AGENDA

British Geriatrics Society
Improving healthcare for older people

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BGS NEW LOOK NEWS LETTER

Community minded

Supporting excellent healthcare at home

PLUS

- **Writing a QI abstract**
- Celebrating our AHPs
- **Demystifying the SCE**

AGENDA
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On the
AGENDA

President's *Message*

Looking forward to the winter, I am contemplating our 'new normal.' As I write this, restrictions have largely been lifted across the four nations and we are being asked to learn to live with COVID. Feedback from colleagues across the UK has been that our hospitals were busier than ever over the summer months, a pattern which looks to continue as we head from autumn into winter.

My patients have struggled to access community services, to be assessed for gradual functional deterioration and cognitive decline and are ultimately presenting at a point of crisis. Primary care colleagues are also working flat out but struggling with the added pressure of administering booster COVID and flu vaccinations on top of greater demand for services. These ingredients have all the makings of a crisis looming, and we need to continue to advocate for restoration of community services and preventative interventions.

You may be aware that BGS recently published a summary of models for urgent acute care in NHS England which promote alternatives to hospital admissions while ensuring access to Comprehensive Geriatric Assessment (CGA). The report, Right time, right place: Urgent community-based care for older people, can be accessed at **www.bgs.org.uk/righttimerightplace.** I sense there is still much variation in provision across the UK and am keen we promote different ways of working to deliver care closer to home to maintain and restore health. Thanks to our members in the Community Geriatrics SIG, GeriGPs group and Nurses and AHPs Council for helping with this work.

This issue of our newsletter, now with a new look, feel and title – *Agenda* – also has a special focus on the role of community services for older people. We reflect on some of the priorities and future directions for primary and community care, and how services can be configured to best meet the needs of our patients. Members and colleagues have kindly shared personal experiences and reflections on their roles and services, and we hope it provides a useful starting point for readers to consider their own experiences and engage with the BGS to help drive lasting improvements in this increasingly vital area of care. The **BGS Autumn Meeting,** being held virtually on 24-26 November, also features a packed community geriatrics stream, which is also not to be missed.

I look forward to working with the new Vice President for Workforce, Dr Amit Arora. I would also like to thank

Dr Clare Copeland, Consultant Geriatrician from Forth Valley Health Board in Scotland for the work that she has done in the role of Vice-President for Workforce over the last two years. She took over from Zoe Wyrko and has led the BGS work on the impact of the COVID pandemic on the workforce *Through the Visor* reports (**www.bgs.org.uk/throughthevisor**) in addition to drafting the BGS position on flexible and less than full time working and training in Geriatric Medicine. Clare has been a great supporter of BGS throughout her career and we wish her all the best in her new role as Associate Medical Director in her Health Board. BGS's loss is Forth Valley's gain.

We also say a fond farewell to other fantastic BGS officers and Trustees at the upcoming BGS Autumn Meeting. Chair of the BGS Nurses and AHPs (NAHPs) Council, Lucy Lewis, will be coming to the end of her term. Lucy has been instrumental in ensuring the voice and value of nurses and AHPs within the BGS is represented through all our work, from policy to events. She has helped initiate a popular series of Community of Practice events on topics such as research and leadership for NAHPs. You can read more about the work our AHP colleagues on page 24 in celebration of the recent **#AHPsDay**. We also welcome the new Chair of the NAHP Council, Esther Clift.

Chair of the Trainees' Council, Carly Welch, also demits this month. Carly has been a fantastic ambassador for both BGS and Trainees, advocating for better research and representing our Trainees through her involvement with the RCP and EuGMS, and on BBC Radio 4. She has contributed useful insight and representation through her work with the Research and Development Committee (RADC), which has included judging abstracts for BGS events. The new Chair of the Trainees' Council is Sangam Malani, who is already active in the BGS Clinical Quality Committee.

Our Honorary Secretary, David Attwood, also approaches the end of his tenure. David, who was the first GP on the BGS Trustee Board, shares his reflections on his term of office on page 4. We thank him in particular for his enthusiastic commitment to supporting older people with frailty, and providing insightful and prompt input into BGS consultation responses and policy documents. The new Honorary Secretary is Anne Hendry, who has been serving as Deputy alongside David.

Alan McKenzie, Chair of BGS Scotland, is also stepping down from this role, to be succeeded by Rowan Wallace. Alan helped develop the BGS manifesto for this year's Scottish Parliament elections and has steered BGS Scotland Council through a time of change and uncertainty. We thank him for his leadership of BGS Scotland.

In September 2021, we were due to have hosted the EuGMS annual congress in London but (much like the Olympics) this has been postponed a year to 2022, and will be taking place 28-30 September 2022. I would like to highlight that BGS Past President Tash Masud is now on the Executive Board of EuGMS, and so BGS are well represented in promoting the role of Geriatric Medicine across Europe, and plans for the meeting in London in 2022 are at an advanced stage.

'Redesigning services, improving access in a timely fashion and ensuring these are more patient-centred has never been more important.'

A new look!

We'd love to know what you think of your revamped BGS newsletter.

As well as being interested in your feedback, suggestions and comments on the refreshed format, we're also always keen to hear from anyone who would like to be involved in future issues. We want to help tell your story and share your experiences - this is your membership magazine, and you and your patients are at the centre of the agenda.

Email editor@bgs.org.uk with your thoughts or to find out how you can get involved.

Every year, the Councils from our four nations put forward an individual for the Marjory Warren Lifetime Achievement Award. It is an almost impossible task to decide between the four nominees and we do this by anonymous vote by the Trustee Board. This year, Professor John Starr has posthumously been awarded this prestigious accolade. He was nominated by Dr Alan McKenzie, outgoing Chair of the Scottish Council, and those of you that knew or worked with John will be aware of his outstanding ability to challenge, think critically and inspire others to excellence. We have let his family know and they were delighted to hear of this recognition of his professional contribution. They will receive John's award on his behalf at the BGS Autumn Meeting at the end of November.

Finally, as always it is great to hear from BGS members and there are lots of ways you can share your experiences and have a voice within the Society. Please have a look at the range of Special Interest Groups (SIGs) at www.bgs.org.uk/bgs-groups and spread the word that non-BGS members can join our SIGs to give them a taste of what the Society has to offer. There are plenty of other ways to get involved including via Twitter using **@GeriSoc**, or by contributing to Agenda or the BGS blog. We are also keen that we get wide representation on our committees and councils so do not be shy about coming forward. I thank you for the time and effort you already devote to the Society. I look forward to seeing and speaking to you (virtually) at the BGS Autumn Meeting.

Dr Jennifer MA Burns
President, BGS
@Burns61Jenny

Policy into practice

As BGS Honorary Secretary Dr David Attwood approaches the end of his term of office, he reflects on the BGS policy environment from November 2019 to November 2021 and speculates on what the future holds.

For the last two years, BGS Policy has been dominated by COVID, which had a profound effect on the workforce and older people. The greatest tragedy unfolded in care homes, which saw 43,000 extra deaths compared with previous years. During this time, the BGS was the only organisation to offer any guidance on COVID in care homes and were an invaluable asset to primary care and community services.

Life in hospital, primary care and community was equally difficult and both *Through the Visor* reports published this year were a sombre read, highlighting a healthcare workforce beyond burnout and exhaustion. Burnout occurs when people are working beyond their capabilities and feel a situation is hopeless.

While the pandemic years have seen a lot of suffering, we have made some huge progress. I thought I might take this opportunity to reflect on some key areas of progress in the last two years for there is much to be hopeful for.

When I started my term of office in November 2019, there were high hopes for a step change in older people's healthcare as envisaged in the NHS Long Term Plan in England. But converting that into real change on the ground at the time seemed uncertain. The new draft Enhanced Health in Care Home (EHCH) national service specification appeared unworkable for primary care networks. The concept of Anticipatory Care was a series of vague words on a page. Discharge support services had variable uptake across regions, as did Community Crisis Response Team (CCRT or whatever acronym your locality goes by). BGS relations with NHS England (NHSE) and other stakeholders needed to be refreshed and there was a genuine concern that we might see the Ageing Well agenda watered down.

These are all spaces that BGS has been campaigning hard in. Developing closer ties with NHSE has enabled BGS to have greater influence in formulating the national strategy for older people during the pandemic.

The first change seen in England was in March 2020 when extra investment was made to discharge support services for six months. This was extended, in September 2020, and looks set to be extended again in September 2021. The hope is that

What does the Honorary Secretary do?

The BGS Honorary Secretary chairs the Policy and Communications Committee which steers the policy direction and activity of the Society. They also advise on and approve press releases for circulation to the media or on our website, as well as provide input, feedback and approval of policy statements and endorsements. The postholder also helps to commission and write articles for *Agenda*. The Honorary Secretary serves for two years and is supported by a Deputy Honorary Secretary who takes on the role of Honorary Secretary after this time. The current Deputy, Dr Anne Hendry, will take over from Dr David Attwood at the end of November 2021.

this "recurrently non-recurrent" funding will become "recurrent funding" to enable better workforce planning.

Following feedback from multiple stakeholders including BGS, the EHCH specification was extensively reworked and implemented. For the last year weekly care home rounds have been taking place in primary care, with medications reviews, advance care planning, and other activities based on a Comprehensive Geriatric Assessment (CGA).

Crisis Response Teams across England have had additional funding since April 2021 and guidance from NHSE (with significant BGS input) came out in July 2021. It laid out the case for urgent community-based care, inclusion criteria, features of the service, metrics, enablers, etc. As this year progresses we will see urgent care response teams being developed across the country, which should improve the health of older people.

A third programme in development by NHSE is Anticipatory Care (AC), which involves identifying a population group at risk of adverse outcomes and delivering proactive, evidence-based interventions, personalised to the individual. This is an area where the BGS have been active; our members are supporting the national Anticipatory Care Clinical and Professional Advisory Group and influencing the forthcoming AC operating model. I have been working hard to implement this work and our locality is the UK's first to have a fully commissioned Anticipatory Care Strategy for older people.

From a research angle AC at scale is rather 'evidence-light,' the main reasons being that implementation is complex to study and requires a multi-provider (acute and community), multi-professional workforce to work together. To do this effectively needs robust information sharing and IT that allows the workforce to communicate well. At the start of my term as Honorary Secretary, information sharing was a huge barrier to joined-up working. However, the pandemic removed many of these barriers and we have seen a cultural shift towards information sharing for direct patient care being the norm rather than the exception.

So where are the key policy areas to focus on in the coming years? In addition to embedding and improving the new services, there are three key priority areas in the next few years for the BGS to grapple with:

1. Frailty identification

It is not possible to offer evidence-based interventions if older people living with frailty are not systematically identified. Each locality needs a dynamic frailty register and the logical place to coordinate this is primary care; nearly every person in the UK has a registered GP, the GP record is the only place where correspondence from every healthcare interaction are stored, and GPs have excellent longitudinal and clinical knowledge of the patient.

However, current tools such as the Electronic Frailty Index (eFI) are still not perfect for this purpose. Although eFI 2 is on the horizon, there is still significant work to do in terms of improving primary care IT systems to support better frailty identification and the creation of a more dynamic register.

2. Upskilling the community workforce

If we are to be proactive, CGAs must increasingly be done in the community. However the primary care and community services workforce may not have been trained in delivering a CGA. This is an area for BGS policy, workforce and education leads to address with the relevant SIGs.

3. Domiciliary care

The last few months have seen the domiciliary care market close to collapse and this has translated into escalating delayed transfers of care and increased hospital pressures. Something radical is urgently needed here. As a commissioner, I am growing increasingly interested in the concept of aligning domiciliary care providers to primary care networks. PCN support has worked well for care homes and could come as part of a package of other measures, including wider social care reform.

Conclusion

While it is true that the pandemic has brought much tragedy and suffering, it has also led to much innovation in care for older people. I hope that my whistle-stop tour of the last two years has given you cause to be a bit more hopeful for the future, particularly as we seem to have a more certain national strategy for older people in England and similar commitments by the devolved administrations.

My successors Drs Anne Hendry and Ruth Law will hopefully see this work bearing fruit and will continue doing what BGS does best: improving healthcare for older people.

Dr David Attwood
BGS Honorary Secretary
@DavidAttwood12

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Autumn Meeting 2021

24-26 November 2021, ONLINE

The **BGS Autumn Meeting** will return as a virtual and event on **24-26 November 2021** in what promises to be another fantastic three days.

