing older surgical population, we hope to refine services to better meet their needs. nThis work builds on previous SNAP studies which have been influential in the development of perioperative services.

What does SNAP 3 involve?

There are three parts to SNAP 3:

1. Observational cohort study of surgical patients 60 years and older.
2. Organisational survey of perioperative medicine services.
3. Medical registrar survey of acute referrals from surgical patients 60 years and older.

How are we doing so far?

The organisational survey is up and running! We have had lots of interesting responses so far which show that perioperative care varies hugely across the UK. The other two parts of SNAP 3 will launch in March 2022.

What about the other studies?

The main study is a short, clinical, observational research study which will run from 21 March, recruiting participants over five days. The study aims to recruit 11,000 participants from across the UK. We will describe the prevalence of frailty, multimorbidity and delirium and examine associations with the outcomes of these patients. The medical registrar survey involves a 24 hour snapshot of the workload imposed by surgical referrals for on-call medical registrars.

Who collects the data for SNAP 3?

The day to day running of SNAP 3, as with previous SNAP audits, involves anaesthetic trainees collecting data. In SNAP 3 we are really keen involve geriatric medicine trainees as well, working together with anaesthetic trainees. In particular we hope that geriatric medicine trainees will be involved with the appraisal of delirium in SNAP 3. The study will involve following up participants on postoperative days 3 and 7 (if they remain inpatients) to look for delirium and postoperative morbidity. We will also be detecting delirium through a retrospective notes review modelled on the Diagnostic and Statistical Manual of Mental Disorders (DSM) 5. Your experience with delirium and using the medical and nursing notes will be of particular value in this part of the study.

How do I get involved?

If this sounds like a project that you would be interested in getting involved in then please contact us. SNAP 3 will recognise all Local Investigators with collaborative authorship and will provide local pseudonymised data for local quality improvement projects. We believe that this study offers an opportunity to advance individual's research skills and forge new cross speciality links.

We welcome emails of interest from any doctors who would like to be involved. If you would like to find out more then please visit the SNAP 3 website at: **www.niaa-hsrc.org.uk/SNAP-3-Frailty-and-Delirium-Hospital-List**

Jude Partridge
Consultant Geriatrician, POPS, Guy's and St Thomas' NHS Foundation Trust, and Chair, BGS POPS Special Interest Group (SIG)

Shaping the *future direction* of your BGS

This year marks the start of a 10-month process to develop the next BGS Strategic Plan. This will guide the work of the BGS over the period April 2023 to March 2026. We want BGS members and anyone with an interest in older people's healthcare to feed into the development of the new Strategic Plan. This will ensure it is rooted in the reality of the health and social care context across the UK and is informed by what you think is the most important role for the BGS to play in improving care for older people.

So we invite your input. Tell us your priorities for better healthcare for older people. Tell us what you like about BGS services and support, what we should do more of, and what you think we should do less of. Tell us how you think we can be more influential, using our expert voice to inform programmes, services, clinical quality and research agendas.

Tell us what you get from your membership and how you like to engage with our educational meetings. Feel free to offer your radical and ambitious thoughts about our role in shaping care for older people that is genuinely person-centred, at the right time and in the right place.

Tell us how you'd like the BGS to fight the battles of workforce shortages across all professions, a post-COVID backlog and competition for resources.

You can contribute in several ways. We will be sending out a survey to members and non-members, which we'll launch on the first day of our Spring Meeting on 6 April and which will close at the end of May. You can join me at 9.30 on Day 2 of the meeting (7 April) for an online discussion about the 2023-26 strategic priorities. You can email us, phone us or tweet to give your thoughts. And you can use the BGS's Forum and networks, and its Committee, Council and SIG meetings over the coming months to discuss priorities.

We'll be analysing the results of the survey in June and gathering the many inputs together, including interviews with key stakeholders. All of this will feed into a workshop for the BGS Board at the end of July, after which we will begin drafting the Plan. Board members will revise and refine this, so that a final draft can be signed off at the Board meeting on 28 October. We will then publish the draft Plan for you to digest, before asking you to approve it at the online BGS AGM on 11 November.

Please don't hold back from sharing your thoughts on how the Society can have more impact. We have a fantastic opportunity to harness the skills, knowledge and strength of our 4,500 members to transform how older people experience care. Help us to chart our strategic direction for the next three years, and to achieve our ambitions.

Sarah Mistry
BGS Chief Executive
@SarahMistryBGS

Becoming a Greener Society

The BGS recognises that the climate change emergency is a threat to human health and that older people are particularly vulnerable to its impacts. Ensuring that the BGS is a robust, dynamic and sustainable organisation was a key strategic objective in our 2020-23 Strategic Plan, and we recognise that being sustainable includes considering the environmental impacts of our activities.

To demonstrate our ongoing commitment to reducing our carbon footprint we have:

- Moved our journal, *Age and Ageing,* fully online, ceasing print production.
- Ensured that *Agenda* is printed on sustainable paper, using compostable wrapping.
- Adopted sustainable practices at BGS meetings, embracing Reduce, Reuse, Recover and Recycle.

We are committed to:

- Continuing with the use of digital platforms as a core part of our conference and meetings delivery and reducing material used at conferences through paperless agendas and the use of digital apps.
- Encouraging overseas conference speakers to present remotely and overseas delegates to attend remotely.
- Providing reusable bottles and cups at conferences, having 50% of catering as vegetarian and not using disposable tableware.
- Continuing to support, where appropriate, flexible and home working among office staff and the reduction of work-related travel.
- Ensuring that the day-to-day management of our office space incorporates initiatives such as using rechargeable batteries, promoting waste recycling and supporting the move to paperless working.
- Ensuring that our committee members have access to meetings via Teams to reduce the environmental impact of travelling to and from the BGS head office.

