AGENDA

British Geriatrics Society
Improving healthcare for older people

Issue 85 | June 2022
ISSN 2754-4532

Dream teams

Celebrating the MDT

PLUS

- **Frailty pharmacists**
- Nurses and research
- **Meeting reports**

AGENDA
Publications information

Agenda is published every second month by:

British Geriatrics Society
Marjory Warren House
31 St John's Square London EC1M 4DN
Telephone 020 7608 1369 Fax 020 7608 1041
Email editor@bgs.org.uk Website: www.bgs.org.uk

Editorial Advisors: **Prof Anne Hendry, Dr Ruth Law**
Publishing and Production Editor: **Amy Brewerton**

ISSN: 2754-4532 (print)
ISSN: 2754-4540 (online)

Printed and distributed by Brown Knight & Truscott (BKT)

Images: Cover: 'Geriaction.' Canva/Amy Brewerton.
Other images: © Pexels/Pixabay/Canva.

On the
AGENDA

President's *Message*

In previous eras when we moved into summer, we all experienced some reduction in acute hospital pressure. Winter wards could close, allowing some relaxation on the relentless pressures on staffing. This year, at the end of May, our 'winter' wards are still all open, although mercifully we have not had a further COVID surge since April.

The effect of the pandemic is clearly being felt across our systems, impacting particularly on the lack of discharge provision for patients ready to leave hospital. We at the BGS continue to raise this at every opportunity with those both in political and commissioning roles.

I am dictating this just as I come off a 'Getting It Right First Time' (GIRFT) online seminar where Dr Adrian Hopper, who is the Geriatric Medicine Lead for the GIRFT programme in NHS England, highlighted the variability across acute care providers in length of stay for patients living with frailty and variation in assessment and management of delirium. It was clear from his presentation that there is a link between proactive care, delivering early intervention for patients admitted with frailty and timely discharge home. We noted his recommendations and support the need for interventions across both the Acute Sector and in Integrated Care Systems, addressing both the infrastructure and interface issues. We were reminded of the need to assess for frailty and capture data on outcomes as a starting point for quality improvement projects. We heard too from a patient and public policy advisor from Age UK highlighting the patient view, with older people asking to access services without barriers and being encouraged to promote resilience. Continuity of care has been a casualty of the COVID pandemic but is highly valued by our patients.

I was interested to hear that the Royal College of Physicians (RCP) London's 2021 Census results will be coming out in July. The last Census confirmed that, of advertised Consultant posts, 48% were unfilled, of doctors in training, 53% would want to try less than full time training if available and 82% would welcome a portfolio career once they reach Consultant stage. I noted too that the average time to become a Consultant after entering medical school is 16.4 years, so even increasing our medical student numbers from the current number to 15,000, it will take some considerable time before we see an increase in the Consultant workforce.

We understand that diversifying the workforce is key to delivering the skills necessary for the NHS over the next 10 years. Dr Amit Arora, BGS Vice President for Workforce,

is working closely with the RCP to design some additional questions within the upcoming Census, and I would continue to encourage all members of the BGS to try and complete this annual review of the consultant workforce.

We joined with RCP London in calling for the Health and Social Care Bill to include a requirement to publish estimates on workforce planning, and will continue to work with our partners to campaign for this. I was delighted to see that David Oliver was successful in his election to take over the Presidency of RCP London in September. As a past President of BGS and with his up-to-date clinical experience, he is well versed in the needs of our UK population and a master at communicating this to the wider audience.

I have also been pondering what the future looks like for continuing professional development (CPD) and educational conferencing. At BGS, we moved to trialing hybrid meetings in May, and enjoyed a successful face-to-face BGS Scotland Spring Meeting in Glasgow (you can read more about this on page 28). Numbers attending were, however, lower than those who might have attended in person prior to COVID.

I noticed a similar pattern when I was in Liverpool at the RCP Medicine 2022 Conference. I chaired a session on Frailty with three excellent speakers to an in-person audience of around 30. We later learned that the virtual attendance was closer to 800. I enjoyed the networking with colleagues in person, but it may be a while before these hybrid-style events start to feel normal, and it will be interesting to see if the numbers of people attending in person start to level up with those joining virtually.

It is so important to ensure our educational and conference offer meets members' needs. We have put a brief survey around our trainee group to find out if restrictions on study leave are having an impact on people's wish to attend an in-person conference. The survey will help us to understand if this is the case, and campaign on your behalf to restore normal access for leave away from the place of work.

Looking ahead

We have been working on developing the BGS strategy for 2023-26. Thank you to everyone who completed our recent member survey; we had a record number of respondents and will take all of your feedback on board as we devise the new strategy. The next stage is for us to analyse and discuss the findings at our Trustee Board Meeting in July, and we hope to finalise a refreshed and relevant strategy for the Annual General Meeting (AGM) in the Autumn.

I look forward to opportunities for meeting up in person in London this year, and would like to remind you of the EuGMS meeting on 26-28 September in ExCeL London, followed by the BGS Autumn Meeting on 14-16 November. Planning and booking study leave ahead of time has always been important in ensuring fair access to these conferences and as they are a key part of our membership offer, I would encourage you to consider attending.

'Continuity of care has been a casualty of the COVID pandemic but is highly valued by our patients.'

Professor David Oliver elected as RCP President

We were delighted to learn that one of our past Presidents, Professor David Oliver, has been elected as the new President of the Royal College of Physicians (RCP) London.

David served as BGS President from 2014-2016 and previously also held the position of BGS Honorary Secretary. David is the first geriatrician to hold the office of RCP London President, winning a close-run election in a strong field of candidates. Current BGS President, Dr Jennifer Burns, said:

"Many congratulations to Professor David Oliver on his election as President of the RCP. This election is an acknowledgement from Fellows of the RCP of David's extensive career as a clinician and healthcare leader. We send David best wishes as he prepares to take on this important and challenging role.

"Most healthcare professionals will treat older people more than any other population group and while David's remit is of course very wide, we have confidence that he will continue to be an advocate for older people's care in his new role. We know that he will apply his dedication to high-quality care to the benefit of everyone working in and using the NHS.

"We would also like to pay tribute to outgoing RCP President Professor Bod Goddard. The BGS has worked closely with the RCP and with Bod, and we are grateful for his leadership during the pandemic. We look forward to maintaining a positive and collaborative relationship when Bod hands over to David in September."

Finally, congratulations to Professor Graham Ellis who has been awarded the William Farr Medal from the Worshipful Society of Apothecaries. Graham is now Deputy Chief Medical Officer in Scotland. It is encouraging to see geriatricians at the highest level in Government. I am delighted that he has been asked and accepted the invitation to be a keynote speaker at the EuGMS meeting in September. Another great reason to attend!

Thanks for all you are doing in your places of work. I am continually inspired by the dedication of our members.

Dr Jennifer MA Burns
President, BGS
@Burns61Jenny

The power of teamwork

BGS Deputy Honorary Secretary, Ruth Law, explains how every member of the multidisciplinary team can be empowered to make a difference, and outlines some simple steps we can all take to help inclusion and cohesion.

A geriatrician, a district nurse and a urologist each dial into a meeting... not the start of a terrible joke but the beginning of what I hope will be a successful multidisciplinary QI project.

Involving the whole multidisciplinary team (MDT) in service development is just one way to capitalise on the power of teamwork. We all know that done well, MDTs are the jewel in the geriatric medicine crown-energising for staff and effective for our patients. So what are the magic ingredients for successful MDT working - how can we lead them well and collaborate better?

Although it often falls to me as the doctor to take the lead role, I strive for a 'first among equals' model of team leadership in the MDT setting. Everyone's view is important and working towards parity of esteem cements this. I expect the team to tell me when I am making a bad decision and the fact they call me by my first name helps them to do this. For this type of leadership style to work well I have found there are two key components that need to align; the elements each team member needs to take responsibility for as individuals and those we need to take responsibility for as a team. If you are the leader, these things need to be demonstrated from the front.

'These relationships are precious, and investing time as a leader in understanding what makes individuals tick is critical in gaining their trust and promoting that elusive parity of esteem.'