The Autumn Meeting 2021 will cover core competencies around **cardiovascular health**, **orthogeriatrics** and **rheumatology**, **neurology** and **movement disorders** as well as the latest scientific research and the best clinical practice in healthcare of older people.

This conference will cover core areas of interest to all specialists responsible for the healthcare of older people.

For the latest information visit www.bgs.org.uk/events

British Geriatrics Society
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If you can't join our virtual meetings live, you can now watch unlimited sessions **on demand for up to 12 months** after the original broadcast. This access is included for people who registered for the original meeting, or you can register to view any time after the event.

Currently available meetings include:

- Spring Meeting 2021
- Trainees Weekend 2021
- BGS Scotland Spring Meeting 2021
- 22nd International Conference on Falls and Postural Stablity
- BGS Wales Autumn Meeting 2021

With more events being added as they happen!

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Thoughts *from a* community geriatrician

Chair of the BGS Community Geriatrics Special Interest Group (SIG), Dr Shelagh O'Riordan, shares her reflections and experiences about moving from acute care into a community geriatrician role, and some of the key differences in providing care in someone's home.

Five years ago I left my job as a geriatrician in an acute hospital, where I had been a consultant for 14 years, to become a community geriatrician.

I didn't leave because I didn't like my job; rather I felt that if we continued to do more of the same then nothing would change.

I had never in my life visited a patient in their own home so I had no idea if I would like it. As it turned out, it was the best decision of my career and I have absolutely loved it!

There are lots of models of frailty services in the community and as a geriatrician I learnt quickly that a knowledge of all the different teams (health, social and voluntary) was essential. However, as someone who knows the acute trust well and has a telephone full of useful numbers, I was able to break down some of those barriers, get expert opinions quickly, and help patients and families navigate the intricacies of acute hospital admission.

The key difference, for me, between acute and community based frailty care is how much easier it is to provide care that a person wants. I quickly learnt that whatever the reason I was asked to review a patient at home, the assessment went the best when I started off by asking what they wanted to discuss. I might have been asked to assess as they had fallen, but falls weren't even in the top 10 things they thought were important!

'I quickly learnt that whatever the reason I was asked to review a patient at home, the assessment went the best when I started off by asking what they wanted to discuss.'

When I'm sitting on someone's sofa they are more empowered to say what really matters and it's humbling in many ways. When this is followed up by a full comprehensive geriatric assessment (CGA) you can really make a discernible difference during the assessment. It's also easier to really have a good conversation about what they would want in future and really do good advance care planning.

I was providing a proactive frailty service, linked to local MDTs, when COVID hit. It quickly became obvious that the most important thing our team could do was provide an alternative to hospital admission for those without COVID, and also COVID-related care for those who did not wish to go to hospital. This led to us providing a hospital at home service, which has been hugely rewarding.

Over the first year we saw over 3,000 patients, with referrals from community teams, ambulance teams and primary care.

The past 18 months have been awful but also really clarified in my mind the important things we should consider when providing care to people living with frailty, wherever that is. Below is a reflection on some of the things I have learnt:

1. Good anticipatory care planning is the key to excellent care. Everyone is different and has different values so if we haven't asked what is important to them, we will never know what they want now or in the future. Medicine often feels like a conveyor belt to our patients and many didn't even know they could get off! It's our responsibility to ask, document and share this information widely.

2. That we need an especially good offer for people living in care homes and or their staff. The Enhanced Health in Care Homes program has moved from only providing reactive care to being proactive, working with care home staff in an equal and collaborative manner. There is a huge amount to do to make this a reality across the UK, but

John: A short community case history

Last week I was called by the ambulance team who were at John's house. He had advanced dementia, had not been eating and drinking well for about a month and had fallen today. His wife had called the GP surgery and was advised to call 999.

John wasn't injured but he wasn't well. He had a temperature and was drowsy. I talked to the paramedic and John's wife, and we agreed to a visit by an advanced clinical practitioner within two hours.

When I said her husband didn't have to go to hospital and we would talk about what was most important to them both, she was tearful and so relieved.

John was assessed at home, where he received antibiotics and treatment for constipation and pressure-relieving equipment was ordered.

Support was arranged for personal care and an anticipatory care plan was agreed that John wouldn't go to hospital for anything bar a major broken bone and that, when the time came, he would want to die peacefully at home.

we should be aiming to offer treatments in the event of deterioration within the home as the default, unless they wish an alternative. We need to absolutely ensure that people in care homes receive excellent, skilled end of life care within the home.

3. All people living with frailty should be offered a viable alternative to hospital admission that includes the ability to assess, diagnose (using point of care testing if required) and treatment within the home. This needs to be offered with the option of timely access to an MDT assessment with equipment and carers urgently available when needed. We need to share the risks with the patient to allow them to make the right decision for them and for us to be able to offer it.

4. We need strong MDTs to manage the complexities of some of our patients. Everyone is extremely busy and nobody has the skills or the time to sort things out alone. The use of video team conferencing has empowered us to include staff from different areas, including those from the acute trust. We should really try embed and retain these new found options and try hard not to slip back into old ways!

5. I have found that it's much easier to talk about breaking down barriers between acute and community care than actually doing it. This involves a change in culture, time to develop relationships and trust in one another. However, it is key to the future and we need to share examples of what works.

6. There are skills in working in the community which many training schemes for NHS staff do not include. This is particularly true of the way we train geriatricians and therapists who can almost never leave the hospital. This is improving but needs to be strengthened further if we are truly going to provide care for our patients wherever they are!

There is a real move across the UK to improve and build upon services provided at or close to home for those living with frailty. I hope you enjoy this edition of *Agenda* focussed on community services and consider what you can do differently, wherever you work, in the future.

Shelagh O'Riordan
Chair, BGS Community Geriatrics SIG; Consultant Community Geriatrician, Kent Community Trust
@jupiterhouse1

Your thoughts needed! Merging the BGS Community Geriatrics SIG and GeriGPs group

The BGS is currently considering whether to merge the Community Geriatrics Special Interest Group (SIG) and the GeriGPs group to form a new group focused on community and primary care.

Both groups share a common agenda around improving the quality of care for older people outside (but linked to) acute settings. This 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@Home and Urgent Care responses.

While it is recognised that there are some issues specific to each group, it is also the case that there is a huge overlap of interests between the Community Geriatrics SIG and the GeriGPs group. It is suggested therefore that in terms of purpose and structure, it makes more sense for these to come together while providing protected space for the specific issues relevant to each and ensuring no loss of voice or authority. In addition, there is a compelling case for the BGS to ensure that there is representation from community and primary care on the BGS Trustee Board, and that this should be written into the governing documents.

For more information on the proposals or to submit your feedback, please email Jo Gough at **j.gough@bgs.org.uk**. There will also be a chance to discuss at the BGS Autumn Meeting in the Community Geriatrics stream or at the GeriGPs meeting.

This is your chance to strengthen the voice, visibility and prominence of older people's healthcare delivered by professionals working in primary and community care.

Making *virtual wards* a reality

England's National Clinical Director for Older People, Dr Adrian Hayter, sets out NHS England and NHS Improvement's vision for fully integrated out-of-hospital care.

The BGS's recent publication, *Right time, right place: Urgent community-based care for older people*, set out a vision for urgent care out of hospital, believing that with the right assessments, diagnoses, care and support, many conditions which affect our older patients can be managed and, in some cases, reversed.

This is completely in line with our thinking at NHS England and NHS Improvement, where our NHS Long Term Plan made a clear commitment to increase out-of-hospital care and create fully integrated community-based health care. We have a number of programmes in play to embrace the 'Home First' philosophy and elevate the role of urgent care in the community. These programmes support acute episodes of care either in providing 2-hour crisis response in the patient's home or to support patient's earlier discharge. Community programmes are balanced by a personalised care approach which identifies what is most important to individual patients.

We also support the rollout of frailty virtual wards or Hospital at Home. Shortly, we'll publish guidance with practical advice on delivering an integrated approach. Ultimately, the goal is to keep people with frailty, with an acute deterioration in their health, living in their own homes, where this is their choice. Through the virtual ward they can be provided acute-level care and monitoring by physical and mental health teams in the community, with point of care testing to facilitate clinical decision-making in real time, and equivalent priority and access to hospital-based investigations.

There are some key components to a virtual ward. Firstly, it's imperative there is a senior clinician responsible for the patient, ideally a community-based geriatrician, a GP with additional skills in diagnosis and hospital level treatment, or an Advanced Clinical Practitioner (ACP) working outside an acute hospital setting.

The Clinical Frailty Score and Comprehensive Geriatric Assessment should be used as part of admission, and there should be clear pathways for recognising deteriorating symptoms. Escalation pathways need to be in place to maintain patient safety when the virtual ward clinical team are not available, for example, by referring the patient into two-hour community crisis response teams.

Wards should also be digitally enabled to support assessment, monitoring and care in the patient's home, which builds on the work happening across the country in partnership with NHSX to implement remote monitoring in care homes.

This needs to be considered alongside the organisation's ambitions to digitalise their service with electronic health records, enabling access to shared care records and using scheduling to understand demand and capacity. Thinking about how teams use digital, data and technology from the start enables teams to ensure that the right care can be provided at the right time by the right person- all aiming to improve patient care experience through a connected MDT.

Existing virtual wards are facilitating speedier discharges, reducing lengths of stay, and decreasing the risk of adverse consequences associated with lengthy hospital stays, such as infections, deconditioning, and increased delirium.

Readmissions are less likely, and ambulance callouts and visits to A&E are less frequent for this cohort of patients.

In Leeds, frailty virtual wards have been in operation for just over a year, admitting people over the age of 70 with moderate or severe frailty.

They recently took on the case of a 77-year-old man with laryngeal and prostate cancer, who had been discharged five days earlier from hospital. He's been diagnosed with acute kidney injury, a chest infection and low potassium levels. Without the virtual ward, it's almost certain he would have ended up back in hospital. In fact, he was treated at home with potassium supplements and his fludrocortisone stopped. He was discharged from the virtual ward 3 days later and referred to a community dietician for further support.

We believe there is enormous scope and potential to scale up virtual wards. We hope our impending guidance will help colleagues develop and implement their own plans to improve care for their patients locally.

If you are interested in setting up virtual wards for your patients or understanding how your teams can harness digital technology, contact:
england.communityhealthservicesorg@nhs.net.

Dr Adrian Hayter
National Clinical Director for Older People, NHS England
@Dochayter

A day in the life

of a Frailty Home Treatment Service Specialty Doctor

Through coordinated and patient-centred care, Joanna Seeley, a Speciality Doctor working in East Kent for the Frailty Home Treatment Service, helps to improve the lives of older people, even if she's not always dramatically saving them.

"So Mummy, did you save anyone's life today?"

My five year old Ted is just starting to show an interest in what I do.

"I don't know about that darling, but I think I helped someone today."

"Well you cant have saved anyone's life mummy, you don't work in a hospital, do you?"

And just like that, the child brings me crashing back down to earth… and there's me thinking I'd had a really good day today!

We'd started as we always do, with a Teams meeting. We run three services; community hospital support, a home treatment service, and proactive frailty support. Three services, Ted! That's a lot of organisation.

I'd then attended a visit to a local residential home with the Primary Care Network Care Homes Team. The home has a lot of unplanned admissions, and as a multidisciplinary team (MDT) we'd been working together for weeks, discussing how we can support them.

The fantastic care home support workers had built relationships with the management team in the home, and we were invited in. Working in networks, Ted! Again, a lot of work.

During the visit, while discussing how they can use our Frailty Home Treatment Service to support residents with acute illness in the home - a 'hospital at home' model - an ambulance pulled up outside (the timing really was impeccable).

A resident had developed lip swelling. A call to 111 later, and paramedics were despatched. I excused myself from the meeting and met Shaun and Emily, the paramedics assessing Maeve.

Emily was preparing to whisk Maeve off to the local A&E, when I made a suggestion: "it looks like isolated angioedema, Maeve isn't showing any signs of respiratory distress… perhaps we could treat her here?"

Shaun had used our service before; "you're the home treatment service?! Yes! You can do anything!" See Ted, we work with paramedics!