Our investment policy

BGS does not invest directly in any one individual company. All its investments are held in specialist multi-asset charity funds at CCLA and M&G investments. Both of these funds have ethical investment policies which seek to meet the needs of charities investing in them.

NHS Net Zero

We recognise that the provision of healthcare itself impacts on the environment and that the NHS contributes to the overall carbon footprint of the UK. The NHS in England has committed to achieving net zero carbon emissions by 2040 and the report Delivering a Net Zero NHS, published in October 2020, sets out the interventions needed to achieve this and challenges all NHS staff to review their clinical practice and work towards this goal.

We encourage all healthcare professionals to engage with this important agenda and to familiarise themselves with the ways they can help to reduce their carbon footprint in the workplace via this initiative.

How we will support our members

Many members will be considering how they can reduce the environmental impact of the care they deliver and to date, there are few resources available that specifically address the care of older people and those living with frailty in this regard.

The BGS will be looking to collate and develop resources that will help to support its members to understand and reduce the environmental impact of healthcare alongside continuing to deliver the highest standards of clinical care.

Help to drive the change!

We would welcome input from our members on ideas and initiatives to reduce the carbon footprint of the care of older people and those living with frailty. If you would like to contribute and support our work in this area please contact: Mark Stewart, BGS Office and Business Manager via email at M.Stewart@bgs.org.uk or by phone on 020 7608 8575.

Event report: BGS Autumn Meeting

The BGS Autumn Meeting was held from 24-26 November 2021 as a three-day virtual event, with more than 1,100 online attendees from over 40 countries. As the third fully-virtual BGS national meeting, a large proportion of delegates were by this point familiar with the online platform Swapcard and the format of the event held across multiple streams during the three days. Those who were new to the online setup were treated to the highly interactive and engaging virtual event experience that has proved such a success in previous BGS meetings.

Despite the obvious drawbacks of being unable to meet face-to-face, one of the benefits of the virtual format is that it allows attendees to switch between sessions at the click of a button, as well as view all the presentations in full at any point in the 12 months following the meeting.

With the forthcoming BGS Spring Meeting on 6-8 April also being held online, the current plan is that that both EuGMS 2022 and the BGS Autumn Meeting 2022 will offer the best of both worlds by being hosted in a hybrid format, offering delegates a choice in how they prefer to attend.

Read on for some of the highlights from the Autumn Meeting 2021. Don't forget, it's not too late to register to view all the content for this meeting, or any of our upcoming meetings, by visiting **www.bgs.org.uk/events**.

Day 1: Community geriatrics

One of the main underlying themes of the conference was a celebration of community geriatric services which provide care to older people with frailty before, after, or as an alternative to hospital admission. More than two dozen short case study presentations from BGS members and their colleagues were uploaded and available ahead of the opening Presidential address on Wednesday morning. Available on demand for the duration of the event and beyond, these case presentations covered the major elements of the Ageing Well workstream in England, which include anticipatory care, urgent community response and enhanced health in care homes. Submitted from front-line professionals from across the whole multidisciplinary team in England, Wales and Scotland, they shared experiences, successes and challenges of initiatives ranging from virtual frailty wards, geriatric specialist input in care homes, delirium, admission avoidance and virtual MDT assessments, among many others.

"Each patient has an individual journey," said Trainee Advanced Clinical Practitioner in Frailty, Ruthy Pritchard, presenting on anticipatory care and comprehensive geriatric assessment (CGA). "It is about what frailty means for the patient as well as for the service."

In addition to the pre-recorded case presentations, each element of the Ageing Well programme had a dedicated 90-minute session on Day 1, which looked more deeply into a more systems, data and research-led approach to delivering the various aspects of the programme. In the integrated services session, Professor Simon Conroy explained how health and social care data could be used to support those living in care homes.

"We are trying to use principles rather and protocols or prescriptive guides," he explains. "The challenge and opportunity that lies ahead," he explains, is how to use "a particular project in the context of a whole system to inform a system-wide approach, and how do we learn to work better in the system?"

Professor Adam Gordon, BGS President Elect and lead author of the hugely popular BGS guidance on COVID-19 in care homes, explained some of the lessons learned during the pandemic around the experience of older people in care home settings. He reinforced how equity in research directly impacted equity in healthcare, and that including care home residents in studies is therefore vitally important. Professor Gordon explained that the need to be "quick and nimble" in terms of service evaluation, trials and governance infrastructure had been major stumbling block during the pandemic, and that investment in the ability to rapidly research, trial and approve new options for older people was required.