Responsibilities for individuals

Know each other

Team working is greatly enriched when we take time to fully understand each other's roles. The latest 'MDTea' podcasts (see opposite page) are currently addressing this superbly, interviewing different MDT members about their jobs. What do you know about the training pathways, appraisal process and CPD requirements of your colleagues? Beyond understanding their professional pathways, knowing each other as people is also key. I never get to know a trainee doctor for more than a year but many of my nursing colleagues have known me for more than ten. These relationships are precious and investing time as a leader in understanding what makes individuals tick is critical in gaining their trust and promoting that elusive parity of esteem.

Celebrate each other

This Christmas we ran an 'advent stars' project on the geriatric medicine wards to celebrate the diversity of contribution across our MDT. Nominated anonymously by colleagues, it allowed us to say thank you to a different team member each day as they opened the door on the advent calendar. Another colleague of mine writes a 'thank you' email every Friday to the person that has made the biggest difference to their week. The options are limitless, and the rewards are huge in terms of team morale and identity.

‘While we regularly deal with difficult and serious situations, everyone needs those moments to laugh and relax.’

Stand up for each other

As ‘the doctor’ it is a privilege to support my MDT colleagues when they feel unheard. It is the one time I am happy to pull rank and I see it as my duty to represent the whole MDT experience to the senior management team. This may include standing up for appropriate supervision and training time, or psychological support. BGS is a place we can help each other across professional boundaries and I hope we can continue to be courageous for each other as we continue the COVID recovery process.

Responsibilities as a team

Learn together

I love learning from my MDT colleagues and much of the learning is informal. In our team our pharmacist guides our decision making around bone health, our physiotherapist is a vestibular wizard and demonstrates for the specialty trainees and our nurses are the gurus of pressure area care. I was shocked to discover how few formal CPD opportunities were offered to my MDT colleagues, particularly in the community. The advent of virtual sessions has greatly improved things but we mustn’t lose sight of the need to plan interdisciplinary learning. The whole MDT should be part of the departmental poster submissions, learning from SIs, invited to grand rounds- again opportunities abound but we need to be intentional about it to maximise the fantastic potential. I look forward to the online learning opportunities that I am sure the community and primary care geriatrics SiG will bring to this neglected space.

Lead together

As I have alluded to throughout this piece, too often the doctor is the default leader. This does not need to be the case. Once we know each other’s skills we will find the best chair, the person who best expresses the team’s vision and purpose, the person most passionate about research or education. It is my job to know my team well enough to release their potential to lead, and trust them enough to let them do it.

Laugh together

It is hard to find joy at work at the moment so it is important to share it when we can. I am a firm believer that all workplaces need a tiny bit of silliness to make them human. In all the hard work we have ahead of us, it is also going to be important to have some fun. While we regularly deal with difficult and serious situations, everyone needs those moments to laugh and relax.

There are many recipes for MDT success, but I hope these reflections give pause for thought - please let us know your ideas for better collaboration in the MDT setting so we can continue to learn from each other.

Dr Ruth Law
BGS Deputy Honorary Secretary
@Ruth_E_Law

MDTea Podcast

The MDTea Podcast is an audio series from the Hearing Aid Podcasts team which particularly focuses on the role of the multidisciplinary team (MDT) in the care of older people.

Now in its 11th series, it takes topics such as CGA, care homes, feeding and exercise and discusses them with guests who form part of the MDT to get a rounded insight into how these issues relate to older adults and ageing.

The latest series further explores the invididual roles of members of the MDT by taking the listener through 'a day in the life' of someone in a specific profession.

Key information from each episode is distilled in a handy infographic to download and share, which can be found on the MDTea website. There is also a facility to log your CPD gained from listening to the content in the podcast.

How can I listen?

There are various ways you can access the podcast.

One way is to stream it via a phone, tablet, laptop or desktop computer at **thehearingaidpodcasts.org.uk**.

We are also excited to report that we are in the process of adding much of this content to the BGS website to help share this excellent resource more widely, and will provide further information on this when it is available.

Alternatively, you can listen and subscribe to episodes via a music or podcast streaming app such as Spotify, iTunes/Apple Podcasts, Chartable or PodBean.

Happy listening!

What's the difference between adult social care and long-term care, and does it even matter? BGS Honorary Secretary Anne Hendry reflects on whether such labels are helpful when trying to reimagine a model for integrated care.

At the heart of the current conversation on adult social care in Scotland are proposals to establish a National Care Service (NCS), one of the recommendations of the Independent Review of Adult Social Care in Scotland. On behalf of IFIC Scotland, the Scottish hub of the International Foundation for Integrated Care, I submitted our consultation response, based on evidence and lived experience that most adults who need social care require a wide range of support and services to enable them to live their best lives. These supports are provided by family and friends, volunteers, voluntary and community partners, unpaid carers, healthcare professionals and housing services as well as social care providers. And, increasingly, technology solutions to enable access, personalisation, control and coordination of care across this wide range of providers, most of whom are not directly managed by statutory services.

It was heartening to see our response chimes with the new World Health Organization (WHO) Framework to support countries to achieve an integrated continuum of long term care. As UK nations have long had publicly-funded social care, however imperfect and inadequately resourced, some would say there's nothing particularly new for us here. I'd say look again. Critically, the framework connects the healthcare and social care paradigms that too often appear ideologically distanced and unhelpfully compete for much needed investment and skilled workforce.

The Framework defines long-term care as a broad range of personal, social and healthcare services and supports that ensure people with, or at risk of, a significant loss of intrinsic capacity can maintain a level of functional ability consistent with their basic human rights and dignity. That speaks to our BGS heritage.

It tasks national, regional and local governments to create the conditions for these services to be integrated within a system that provides a continuum of promotion, prevention, treatment, assistive care and social support, rehabilitation and palliation. And that speaks to our current mission.

In the recent European Regional consultation on strengthening integrated long term care provision, WHO officials helpfully made clear the vital role of unpaid carers and the requirement to support their needs too within enabling, age-friendly and inclusive local communities. The report is available at: **tinyurl.com/bgswho**.

The dialogue was about creating systems that span the porous boundaries between formal health, housing and care services and the range of supports from unpaid carers, volunteers and community assets. As an unpaid carer, community volunteer and a healthcare professional it is great to see this recognition of the various roles many of us regularly play!

The Framework doesn't have all the answers but I think it helps us ask the right questions. How best can we organise governance, finance and accountability across boundaries at national, regional and local levels? What arrangements enable meaningful co-design of creative and sustainable solutions by citizens, communities and care providers together? How can we ensure strong horizontal integration between primary care, community providers, public health and local communities to improve and protect wellbeing, particularly for populations who face socioeconomic disadvantage and inequalities, exacerbated by COVID-19? How can specialists

'That's where the magic of integrated care happens - at the level of place, neighbourhood, and teams - because it's people who change lives, not governance structures and sectors.'

in the care of older people and secondary care clinicians integrate with all of the above, particularly in rural, remote and island communities facing more severe workforce challenges? And how can we build on the local collaborations achieved during the pandemic to strengthen locality workforce planning? For that's where the magic of integrated care happens - at the level of place, neighbourhood, and teams - because it's people who change lives, not governance structures and sectors.

At point of care, continuity and co-ordination (the essence of integrated care) are greatly influenced by culture, trust and relationships between practitioners and partners across teams, care settings and sectors. It takes time to influence organisational and professional cultures and build trusting fellow professionals! We know effective relational practice can be enabled through collaborative interdisciplinary and cross sectoral learning. We have much to learn from our colleagues in social care. And we could achieve so much together if we work as equal partners in the design and delivery of long-term health and social care.

I'm proud that the BGS community stands with our colleagues in social care and that we affirm our support in our *Ambitions for Change* publication. If we are to realise these ambitions is it time to drop the healthcare and social care labels and focus on our shared purpose of enabling people to live their best lives?

In the words of Social Care Future *"We all want to live well in the place we call home, doing the things that matter to us with the people and things that we love, and in communities where we look out for one another."*

BGS members working with older people have an important part to play in realising that vision. Let's not let labels get in the way.

Professor Anne Hendry
BGS Honorary Secretary
@AnneIFICScot

Meet the new BGS Care Homes Fellow

The BGS has appointed a Care Homes Fellow to lead on strategic work around residential care for older people. You can find out more about our Care Homes Fellow, Leah Bressington, below.