After treating Maeve with some steroid and antihistamine, and leaving her under the watchful eye of the Care Homes Team GP, I head off to a frailty hub; an MDT made up

'We discuss new referrals and patients we've all seen. I'm always amazed at how the whole team comes together to find out what matters to the person, and tries to find a way to make it happen.'

‘While the bloods are processed I examine Roy. Significant supra-pubic tenderness... could I be about to diagnose an actual UTI?!’

of representatives from primary care, mental health, social services, third sector, community health… you name it, they’re there.

We discuss new referrals and patients we’ve all seen. I’m always amazed at how the whole team comes together to find out what matters to the person, and tries to find a way to make it happen. We might not be “saving lives” Ted, but I’m sure we’re improving their quality.

After the meeting I get a call from the Senior Clinical Decision Maker of the day. A paramedic has called, who’s with Roy. His wife called an ambulance in desperation because he’s looking unwell, isn’t eating or drinking, and has been agitated all night, but he doesn’t want to go to hospital. A colleague is free to go with me so we gather our equipment (four bags Ted, four bags!) and set off.

When we arrive we’re met by Jean, Roy’s wife. She looks exhausted. She explains that Roy has dementia and she’s been caring for him for years now. She’s noticed things have been getting worse over the past few months, but for the last day or so he’s really seemed unwell. Off his food, and much less calm than usual. I chat to Roy. He’s agitated, delirious, and just seems uncomfortable.

I take some blood while my colleague talks to Jean about Roy’s Treatment Escalation Plan, confirming that home is his preferred place of care. While the bloods are processed I examine Roy.

Significant supra-pubic tenderness… could I be about to diagnose an actual UTI?!

By the time I’m done the blood tests are ready. CRP 12. Think again. Jean has been showing my colleague Roy’s medications. “Oh no, he stopped taking that powder for his bowels about 10 days ago.” Ah…

We gently roll Roy and confirm our suspicions. He’s incredibly constipated. Luckily we came prepared. An enema and half an hour later and Roy looks at me. "That feels better.”

We leave Jean with a promise to get back in touch tomorrow, and a some advice about delirium. She understands he might not get better straight away, but also that keeping him at home is the right decision for him.

As we leave, she comments, “just imagine how frightened he’d be in hospital.”

“So Ted, today I’ve prevented two admissions for people who wouldn’t want to go to hospital. As a team we’ve supported five community hospitals, and we’ve worked as part of the wider MDT, focused on supporting people with frailty to live well at home.”

He erupts onto fits of giggles: “Mummy, you didn’t save a life, but you did help someone do a really big poo!”

Joanna Seeley
Speciality Doctor, East Kent Frailty Home Treatment Service
@JoannaHNewman

Community **MDT** in action

Ruthy Pritchard is a Trainee Advanced Clinical Practitioner who specialises in managing older people with frailty as part of the Long-Term Conditions team. She describes her personal perspective of the experience of working in a pilot scheme in South West England centred about Comprehensive Geriatric Assessment (CGA) in the community.

Livewell Southwest is an independent social enterprise providing integrated health and social care services for people across Plymouth, South Hams and West Devon, and some specialist services for people living in parts of Devon and Cornwall.

An 'ageing well multidisciplinary team (MDT)' - where integrated health and social services come together to identify those patients with frailty who would benefit from a Comprehensive Geriatric Assessment (CGA) - was piloted in a partnership between Pathfields Primary Care Network (PCN) and Livewell.

The concept

The idea is that as the CGA comes together, a list of problems is generated by the MDT. The right service then sees the patient, and the team starts addressing each concern and proactively providing patients with the care they need in a holistic way.

The CGA summary, including their Advanced Care Plan (ACP), is then given to the patient so that if they go into hospital, they can take the CGA with them as a way to give a quick overview to the acute medical team.

This summary goes on our system and the GP records (which can of course be updated). An alert is then sent to the ambulance and acute services, with a view that if the patient goes into hospital or sees a new service there are thorough assessments for each domain of care which

‘All services aim to provide holistic care, however the reality is that many patients living with frailty receive unidimensional care, depending on the service silos.’

should facilitate care. This pilot sits with the BGS *Fit for Frailty* guidance which highlights the recommendations on shaping services with a strong frailty conscience.

Before the pilot started, most of the patients referred to our Long Term Conditions (LTC) Service were older people with multiple co-morbidities, polypharmacy, and various degrees of social difficulties. They were usually known to one or more clinical services, specialist clinical teams, and/or adult social care.

Thinking back, these patients typically presented with one or more frailty syndromes, and were living with frailty alongside their other LTC(s). At the time, I didn't really know much about 'frailty' as a long-term condition but rather an inevitable part of the aging process. How wrong was I? A few weeks into the 'Ageing Well' pilot, it was evident that I had much to learn - and I'm still learning!

The pilot

As the pilot came together, it became clear that for the Ageing Well MDT to work, it needed equal representation from health, adult social care, therapy, and an efficient MDT coordinator to hold it all together. It must also be accessible to any health or adult social care professional wishing to bring a patient for MDT discussion. We met weekly to start with. Under Dr David Attwood's medical steerage, we all had the same drive to improve outcomes for our older patients, so delivering CGA became the focus of our work.

What have I learned?

Firstly, I've learned that managing older people living with frailty is complex and often needs medical direction.

It's necessary to have timely access to integrated care, in a way that the invisible barriers between services are removed. A year on, I can see in some respects that this is easier said than done – and as an organisation, we continue to evolve to lessen the impact those barriers have in delivering care.

I've also found that many of our interventions in the elderly population are reactive rather than proactive. Therefore, the pilot has facilitated an opportunity to learn about the benefits of CGA and how to best deliver it to promote proactive care.

All services aim to provide holistic care, however the reality is that many patients living with frailty receive unidimensional 'holistic' care, depending on the service silos. The pilot enabled services to come together to learn, reflect, develop and deliver a genuinely joint approach to manage our patients.

The benefits

At the locality level, the pilot allowed us to identify those patients most at risk and target their intervention to improve or reverse elements of frailty.

It also facilitated inter-disciplinary work to be more effective in meeting the patient's needs. It enabled

> ‘I feel like understanding what frailty means for the patient is like putting together the edge of a puzzle, from which, once completed, we can put the other pieces too.’

engagement between professionals and looked at ways to improve how we prioritise care, what services are offered, and identify the most appropriate person to lead the care. I found that families felt empowered and listened to as they could participate in their loved ones' care in an anticipatory way. It also empowered the patient to feel in control of their goals, enabling them to have conversations while they feel well to allow them to feel less apprehension about the future.

The CGA summary then provides the health or social care teams with a holistic overview of the patient in front of them, including their treatment escalation plan and future wishes, at a time where our patients are unable to give a complete history or express their needs.

The rewards

Personally, it has allowed me to develop and focus my practice, and to make a difference, one patient at a time. I feel like understanding what frailty means for the patient is like putting together the edge of a puzzle, from which, once completed, we can put the other pieces too. Furthermore, it has been a joy to be part of a team where we have all grown in knowledge of each other's services, which supports better holistic assessment and management plans for our patients.

The pilot has highlighted that CGA is vital to facilitating communication between patients and services, a better flow of care, a more seamless transition from acute to the community, or in medical crisis, from community to acute.

Future challenges

There remain challenges, such as interoperability of different IT systems between health and social care within the organisation - and similarly, communication systems between the acute hospital and community services.

However, this pilot has increased awareness across services and, as a result, continues to explore ways to close the gap and develop new, more valuable ways to achieve more efficient communication systems.

And finally, the challenge of accessing timely rehabilitation, with the ever-increasing demand being more significant than supply, leads to long waiting times that many older patients living with frailty simply may not have.

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A patient-centred journey:
Following the pharmacist through the virtual frailty ward

Consultant Pharmacist for Older People Heather Smith, along with pharmacist colleagues, explore the value that the pharmacist brings to the multidisciplinary team in a virtual frailty ward in Leeds.

This case study of virtual frailty ward team in Leeds highlights the importance of person-centred consultations for frail older people including shared decision making to determine the patient preferences, beliefs and values in relation to their medicines and desired outcomes.

Virtual Frailty Ward setting

The Virtual Frailty Ward (VFW) in Leeds enables patients to be treated for acute conditions in their own home. While the lead provider is Leeds Community Healthcare NHS Trust, the VFW is a collaboration between Leeds city partners. The service is delivered by members of the 'neighbourhood team' consisting mainly of nurse independent prescribers and allied health professionals who are supported by a wider multidisciplinary team (MDT) including consultant geriatricians and pharmacists who are directly employed to work on the VFW. There is an MDT meeting every week-day where patients admitted to the VFW are discussed and plans for treatment and monitoring are agreed.

Who runs the virtual frailty ward?

The virtual frailty ward service is delivered by the 'neighbourhood team' - nurses and allied health professionals supported by a wider multidisciplinary team which includes consultant geriatricians and pharmacists.

Patients can be stepped up from community or stepped down from hospital to the VFW. Although the ward itself and the MDT are virtual, patient care is delivered face to face in the patient's own home.

Here we describe the case of a complex frail older person referred to the VFW pharmacist by the community matron. We highlight the importance of shared decision making, reviewing all medicines a person is taking including non-prescription medicines and the value that pharmacy brings to the MDT.

Case study

Ms ST is an 81 year old female who was admitted to the VFW with hypothermia and hypoglycemia. ST was a step-down patient admitted following her discharge from hospital following a viral exacerbation of asthma/COPD. Her medical conditions include asthma, chronic obstructive pulmonary disease (COPD), pemphigus herpetiformis, hypothyroidism, and osteoporosis. ST has moderate frailty with a Rockwood clinical frailty score of 6. ST lives alone but has daily support from her daughter. ST was referred to the VFW for ongoing monitoring of blood glucose given the hypoglycemia that had caused her admission and for supervision of her reducing steroid regimen.

What matters to the patient?

The pharmacist visited ST at home with her daughter for a person-centred medication review and established at the beginning of the consultation what mattered to ST. She was most concerned about her skin condition which was now widespread. The pharmacist established that overall adherence to ST's prescribed medicines was good and that she was taking a lot of additional non-prescription or over-the-counter (OTC) medicines and supplements which concerned her daughter. The medicines before and after person-centred pharmacist structured medication review are illustrated in Figure 1.

Skin concerns

ST had an ongoing skin flare and described scratching throughout the night even though she was taking fexofenadine 180mg three times a day and using topical agents. She was not keen on increasing her fexofenadine to a four times daily dose as she had experienced a very fast heart rate and dizziness when she had taken fexofenadine four times a day in the past. ST stated that she hadn't had her usual topical treatments available to her in hospital, which may have exacerbated her existing skin condition. ST had a widespread inflamed rash over her trunk and limbs and was using her Dermol® lotion frequently up to six times a day. She was using the clobetasol cream twice a day but wasn't always waiting 30 mins until the Dermol® had been absorbed before applying the steroid cream. ST's daughter was only available to apply the Dermol® twice a day to the whole back. The pharmacist explained how to use the topical agents to gain the most benefit and arranged for ST to have an aid (long-handled applicator) to enable her to apply the cream to the whole of her back when her daughter was unable to assist. It was agreed in the MDT discussion for the VFW that a trial of better application of topical agents would be enacted but if this didn't resolve the situation, that ST needed urgent review of her current treatment plan by Dermatology.

Key point

Establish what matters most to the patient, with shared decision making to determine the patient preferences, beliefs and values in relation to their medicines and desired outcomes.