Ruth Law @Ruth_E_Law
@WhitHealth @IslingtonGp PAWS and ICAT care homes services representing their amazing work today at the BGS Autumn meeting @NadineJeal @S_HarringtonNHS @phillyor #BGSConf

Dr Frazer Underwood RN @frazerunderwood
Good Morning @GeriSoc #NAHPCouncil - Great start to our three-day autumn conference with our breakfast meeting - make sure you follow the hashtags #BGSConf #NAHPCouncil

Later Life Training @LaterLifeTrain
Really good talk by @VickiG_physio at #BGSconf on treating exercise with respect in terms of fidelity and dose as we do pills. Why do commissioners of services think it's ok to half the effective dose? @AGILECSP @thecsp @IPTOPphysio @TashMasud @CathieSherr

Cardiovascular emergencies

The BGS Cardiovascular Special Interest Group (SIG) hosted a day-long series of sessions on cardiovascular disease in the older adult. Professor Rose Anne Kenny, Consultant Geriatrician from Dublin, kicked off the first session by talking about cardiovascular disease and frailty, focusing on the interplay between the two. She explains how the prevalence of multimorbidity in frail older people leaves them disproportionately at risk of cardiovascular complications, stemming from issues such as orthostatic hypotension and metabolic syndrome. She stressed, however, the role of modifiable risk factors which can help improve and influence both frailty and cardiovascular outcomes. Elsewhere in the session, Dr Clare Murphy, Consultant Physician and Cardiologist from Glasgow, looked at acute heart failure in older adults, while Dr Iqbal Malik, Consultant Cardiologist and Clinical Lead for Structural Heart Disease at Imperial College Healthcare NHS Trust spoke about acute chest pain in older people. He recommended that older people should not be excluded from treatment based on age, and that all evidence-based medication should be considered. Even invasive treatment options should not be necessarily ruled out if deemed to be effective.

Meet-ups and social sessions

The first day offered lots of networking and socialising opportunities both on and off the Swapcard platform. The BGS Retired Member's Group met for a chat via Zoom, while those interested in environmental concerns were invited to register for the Green Issues Chat Room for a post-COP26 discussion on Net Zero ambitions for the NHS, as well as in people's personal lives.

The ever-popular BGS Fringe held a Film Club which discussed 'Limbo' by Lotje Sodderland, a poignant 20-minute film that explores the crisis of care for older people and how it has been exacerbated by the pandemic. The film has won several prestigious awards, including a BAFTA, and the director joined for a fascinating question and answer session with delegates, explaining her inspiration and motivation.

The BGS Nurses and AHPs Council hosted a further instalment of their successful Communities of Practice (COP) meetings, focused this time on research, which offered those in attendance a rich opportunity to share focused best practice presentations and the latest research approaches. This was the first of two such sessions held across the course of the meeting, with a later session focusing on leadership on Day 2.

Day 2: Joint symposium

One of the highlights from Day 2 was the regular Association of Academic Geriatric Medicine (AAGM) symposium, this time focusing on research in the pandemic. Held jointly by the BGS, British Society of Gerontology (BSG), and the British Society for Research on Ageing (BSRA) this session covered interdisciplinary research perspectives on topics including future pandemic preparedness, inequalities and social isolation. Speaking on the topic of further pandemics, Professor Miles Witham, National Speciality Lead for the NIHR Ageing Clinical Research Network, explained that these were "inevitable" but that it is difficult to predict a timescale or what the next major infection or virus might be. He highlighted that while there were many successes in research during the COVID-19 pandemic, there are lots of lessons to be learned from what didn't go so well which can be applied to future pandemics. He did however caution that planning in too much detail may be counter-productive, as so much is unknown about the nature of the next pandemic – for example, our government's plans to tackle a major a flu pandemic were of limited use for COVID.

Professor Lorna Harries, Professor of Molecular Genetics from Exeter, spoke about balancing protection and freedom for people in vulnerable settings such as care homes. She explained the pros and cons of various models and testing methods, offering insights on some of the latest research on safe and effective quarantine periods. The social and

Autumn Meeting Prize Winners

Congratulations go to the following presenters for their winning abstract submissions:

Norman Exton-Smith prize for Best Scientific Presentation poster
Andrew Arnott
Utility Of 24 Hour Ambulatory Blood Pressure Monitoring (ABPM) In Patients With Orthostatic Hypotension (OH) At Syncope Clinic

John Brocklehurst prize for best Clinical Quality poster
Melroy Rasquinha
Improving the Quality of Do Not Attempt Cardio-pulmonary Resuscitation (DNACPR) Form completion

Best Clinical Quality Platform Presentation
Martha Twigg
Improving Advance Care Planning discussions and communication with primary care in geriatric medicine in a district general

Best Scientific Platform Presentation
K Sheehan
Prognostic factors of depression after hip fracture surgery: Systematic review

Eva Huggins Prize for best Nurse or AHP Poster
Beth Griffiths
Collaboration with care homes to provide appropriate medical care in the pandemic

Best President Round Presentation
Emily Taylor
Predictors of independence in community-dwelling older people

For details of how to submit an abstract for an upcoming BGS meeting, including deadlines and instructions, please visit www.bgs.org.uk/abstracts.

emotional impact of isolation during the pandemic was highlighted by Dr Sophie Yarker, Research Associate at the University of Manchester, who told the stories of older people affected by lockdown of people from different social backgrounds, illustrating the breadth of pandemic experiences of older people in Greater Manchester.

Orthogeriatrics, osteoporosis and rheumatology

The falls stream was held across three sessions, bringing together members of the multidisciplinary team to address topics such as falls prevention, trauma in older people, osteoporosis and Paget's disease. Professor Victoria Goodwin, Physiotherapist and Associate Professor in Ageing and Rehabilitation at the University of Exeter, spoke about rehabilitation and the relationship between research and practice. Research findings that cannot be implemented are of limited use, she explained, and the right people – including older people – need to be engaged from the outset. "We need to get help from experts who know about spreading innovation," she encouraged.

Elsewhere in the falls streams, Professor Celia Gregson, Consultant Geriatrician and Consultant Senior Lecturer from Bath, looked at some of the new and emerging treatments for osteoporosis. Dr Jonathan Marks discussed swollen joints in the older person, reinforcing the importance of taking a thorough history of the patient, including consideration of the onset, pattern and associated features, and not excluding unusual presentations of common conditions.