My name is Leah Bressington and I feel honoured to be taking on the BGS Care Home Fellow role.

For the next year I will be working on development and implementation of ideas for the care home strategic project, focusing on delivering high quality of care for all care home residents in the UK.

Having begun my nursing career in care homes, I have a lived 360-degree experience of care home work across all health care sectors, and hope to be a driving force in promoting high quality of care and support, putting care home work at the forefront of health and social care.

Based in the South West of England I have been embedded in a thriving inter-agency Primary Care Network care home hub at One Weston, and supported local care homes with some of the biggest inequalities and challenges experienced, the most recent being the COVID-19 pandemic.

My enthusiasm to drive forward high quality of care in care homes derives from the belief that all care home residents deserve the best healthcare to live their best life, and I believe this can be achieved by sharing good practice, partnerships, and equipping care home staff with the right skills.

I am looking forward to this inspiring project and cant wait to make some great connections here at the BGS.

Leah Bressington
BGS Care Homes Fellow
@BressingtonLeah

For more information about the BGS' work around care homes and for updates from Leah and the rest of the BGS team, visit the BGS Care Homes Group page at www.bgs.org.uk/care-homes-group

‘The differing perspectives that AHPs and nurses bring to clinical practice have resulted in different research questions being asked, which in turn has led to a greater variety in study methods, populations and interventions.’

Making *research* count

Submissions of research to *Age and Ageing* from nurses and Allied Health Professionals (AHPs) continue to rise, contributing the valuable pool of research evidence from this huge area of older people's healthcare. Dr Alison Cowley highlights some recent papers and explains why we must continue to do more to encourage and support research from within the nurse and AHP community.

Assessing, managing and supporting older peoples complex health and social care needs is a multi-disciplinary endeavour and it should therefore come as no surprise that research takes a similar approach. Nurses and Allied Health Professionals (AHPs) have long been active research team members and leaders and have published extensively in *Age and Ageing*.[1-3]

Programmes such as the National Institute of Health Research (NIHR) Integrated Clinical Academic (ICA) pathways have led to the growth of clinical academic careers in non-medical professions. The differing perspectives that AHPs and nurses bring to clinical practice have resulted in different research questions being asked, which in turn has led to a greater variety in study methods, populations and interventions. Recent articles published in Age and Ageing demonstrates this diversity and growth and the wide variety of clinical roles of nurses and AHPs.

A systematic review by McIlroy et al[4] found that better pre-operative walking ability was associated with greater post-operative walking capacity in patients undergoing surgery for lumbar spinal stenosis, but not spondylolisthesis. They concluded that more robust research is needed to identify prognostic factors to guide surgical clinical decision making and optimise rehabilitation and health outcomes.

The health needs of older people who reside in care homes has always been an integral part of our clinical practice, but has come into sharp focus during the COVID-19 pandemic. A recent cluster randomised controlled feasibility trial by Forster et al,[5] the REACH trial, found that an intervention to increase physical activity in care home residents was feasible, acceptable and safe, even with the most severely frail residents.

Cognitive impairment is frequently cited as a barrier to rehabilitation, eloquently discussed in the highly accessed article *'Mrs Smith has no rehab potential': does rehabilitation have a role in the management of people with dementia?* by Goodwin and Allan.[6]

However in clinical practice there are always those patients who surprise us, where positive gains can be achieved with even the most physically and cognitively impaired adults. A randomised controlled trial by Law et al[7] found that functional task exercise was effective in improving the everyday problem-solving abilities and functional abilities of older adults with mild cognitive impairment.

Nursing and AHP contributions to research published within *Age and Ageing* are not isolated to systematic reviews and trials. Qualitative studies provide valuable insights into the beliefs, experiences and perceptions of older people, care givers and clinicians. A semi-structured interview study exploring the impact of COVID-19 restrictions on carers of persons with dementia found that care givers provided physical, emotional and practical support but more robust support systems were needed.[8] They found that care givers struggled to access formal care and respite services, needing more support and education to access telecare solutions which were rapidly implemented during the pandemic.

These studies represent a small sample of those published in *Age and Ageing* over recent years by nurses and AHPs (so apologies to anyone who I have missed; it wasn't intentional!) They demonstrate the diversity of research methods, questions and teams working to progress the evidence base in our clinical speciality, which, with implementation into practice, has the potential to improve outcomes and experiences for our service users, their families and care givers.

Dr Alison Cowley
Honorary (Clinical) Assistant Professor, School of Medicine, University of Nottingham; BGS Nurse & AHP Council Member
@Alison_Cowley

References

1. Logan PA, Coupland CAC, Gladman JRF, Sahota O, Stoner-Hobbs V, Robertson K, et al. Community falls prevention for people who call an emergency ambulance after a fall: randomised controlled trial. BMJ. 2010;340(7755):79-1070.
2. Sheehan KJ, Fitzgerald L, Hatherley S, Potter C, Ayis S, Martin FC, et al. Inequity in rehabilitation interventions after hip fracture: a systematic review. Age and Ageing. 2019;48(4):489.
3. Goldberg SE, Cooper J, Blundell A, Gordon AL, Masud T, Moorchilot R. Development of a curriculum for advanced nurse practitioners working with older people with frailty in the acute hospital through a modified Delphi process. Age and Ageing. 2016;45(1):48-53.
4. McIlroy S, Walsh E, Sothinathan C, Stovold E, Norwitz D, Norton S, et al. Pre-operative prognostic factors for walking capacity after surgery for lumbar spinal stenosis: a systematic review. Age and ageing. 2021;50(5):1529-45.
5. Forster A, Airlie J, Ellwood A, Godfrey M, Green J, Cundill B, et al. An intervention to increase physical activity in care home residents: results of a cluster-randomised, controlled feasibility trial (the REACH trial). 2021.
6. Goodwin VA, Allan LM. 'Mrs Smith has no rehab potential': does rehabilitation have a role in the management of people with dementia? Age and Ageing. 2019;48(1):5-7.
7. Law LLF, Mok VCT, Yau MKS, Fong KNK. Effects of functional task exercise on everyday problem-solving ability and functional status in older adults with mild cognitive impairment-a randomised controlled trial. Age and Ageing. 2022;51(1).
8. Sriram V, Jenkinson C, Peters M. Impact of COVID-19 restrictions on carers of persons with dementia in the UK: a qualitative study. Age and Ageing. 2021;50(6):1876-85.

“Could you look *at the* medicines?”

An innovative multidisciplinary approach to the training and education of pharmacists within the acute frailty setting in the North West of England has driven improvements in the understanding and care of older patients, explains Louise Organista.

“Could you just look at the medicines?”

A seemingly simple question, yet one I’m often asked as a pharmacist working in the Frail Elderly Assessment Team (FEAT) of a busy medical admissions unit. My key role in reviewing and optimising medicines for older patients involves a lot more than simply checking doses, drug interactions and making supplies.

Yes, as pharmacists we do ensure that prescribed doses are correct and clinically appropriate, then order accordingly. However, my role in “looking at the medications” involves so much more than this and is an essential component to the Comprehensive Geriatric Assessment (CGA).

With the pharmacists of the future now graduating as prescribers from 2026[1] and a current lack of deprescribing skills taught within UK undergraduate pharmacy courses, it’s imperative that patient consultation skills, medicines optimisation and deprescribing are instilled at an early stage to support our increasingly frail patient population.

So what does a typical frailty pharmacist’s review look like, and how are we supporting the training of future pharmacists during their clinical placements?

Let’s start with an observation: patients with frailty admitted to hospital are often on a lengthy list of medicines. Sometimes, this polypharmacy is appropriate (advanced age brings multiple morbidities, and medicines can prolong life); or problematic (causing increased adverse drug reactions and a contributory cause to admission, such as delirium or falls).[2]

The first step is finding out everything this lengthy list entails - repeat prescription medicines, supplements (one patient swore by garlic capsules for preventing common cold - something which may have some truth![3]), topical therapies, injections, drops, patches and sprays. Frequently, the original indications have expired, and it can take time to investigate exactly when and why each medicine was started.

Unfortunately, it isn’t uncommon to find drugs prescribed for over 40 years that now contribute to an unhelpful side effect profile, with the patient merely taking them because the “doctor said so”, with no idea why.