Figure 1: Before and after ST's person-centred pharmacist structured medication review

Medicines on admission to the Virtual Frailty Ward

Prescribed medicines

- Clobetasol 0.05% cream 1-2 x daily for skin flares
- Dermol 500 lotion three times a day
- Fexofenadine 180mg three times a day
- Levothyroxine 75 micrograms daily
- Macrogol compound oral powder sachets twice a day as required
- Prednisolone 20mg daily- to reduce to usual dose of 10mg daily in a few days
- Salbutamol 100 microgram/dose inhaler 2 puffs as required for breathlessness/wheeze via spacer

Over the counter medicines/supplements

- Gaviscon® liquid
- Gingko
- Glucosamine/chondroitin
- Garlic
- Calcium, magnesium and zinc
- Calcium and vitamin D
- Selenium tablets
- Vitamin B complex
- Turmeric
- Evening primrose oil including vitamin B1
- Cod liver oil
- Methylsulphonylmethane (MSM)

Medicines after Pharmacist Structured Medication Review

Prescribed Medicines

- Alendronate 70mg weekly
- Clobetasol 0.05% cream 1-2 x daily for skin flares
- Dermol 500 lotion six times a day
- Fexofenadine 180mg three times a day
- Lansoprazole 15mg daily
- Levothyroxine 75 micrograms daily
- Macrogol compound oral powder sachets alt days- daily as required
- Prednisolone 20mg daily - to reduce to usual dose of 10mg daily in a few days
- Salbutamol 100 microgram/dose inhaler 2 puffs as required for breathlessness/wheeze via spacer

Over the counter medicines/supplements

- Calcium and vitamin D
- Cod liver oil

OTC/supplementary medicines

ST's extensive OTC supplements/ medicines included Gaviscon® liquid; gingko; glucosamine/chondroitin; garlic capsules; calcium, magnesium and zinc tabs, calcium and vitamin D tablets; selenium tablets; vitamin B complex tablets; turmeric capsules, evening primrose oil including vitamin B1; cod liver oil and methylsulphonylmethane (MSM) tablets. ST explained that she was very health conscious and concerned that her diet wasn't providing her with everything that she needed to stay well. The pharmacist established that ST had a good, varied diet and explained to her that she was not missing anything from her diet that would need additional supplements. The pharmacist explained that there was duplication between the supplements as four contained calcium and four also contained vitamin B12 which probably explained the high level of vitamin B12 >2000mg/L detected (ferritin and folic acid normal). Turmeric could be added directly to food. The pharmacist also highlighted to ST and her daughter that MSM tablets could be aggravating her skin as a listed side effect of MSM is that it can cause itching and worsening of allergy symptoms. After further discussion, it was agreed that ST could continue with calcium and vitamin D and cod liver oil but would stop all other supplements. It was important that ST continued vitamin D as she was not exposed to enough sunlight to produce this naturally.

Key point

Establish *all* the medicines a patient is taking, including non-prescription medicines and/or supplements.

Osteoporosis management

ST had osteoporosis but wasn't currently taking any bone protection agents. The pharmacist explained that the osteoporosis was likely to be steroid-induced. Her GP had previously prescribed alendronic acid and lansoprazole but ST had stopped these as she was concerned it had been causing her skin problems. The pharmacist explained the rationale for prescribing alendronic acid (bone protection to prevent fragility fracture and the mechanism of action) and lansoprazole (gastroprotection while on steroids). The use of these agents in ST is complex and fraught with uncertainty in relation to the risks and benefits, as there is a risk of atypical fractures with alendronate and proton-pump inhibitors have been associated with an increased risk of fracture, *C.difficile* infection and hypomagnesemia with long-term use. ST was keen to re-start both alendronate and lansoprazole at the lowest effective dose. As alendronate was re-started, it was even more important that ST had adequate vitamin D intake.

Key point

Patients may accept a level of risk as a trade-off for something more meaningful to them.

Thyroid monitoring

ST's levothyroxine dose was increased during her hospital admission. The pharmacist advised the GP practice to repeat thyroid function tests (TFTs) in a few weeks time and established that ST wasn't having any adverse effects after the dose increase. As over-treatment of hypothyroidism with

levothyroxine can decrease bone quality and bone mineral density, it was important to check that TFTs were within the normal range.

Inhaler technique

ST's inhaler technique was checked and she was able to use the short-acting beta-agonist (SABA) inhaler using the aerochamber spacer with no issues. ST had no night time symptoms or wheeze currently and was using salbutamol approximately once a week so the SABA was the recommended treatment for her asthma.

Take home message

The pharmacist working as part of a multidisciplinary team on the Virtual Frailty Ward along with person-centred, face to face visits with patients and carers, results in improved medicines optimisation for frail older people. Shared decision making[1,2] is key and is part of person centred care, involves listening and with-holding judgement, helps to explore different perspectives such as discussing and understanding the patients realities including barriers and exploring risks and benefits not just from a clinical perspective but from a patient's. Therefore, patients may accept a level of risk as a trade-off for something more meaningful to them.

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Enhancing health *at the heart* of the home

Deputy Chair of the BGS England Council, Asan Akpan, shares his experience of the enhanced health in care homes model in Mersey

Simply put, enhanced health refers to the additional services healthcare providers can put into care homes in their area. Most care homes are privately owned, and traditionally they have had no formal arrangements for routine proactive care as an entity. Residents who have any health condition requiring the attention of a health care professional usually were either reviewed by their GP or transferred to the local hospital.

Over the last 20 years, and certainly in the last decade, other additional health care providers have become involved but this has been sporadic and patchy across the UK.

The Enhanced Health in Care Homes (EHCH) model[1] was introduced in England and healthcare providers were encouraged to implement this service support in their areas.

The model encourages a multidisciplinary team (MDT) approach with providers from community, primary and secondary care working with social services and relevant others to proactively identify residents at risk of a crisis, and to manage these people as far as is feasible in their care home.

Today we have clear guidance that details what needs to be in place for an ideal MDT support for care homes and the BGS has produced very good recommendations that can help any one or area looking to set this up.[2]

In Merseyside, like in other parts of the UK, we have some form of EHCH that continues to evolve. Care Home Community Matrons (CHCMs) are the bedrock upon which the model is built. These senior and experienced community nurses proactively identify residents at risk of crises by checking in regularly (at least once weekly) with each care home in their area of responsibility, to review those recently admitted and anyone the care home staff have concerns about.

‘The model encourages an MDT approach with providers from community, primary and secondary care working with social services and relevant others to proactively identify residents at risk of a crisis.’

The CHCM can lease with the individual’s GP or community geriatrician for additional reviews and /or guidance if required. Additional clinical and on going care can be provided through the two-hour response teams that most areas now have in place. In some parts of the UK, hospital at home models that can give more clinical support and care are already in place.

Weekly MDT care home meetings are now routine in some areas and in South Sefton we have had this since June 2019.

Referrals come directly from the care home staff who have discussed the case with their care home matron, usually on a form, with key information provided. The MDT includes care home staff (carers and/or manager), CHCM, pharmacist, social worker, integrated care coordinator, administration support clerk, community mental health nurse, old age psychiatrist and a community geriatrician. GPs and relatives or those with power of attorney can join the MDT discussion, which is held virtually on MS Teams.

Usually no more than four cases are discussed in a one hour period. This is for an area with 34 care homes. All records are on EMIS so the GP has immediate access to the discussion summary, including any recommendations. Most residents discussed are frail with psychological and behavioural symptoms of dementia. The MDT has been most helpful for this group and has helped maintain residents in their home.

As a community geriatrician my knowledge in managing this group has improved considerably because of my old age psychiatry colleagues on the team. It has also made it easier and more efficient to manage that grey are between delirium and onset of dementia, as we are able to review any relevant investigations and history together and agree on a diagnosis that then allows for the appropriate care to be put in place.

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Community Geriatrics: A SAS-sy perspective

Amy Heskett is a Specialty Grade (SAS) Doctor working in community geriatrics in West Kent. She explains what led her to pursue a career in the community and what she loves most about her job.

My career path has not been a carefully carved set of aims, but rather a series of sudden stumbles initiated by personal challenges which meant I was able to consider changing direction. These challenges were compounded by limited options for less than full time (LTFT) trainees at that time (I hope this is less of an issue now) and an opportunity to pause for a year in a pilot for a Community Geriatrics team.

I didn't jump in with enthusiasm but was intrigued by the ideas that Dr Peter Maskell (Geriatrician and Medical Director at Maidstone and Tunbridge Wells NHS Trust) filled me with about the options to manage frailty syndromes in people's homes. I dipped into this new concept tentatively, and although often a turbulent experience, I have been truly sucked into Community Geriatrics. Peter continues to challenge and inspire me and the time he allows me to reflect is very appreciated.

Community Geriatrics has given me space to slowly build back confidence and explore my values. I have reconnected with my clinical diagnostic skills and found I enjoy working creatively toward patient-centred goals. I am fully immersed in a multi-disciplinary team that includes the person with frailty and their families; guidelines are cheekily (but thoughtfully) adapted to encompass a person's decisions and there is space for fun to be prioritised too.

'I have reconnected with my clinical diagnostic skills and found I enjoy working creatively toward patient-centred goals.'

Community Geriatrics is a peculiar mix of appreciating the need to have thoughtful, candid discussions that require patience, and the identification of those with frailty syndromes requiring quick, pragmatic interventions. Acknowledging the risks of community management and balancing against those associated with transfer to hospital is key. Holding those risks together and following a person's progress in the place of their choosing often results in a joyful satisfaction for all involved, or an acknowledgement that wishes were respected.

I had never considered being a SAS doctor; I intended to return to a training post or become a Consultant via a Certificate of Eligibility for Specialist Registration (CESR) route. However, this 'tick box' process became a distraction from enjoying the development of my current team. I have been able to develop training opportunities for other SAS doctors, allied health professionals (AHPs) and trainees. I enjoy watching the skills and equipment available to the team increase.

SAS posts afford autonomy if you are willing to challenge yourself, identify learning needs and make links to other organisations to champion your role. I have been able to continue my professional development and the links with the local acute trust are respected because of consultants such as Dr Owen Ingram (Maidstone and Tunbridge Wells NHS Trust) who are willing to embrace different ways of working. I have been so fortunate to have my leadership role backed by Dr Shelagh O'Riordan and for SAS to continue to be an adventure and not a stopping point.

Thriving as a SAS doctor often means taking initiative for your own career options, carving out space in an area that requires your unique skills, and to champion that role. In short you have to be prepared to be SASsy!

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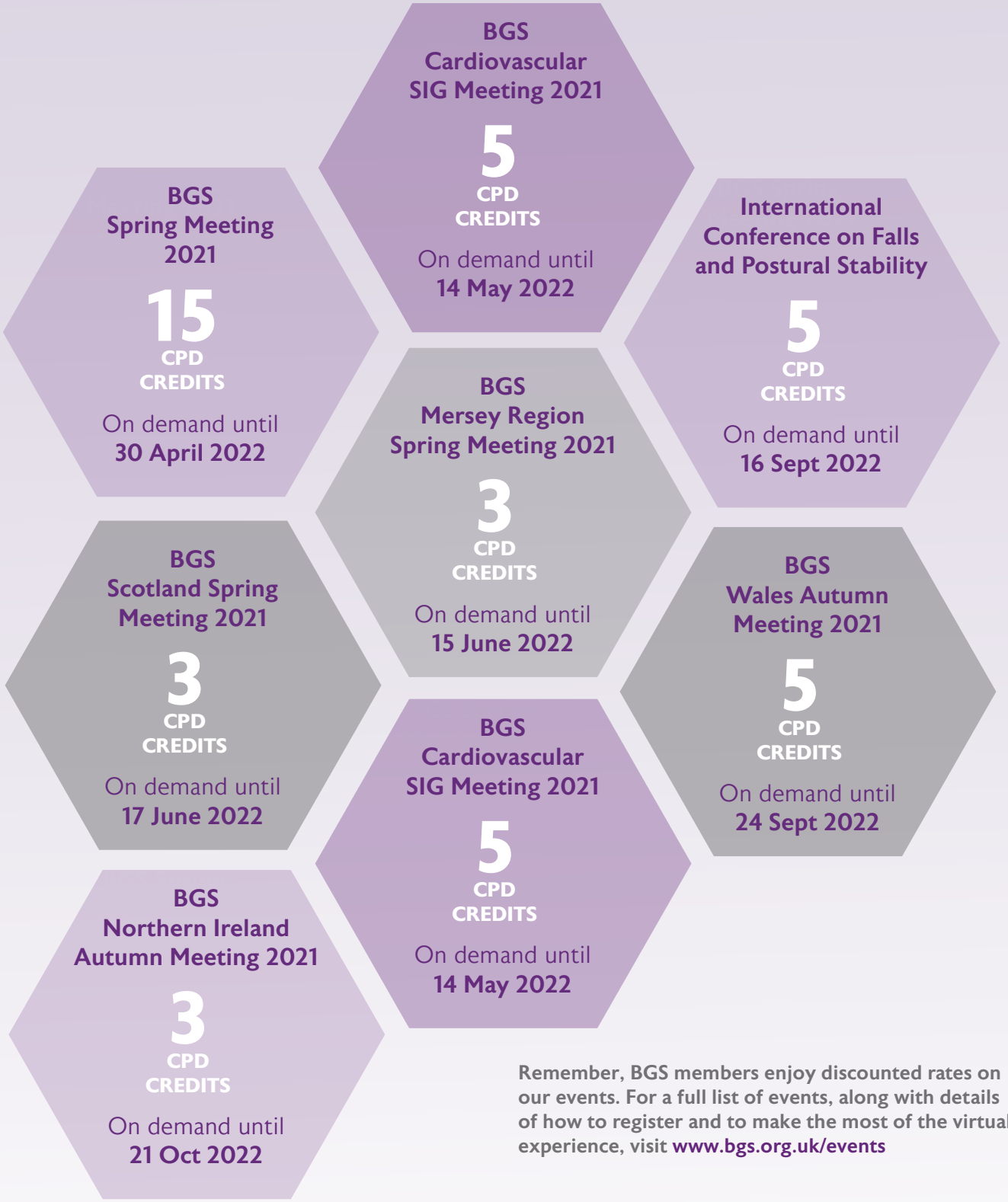
Virtual events **on demand**

All BGS virtual events are available via live stream, but did you know that you can register and watch almost any BGS virtual event for up to 12 months after it happened? You can still claim CPD hours for viewing these recordings - you will just need to manually record this in your CPD diary using the event code and hours watched. A selection of currently available events is below:



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Ebbs and flows
in acute and community care

Lesley Bainbridge is the Lead Nurse for Frailty and Integration Newcastle Gateshead Clinical Commissioning Group. She reflects on the relationship between admissions and discharge and how systems need to work together to help keep older people out of hospital.