Guest lecture

Thursday's guest lecture was given by Professor Maggie Rae, President of the Faculty of Public Health, who provided an in-depth presentation on older people and health inequalities. She spoke about the four domains of inequity – those living with deprivation, vulnerable populations, minority groups with protected characteristics, and those living in areas with poor service provision. These inequalities are more pronounced as people age, explained Professor Rae, and there are poorer health outcomes and shorter life expectancies for older people in the most deprived groups. She highlighted particular inequalities between older people from different ethnic backgrounds, which have been further exacerbated by COVID.

She thanked BGS members for all their work during the pandemic and for helping address some of these inequalities. Reinforcing the role of healthy ageing, Professor Rae explained how all older people need to be able, and supported, to eat well, be physically active and stay connected, and need to access housing, care and other services.

"Falls account for 4 million hospital bed days each year and promotion of safe physical activity among the older population is essential," she explained. She finished by praising the multi-disciplinary ethos of the BGS and how this lends itself to supportive collaboration across the health and care system, and encouraged members to continue to support a reduction in health inequalities among the older population.

Emma Vardy @emmavardy2
If you change gender at GP you drop off various healthcare recall systems. Thats not good. Brilliant session on LGBTQ+ and older people @GeriSoc #BGSconf

Workshops

Two hugely popular workshops took place on Day 2, the first of which centred on the experiences of older LGBT+ people in accessing and receiving healthcare and how these influence wider health outcomes in this group. A panel including Dr Michael Brady, the first National Advisor for LGBT Health at NHS England, alongside Patrick Hogan, Andrew Crowe, Lucy Mealey and Dan Bailey, spoke about research and projects to help improve the experience and outcomes of LGBT+ people in the NHS. They illustrated initiatives such as the Pride in Care standard which can be implemented in secondary care settings to offer training and support for staff to help improve inclusivity for older LGBT+ patients. The workshop also offered practical advice which anyone working with older people can immediately begin to introduce to their work, such as using gender-neutral language when referring to partners, or being understanding of the nervousness around accessing health and social care services among some older LGBT+ people.

A second fascinating workshop, this time lead by the *Age and Ageing* journal editorial team, took the form of a friendly question and answer session which focused on how participants might go about getting their work published. Queries relating to writing a case report and how to decide on a project to write up for publication were answered by the expert team, which included Professor Rowan Harwood, Editor-in-Chief of Age and Ageing, and Antonella Di Marzio, Marketing Executive from Oxford University Press, joined by Katy Ladbrook, BGS Journal Editorial Manager. Participants were treated to some insights into the behind-the-scenes workings of the journal, as the panel took time to demystify some of the processes to would-be authors from across the multidisciplinary team.

Day 3: Platform presentations and Fringe

As the event entered its third and final day, a final batch of platform presentations were presented on topics as diverse as aromatherapy, delirium and blood-pressure lowering medications. Spread across the three days, these platform presentations were chosen from among the accepted abstracts to be presented as short 15-minute video recordings. The President's Poster Round was also held on Friday, with all the top poster submissions available to view via the event platform. A wealth of other high-quality posters from the meeting were also made available via a virtual poster book on Swapcard in place of physical printed posters.

The BGS Fringe continued into day three, with an 'in conversation' session featuring Dr Michael Denham, BGS Honorary Archival Librarian and Mark Stewart, Office and Business Manager who met to discuss the fascinating origins of geriatric medicine. Elsewhere in the Fringe, desk yoga was offered for those delegates needing a break from their seat, hosted by The Yeh Yoga Co.

Quality Improvement (QI) workshop

During the BGS Autumn Meeting, a highlight was the QI (Quality Improvement) workshop. This was an interactive, roundtable discussion aimed at helping attendees with designing projects, developing their understanding of QI methodology and providing inspiration on distributing results.

The attendees ranged from consultants, GPs, trainees to allied health professionals, demonstrating that anyone can get involved in QI. Prior to the session there was a questionnaire sent out inviting attendees to share their project ideas to use as examples in the session.

The session was flexible and was led predominantly by questions from the audience. Attendees brought their project ideas and also raised any potential issues they had. The facilitators and other attendees on the call gave advice on how to overcome these issues and further the projects. It was clear to see the benefit it had to the individuals who posed questions and also to those listening. It is hoped that these discussions have been influential to others in initiating projects, completing projects and getting published/presentations.

This workshop also poses an opportunity for those whose abstracts were not accepted to discuss their submissions to see how they could be accepted next time. The free-flow nature of the discussion allows the session to be adapted to meet the needs of the attendees.

The BGS Spring Meeting 2022 will host another QI workshop so why not come along, bring your project or starting ideas and see how the BGS can support and help you?

Rachel Melrose
BGS Clinical Quality Trainee Representative

Jennifer @Burns61Jenny
Enjoying the final day of #BGSconf and looking forward to hearing @EileenBurns13 keynote address from sunny Glasgow

Trevor Howell Guest lecture

The third day of the BGS Autumn Meeting is traditionally the day when the Trevor Howell guest lecture is delivered, which this year came from Dr Eileen Burns MBE, a Consultant Geriatrician in Leeds and former BGS President. She begun by commemorating the memory of Dr Trevor Howell, a founding member of the BGS, before moving onto the main theme of her lecture, 'Doing the right thing' for older people.

"More than one study has shown that doctors often plan interventions for their patients that they wouldn't want for themselves," she explained. "Why on earth do we do that?" she asked.