This aspect of medicine reconciliation takes time and requires a certain amount of detective work. It is however helpful in painting a picture of the patient’s clinical history and prescribing journey (often with multiple prescribers involved), an aspect that helps to guide the next step: medicines optimisation.

Decision-making around optimising medicines should always be undertaken in consultation with the patient, or the next-of-kin/carer involved in their care, to reach a shared decision.[4] Whereby ward round prescribing decisions can happen at the end of a bed, swiftly scrawled into notes, my assessment of patient’s therapy will be led by their views,

‘Unfortunately, it isn’t uncommon to find drugs prescribed for over 40 years that now contribute to an unhelpful side effect profile.’

concerns and expectations of their medicines. I’ll often engage the patient in this approach by asking an opening question, such as, “Do you think you’re taking a lot of medications?” On occasion, deprescribing of drugs which I perceive to be problematic (due to adverse side effect profiles such as the notorious anticholinergic drugs), or those which have limited evidence, such as quinine for leg cramps,[5] are met with resistance. I will take this into account, provided no harm is done and safety-net advice is given. Confirming whether all medicines are even taken at all is another key detail which shouldn’t be overlooked.

After discussing with the patient, the plan for the medication review - including any explanations to changes in therapy - is recorded in the patient's notes, actioned in hospital by us pharmacist prescribers in liaison with the multidisciplinary team (MDT) and communicated back to primary care on the discharge letter. We complete this aspect, under an 'Allied Health Care Professional' section, in addition to inputting into the e-copy of the patient's CGA which is completed by the whole frailty team. The CGA is sent to the discharge co-ordinator who can task the GP with any outstanding actions or care issues. The ward MDT have reported that the recording of rationale for changing medicines and deprescribing decisions are both educational and helpful to facilitate a higher standard of discharge letter.

Our current pharmacy undergraduate trainees spend a week of their clinical rotations with our frailty MDT under the guidance of the senior frailty pharmacists. We first share essential reading for the students, including relevant guidelines on topics such as bone health, falls and anticholinergic burden, as well as evidence-based deprescribing tools. We also ask the students to consider what they know about frailty and the pharmacist’s role, as well as setting objectives for the week ahead.

The trainees begin by shadowing the frailty pharmacist in reconciling and optimising the patient’s medicines through the aforementioned steps to gain understanding into our detailed and methodical way of working. Although medicine history-taking is a key skill taught to undergraduates, a frailty pharmacist goes further to seek specific details, such as finding out if the patient has dexterity to open their medication, swallow their tablets, read the labels and use their inhalers correctly. There are many aids and solutions which can be explored in answer to these problems if older patients are given the opportunity to share their concerns.[6]

Time is also spent with the frailty nurse and therapists who assess the functional, social and environmental aspects of the patient, discussing mental health, nutrition, mobility and incontinence. It’s important for future healthcare professionals to gain an appreciation of the unique roles that make up the frailty team, with respect to our specific contributions to the CGA.

The trainees also become aware of the care needs, challenging home environments and tricky social situations that shape discharge planning and pathways - an aspect that is not highlighted in current undergraduate pharmacy training.

‘Decision-making around optimising medicines should always involve consultation with the patient.’

This understanding helps us to know when Medicine Administration Records (MARs) should be provided and allows us to inform carers or community pharmacists of any changes to the medicine regime (the provision of blister packs, for example).

The Consultant Geriatricians and Advanced Clinical Practitioners provide opportunities for the trainees to gain understanding of clinical history taking, assessment and investigations by joining a morning ward round.

Pictured: Frailty pharmacist, carrying out a medication consultation observed by trainee pharmacist

The wisdom and knowledge imparted by these physicians enhances their understanding of the clinical rationale behind ordering tests and prescribing decisions, as well as the value of investigations such as a lying and standing blood pressure measurement to aid medication review.

During the final days, we ask the student to lead in the pharmacy role under our supervision and guidance, providing support, input and feedback where needed to help provoke thought and improve practice. It has been wonderful to see how this approach of teaching, encouraging and allowing leadership can improve confidence and knowledge in the management of patients with frailty after just a week.

Some of the feedback we have received demonstrates the value of increasing awareness of frailty, and the importance of a pharmacist’s expertise for this cohort of patients who can often struggle to see a GP face-to-face with their concerns regarding their long-term medications:

“I feel that the FEAT pharmacist takes an accurate and completely holistic approach to the patient and the medication. This includes the basic medicines reconciliation in terms of what they're taking, the dose, frequency etc but it also adds a level of depth with respect to problems that are being experienced by the patient, how these can be better managed either pharmaceutically or non-pharmacologically but mainly every intervention made is patient focused.”

“They [FEAT pharmacists] empower patients to be part of the shared decision making in relation to their medicines.”

“The FEAT pharmacists ensure there is a rationale for each of the prescribed medications and if a medication may be unnecessary, they may deprescribe in order to reduce the polypharmacy burden in a patient. They provide opportunistic counselling to medications the patient is already on, or newly started, to make sure they get the most out of their medicine.”

I am happy to report that the value that pharmacists bring to the frailty team is very much encouraged and supported where I work and has brought a greater awareness to our role within the team itself, by involving each member in the student’s training and development.

I would implore other BGS pharmacists to lead in an MDT-focused approach to training and education within the frailty setting, especially as this future generation of prescribers will be embedded in ward teams in every setting, improving the care of older patients, one medicine at a time.

References

1. General Pharmaceutical Council. FAQ: reforms to the initial education and training of pharmacists. Available at: www.pharmacyregulation.org/education/standards-pharmacy-education/faq-reforms-initial-education-and-training-pharmacists.
2. Duerden M, Avery T, Payne R. Polypharmacy and medicines optimisation. Making it safe and sound. London: The King’s Fund. 2013 Nov.
3. Lissiman E, Bhasale AL, Cohen M. Garlic for the common cold. Cochrane Database of Systematic Reviews. 2014(11).
4. Royal Pharmaceutical Society. Prescribers Competency Framework. Available at: www.rpharms.com/resources/frameworks/prescribers-competency-framework.
5. El-Tawil S, Al Musa T, Valli H, Lunn MP, Brassington R, El-Tawil T, Weber M. Quinine for muscle cramps. Cochrane database of systematic reviews. 2015(4).
6. Carli Lorenzini G, Bell A, Olsson A. ‘You need to be healthy to be sick’: exploring older people’s experiences with medication packaging at home. Age and Ageing. 2022;51(3):afac050.

Louise Organista
Advanced Clinical Pharmacist, Frail Elderly Assessment Team, University Hospitals of Derby and Burton (UHDB) Foundation Trust

Movers & *shakers*

This year's BGS Special Medal winner is Leon Wormley, who created a holistic exercise programme for older people during the pandemic with his mother Janet, who has arthritis.

The British Geriatrics Society (BGS) awards its Special Medal each year to someone who has made an outstanding contribution to promoting the health and wellbeing of older people. It recognises non-clinical professionals who have gone the extra mile through their work or volunteering in supporting older people.

Let's Move with Leon is a 12-week programme which was filmed during lockdown and reached more than 50,000 people. The programme helped educate older people on how to exercise safely at home, building their skills, knowledge and understanding so they could tailor exercise to suit their own health. It was linked to the activities that people carry out every day and used household objects to exercise with. The Let's Move programme is run by Versus Arthritis and funded by Sport England, which aims to transform lives and communities through sport and physical activity.

The key to Let's Move with Leon was giving people ownership of their condition, so that they could manage it better. Leon helped design an activity tracker which gave simple ways to track progress, and motivated participants in their journey. Leon and Janet delivered live question and answer sessions, moderated a Facebook group, shared motivational posts and added humour with their unique relationship.

Speaking about the programme, Leon (pictured above, left) said: "None of us expected the programme's success. I was taken aback when people said it had changed their lives, or in some instances, that it had saved their lives, along with reducing pain, increasing independence, improving quality of life, and reducing their medication dependency.

'My confidence rocketed and my strength and mobility vastly improved. It is great to hear and see people benefiting from the exercises.'

"The whole experience has been a win-win for everyone involved, and the BGS Special Medal is the icing on the cake. I cannot think of anyone else I would rather share it with than my mum, Janet. She is the real star of the show, proving that movement can build capacity and unlock potential."