I recently accepted an invitation to discuss 'Trusted Assessment' and 'Reducing Hospital Admission' referencing the Local Government Association 'High Impact Actions' for managing transfers of care[1] and reflected afterwards the conference presentation hadn't gone well.

Although heavily influenced by good evidence and nursing experience gained over many years, I felt I hadn't got the message across to the audience, and for a short while afterwards I felt a bit uncomfortable. Afterwards however, I was contacted by the BGS to write this article, so felt reassured that I was speaking sense.

Then it dawned on me of course that perhaps it was simply an indication that I had caught the ear of the already understanding.

And yet, talking about 'reducing hospital admissions' and 'trusted assessment' surely means talking about more than the part of the system you work in?

There isn't any point trying to 'flow' patients through our hospitals if we don't know the ebb and flow of the care system we're part of.

There isn't any point celebrating our successful ability to comprehensively assess our patients to identify their needs, and problem solve to meet those needs, if we don't understand that those in other parts of the system might not know what we're on about.

Understanding the ebb and flow of the care system we work in is the same as understanding the ebb and flow of our patient's lives, so there is a solution. 'Ah', you're probably saying to yourself, 'so we're back to comprehensive geriatric assessment (CGA)'.

Well not altogether because while there isn't any doubt that a CGA done well focuses the mind to identify and meet needs in an unrivalled way, it doesn't guarantee that we know more than our bit, our organisation, our team or our discipline's unique contribution.

Using CGA to focus on more than the problems arising from it does however because it not only lets us see our patients lives but the care our partners in other places provide also.

Take Jackie here: **https://tinyurl.com/JackieBGS**. Yes, of course if he hadn't had a CGA we wouldn't have been able to tell his life story, but let's also talk about what else we see. It is clear that he had many years of good health when he rarely accessed health care and when he did, a full recovery without disability was made.

We can hypothesise that a couple of his long-term conditions may indicate the public health messages didn't hit the mark, and we can see that long before he started accessing secondary care in the last two to three years of his life, his long term conditions were well managed by the primary care team for many years.

On a personal level we get a feel for the man and his family, the love held for his trade that kept him working, and thereby physically active, into his late 70s. We feel the pain of his bereavement and see it coincide with a sustained use of health care, and we also see that even with a big care commitment from his family, he accesses social care.

Outtakes reveal the voluntary sector made sure he was able to continue attending the war veteran association he was a member of, prompted by the community occupational therapist who knew that managing occupation in later life was more than aids and adaptations for daily living. We see this also relieved the family of something they'd have had to do otherwise, so we see carer consideration and support at the same time. When his needs were most complex and his consumption of care greatest we see 24/7-365 rapid response community nursing and cohesive in- and out-of-hours primary care. From this we see that not only was he kept out of hospital appropriately on six occasions but that he had timely access to specialist older people's services in secondary care when needed.

All this system sight from a single patient's life - but the question now is why is it so important we understand this?

We know that we have an ageing population that have increasingly complex needs and that they are the biggest consumers of care. We know also that the biggest inquiries into care failings in recent times have overwhelmingly involved older people (for example, Francis[2] and Shipman[3]).

While of course these two things go together, biggest consumers = biggest affected group, it prompts us to look for reasons. One reason could be that to date only medicine as a discipline has formally trained its people to specialise in the care of older people. That isn't to say that other disciplines haven't become specialists, but they've had to do so in a less structured and less formal way.

Unless we understand the system in the context of our patient's lives, building an army of advanced frailty care practitioners won't be enough, and there is an argument that neither primary care nor secondary care is set up to meet the needs of older people with complex needs, given we are still trying to fit them into single system disease boxes.

To make discharge planning meaningful and transfers of care optimum, we need more than High Impact Actions - we need workforce development and purposeful commissioning that proves itself through critical and robust evaluation to be integrated and system considerate.

To understand what is needed for flow out, we've got to understand the reasons for flow in.

With younger adults, where they've previously been well and can give a history, it is clear they have an acute illness, usually with single system pathology which means it is easy to spot and make a diagnosis.

With older adults, multiple health problems mean there can be an acute or chronic problem to be dealt with and there may be more than one presenting at a given time making it difficult to spot. History taking can be more problematic and corroboration may be needed and sometimes, unless they fall into the right hands in the right part of the system, a label rather than a diagnosis can follow. Think 'social admission', 'bed blocker', 'family can't manage', 'it's just your age' or similar harmful labels that are used too often.

Labels can't lead to diagnosis or treatment in any part of the care system, and a leaf that could be taken from the book of those specialising in older people's care is the ability to understand and consider normal ageing at the same time as the clinical/problem presentation.

Jackie had good care at a time when his care needs were most complex and acute. It started at home with CGA undertaken by an older person's nurse specialist, shared care planning and case management. He had access to rapid response nursing teams able to make differential diagnosis and initiate treatment using Patient Group Directions (PGDs) as well as facilitate an earlier discharge by being able to administer intravenous antibiotics at home.

The nurses worked closely with GP colleagues in- and out-of-hours and there's no doubt these collaborative relationships were key in the delivery of safe home care as an alternative to hospital, but so too was the fact the family carers could follow the care plan and easily refer directly to the services. Moreover, with each of his very necessary hospital admissions Jackie had access to geriatricians and wider multidisciplinary team (MDT) members for specialist medical and therapy care, as well as thoughtful discharge planning involving his family.

To use the lingo of current directives; what Jackie had was personalised care, anticipatory care and, if it wasn't for his family, it would have been enhanced health for care homes too. Before we pat ourselves on the back however, let's ask ourselves how was all this put into place, who did it, is it still there achieving the same and is it being replicated. Or is it an integrated care system freak?

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British Geriatrics Society
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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**

Going for gold: Frailty via the front door

As we start to emerge from the pandemic it is time to re-focus our efforts on ensuring services for older people, especially those living with frailty, are integrated across primary, community and secondary care settings. Rebekah Schiff and Bettina Wan describe a new acute service specification document developed to help integrate frailty services via the front door.

Given the increasing evidence base[1] that for many acute medical issues hospital admission is not the best place for treatment of people living with frailty, combined with the national programme to enhance community services for older adults,[2] it is vital that acute front door frailty services use their specialist skills to ensure older adults receive the right care, at the right time, in the right place.

We now have significant backing for the development of front door acute frailty services, with the *NHS Long Term Plan* stipulating that, in England, all type 1 emergency departments should have an acute frailty service.[2] Likewise, it is imperative that acute frailty services are an integral part of same day emergency care services. These services, often co-located with the emergency department, aim to provide same day care for emergency patients who would otherwise be admitted to hospital, by offering rapid assessment, diagnosis and treatment, and discharge within 24 hours where appropriate. Acute frailty services, as part of same day emergency care services, routinely systematically identify frailty in people who present acutely, consider the personalised needs of individuals, their degree of frailty and severity of acute illness to develop a shared plan, supported by clear reliable integrated care pathways into and out of hospitals, aligned to the degree of frailty identified.

As a tool to help Trusts develop their acute front door frailty services, the London Clinical Frailty Network has published a guidance on acute front door service specification entitled *London: Unplanned Hospital Care Acute Frailty Service Specifications – Guidance Document*.[3] This has been endorsed by NHS England and Improvement (London). The guidance aims to describe the acute frailty pathway after a patient arrives at the hospital and focuses on what the service looks like for people living with frailty who are expected to be in hospital for between four and 24 hours, either as walk-in patients, or directed in by GPs or 111/999 services. It should be read in conjunction with the NHS England and Improvement document *Principles and Characteristics of an Acute Frailty Service for Same Day Emergency Care*.[4] The intention is to provide guidance on setting up and improving Same Day Acute Frailty Services (SDAFS) in hospitals, enabling an older adult living with frailty to experience a consistently excellent level of care whichever hospital front door they enter.

Following the triple assessment using NEWS scores, Clinical Frailty Scale and the 4AT, the guidance describes a triage process: People identified as living with frailty arriving at hospital generally fall into one of three groups according to their acute healthcare issue and medical stability:

A. Likely to require admission beyond 24 hours
B. Likely to go home within four hours from emergency department
C. Potential for same day (within 24 hours) discharge but unlikely within four hours, suitable for SDAFS.

For groups A and B the guidance stresses links to ongoing frailty care pathways either in the community for those discharged within four hours or in the inpatient wards for those admitted. Older adults admitted to Geriatrician-led wards should receive comprehensive geriatric assessment (CGA) there but on non-Geriatrician led wards a minimum standard using FRAILSAFE[5] is advised.

The SDAFS Specification is designed as a self-assessment tool to help each Trust determine the strengths and weaknesses of their local service with a view to continuous improvement. Divided into five sections it gives guidance on patient assessment and management, the make-up of the multi-disciplinary team, key stakeholder links, necessary infrastructure and governance (including quality improvement and research). Working through the specification Trusts are encouraged to award their service with Bronze, Silver or Gold status with a view to all Trusts aiming for Gold.

Priorities for improvements should be locally led and we hope the guidance will support business planning. Although concentrating on the service once a person arrives at the hospital front door, the specification stresses that front door acute frailty services belong to a cross-sector integrated urgent care system that spans primary care, community services, ambulance services, social services, voluntary sector and acute hospitals. The success of any service will depend on collaboration with all these stakeholders and needs to be supported by commissioning

The guidance is available via the BGS Frailty Hub at www.bgs.org.uk/FrailtyHub. Feedback with a view to revisions in the future would be welcomed by the authors.

Rebekah Schiff and Bettina Wan
Consultant Geriatricians, London

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Benchmarking Excellence

The NHS Benchmarking Network is a member-led organisation, open to all commissioners and providers of publicly funded health and social care services. Debbie Hibbert from the NHS Benchmarking Network explains how clinicians can get involved in submitting data to help drive improvements in frailty care.

Why should units submit data?

By submitting data to the NHS Benchmarking Network's Managing Frailty in the Acute Setting project you have the tools to compare your acute frailty services against the national picture, as well as reviewing your peer position. The interactive toolkit provides essential insight, showing your service against a range of key metrics, highlighting areas for service/quality improvement, and supplying relevant data/evidence to create business cases and initiate change. You will gain access to a network of healthcare professionals all working together to create system-wide change, with shared learning being a key aspect of all our benchmarking projects.

How do you submit data?

The Managing Frailty in the Acute Setting project currently has two data collection cycles – one annual cycle, collecting the previous year's data, and one quarterly cycle, collecting recent intelligence.