Suggesting that maybe guidelines and fear of litigation could be potential reasons, she went on to explain how older people with frailty are often not well-represented in the evidence which informs national guidelines, and reiterated that professional skills and knowledge also play an important role when it comes to providing good person-centred care. "We need to be much more thoughtful about the way we interact with our patients. We need to engage with them and learn something about their values," concluded Dr Burns. "What's important to them, what their preferences are and what sort of lives they've lived and how that's going to influence the choices they make."

Richard Genever @DrGenever
Getting ready to speak at #BGSconf on Drug Treatment of Parkinson's Thanks to @BrendanAMcGrath for hosting me @GeriSoc #BGSConf

Joanne pattinson @JoPattinson2
Patients with PD need a full MDT approach to care as modelled by Dr Rob Skelly and team @UHDBTrust @UHDB_DME #BGSConf

Neurology and movement disorders

The BGS Movement Disorders Special Interest Group hosted a series of sessions which included presentations on Parkinson's Disease and mental health, including a fascinating talk on Parkinson's psychosis delivered by Consultant Neurologist Dr Neil Archibald. Symptoms such as anxiety, depression, impulse control issues, dementia and psychosis can be associated with Parkinson's and/or its treatment. Psychotic symptoms, including hallucinations, are particularly common, although only around 10% are likely to be severe and distressing. "You don't need to have dementia to have Parkinson's psychosis," he explains, "but it helps." Other sessions in this stream addressed areas such as dopamine dysregulation, atypical Parkinsonian syndromes, and tremor diagnosis and management.

Closing words

Concluding the conference, BGS President, Dr Jennifer Burns, gave her closing address, highlighting many of the fantastic talks from the three days as well as some of the recent, current and forthcoming projects the BGS is involved in. "What a great conference it has been, I hope you have all enjoyed it as much as I have!" she beamed.

While Dr Burns understandably didn't feel able to pick a favourite presentation from the event, she did particularly commend the community geriatrics sessions which formed a large part of the conference. She thanked the organising committee, sponsors, partners, speakers, moderators and delegates for their contribution to the meeting and their help in making it such a success.

Abstract concepts

Following on from the article in the last issue of *Agenda* on 10 Top Tips for writing a clinical quality abstract, we wanted to provide some helpful pointers using the example of a successful abstract from a recent meeting. Writing an abstract is such a great way to share good practice and to provide some recognition for the hard work that goes into these projects.

This is one of the Clinical Quality posters, submitted under the category of patient safety, that was successful this year and was chosen for a platform presentation. You may have seen this at the BGS Autumn Meeting – *Introducing Treatment Escalation Plans (TEP) for older persons; Response to the COVID-19 pandemic* by SJ Woodford and HP Patel.

Why submit an abstract to a BGS meeting?

"I'm Rachel, one of the geriatric medicine registrars currently working in Hull. My registrar, Dr Kershaw, and I have been fortunate enough to have our abstract accepted for poster presentation at the BGS Autumn Meeting 2021.

"Our project looked at the use of melatonin for sleep disorders in patients with Parkinson's Disease within our region, with the aim of implementing the Parkinson's Disease Sleep Scale as an objective measure.

"I found that writing an abstract helped me review the project, recapping what were our main aims and objectives and evaluating whether the project achieved these. It allowed me to reflect on the most relevant and important conclusions that could be drawn. It is easy with a project to get bogged down in the details of the methodology and individual results, but I feel writing an abstract gives the opportunity to review what went well and how to progress the project or what strategies I can take forward to my next quality improvement project. Reading others abstracts and posters is inspiring and encouraging to get even more involved in QI."

Getting started

Firstly, you need to describe your problem and how your proposed change will improve quality. This project was based around an important and clinically-relevant topic. The abstract begins with a clear definition of treatment escalation plans with an emphasis on shared decision making. This demonstrates an understanding of the project focus and relevance to clinicians as well as patients and carers.

"TEP documentation was not standard within our trust up to 2018. We aimed to design and introduce a standardised TEP proforma and evaluate its use in older persons aged ≥80."

The introduction describes a specific and relevant aim. Using the acronym SMART can be beneficial in ensure the aim of the project is specific, measurable, achievable, relevant, and timely.[1]

The project must use quality improvement methodologies with at least one completed PDSA cycle and describe the full cycle where the change has been made and evaluated.

"Data was obtained from patient notes and questionnaires within the Medicine for Older Persons department (MOP) from four PDSA cycles between 2018-2020. Cycle 1 was a service evaluation. Based on this data, a TEP form was created and approved for use in all adult patients. Cycles 2, 3 and 4 evaluated TEP after introduction of the proforma."

As you can see this project had four completed PDSA cycles over a period of two years, but you could submit with one completed cycle. If there is a topic that would be likely to generate learning and discussion, a single audit or survey can be submitted.

Highlighting the interventions of each PDSA cycle and how these were generated and implemented can demonstrate understanding of the progressive and pliable nature of quality improvement.

Introducing Treatment Escalation Plans (TEP) for older persons: Response to the COVID-19 pandemic

SJ Woolford,[1] HP Patel [2,3,4]

1. Academic Foundation Trainee, University Hospital Southampton, UK; 2. Medicine for Older People, University Hospital Southampton, UK; 3. Academic Geriatric Medicine, Faculty of Medicine, University of Southampton, UK; . NIHR Southampton Biomedical Research Centre, University of Southampton & University Hospital Southampton NHS Foundation Trust, UK

Introduction: TEP detail appropriate ceilings of care and guide treatment of patients based on shared decision making. TEP documentation was not standard within our trust up to 2018. We aimed to design and introduce a standardised TEP proforma and evaluate its use in older persons aged ≥80.