Liam's mum, Janet Wormley (pictured above, right), added: "I am so proud that the Let's Move with Leon programme has won this award. When he asked me to do this, my first thoughts were negative. I had not exercised for a while, had a few health issues and was not long recovered from a foot injury. My wrists and shoulders were also painful.

"But I'm so glad I agreed. My confidence rocketed and my strength and mobility vastly improved. It is great to hear and see people benefiting from the exercises in the comfort of their own home. Many people, including myself, need this encouragement and support to move, even more so after living in these very restrictive times. Not everyone can openly access a gym or go for a walk outside and feel safe.

"We are pleased to have been able to help those most in need and I just hope this success and attention to older people's health continues to grow."

Professor Dawn Skelton, Professor of Ageing and Health at Glasgow Caledonian University and BGS Rehabilitation Group chair, added: "Leon is a trained Postural Stability Instructor, amongst other specialist instructor qualifications, and used his training, alongside his commitment to his mother and others like her, to produce a programme that clearly engaged people and made a difference when other opportunities for exercise were not available.

"Wider than just videos, his engagement on Facebook with members means that barriers could be broken down, successes shared and a feeling of community built. A reminder that an exercise programme is more than a set of exercises and motivation is key to adherence and positive outcomes."

Taking *the* LEAD

What does leadership mean in the context of nursing, and what role does it have in helping to bring together the multidisciplinary team in older people's healthcare? Lyndsey Dunn, Vice Chair of the BGS Nurse & AHP Council, shares what it means for her.

The question "what is nursing leadership?" is one that I am frequently asked. Perhaps having 'lead nurse' in my job title could be the main reason, however it's fair to say my answer remains unwavering.

Nursing leadership is one of the single most important factors in motivating, influencing and inspiring all healthcare professionals as they work together to achieve their goals.

Leadership has played a pivotal role in setting out my main priorities as Vice Chair of the BGS Nurses and AHP Council. My goal has been delivering high-quality person centred care for the older population.

Nursing leadership is most successful when the entire team is also successful. To achieve this, I feel I have a key role in influencing and engaging all members of the healthcare team to drive and improve healthcare for older adults. The position of Vice Chair also gives me the voice to highlight key issues in older people's care.

The Western General Hospital's recent work on a team approach to detection and management of delirium raised a united front across NHS Lothian and saw collaboration with several heath boards in Scotland for World Delirium Day.

This was a fantastic example of successful leadership and the teams working together.

I want to reach out to all nurses and AHPs in Scotland who are passionate about improving the health and well-being of the older adult and promote the benefits of being part of the BGS.

I am very privileged and proud to play a part in increasing and encouraging nursing and AHP membership across Scotland where the Council aims to represent all our multi-disciplinary colleagues.

Leadership is more important now than ever especially with the immense challenges we have all faced throughout COVID-19. I have been given a fantastic opportunity from the BGS to encourage the voices of our nursing and AHP workforce who continue to champion for better care for the older population.

BGS Nurses & AHPs Council

The BGS Nurses and AHPs Council represents all 'category C' BGS members who work as Nurses or Allied Health Professionals (AHPs).

They meet four times a year and run regular interactive Communities of Practice events online via the BGS website.

You can view all upcoming events by visiting www.bgs.org.uk/events

British Geriatrics Society
Improving healthcare for older people

Join us

Group membership

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

The key benefits are:

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

Benefits **not** included in group membership:

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

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

How to join?

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

A career that ADDS UP

Sarah Goldberg is Professor of Older Persons Care at the School of Health Sciences, University of Nottingham and is Honorary Treasurer of the BGS. She talks about her unusual career path and how her experiences have shaped the rewarding academic role she has today.

Leaving university at 22, my only aim was to be paid well and I planned to achieve this by training as a Chartered Accountant. My aim was met, but over the years, I found the work as an auditor unsatisfying. A career break to care for my three young children resulted in me deciding to train as a nurse.

My first staff nurse job was on a healthcare of the older person ward. The ward had a high proportion of patients with dementia. I had received no training on how to care for these patients' complex needs during my nursing diploma and none was offered post-qualification. I found my lack of knowledge and skills uncomfortable, and a sharp contrast to the high level of training I'd received as an accountant. I left after seven months to become a diabetes research nurse and then a practice nurse.

I then met Professor Rowan Harwood, who had funding to develop and evaluate a medical and mental health unit (MMHU) which aimed to improve the hospital care of cognitively impaired older people. Inspired by Rowan's vision of excellence in hospital dementia care, I joined his team as a research assistant. The trial of the MMHU demonstrated that patients cared for on the unit received a better care quality and had a better experience than those cared for on standard care wards.[1,2]

My project management expertise developed as an accountant resulted in me becoming the trial manager. I also completed my PhD while managing the trial and developed a passion for research.

I was then fortunate to be funded by Nottingham Hospitals Charity to develop the role of Advanced Nurse Practitioner specialising in frailty. I used the Delphi method to gain expert consensus on competencies for this new role.[3] Many members of the BGS Nurses & Allied Health Professionals (AHPs) Council contributed to this research by being on the expert panel.

I then secured a job at the University of Nottingham as an Associate Professor. Continuing to work with Rowan Harwood I was awarded funding as co-investigator on three large NIHR funded studies. PrAISED is a complex intervention to keep people with early dementia active

'As Director of Research for my school, I am responsible for the strategic direction of research, and of course I still use my accountancy experience as the Honorary Treasurer of the BGS.'

and independent (results of the multisite randomised controlled trial are due in October 2022). VOICE1 used analysis of video recordings of conversations between healthcare practitioners and people with dementia to understand which communication practices are effective when delivering care. The findings were used to develop a dementia communication skills training course for healthcare practitioners.[4] We have recently started VOICE2 which aims to understand effective communication when healthcare practitioners are caring for a distressed patient with dementia.

In addition to research, I support undergraduate and post-graduate nursing students, clinical academic PhD students from a range of disciplines, and have developed teaching and learning resources including the Foundations in Dementia MOOC (**www.futurelearn.com/courses/dementia-awareness-training**) and a series of online resources for hospital staff (**www.bgs.org.uk/blog/reusable-learning-objects-in-dementia-care**).

As Director of Research for my school, I am responsible for the strategic direction of research, and of course I still use my accountancy experience as the Honorary Treasurer of the BGS.

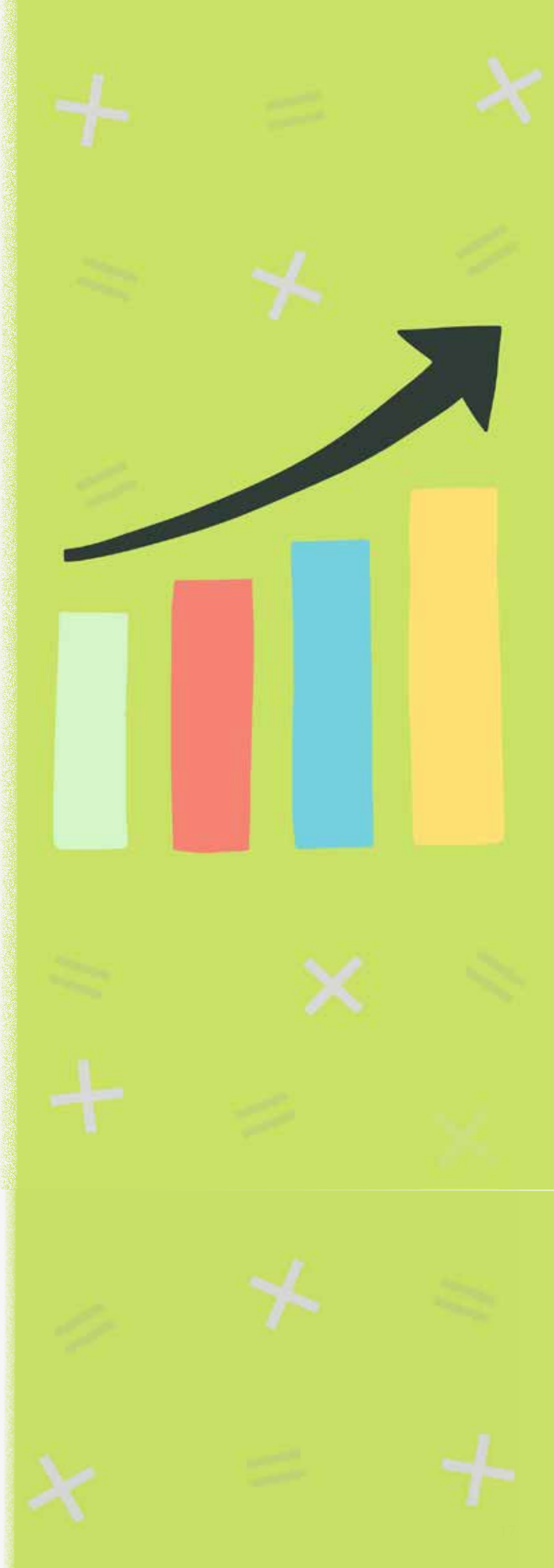
When I changed career to become a nurse, I did not appreciate the diversity of the role I would end up doing.