The annual cycle comprises both the central organisational level collection and the Service User Audit. Both collections require data to be submitted via the online data collection pages, which are located on the members' area. The annual project has just closed for data collection, and the data is being analysed and validated, ready for publication in the New Year. The project will run again in the Network's 2022/23 work programme.

The quarterly collection is one of six workstreams in the Acute Transformation Dashboard (ATD) and requires data on a carefully selected, limited number of activity metrics. These are submitted on a month-by-month breakdown to enable members to track and monitor trends, in particular, recovery from COVID-19 and transformational activity. Submissions to the ATD are entered offline on an Excel spreadsheet, and returned via email to either Hester (**h.girling@nhs.net**) or James (**j.riley@nhs.net**) in the Network Support Team. Members can submit data to the ATD at any point throughout the process and can enter back-data to fill in the gaps, providing a stronger evidence base for Board level briefings.

The Acute Transformation Dashboard will open to collect data from Quarter 3 of 2021/22 on **4 January 2022**. Please contact the Support Team (Hester or James) if you would like more information.

Linking with routinely collected data

The data requested should be part of routine data collected by your unit/Trust/Health Board, but as it covers a pathway approach, it is not likely to be found in a central data repository or national data collection, which can be easily extracted (although you could of course ask your IT colleagues whether this is possible!). You may need assistance from your Performance Management, Finance and HR colleagues to source elements of the activity, finance, and workforce data, but much of the data specification is likely to be easily accessible from within Medical Divisions/Department of Medicine for the Elderly, etc.

How does this link with other audits/data?

We are pleased to work with valued stakeholders and have collaborated with organisations such as the Wessex Academic Health Science Network (AHSN) to produce a regional cut of the data for their acute providers. This has contributed to an AHSN-wide quality improvement programme, which has in turn led to further collaboration acting upon key evidence from the benchmarking project (for example, with Health Education England). The result of this work has been the successful development of frailty education and training tools. You can listen to our recent podcast to hear how the collaboration between NHS Benchmarking Network, Wessex AHSN, and subsequently, the London Clinical Network, has supported national developments in the frailty education arena. The Network have also linked into other workstreams nationally (see below).

How do you see your own data?

All data submitted by members is fed into interactive online toolkits, which highlight your organisation's position against the national averages (mean and median) and against your peers. The Acute Transformation Dashboard plots a select number of metrics on time-series charts, to provide further insight into recovery and transformation of services and pinpoint where issues are located in the system. This provides invaluable information to support system improvement, at board level and operationally.

Participants of the annual Managing Frailty in the Acute Setting project also receive an additional bespoke (organisational level) report and we encourage attendance at the annual National Findings Conference in February 2022. You can register for upcoming events via the members' area or by emailing the Support Team: **enquiries@nhsbenchmarking.nhs.uk.**

What does NHS Benchmarking Network do with the data beyond the report?

Our expert Support Team identify the national trends and key areas of focus, such as the new hospital discharge policy, and two-hour, two-day wait standards. This story is then reported back to our participants and key stakeholders at our National Findings Conference, which directly support networking opportunities. We also identify organisations who have demonstrated service/quality improvement using the benchmarking; these are then developed into good practice case studies or colleagues are invited to speak at our annual events.

How do people organise NHS Benchmarking Network membership?

The Network is a member-led organisation, open to all commissioners and providers of publicly funded health and social care services. The subscription model works on an organisation-wide basis, to support planning and service improvement across the system. Membership enquiries can be directed to the Support Team via **enquiries@nhsbenchmarking.nhs.uk**. They will discuss how you can optimise membership across your organisation and outline the benefits from being a member. Further information about membership benefits can be found here: **www.nhsbenchmarking.nhs.uk/membership-benefits**

The Network Support Team are also on hand to help you further understand your services and data with board level briefings or by delivering members' area toolkit training and support. We encourage members to share the resources from each cycle with their teams, which provide valuable resources to maximise their data and facilitate service improvement.

What can teams do with the data locally?

Our Support Team have developed a series of publicly-available case studies, along with our members, to demonstrate how benchmarking can be used to implement change. You can find our latest case studies from participants of the *Managing Frailty in the Acute Setting* project in the *How to get the best of benchmarking* guide.

This guide explains how your peers at Frimley Health NHS Foundation Trust and Ashford & St Peter's Hospitals NHS Foundation Trust have avoided unnecessary admissions by improving their frailty services at the front door. Colleagues at Frimley Health explain how they have used the benchmarking project to act as a framework for what their frailty service should deliver, with project questions highlighting key new service models to incorporate. You can read more about the process here: **www.nhsbenchmarking.nhs.uk/all-sectors#howto**

The Network also supports more in-depth member good practice case studies on a range of topics and themes. These can be accessed via the members' area. Sharing best practice is a cornerstone of the Network, and we welcome colleagues to get in touch to develop their own case study, with extensive support from members of our Support Team. If you would like to find out more, please contact **enquiries@nhsbenchmarking.nhs.uk**.

How does this work link with HQIP, GIRFT, ECIST or with NHS Elect work?

The NHS Benchmarking Network regularly consult with key stakeholders, including the Acute Frailty Network and the NHSE&I Ageing Well Team to name just a couple. We maintain these strong relationships to ensure we are appropriately tracking key policy initiatives within our projects. National policy makers will often use the findings from our Network projects to inform their thinking around key national workstreams. Earlier this year (2021), the Network delivered indicative reporting on the new two-hour, two-day wait standards for Urgent Community Response Services, ahead of any national data collections. The *Managing Frailty in the Acute Setting* project has responded swiftly to the new Hospital Discharge Policy and the new discharge to assess pathways (D2RA in Wales). The agile nature of the annual projects means that the Network will hold early indicative findings on the proportions of discharges on each pathway from acute hospitals. Likewise, we are tracking the national (England) targets in the *NHS Long Term Plan* on the requirement to have at least 70 hours acute frailty provision per week, and the requirement to work towards achieving clinical frailty assessment within 30 minutes of arrival at the hospital front door.

The Network have also collaborated with the Getting it Right First Time (GIRFT) Geriatric Medicine workstream. To relieve data burden for our provider members, and with prior consent from participating Trusts, submitted data for the *Managing Frailty in the Acute Setting* project was shared with GIRFT to inform their report. You will see the NHS Benchmarking Network referenced extensively in the report. The data collection has effectively fed into other national workstreams.

How can we use the findings to support clinicians to develop patient-centred, evidence-based services?

The Managing Frailty in Acute Setting project uniquely demonstrates a pathway view of acute care through acute settings. The pathway is evidenced from front-door/ Emergency Department intervention, through to the assessment function, inpatient stay and supported discharge. The project uses an age cut of the data to provide a proxy measure, evidencing a frail (often older) person's journey through the acute hospital.

Unique benchmarks and clear toolkits support organisations, teams, and clinicians to review their position to pinpoint where service/quality improvement activity might be appropriate. New policy initiatives are captured quickly, to enable indicative positions against key national targets. In addition, our Knowledge Exchange Forum is a great mechanism to reach out to other healthcare professionals to discuss key clinical issues. Our good practice case studies and *How to get the best of benchmarking* guides also provide useful guidance, highlighting how others have maximised the benchmarking findings locally. Our Share Learning and National Findings conferences provide a fantastic, comprehensive insight into the latest good practice delivering improved outcomes for patients. Why don't you take advantage of all the Network has to offer?

We are proud of the Network's continued collaboration with the British Geriatrics Society (BGS) and consider them as a key stakeholder in the development of our projects, which deliver robust evidence around older people's health and care.

Debbie Hibbert
Programme Manager and Associate Director (Community), NHS Benchmarking Network
@Debbie_NHSBN

Celebrating our amazing *Allied Health Professionals*

Providing good quality health and social care for older people takes an interdisciplinary approach from a variety of skilled, knowledgeable and experienced professions. The BGS is proud to be a multidisciplinary society and we welcome Nurses and Allied Health Professionals (AHPs) working with older people to join our Nurse AHP (NAHP) Council. As part of this year's #AHPsDay celebrations in October, we spoke to a range of AHPs about how their role contributes to the health and wellbeing of older people.

Hi, I'm a... Speech & Language Therapist

Name: Julie Pollock
Profession: Speech & Language Therapist (SLT)

How do SLTs contribute to the health and wellbeing of older people?

Speech & Language Therapists (SLTs) provide support to older people who have swallowing and communication difficulties as a result of medical conditions such as stroke, dementia, and progressive neurological conditions. SLTs work in a variety of acute and community settings, including hospital wards, outpatient clinics, care homes and in people's own homes.

My job as an SLT includes the assessment and management of eating, drinking and swallowing difficulties to help older people to eat and drink safely, to minimise their risk of aspiration (food or fluids going down the wrong way which can lead to chest infections), and to reduce the likelihood of malnutrition and dehydration. I also have a role in palliative and end of life care, advising about eating, drinking and oral hygiene for comfort. As an SLT, I work directly with older people to treat communication difficulties, and provide advice and training to others about how best to support someone to communicate to the best of their ability, and support decision-making.

Hi, I'm a... Physiotherapist

Name: Alison Cowley
Profession: Clinical Academic Physiotherapist
Current role: Advanced Frailty Practitioner (trainee)

How do Physiotherapists contribute to the health and wellbeing of older people?

Physiotherapists bring a wealth and experience and expertise in supporting the health and wellbeing of older people. They assess mobility, movement and functional needs of older people, identifying and delivering rehabilitation goals and programmes which are focused around person-centred care principles. Physiotherapists can support older people to improve or maintain functional abilities which can have a positive impact on their quality of life and social interactions.

In my current role as a clinical academic physiotherapist, I not only provide clinical expertise and leadership in my acute hospital trust, but also seek to advance the evidence base which informs our clinical practice through research. I support aspiring clinical academics from across the AHP and nursing professions, and clinicians in applying research evidence into clinical practice and for research grants and fellowships. I am passionate about developing and delivering high quality, clinically-focused research, specifically around acute care decision-making and geriatric rehabilitation.

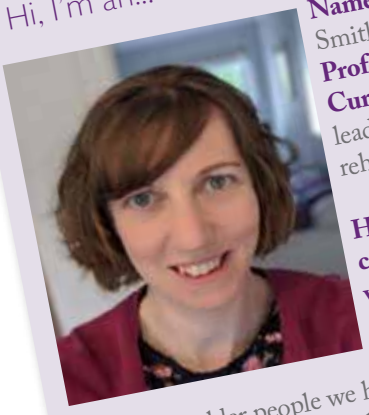
Hi, I'm an... Occupational Therapist

Name: Jo McAulay
Profession: Occupational Therapist
Role: Occupational Therapy Advanced Practitioner

How do Occupational Therapists contribute to the health and wellbeing of older people?

Occupational Therapists (OTs) work with older people in many settings, looking at their functional abilities in relation to activities of daily living, and taking into account their physical, cognitive, and mental wellbeing. They are responsible for assessment of need and provision of services across health and social care, and are involved in a range of person-centred activities with older people, from provision of equipment and environmental adaptations, to cognitive and physical rehabilitation. In my current role as an advanced practitioner in older people's mental health, I provide advice and support to OTs in an acute trust on working with older people with mental health issues, including dementia and delirium, and especially with Mental Capacity Act assessment. I manage a small group of activity co-ordinators, who aim to improve patients' experience of inpatient stays, and reduce risks of deterioration whilst in hospital.

Hi, I'm an... **Orthoptist**



Name: Henrietta Holmes-Smith
Profession: Orthoptist
Current role: Orthoptic lead for stroke and neuro rehabilitation

How do Orthoptists contribute to the health and wellbeing of older people?

Orthoptists are eye movement specialists. When caring for older people we help with diplopia as a result of eye movement abnormalities caused by a range of chronic and acute conditions including, but not limited to Parkinson's, MS, brain tumour, diabetes, myasthenia gravis and stroke. We treat symptoms by correcting defects with prisms, lenses, patches and exercises or refer for surgery as appropriate. With stroke and neurological problems we also examine visual field loss, monitor defects and changes offering advice as well as teaching compensatory techniques. We aim to make every contact count, engaging meaningfully with patients around wider health and social care.

Hi, I'm a... **Paramedic**

Name: Karen Parker
Profession: Paramedic
Current role: Advanced Frailty Practitioner (trainee)

How do Paramedics contribute to the health and wellbeing of older people?