Methods: Data was obtained from patient notes and questionnaires within the Medicine for Older Persons department (MOP) from four PDSA cycles between 2018-2020. Cycle 1 was a service evaluation. Based on this data, a TEP form was created and approved for use in all adult patients. Cycles 2, 3 and 4 evaluated TEP after Introduction: of the proforma.

Results: There was a 239% increase in TEP after Introduction: of the proforma, compared to baseline (cycle 1: n=14/47 [29.8%], cycle 2: n=17/112 [15.2%], cycle 3: n=30/97 [30.9%], cycle 4: n=42/59 [71.2%]). The increase in TEP between cycles 3 and 4 coincided with the COVID-19 epidemic. Clinicians were more confident in actioning TEP based on the proforma, compared to those written in the notes (cycle 2: 83% confidence vs 54%, cycle 3: 100% vs 35%, Cycle 4: 98% vs none written in the notes). An improvement in understanding the purpose, comprehensiveness and location of TEP forms was observed. Feedback suggested TEP provided clear guidance for 1. ceilings of care; especially useful out of hours 2. discussions with critical care and 3. patient handover between staff and successive shifts.

Conclusion: TEP forms offer clear guidance on ceilings of care. Introduction: of the TEP proforma has led to more frequent and proactive discussions with patients on ceilings of care and have facilitated a culture change in the management of older persons. Use of the forms increased during the COVID-19 pandemic but are now viewed as an essential component of patient safety and have been successfully implemented trustwide.

The results section can be a tricky one to write, the key is to get the relevant results across and demonstrate the significance without numerical overload.

This project measured more than just the improved numbers of TEPs so was good to see the process of evaluation in action.

"There was a 239% increase in TEP after introduction of the proforma [...] Clinicians were more confident in actioning TEP based on the proforma, compared to those written in the notes (cycle 2: 83% confidence vs 54%, cycle 3: 100% vs 35%, Cycle 4: 98% vs none written in the notes)."

This demonstrates how the team have considered both the systemic and human factors involved in quality improvement.

As we know quality improvement projects may not 'stick' if there is not a plan to disseminate so it is important to talk about sustainability and spread – even if this hasn't been done you can describe your plan:

"now viewed as an essential component of patient safety and have been successfully implemented trust wide."

The word count can be a challenge so it is important to use the Revised Standards for Quality Improvement Reporting Excellence Guidelines (SQUIRE 2.0) – the link to submitting abstracts can be found here: **www.bgs.org.uk/abstracts.**

In conclusion, writing an abstract can give the opportunity to reflect on your project and review the key results and findings. It's something to be proud of, look what you have achieved and be inspired to keep going with QI.

Aileen Fraser
BGS Clinical Quality Committee Nurse and Allied Health Professional Representative

Rachel Melrose
BGS Clinical Quality Committee Trainee Representative

Reference

1. Bjerke M and Renger R (2017) Being smart about writing SMART objectives. Evaluation and Programme Planning. April 61;125-127

Welcoming our new BGS officers!

The BGS Autumn Meeting saw a number of our long-standing BGS Officers coming to the end of their term of office, with a new group of officers taking over. We meet the new postholders to find out more about them, what motivated them to put themselves forward for an officer position within the BGS and what they hope to achieve in their new role.

Deputy Honorary Secretary: Dr Ruth Law

About Ruth

I am a Consultant in Geriatric Medicine at Whittington Health NHS Trust.

Main priorities as Deputy Honorary Secretary

The last two years have been incredibly challenging for the whole MDT workforce, but I feel there is no better time for the British Geriatrics Society to be increasing its profile, impact, influence, and most importantly relevance to its members. My main priority is for the Society to continue to connect with its members as they navigate the highs and lows of working in the NHS. Despite the intensity of working through the pandemic, I still love the privilege and challenge of being a geriatrician and I hope I can use this role to help restore some of the joy to our specialty.

How can members get involved?

Take the opportunity to connect in whatever way you can! There are opportunities advertised every month in the e-bulletin and plenty happening over on Twitter too. Attend a conference or regional meeting. Look through some of our excellent policy documents. Most importantly - tell us what you think and what matters to you.

Chair of the BGS Nurses and AHPs Council: Dr Esther Clift

About Esther

I am a Consultant Practitioner in Frailty for Southern Health NHS Foundation Trust, and Visiting lecturer at Winchester University. I am also Credential Lead for Community Rehabilitation - Healthy Ageing with Health Education England.

Main priorities as Chair of the BGS Nurses and AHPs Council

To increase our membership and voice across all four nations, and to continue to grow our fantastic communities of practice in Advanced Practice, Leadership and Research.

How can members get involved?

If everyone encourages a colleague to join the society - I'd be delighted!

Deputy Chair of the BGS Nurses and AHPs Council: Lyndsey Dunn

About Lyndsey

I am Lead Nurse for Quality Improvement and Standards at Western General Hospital Edinburgh, NHS Lothian. I have had the privilege to serve NHS Lothian for nineteen years. I have held the position of Frailty Nurse Specialist in both the medical and surgical directorate, then most recently as Integrated Discharge Hub Manager in the Western General Hospital Edinburgh performing a key link between acute care and the wide range of community services by our ongoing collaboration with the Health and Social Care Partnership.