Research is always interesting and stimulating and makes a huge contribution to improving the healthcare of people with dementia and the skills and knowledge of those caring for them.

References

1. Goldberg SE, Whittamore KH, Pollock K, Harwood RH, Gladman JR. Caring for cognitively impaired older patients in the general hospital: a qualitative analysis of similarities and differences between a specialist Medical and Mental Health Unit and standard care wards. Int J Nurs Stud 2014; 51:1332-43.
2. Goldberg SE, Harwood RH et al. Comparison of a specialist Medical and Mental Health Unit with standard care for older people with cognitive impairment admitted to a general hospital: a randomised controlled trial (NIHR TEAM trial). BMJ 2013;347:f4132
3. Goldberg SE, Cooper J, Gordon A, Blundell A, Masud T and Moorchilot R. Development of a curriculum for Advanced Nurse Practitioners working with older people with frailty in the acute hospital through a modified Delphi process. Age & Ageing. 2016; 45 (1): 48-53.
4. O'Brien, R., Goldberg, S., Pilnick, A. et al (2018) The VOICE study- A before and after study of a dementia skills communication course. PLOS One: http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0198567

Professor Sarah Goldberg
Professor in Older Persons Care, University of Nottingham, and BGS Honorary Treasurer



Evidencing EXCELLENCE

You can find out more about the Diploma in Geriatric Medicine (DGM), including a link to register your interest in the next round of Part 1 examinations which will open for applications this winter, by visiting www.bgs.org.uk/DGM

The Diploma in Geriatric Medicine (DGM), run jointly by the BGS and Royal College of Physicians (RCP) London, opened up to nurses and AHPs for the first time this year. Stacey Finlay, the Northern Ireland representative on the BGS Nurses and AHPs Council, explains how taking the Part 1 exam has helped her demonstrate her skills and expertise in frailty.

The four pillars of advanced practice are the elements that are required for a clinician to practice at an advanced level: clinical practice, leadership and management, education and research. Skills in each of these areas are usually gained through master's level postgraduate education and clinicians practising at this level are characterised by having a high level of autonomy in their roles, keen problem-solving skills and the ability to make complex decisions in collaboration with other members of the multidisciplinary team, individuals and their families or carers.

Until recently, there has not been a specific method of credentialing this level of expert practice in older people's healthcare for those outside of the medical profession. A lack of a consistent method of credentialing advanced practice, and particularly what advanced clinical practice is within the specialism, can mean that there is a lack of consistency in the level of clinical skills and reasoning between different clinicians. In essence, there could be professionals in apparently similar advanced practice roles who practise at different clinical levels.

Healthcare for older people is one of the most multidisciplinary specialisms in modern healthcare. Teams specialising in older people's healthcare are led by different members of the multidisciplinary team and other professionals operating at an expert level within the specialty. Therefore, in 2022 with rising numbers of older people and a growing shortage of consultant geriatricians, it no longer makes sense to limit which professionals practising at an expert level in older people's healthcare can demonstrate their expertise through obtaining the Diploma in Geriatric Medicine (DGM). Recently, The BGS and RCP recently opened the DGM to all registered professionals who have at least two years post-qualification experience and have been working in geriatric medicine for a minimum of four months.

The DGM is made up of two exams. Part 1 is a knowledge-based exam (online). Part 2 is a clinical skills exam which is taken at the RCP's examination centre in Liverpool.

In March of this year, after being qualified for almost five years, spending all my career in older people's healthcare, and obtaining a masters level qualifications both in advanced practice and care of older people, I decided to take the DGM. It is not something that is usually said about exams, but I enjoyed studying for and taking the DGM as the concepts I was studying, such as frailty, comprehensive geriatric assessment, stroke syndromes, medicine in older people and discharge planning were familiar to me already from encountering them frequently in day-to-day clinical practice.

Fortunately, I passed Part 1 on my first attempt and now have two years to take and pass Part 2 which I am also looking forward to. Part 1 has enhanced my knowledge in the specialty and formally credentialed the knowledge and expertise I have gained. This has enhanced my confidence in advanced clinical practice as an expert in older people's healthcare. I would thoroughly recommend it to all registered professionals who wish to build their knowledge, expertise and confidence in themselves as experts in older people's healthcare.

Stacey Finlay
Intermediate Care Sister, Domnall Intermediate Care Centre; Northern Ireland Representative, BGS Nurses & AHPs Council
@staceylou_18

New BGS/Dunhill Doctoral Training Fellow to study immune cells in delirium

Dr Hannah Moorey (*pictured inset*) is the third recipient of the prestigious Clinical Fellowship jointly funded by the British Geriatrics Society and the Dunhill Medical Trust, as announced at the BGS Spring Meeting in April.

Her PhD application impressed the Fellowship panel with the relevance and focus of her proposed research, which aims to improve understanding of what causes delirium, a common age-related disease. By testing how immune cells respond to different drugs she hopes to find future treatments for delirium.

Although delirium is often triggered by infection or surgery, the biological mechanisms are not well understood, but it is possible that immune cells are involved.

Hannah's research will examine the immune cells of older people with infections who get delirium and compare them to those who do not.

She will be testing drugs on these cells to discover how immune cells respond to them. This is in the hope of finding future treatments and reducing the number of people who require residential care or develop dementia as a result.

Hannah is the third recipient of the BGS/Dunhill Medical Trust Doctoral Training Fellowship, which is a joint initiative to support research relevant to age-related diseases and frailty. The Fellowship will fund her PhD research over three years.

Pharmacist Adeela Usman was the first recipient of the BGS/Dunhill Fellowship, and Geriatrician Dr Sarah Hopkins is the second Fellow. She began her research on advance care planning in early 2022.

The BGS and Dunhill Medical Trust have agreed to fund a second round of three Fellowships. Applications for the first Fellow of this second round closed in April, but for details of how to apply for future Fellowships, see:

https://dunhillmedical.org.uk/apply-for-funding

Question of quality

Adeela Usman *(pictured right)* is a Pharmacist and a joint British Geriatrics Society/Dunhill Medical Trust Doctoral Training Fellow based at the Centre for Rehabilitation and Ageing Research in Nottingham. She is undertaking a PhD looking at quality of life among care home residents, and explains how COVID has been both a challenge and an opportunity in terms of her research ambitions.

I have reached that point in my PhD when everyone is asking me "when is your PhD ending?" I'm about halfway through and I'm enjoying it. I'm not wishing it away just yet! I respond by saying I am enjoying it and wish it would never end because, I do feel like that.

Nevertheless, this question makes me reflect on my journey so far. It all started in 2016-2018, when I was working as a research associate on a research project where every single month I had to ask care home residents about their Quality of Life (QoL) using a general questionnaire.

Eventually one resident got fed up and asked me if I could please change the questions because they didn't make sense to them. I listened and went away to look at the literature. I found QoL tools that could be used in care homes, but none that were designed to be routinely used by care home staff to help them support quality of care.

In 2019 I was so excited when I secured funding from the BGS and Dunhill Medical Trust to start working on developing a care home-specific quality of life tool that could be used routinely by care home staff.