Paramedics have an excellent background in history-taking and physical assessment and will look at an older person in a holistic manner. We see a huge amount of older people in this role and are required to 'unpick' the home situation to decide what the acute problem is - often these people have come to a crisis point because of a decline in their wellbeing. Paramedics do try to prevent hospital admission where possible but there has been some development of community teams to assist them with this. I now work within The New Forest Frailty Team as an Advanced Frailty Practitioner (trainee) and complete a full complex holistic assessment to enable the diagnosis and treatment of Older People to prevent hospital admission when they have episodes of acute decompensating frailty. This helps to prevent further decline in their wellbeing caused by hospital stays.

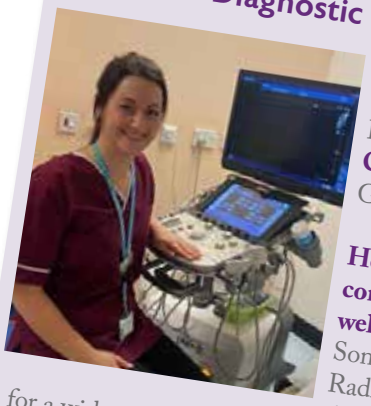
Hi, I'm a... **Prosthetist**

Name: Erica McCarthy
Profession: Prosthetist
Current role: Clinical Lead Prosthetist

How do Prosthetists contribute to the health and wellbeing of older people?

A high percentage of amputees have had an amputation because of poor circulation which occurs as a result of peripheral vascular disease or diabetes. This means that most of our patients are older with many comorbidities. The supply of an artificial limb following amputation may allow an older person to continue to walk outdoors and socialise, remain independent indoors or simply allow them to feel complete by having a cosmetic limb supplied. In some cases, a limb is supplied simply to aid transfers and perhaps allow independence when going to the toilet. Limb prescription is very much dependent of the setting of realistic goals.

Hi, I'm a... **Diagnostic Radiographer**



Name: Ruth Reeve
Profession: Diagnostic Radiographer
Current role: Clinical Specialist GI Sonographer

How do sonographers contribute to the health and wellbeing of older people?

Sonographers work within the Radiology department, where the use of ultrasound is used for a wide variety of reasons. Unlike other radiological tests, ultrasound is non-invasive, requires little preparation from patients and is relatively portable, which makes it a great tool for initial diagnostic work-ups in a variety of clinical situations for older people. Sonographers often find themselves as the first point of contact for patients where, as a part of the sonographer's role, we communicate findings that inform future care and management. I enjoy working in the acute setting where I can take my time and work with older people to ensure their wishes are respected, and in the community where we see regular service users coming for surveillance and follow-up scans, providing immediate reassurance where appropriate.

Hi, I'm a... **Podiatrist**

Name: Natalie Roe
Profession: Podiatrist
Current role: Senior Specialist Podiatrist – Community High Risk Foot Service for care homes and house bound

How do Podiatrists contribute to the health and wellbeing of older people?

As a podiatrist who works with those with frailty my role involves minimising risk of falls, reducing foot pain, and preventing and managing complex foot ulcerations. This is achieved through identifying footwear concerns, managing callosities, identifying vascular insufficiency and sensory deficit, looking at their mobility, and if bed bound, how their feet are being offloaded. For those with dementia, the ability to recognise, identify and alert someone that they are in pain due to their foot is often impaired. Therefore education to those that care for them to recognise subtle signs of pain is also part of our role.

Nurses and AHPs: *Why QI?*

The quality improvement (QI) work of nurses and allied health professionals (AHPs) is under-represented at BGS meetings due to a shortage of submissions from those working in these professions. James Lee, Nurse Consultant and member of the BGS Clinical Quality Committee, explains how and why nurses and AHPs should feel inspired to become more involved in QI work.

QI continues to be an important aspect of healthcare, and the opportunities to take part in QI projects, and present the results of your labours in a conference poster or platform presentation, are growing.

Despite this level of interest and opportunity we see only small numbers of QI abstracts put forward to the BGS conference by nurses and AHPs. Why is this? Hopefully it is not because this is still seen as the preserve of our medical colleagues. Perhaps QI is still poorly understood and methodology is not routinely taught to all nurses and AHPs, at least not at an undergraduate level. Also, nurses and AHPs do not 'have' to complete an Audit or QI project as part of their training, like our doctor colleagues do.

We do know however that nurses and AHPs have all the requisite ingredients to undertake a QI project – that daily nag that some aspect of care could be improved, that your patients are missing out because something is done poorly, or the feeling that you could do it better. That's all it takes to get started, and if you feel strongly enough about the improvement idea, that's all you need to get through the process, with a little help!

So what help is available? Here's a list of my top tips:

- Approach your organisation's QI or transformation department – most seem to have one now, and some are quite new and full of enthusiasm and offers of support! There might be a QI methodology course you could do.
- In England, try your local Health Education England (HEE) branch – I barely knew what they were until I was lucky enough to join a QI fellowship programme. Great educational and peer support for QI projects.
- The Academic Health Science Network (AHSN) runs lots of projects, many of which will include quality improvement aspects, and in my experience they facilitate a host of opportunities to join working groups and disseminate results.
- Look at what your Education department has to offer for Nurses and AHPs within the organisation – there may be some apprenticeship money just waiting to be spent, and before you know it you are part of a Master's degree programme and looking for a service improvement project for you dissertation!

And of course the BGS offers support through the Nurses and AHPs Council, as well as through the Clinical Quality Committee. Get in touch with Joanna Gough (**j.gough@bgs.org.uk**) or use the BGS Members' Directory and/or Forum to find out how you can connect with others with similar interests. Good luck!

James Lee
Nurse Consultant, Older Persons and Frailty, Salisbury Hospital NHS Foundation Trust
@lee68_james

10 Top Tips for writing a **clinical quality** abstract

The BGS Clinical Quality Committee has a wide remit, and among other things, this is the group responsible for reviewing and assessing the Clinical Quality abstracts submitted for BGS conferences. One of the most common questions we get asked at Quality Improvement (QI) workshops is "how do I write a good abstract?" This short article is written to help answer that question.

If you need more help, do join one of the open QI workshops at the next event, where you can chat to one of the Committee members. We really want to showcase the many examples of your great work and to keep raising the quality of abstract submissions.

The most common scenario is as follows: you led or have been involved in an improvement project, it made a positive difference, and rightly, you are proud of the effort put in by the team and the outcome.

It has been suggested (often by someone else) that your work could be written up as an abstract for submission to a BGS conference - but if you haven't done this before, this can be challenging. We think it is useful to take the following steps:

1. Take time to prepare your abstract

An abstract is word limited and needs to stand alone - it cannot simply be a cut and paste job. Reading the abstract, a colleague should be able to understand why and how you completed your programme, with the keys steps outlined, what you achieved and what they can learn/translate from your work.

'Remember you do not need to take half the word count to explain the clinical and policy rationale, but instead use it to show what you did and achieved.'

2. Follow the guidelines

Often there is an abstract template which you need to follow. The BGS has two sets of abstract guidelines, one for Clinical Quality, the other for Scientific Presentation. Most other organisations will have their own guideline or template and your submission will be assessed against the preferred template. If you do not follow the template or the abstract guidelines your submission may be rejected.

Make sure you do stick to the word count but be careful what you use your words for; remember you do not need to take half the word count to explain the clinical and policy rationale, but instead use it to show what you did and achieved.

You can find the BGS abstract submission guidelines at **www.bgs.org.uk/abstracts**.

3. Make sure you select the right category

For BGS events there are two categories: Clinical Quality or Scientific Presentation.

- **Clinical Quality or QI abstracts:** The work you are describing will have used QI methodology. For example, the Model for Improvement, Lean, Six Sigma or a full Clinical Audit cycle. The approach you have used doesn't matter but there must be clear Improvement thinking behind your work; an intervention must have been tested and a recognised QI method must have been used. Your project aim will be to get one or more defined quality outcomes, this could be in any one of the six components of quality. And your work will make use of a series of tests, in real time and each one of a small scale.

- **Scientific Presentation or Research abstracts:** The work you are describing will have focussed on developing new knowledge using research methodology.

4. Make sure your project aim is clear

For both Scientific Presentation and Clinical Quality abstracts the aim is fundamentally important – what were you trying to achieve?

Were goals expressed in a Specific, Measurable, Achievable, Realistic, Timely (SMART) way?

5. Describe the scale of your work

How complex was your project? Did your work take place in one speciality, or one organisation or did it involve multi professional teams or several organisations working together?

6. Give detail on the measures you used

Which metrics did you monitor as part of your work and why? How did you know that your change was an improvement? Much of the detail may well be in a more comprehensive paper or a poster but your abstract needs to assure the assessor and readers that you really know whether the change you have tested is an improvement or not.

7. Describe how you went about your work

What did you do, and who did what? Where did your idea come from? Did you map the process to find things which wasted clinical or patient time? Did you generate the change idea with staff who might be impacted by the change? Did you talk to patients and other stakeholders to find out what would work for them?

8. Share the results, whether expected or unexpected

In QI projects the data analysed is usually very targeted and collected in real time. It is often presented in SPC charts. Don't forget that much learning comes from failure – your project does not have to have been a resounding success, sharing "what not to do" is valuable learning and helps colleagues from wasting time.

9. Think about next steps

There may not be much space for this in an abstract but if you have any reflections on next steps, it is great to try and include them.

If your project was a success, this might include how you might scale up your work. For example; are you thinking about moving from one ward to all wards in a speciality, or testing the same change at a different time of the week, or from daytime to night-time?

If you didn't get the results you were expecting, is there another idea that you are going to test to see if this gives you better results?

10. Ask a trusted colleague to read your abstract before you submit

When something is important to you and you have spent a while working on it, it is common for your objectivity to fail.

BGS Clinical Quality Committee

The BGS Clinical Quality Committee is a sub-committee of the BGS that aims to promote and facilitate quality care for older people by providing guidance on key clinical themes that affect older people. The Committee meets four times a year to define, review and ensure progress against an annual work plan. The Clinical Quality Committee work plan is approved and monitored by the BGS Trustee Board.

Who's on the committee?

- Jugdeep Dhesi (BGS Vice President of Clinical Quality and Committee Chair)
- Amit Arora
- Tom Bartlett
- Aileen Fraser
- Susannah Long
- James Lee
- Sangam Malani
- Rachel Melrose
- Mehool Patel
- Krishanthi Sathanandan
- Ganan Sritharan
- Susan Went

'Ask at least one colleague to read your abstract before you submit, so that you can make sure your language is understandable, the meaning is clear, and you haven't missed out anything important.'

We sometimes see what we think we have written, not what is on the page. Ask at least one colleague to read your abstract before you submit, so that you can make sure your language is understandable, the meaning is clear, and you haven't missed out anything important.

And remember...

Lastly it is not uncommon to see abstracts which include typos, spelling mistakes, cut and paste errors and formatting errors. These will be penalised. Make sure this does not happen to your work!

Susan Went
Improvement Consultant and member of the BGS Clinical Quality Committee
@susan_went

Good to SCE you

Passing the Specialty Certificate Examination (SCE) in Geriatric Medicine became a requirement for the successful completion of specialist training for Speciality Registrars (SpRs) in Geriatric Medicine from 2009. The exam comprises two papers, each of 100 questions, and in a best-of-five format. It is run by MRCP(UK) in collaboration with the BGS.

The aim of the examination is to help demonstrate that doctors have an adequate knowledge base to enable them to practice as a consultant in Geriatric Medicine in the UK. Like any form of assessment, it has its limitations, and an ability to pass a multiple choice question (MCQ) exam is different from the skills required to be a good geriatrician. For the latter, it is essential to be able to collate the information from a patient (where confusion and communication issues may make things more challenging), provide holistic patient-centred care and work within the multidisciplinary team.

Also, when seeing patients, we don't have a pre-printed list of different options in front of us. Similarly, passing the exam is not the same as completing a training program; the two work together. While trainees do need regular assessment throughout their training, these are predominantly done in the workplace, and there is no need for regular written exams. There is some profit from the exam, but this is quite small.

Question writing process and setting of the exam

The questions are written by geriatricians who spend most of their days working in the same clinical areas as the trainees. Each year, the writers draft their questions, which are then discussed in groups. It's quite an eviscerating experience having your own knowledge/ignorance torn to shreds by your peers (especially when some used to be your Consultants from your Registrar days!)