Main priorities as Deputy Chair of the BGS Nurses and AHPs Council

Throughout my journey my passion and goal has been delivering high-quality person-centred care for the older population, with a key role to influence and engage all levels to drive and improve health care for older adults. I am very proud to have been elected this year for the position of Deputy Chair of the Nurses and AHPs Council.

Our social care system remains under continuous strain and pressure therefore my focus will be to continue to explore ongoing collaboration work between acute and community which are essential and necessary, with our community services given the same prioritisation, aiming to reduce unnecessary prolonged stays in hospital for our older population.

How can members get involved?

In my new role I wish to reach out to all nurses and AHPs who have a passion for improving care for older people and promote the benefits of being part of the BGS. It's fantastic to have representation from Scotland and I'm looking forward to supporting Dr Esther Clift as Chair.

Chair of the BGS Trainees Council: Dr Sangam Malani

About Sangam
I am currently an ST4 Specialty Registrar in Elderly Medicine at Northwick Park Hospital.

Main priority as Chair of the BGS Trainees Council
One of the main reasons I joined the BGS family is to advocate for colleagues and patients alike, which will remain a priority for me throughout my term. I hope to positively contribute to shaping the future of care of older people in the UK whilst also creating a stronger link with the trainees, so that as their Chair, I can deliver not on what I want but what they want.

How can members get involved?
At BGS, there is something for everyone, but one fantastic way everyone, even non-members, can get involved is via the Forum. Over time, I hope that the platform will grow to reflect the vibrant, helpful, and incredible community that we are!

Chair of BGS Scotland: Dr Rowan Wallace

About Rowan
I'm a Consultant Geriatrician at University Hospital Crosshouse, NHS Ayrshire and Arran. I'm also Clinical Lead for Frailty and Co-ordinated Care. I have a keen interest in contributing to, and bettering the care of older and frail people as close to their home as possible. My main base at present is within the front door Combined Assessment Unit leading our multi-disciplinary Frailty Team. I will be contributing my skills to our Hospital at Home service which we have piloted and will launch in 2022. My other interest is in peri-operative medicine. Together with our anaesthetic peri-operative lead, we have built a new service targeting comprehensive geriatric assessment to older people living with frailty who are in need of a an elective surgical procedure. It's early days for us and a growing service. We are hopeful to demonstrate improved outcomes, but more importantly, how realistic medicine principles and having the patient voice front and centre can improve the journeys through complex care for our Ayrshire people.

Main priority as Chair of the BGS Scotland
The BGS in Scotland needs to hear the voices of those who can advocate for better care of our older people. As we see further integration between primary and secondary care, community and acute, and importantly, social care both at home and in care homes, it's important we aim to include as many keen individuals as we can.

How can members get involved?
Our Scotland Council aims to represent all of our multi-disciplinary colleagues. We would love to hear from you. You can reach me on Twitter **@rowan_wallace**

BGS Vice President for Workforce: Dr Amit Arora

About Amit
I am the new BGS Vice President for Workforce. I am also a Consultant and an Associate Medical Director in the Midlands, and also a Regional Clinical Director with ECIST- NHS England/ Improvement.

Main priorities as Vice President for Workforce
My main priority is to support and develop the diverse multidisciplinary workforce to support further improvements in care of older people. I intend to look inwards, outwards and upwards, influencing national policy and direction to achieve this.

How can members get involved?
I am looking for any offers of support, ideas and actions and will be working with the forthcoming workforce sub group to take the workforce agenda forward.

With special thanks

We also thank all our outgoing officers demitting from their posts for their service to BGS and achievements in contributing to the Society's goals:

- **Dr David Attwood**
  as Honorary Secretary
- **Lucy Lewis**
  as Chair of the Nurses and AHPs Council
- **Frazer Underwood**
  as Deputy Chair of the Nurses and AHPs Council
- **Dr Carly Welch**
  as Chair of the Trainees Council
- **Dr Claire Copeland**
  as Vice President for Workforce
- **Dr Alan McKenzie**
  as Chair of BGS Scotland

For more information about roles and vacancies within the BGS, including current opportunities in our Nations, Regions and SIGs, please visit www.bgs.org.uk/bgsvacancies

Obituary: Dr Joan McAlpine

Dr Joan McAlpine, a BGS member who served as President of the BGS Scotland Branch, passed away in December 2021 aged 94.

Dr Joan McAlpine died in December 2021, just before her 95th birthday. After graduating in medicine with commendation from Glasgow University in 1949 (where she was one of only 42 women in her year of 200 students). Joan did her early general medical training in Glasgow, where she was usually the only female junior doctor. Returning to work after having her 3 children, she was appointed Medical Assistant in geriatric medicine in Paisley's Royal Alexandra Infirmary (RAI) – now the Royal Alexandra Hospital.

Shortly after she took up post, Dr Jack Kelly, the single-handed geriatric medicine consultant, went to India to do missionary work and Joan was left in charge. She relished the challenge and, when he resigned shortly after his return, Joan was appointed as the consultant in geriatric medicine.

She steadily built up the department, increasing the number of consultants and trainees and developing the services offered to patients. Joan transformed the department from a largely long stay unit into an active forward-thinking service providing assessment and rehabilitation. She was an early pioneer of moving patients with hip fracture to geriatric medicine wards almost immediately post operatively. She established a link with Edinburgh University and medical students came to spend part of their training in geriatric medicine in the RAI, with very positive student feedback.