I was completely thrown when three months into my PhD, COVID happened. Initially I was completely lost. I couldn't go into care homes to meet staff and residents. I couldn't even go into my office at the medical school, and

'Every month I asked care home residents about their quality of life using a general questionnaire. Eventually one resident got fed up and asked me if I could please change the questions because they didn't make sense to them.'

my supervisor was needed on the COVID wards. Slowly I found my feet and realised this was a good opportunity to read more substantively around the topic and plan the rest of my work.

Eventually, care home staff found enough time to start to meet with me again online and then, in 2021, I was able to get back in and visit.

What struck me in speaking to staff was how the pandemic had reinforced the need to routinely capture information about quality of life. Lockdowns, quarantine, regular testing – all these things had affected residents' QoL, but it was difficult for staff to express in what way and how much.

I have conducted a structured review of the literature, which I use alongside interviews with older care home residents. The next stage is to use a consensus approach to develop a prototype tool. My PhD fellowship has allowed to me to act on and address the feedback I received from care home residents in 2018.

I'm proud that my PhD will move us closer to having a tool that allows us to capture the quality of life of older residents, in a meaningful way, to help support their quality of care.

This fellowship has benefited me in several ways. Firstly, by giving me the opportunity to do what I value and am passionate about. When I started my fellowship, l asked myself what quality of life means to me, and this is one of my interview questions when speaking to older care home residents, their relatives and care home staff.

One of the top responses was 'working on something meaningful', and this is exactly what I myself am doing because it is fulfilling knowing that my tool will be used in future to improve older care home residents' quality of life.

Secondly, through this fellowship I was able to undertake external training in research methodologies and in data management software, as well as being supported to work closely with a group of patients and members of the public whose insights have been invaluable.

Finally, this prestigious BGS/Dunhill Fellowship award has opened doors for me to be invited to sit on fellowship interview panels, present at local and national events and led people with an interest in my work reach out for informal chats about my project. I have left each of these interactions with food for thought about my project and with new ways of approaching my research.

Asking myself now, if I went back in time, would l apply for this fellowship again?

Absolutely! I would embrace it with open arms.

Adeela Usman
Joint BGS/Dunhill Medical Trust Doctoral Training Fellow
@adeela_usman

Home and well

The Living Well in the Community initiative in Lanarkshire is a multi-professional cross-sector collaboration which brings together community staff from across rehabilitation, nursing, health visiting, mental health, Third Sector, frailty specialism, information technology, pharmacy, primary care and public health to develop a preventative approach for older people in the community. Dr Lyndsay Whyte and Dr Liana McMillan explain how and why this truly multidisciplinary effort works for older people in Lanarkshire.

Lyndsay says:

"We are all too aware of the increased numbers of people living with frailty and often multiple health conditions. Services are stretched, even more so after the COVID pandemic.

"Caring for those who unfortunately end up in hospital is just the tip of the iceberg – many more people are living with frailty in the community.

"Some may be well known to primary care but others are not in contact with any health professional. I'm sure we've all encountered patients who have been deteriorating at home, struggling with increasing impairment, until they reach crisis point.

"That's why I was interested in joining the Living Well in the Community collaborative when I rotated to work in Lanarkshire. This multidisciplinary team (MDT) includes GPs and geriatricians, community nurses, the community mental health team, pharmacists, social care and more; and are providing multifactorial assessment and interventions for people living with frailty on a proactive and preventative basis.

'The response from everyone involved has been positive and we are all optimistic about the benefits of early intervention to reduce impairment, falls and admissions further down the line.'

"The project kicked off in late 2019, so unfortunately was soon disrupted by pandemic pressures and, crucially, loss of the Health Visitors who had been undertaking comprehensive assessments in the patients' homes and reporting back to the MDT.

"It was vital that somebody, a key worker, could spend time with patients, their family and carers, to understand their main problems, and 'What Matters'.

"Thankfully, Equals Advocacy stepped up to take on that vital role as a Third Sector organisation providing independent advocacy for people in Lanarkshire. Their highly trained staff were able to undertake these crucial assessments and provide support to the MDT.

"By the end of 2021, the MDTs were gaining momentum and we had just provided tailored interventions for our 100th person living with frailty in the community. Interventions ranged from polypharmacy reviews to care packages, referrals to other professionals and to social prescribing supports.

"I have been hugely impressed by how the team go beyond the clinical condition to look at wellness and quality of life. Feedback from patients and their carers has been very positive. More challenging is ensuring engagement with all the professionals needed to provide a wide range of interventions. Freeing up time to join an online MDT meeting which may produce more work may not be attractive initially! However, the response from everyone involved has been positive and we are all optimistic about the benefits of early intervention to reduce impairment, falls and admissions further down the line.

"Improving care for people with frailty is a shared ambition across the UK. It is great that BGS members are sharing experience about effective and sustainable models to deliver proactive CGA and early interventions."

Dr Lindsay Whyte
St7 in Geriatrics/GIM, University Hospital Wishaw
@l_whyte / @LivingWellColl1

‘Why would we not want to engage in a process that allows us to draw on the skills of other members of the health and social care team to support our older patients and their carers to live well at home?’

Liana says:

"We have progressed from describing people as being frail to now diagnosing frailty and even naming frailty as a primary cause of death on certificates. Is this just a phase or should we all be managing ‘frailty’ like other long term conditions?

"There are few specialties now that are truly ‘generalist’ apart from GPs and geriatricians. Both specialties care for older people and it makes absolute sense to me that we should be working together to deliver better care for older people.

"I have always felt quite isolated caring for people who have multi morbidities, polypharmacy and complex needs with no specific clinic to refer to. So I have been working hard with a group of other ‘early adopter’ practices to identify our patients with escalating levels of frailty.

"Together we have developed a MDT process to assess their needs, try to delay the progression of their conditions and create good anticipatory care plans that are available for all to see.

"The core MDT is the GP, geriatrician and pharmacist but we call on support from allied health professionals, social care, dietician, community mental health team and third sector advocacy.

"Having a motivated group of professionals who care about their patients is half the battle. Our major challenge is we all use different computer systems that don’t talk to each other!

"COVID-19 has had a huge impact on this work, although not all negative. Increased familiarity with virtual meetings has allowed more flexibility to attend MDTs and anticipatory care planning has been given more attention nationally. We have managed to streamline our processes to a point where we can encourage other practices to come on board.

"There are still many challenges ahead. Given the capacity in General Practice, convincing people to ‘take on more work’ is tricky.

"My response is to ask whether this really is *extra* work. Is this not at the heart of primary care? Why would we not want to engage in a process that allows us to draw on the skills of other members of the health and social care team to support our older patients and their carers to live well at home?"

Dr Liana McMillan
GP, Coatbridge

The BGS website is a treasure trove of resources for all members of the multidisciplinary team (MDT) and their colleagues in both community and acute settings. Here is a rundown of some of our most popular cross-disciplinary resources:

1. Frailty Hub

www.bgs.org.uk/FrailtyHub

Our Frailty Hub resource brings together articles, national guidelines and best practice relevant to frailty, covering best practice, frailty in specific settings, training, commissioning and research. It provides useful information for collegaues who might be just starting out in learning about frailty, as well as those who are highly experienced in this area and looking to develop new skills, evidence or services.

2. Delirium Hub

www.bgs.org.uk/FrailtyHub

The Delirium Hub guides users through the topic of delirium, including presentation, screening and treatment in specific settings, education, training and current research evidence. It aims to help professionals from all backgrounds recognise and act upon the distressing signs of delirium in older people, which is often underdiagnosed.

3. End of Life Care in Frailty

www.bgs.org.uk/EOLCfrailty

The aim of this guidance is to support clinicians and others in considering the needs of and providing high quality care for frail older people as they move towards the end of their lives. It covers aspects such as nutrition, medicines management, psychological support and rehabilitation at the end of life

4. Silver Book II

www.bgs.org.uk/SilverBook2

The Silver Book II addresses a wide range of urgent care issues specific to older people. Aimed at clinicians and other healthcare professionals working in emergency departments and urgent care settings, and describes key competencies for nursing staff, physiotherapists, social workers and paramedics.

5. Keeping older people safe and well at home

www.bgs.org.uk/safeandwell

These resources have been developed to help keep older people safe at home by reducing deconditioning and falls hazards, supporting people with conditions such as dementia or Parkinson's, and improving overall wellbeing to help to keep their minds and bodies active.