The question- writing days are quite tiring, but also some of the best CPD you can do - you are stretched across the whole range of the curriculum, constantly being updated on guidelines and learning new information.

Introductory self-assessment

What is the key outcome that comes from having the SCE in Geriatric Medicine?

A. For anyone to prove they can be a consultant geriatrician
B. Regular assessment is required for all Trainees
C. To earn money for RCP/BGS
D. To ensure that we produce good consultant geriatricians
E. To help demonstrate that doctors have an adequate knowledge base before going on to the Specialist Register

Answer: D

When writing questions, trying to reduce the complexities of good geriatric care to a single, objectively correct answer out of five can be tricky; there are typically three or four different correct answers! One key way of doing this is to ensure we adhere to guidance from the National Institute for Health and Care Excellence (NICE) or the Scottish Intercollegiate Guidelines Network (SIGN). Where possible, we try to write questions which require an application of the knowledge base rather than just testing facts.

There is a blueprint which is mapped to the curriculum and outlines the proportion of question for each topic. Of note, the curriculum requires an understanding of some of the basic science behind normal and pathological ageing, while the nature of our work requires us to know about other specialities and others in the multidisciplinary team (MDT).

Testing very basic knowledge is not discriminatory, so we can't ask about the importance of prescribing further trimethoprim for mechanical falls after a urine dipstick test! We have to balance stretching the candidates' knowledge base with trying to keep the topics relevant for jobbing geriatricians. Once amended and approved, questions are submitted to a question bank. In setting the exam, around 300 questions are selected and reviewed by the exam board to ensure they remain correct and relevant. For anyone who is interested, we have recently switched to Test Equating from an Anghof methodology for setting the standard of the exam, which means that the same standard is required across the diets. For those not interested, please do not read the previous sentence.

How good is the exam?

While there is a lot more to 'good' than statistical performance, this is what we can measure. The performance of questions is reviewed after the exam, demonstrating consistent and good statistical performance across the years. Our exam is generally felt by candidates to be as, or more, relevant to our daily work than the other SCEs. It doesn't, and never will, measure how good someone is as a doctor.

The pass mark is around 56%, and the pass rate over 80%, with women performing better than men. The pass rate is one of the highest for all the SCEs. The concern from this was that the pass mark was too low. However, a survey of SAC members was very clear that the vast majority felt that newly qualified consultants had an adequate knowledge base (which the exam can help assess) and where newly appointed consultant had issues, these tended to be with non-clinical aspects of the consultant role.

When to sit

Trainees are required to sit the exam before the end of their ST6 year and to have passed it for their Certificate of Completion of Training (CCT), which will remain the case with the new curriculum. The preparation for the exam improves the trainees' knowledge, and I advise taking it around ST4-5, to give time to consolidate this knowledge, while also getting the exam out of the way.

Common gripes

"It's no different from MRCP, just with the ages pushed up."

Sometimes, this is true. However, the exam is sat within a few years of the MRCP, and many of the patients are the same, so some of this is entirely appropriate. Most junior doctor training is based in hospitals where the majority of patients admitted are older people, giving the trainees greater exposure to the problems encountered in our patients than in other more outpatient-based specialities. As a result of this, the jump in knowledge base between MRCP and the SCE is not as marked. My guide when writing or reviewing questions is "Is this something that I may see in my clinical practice as a geriatrician?"

"It asked questions that aren't relevant to me."

Some understanding of the work our colleagues do, both with regard to other specialities and the rest of the MDT, is an essential part of being a geriatrician and one of the things that makes it such an enjoyable speciality. While I don't need to know about specific physio exercises, an awareness of different mobility aids or the importance of replacing worn ferrules helps me provide good care. We don't always get the balance right, such as with a recently reviewed question asking about the key features to look for when monitoring the progression of fibrotic lung disease – this is not something we would routinely do, though the ability to diagnose the condition is important and relevant.

"It felt like the examiners were just trying to catch us out."

We try not to do this - we want to test knowledge and its application, not our ability to catch people out! It is important to read the question carefully – for example, for a patient with pneumonia, the initial management step would be with providing oxygen (ABC approach), whereas the best way to help cure the condition would be with antibiotics. And remember that common things are common – patients with dementia, ataxia and incontinence are more likely to have vascular dementia than normal pressure hydrocephalus.

> 'We have to balance stretching the candidates' knowledge base with trying to keep the topics relevant for jobbing geriatricians.'

"It's too expensive."

There are significant costs in hosting the various meetings required to generate questions and set the paper. There is a team at MRCP(UK) who run the exam and edit the questions to ensure they are as usable as possible. There are also significant costs with the delivery of the exam; the current contract is with Pearson Vue, who have consistently had good feedback overall for the last few years.

And please can candidates continue to complete the feedback survey after the exam – we do listen and try to improve things.

Future developments

The blueprint which guides the range and proportion of questions is currently being reviewed, not least to ensure that it matches the new curriculum in geriatric medicine from August 2022. It is unlikely to change significantly, though, as our patients haven't changed.

The exam is likely to be largely provided through Pearson Vue centres, though remote online proctoring is starting to come in for MRCP and will help keep the exam 'pandemic proof.' Experiences with this have found technical issues in around 5-7%, and there remain concerns over security.

For a number of years there have been calls to have two diets per year. Due to the size of the question bank and the work required to put the exam together, this hasn't been possible. We are, however, hoping to increase the frequency of the exam from yearly to every nine months, possibly from as early as November 2022.

And finally...

There was lots of upset when the exam was first introduced, with many perceptions that they only came in because the General Medical Council (GMC) was on the back foot after various scandals and had to be seen to be doing something. However, for all its limitations, it is good to have an objective assessment of trainees' knowledge, and this knowledge is invariably expanded and deepened through preparing for the exam, which can only be good for us and our patients.

Adam Harper
Chair of Examination Board for Geriatric Medicine;
Consultant Geriatrician, University Hospitals Sussex

CPOC and BGS release new perioperative care in frailty guideline

The Centre for Perioperative Care (CPOC) and the BGS recently published the *Guideline for Perioperative Care for People Living with Frailty Undergoing Elective and Emergency Surgery*. Jugdeep Dhesi and Jude Partridge summarise what this includes.

This is the first full pathway guideline for patients living with frailty, following them from the contemplation of surgery through to recovery. It has been co-ordinated and led by the BGS and the Centre for Perioperative Care (CPOC), which is a cross organisational body aiming to facilitate and promote delivery of quality perioperative care. To write this guideline, the two organisations brought together representatives from over 20 organisations involved in the care of patients living with frailty, alongside patient and lay involvement.

What is the scope of the guideline?

The guideline covers all aspects of perioperative care relevant to adults living with frailty undergoing elective and emergency surgery. It is written for all healthcare professionals involved in delivering care throughout the pathway, as well as for patients and their carers, managers and commissioners.

The process used to develop the guideline is available as an appendix and the recommendations have been based on a systematic review of the literature that has allowed grading of evidence and recommendations.

What does the guideline provide?

The guideline provides standards of care and these are supported by recommendations for each stage of the pathway. These recommendations, relevant to patients, commissioners, managers and clinicians, have been developed to support those establishing multidisciplinary and multispecialty teams to provide quality perioperative care for patients living with frailty.

A section on metrics is aimed to aid quality improvement and measurement for improvement. Furthermore, the research recommendations are aligned with those from organisations such as NICE, GIRFT and priority setting partnerships such as the James Lind Alliance.

What is the anticipated impact of the guideline?

We believe the guideline is a necessary initial step in improving outcomes for the estimated 300,000 older people living with frailty who undergo surgery each year and will support:

- Effective use of surgical waiting lists as 'preparation lists'
- Improved general health of people living with frailty
- Improved shared decision making, ensuring equity, appropriate surgery and avoidance of decisional regret
- Improved postoperative recovery for people living with frailty
- Efficient perioperative pathways avoiding duplication and waste
- Establishment of services aligned to the needs of people living with frailty
- Equity of access to specialist care
- Improved trans-disciplinary working and inter-speciality communication.

What are the next steps?

It is clear that delivering whole pathway, quality perioperative care for people living with frailty requires multicomponent intervention, with integration across community, primary, secondary and social care.

A multidisciplinary 'one-team' approach across these sectors is necessary to deliver each component of the pathway:

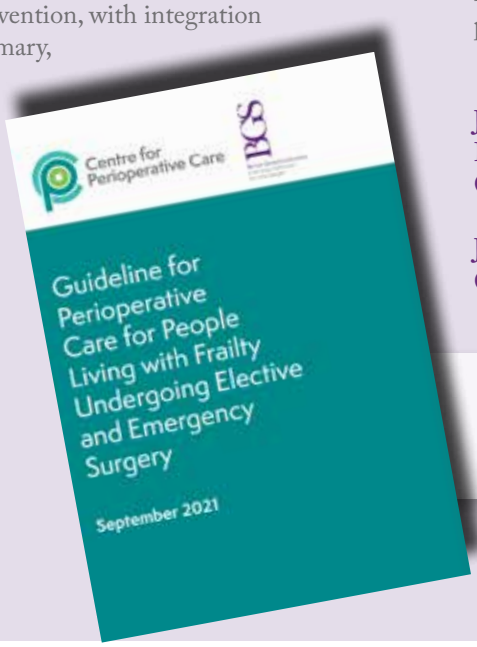
- Patient and carer involvement, education and empowerment.
- Preoperative risk assessment and optimisation of physiological status, comorbidities and geriatric syndromes including frailty.
- Lifestyle modification to improve both perioperative and long-term health outcomes.
- Shared decision making (SDM).
- Optimal intraoperative surgical and anaesthetic management.
- Quality postoperative care in the most appropriate setting to include rehabilitation.
- Links and referral to relevant community, primary care and follow up services.

To deliver this, an implementation programme is currently being developed to ensure collaboration across the four nations of the United Kingdom between all stakeholders; workforce development with supporting education and training resources; and evaluation through research and refinement of current national audit tools. CPOC and the BGS are working together with partner organisations such as NHS Elect in establishing in POPS networks, and with GIRFT, NELA and others to deliver on the implementation programme.

If you are interested in being involved or would like support in establishing or expanding your local perioperative services, please do not hesitate to get in touch.

Jugdeep Dhesi
BGS Vice President, Clinical Quality
CPOC Deputy Director

Jude Partridge
Chair, BGS POPS SIG



You can view and download the complete guideline at www.bgs.org.uk/cpocfrailty

Join a BGS *Special Interest Group*

The BGS currently has 17 active Special Interest Groups (SIGs).

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

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.

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

Consultant Geriatrician: Your perfect job, in a great team, in beautiful Bath

NHS Royal United Hospitals Bath NHS Foundation Trust




We're seeking Consultant Geriatricians for our Older Persons' Unit at the Royal United Hospital Bath and will work with you to build your perfect job.

We offer great opportunities to pursue specialist interests, front door/interface geriatrics, liaison work, perioperative medicine and community roles. We're a dynamic and cohesive team, keen to learn and grow with new colleagues and with a determination to achieve the best for our patients and our team members.

Contact Dr Veronica Lyell (Clinical Lead) with all enquiries v.lyell@nhs.net

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

BGS North East Thames Region

The BGS North East Thames Region (**www.bgs.org.uk/north-east-thames**) has vacancies for the following roles:

- Region Committee Member
- Trainee Representative
- Nurse and AHP Representative

The deadline for applications is **30 November 2021**. 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 Finance Committee

Do you want to acquire transferable financial and governance skills you could use in decision-making processes within your hospital or workplace?

Extensive experience of finance or budgets is not necessary. We're looking for someone who has an interest in how resources are managed and the ability to think in a strategic way, asking probing questions of the executive team. We're encouraging multidisciplinary members of the Society to apply, and we'll provide an accessible induction for all new committee members.

Apply to join our Finance Committee via email to Mark Stewart, Office and Business Manager (**M.Stewart@bgs.org.uk**) by **30 November 2021** giving a very brief description of why you are interested in becoming a committee member.

For more information please visit **www.bgs.org.uk/BGSvacancies** or email **j.sarll@bgs.org.uk.**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AGAINST POOR ADHERENCE
IN MAJOR DEPRESSION
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