She served as President of BGS Scotland and commissioned the President's chain now worn at BGS Scotland meetings by the Chair. She enjoyed the interaction with the national BGS team and colleagues across the UK – at this time geriatric medicine was a relatively new and evolving speciality. She was a Fellow of both London and Glasgow Colleges of Physicians.

She retired in 1989 with reluctance as she felt there was much she wanted to do. She channelled that energy into key roles at Erskine Hospital where she was an honorary consultant and chair of its Care and Clinical Governance committee guiding the transformation of the nature of the services it provided.

She served as a Board member in the Glasgow's Primary Care Trust during a period when major positive changes for community services were driven forwards. She chaired the Ure Elder Trust and researched the life and work of Isabella Ure Elder, a major philanthropist in Glasgow especially in the field of education for women: Joan felt strongly that Mrs Elder's work was under-recognised. She published a book about Mrs Elder in 1997 (The Lady of Claremont House) and gave many talks about her.

Joan led an energetic and productive working life and enjoyed it to the full. She also had a fulfilling and happy retirement. She was stylish, charismatic, enjoyed her Jaguar cars, and had a lively sense of humour. She played golf, bridge, enjoyed travel, and family life. She had a long and happy retirement.

Christine McAlpine
Consultant Stroke Physician, Glasgow Royal Infirmary

Second round of **BGS/ Dunhill Medical Trust Doctoral Fellowships** for age-related research open for applications

We are delighted to announce that the second round of their joint Doctoral Fellowship scheme is now open for applications.

The BGS has partnered with the Dunhill Medical Trust in co-funding a second round of three Doctoral Fellowships to support research relevant to age-related diseases and frailty undertaken by front-line health professionals. Eligible candidates include doctors, nurses and allied health professionals working with older people. One award will be made per year over the next three years, with each award covering the costs of a Fellowship. Candidates may apply for funding for three years' full-time or up to six years' part-time.

The Fellowship is open for research projects that have the potential to prevent, delay or reduce future health and social care requirements and to improve older people's functional ability. The COVID-19 pandemic continues to have a hugely damaging effect on older people's health and quality of life. The impact of the pandemic and the demographic reality of an ageing population create an urgent need for reform of the health and social care system to ensure all older people can access high-quality care in their later years. Research into aspects of clinical care for older people and its application in diverse settings therefore remains essential in this volatile context.

The application deadline is **8 April 2022**. Shortlisted candidates will be interviewed on 27 September 2022.

Applicants must be a member of the British Geriatrics Society for the lifetime of the grant and meet the requirements for a programme of PhD study at a UK-based University. The grant will cover salary, tuition fees and running expenses for the proposed project.

For more information, including links to apply, please visit www.bgs.org.uk/BGSDMT2022

External vacancies and training

View or post job vacancies online at **www.bgs.org.uk/jobs**

Improve healthcare for older people with the Flow Coaching Academy programme

FCA
Flow Coaching Academy

Harness the collective brilliance of your team to support people to age well

The Flow Coaching Academy enables healthcare professionals to master the art of improvement in a fun, engaging, and effective way.

Built from within the NHS, for the NHS, Flow Coaching methodology harnesses the energy and ideas of staff at all levels to make **positive change.**

Patients are at the heart of everything we do. As part of our virtual programme, we develop the quality improvement and coaching skills needed to continuously improve care across a patient pathway.

We have a proven track record of enhancing patient experience, raising staff morale, developing leadership skills, and reducing the costs associated with delivering care.

Our network is made of clinical and non-clinical staff who are successfully making improvements across the UK in patient pathways such as:

- Frailty
- Acute care
- Dementia
- End of life care
- Cancer
- Mental health
- Diabetes
- Stroke

Supported by: The Health Foundation

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fca.sth@nhs.net

To find out more about our upcoming training programmes and how to get involved, visit: **https://flowcoaching.academy/contact-us**

BGS vacancies and notices

View all current BGS opportunities online at **www.bgs.org.uk/BGSvacancies**

BGS region vacancies

We are currently seeking applications for the following regional roles:

- **BGS Mersey Region**: Secretary, Deputy Secretary, Trainee Rep, England Council Rep
- **BGS Yorkshire Region**: Chair
- **BGS Northern Region**: Chair

For more information on these roles and details of how to apply, visit: **www.bgs.org.uk/regionops.**

Update your details!

To ensure you are receiving the latest news, information and reminders about your membership, check and update your details via our website at **www.bgs.org.uk**. If you need help updating your information, please email **membership@bgs.org.uk**.

BGS Community and Primary Care Group

The new BGS Community and Primary Care Group (CPCG) is assembling its committee and BGS members are invited to get involved. In addition to two Co-Chairs, the committee will comprise:

- Committee Secretary
- Research lead
- Ageing Well/Anticipatory Care lead
- Ageing Well/Urgent Community Response lead
- Care homes/Enhanced Health in Care Homes sub-group lead
- GP sub-group lead
- Reps from each of the four nations
- Communications lead
- NAHP rep

If you would like to learn more about these roles or are interested in becoming a committee member please contact Joanna Gough at **j.gough@bgs.org.uk** or visit **www.bgs.org.uk/CPCGinfo**

British Geriatrics Society
Improving healthcare for older people

BGS

Spring Meeting 2022

Online 6-8 April 2022

Sessions include:

- Dementia and Delirium
- Frailty and Sarcopenia
- Infections and Sepsis
- Quality Improvement
- Rehabilitation of the older patient
- Tissue viability
- Digital health
- Curriculum updates
- Movement disorders

Plus meetups, workshops, and much more!

View the full programme and book your place!

www.bgs.org.uk/ Spring22