The BGS Spring Meeting was held on 6-8 April 2022 as a fully virtual meeting, streamed for the first time on a brand new bespoke events platform via the BGS website. With three packed streams along with a host of workshops and breakout sessions across the three days, it was once again a fantastic learning and networking opportunity for the several hundred delegates who joined live, as well as those catching up on demand later on.

Day 1: Dementia, sarcopenia and nutrition

The meeting kicked off with an introduction from President Dr Jennifer Burns, who highlighted some of the key sessions and activities that were planned across the three days. She also announced the launch of the new BGS Community and Primary Care Group, replacing the existing GeriGPs group and Community Geriatrics Special Interest Group (SIG). She took the opportunity to recognise and give thanks to the BGS officers for whom 2022 represented the end of the term of office for their respective roles, and reflected on some of the Society's biggest achievements since the last meeting, including the publication of the BGS *Ambitions for Change* and *Right Time, Right Place* reports, as well as a growth in membership to more than 4,600.

Dr Burns announced Dr Hannah Moorey as the latest BGS/Dunhill Doctoral Fellow who is conducting research of delirium (for more information see page 20), and the winners of the BGS Special Medal, Liam and Janet Wormley, for their work with Functional Fitness (see page 13 for more from the winners).

On the Wednesday, Stream 1 was dedicated to the topic of dementia and related disorders, and the first speaker on this topic was Professor Alistair Burns, National Clinical Director for Dementia in England, who provided a timely update on dementia following the pandemic. Noting a drop in dementia diagnoses and referrals in the second half of 2020 due to COVID, he presented data which indicated that rates of diagnosis and referrals were starting to increase again in 2022. He acknowledged however that waiting lists for memory clinics were still high, presenting further challenges in the management of dementia.

Dr Judy Rubinzstein gave an informative presentation on Dementia Intensive Support (DIS) teams and their role in preventing acute psychiatric admissions. Summarising the service her team set up in Cambridgeshire, she explained: "We exclude delirium, we try to understand BPSD [behavioural psychological symptoms of dementia] and use a person-centred approach."

Aaron Dehghan @AaronDehghan
Thank you @ganan_sritharan for your talk at #bgsconf an interesting and inspiring insight into developing a new role. Great food for thought @GeriSoc #GeriGPs

Talking about crises in dementia, Professor Martin Orrell, Director of the Institute of Mental Health in Nottingham, presented evidence for home treatment to reduce the need for acute psychiatric admission, as well data on risk factors. "We found that certain things were more likely to result in people coming into hospital; changes in their daily environment or routine, behaviour problems, decreased ADL [activities of daily living] and falls," he explained.

Later on in this stream, a session on detecting delirium with cognitive impairment was chaired by Dr Rose Penfold and Jacqueline Thompson which examined drug treatments and triaging.

Over in Stream 2, in a session looking at sarcopenia and nutrition, Professor Philip Atherton spoke about the role of micronutrients. Reiterating the role of skeletal muscle in maintaining functional ability and preventing falls, fractures and hospitalisation in older adults, he highlighted the importance of protein in reducing muscle atrophy and sarcopenia, as well as providing data on the effect of magnesium and Vitamin D.

Sian Robinson spoke about dietary patterns and outcomes for frailty and sarcopenia, concluding that while there are strong mechanistic reasons to link diet quality and disease risk, there are still gaps in the evidence, particularly on the impact of dietary choices in mid-life, and a need for further studies of UK-based populations.

The impact of malnutrition on older people in hospital was discussed by Dr Natalie Cox, who explained that despite the fact that 39% of older people in hospital are at risk of malnutrition, there is minimal evidence for effective interventions specific to sarcopenia and frailty.

Later in this stream, Dr Caroline Bowler and Dr Lizzie Moriarty were adorably joined on screen by Lizzie's snoozing newborn as they summarised the findings of a survey of current UK assessment and referral practice for nutrition in frailty and sarcopenia. They found that factors such as low weight or high malnutrition universal screening tool (MUST) scores were often a driving factor for referrals rather than the presence of sarcopenia, frailty or obesity.

Anna Julian @AnnaJulianRD
Catching up on #BGSconf. Interesting data on protein ingestion prior to sleep @EmmaJStevenson

Jenni Burton @JenniKBurton
Hearing about HowFit rollout in North East supported by @ageukcampaigns https://howfittoday.co.uk Digital analytics following social media campaigns #bgsconf

Fran Hunter (Denham) @FranDenham
Infection and Sepsis session. Admissions are sicker and have more comorbidities….. patients are living longer and are therefore more complex #bgsconf @GeriSoc

Spring Meeting Prize Winners

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

Fergus Anderson Prize
for best Research poster (joint winners)
S Drew; F Fox; CL Gregson; R Patel; A Judge; A Johansen; EMR Marques; E Capelas Barbosa; J Griffin; M Bradshaw; K Whale; T Chesser; XL Griffin; MK Javaid
Multiple Organisational Factors Improve Multi-Disciplinary Care Delivery to Patients with Hip Fractures: A Qualitative Study

And:

Peter Hanlon; Elaine Butterly; Anoop V Shah; Laurie J Hannigan, Sarah H Wild; Bruce Guthrie; Frances S Mair; Sofia Dias; Nicky J Welton; David A McAllister
Analysis of Randomised Controlled Trial Serious Adverse Event rates as a marker of trial representativeness

Elizabeth Brown prize
for best Platform Presentation (joint winners)
L Birt; K Lane; J Corner; K Sanderson; A Deakins; D Bunn
Learning from the experiences of nurses in care homes during COVID-19 (THRIVE study): Steering the ship through the storm

And:

M J Cook; M Lunt; T Board; T W O'Neill1
The impact of deprivation and frailty on the likelihood of receiving hip and knee arthroplasty due to osteoarthritis

Best President Round presentation
S Makin; C Brack; M Kynn; P Murchie
Diagnostic Test Accuracy of Frailty Screening Tools Using Data in Electronic Primary Care Records

Best Clinical Quality platform presentation
Dr I Stoodley; Dr R Kyzy; Prof S Conroy; J McKenzie; S Geen; J Asino; E Cruz; Dr J Hazan
Delirium recognition and management in an inpatient rehabilitation unit

Eva Huggins Prize
for best Nurse or AHP Poster
Dula Alicehajic-Becic
Using Clinical Informatics to Improve Outcomes and Patient Experience for Admissions to WWL with PD and related conditions

John Brocklehurst Prize
for best Clinical Quality poster
A Vasudev; S Baachaa; P Meakin; I Mohamed; P Nicolson
Quality Improvement Project aimed to reduce the average number of patients developing constipation on Bournville Ward in QEHB

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

#hellomynameisAmy @ElliottAmy
A brilliant talk from @JenniKBurton on academic training and care home research. A lot to think about, esp improving how we collect care home data in hospital #BGSConf

Natalie Cox @NJCoxGeriDoc
A brilliant talk by @GeriSoc rising star @JenniKBurton starting off #bgsconf this morning. So inspiring to hear about all her work on #carehomes & #data.

A range of workshops and breakout sessions also took place on Day 1, including a chat room on green and environmental issues, and workshops on dizziness and cerebral palsy. A panel discussion with members of the newly-formed BGS Community & Primary Care Group helped set out the aims and scope of the newest BGS professional group, which replaces the existing GeriGPs Group and Community Geriatrics SIG.

Day 2: Clinical quality, research and stroke

The second day started off with the Association of Academic Geriatric Medicine (AAGM) symposium in Stream 1, which featured presentations from the BGS Rising Star winner. Dr Jenni Burton, whose talk entitled 'Twenty years on and you're still not qualified' documented the journey to becoming a geriatrician working within academic geriatric medicine, and the opportunities this presents to shape policy, practice and care. Platform presentations, selected from abstracts submitted to the meeting, also formed part of this session, covering topics such as exercise plans and hip fractures.

A research panel discussion with members of the BGS Research and Academic Development Committee and *Age and Ageing* journal Editorial Board members covered issues such as funding, balancing workload and getting started in research, providing a useful update for both experienced researchers and those just thinking about getting started in academic geriatric medicine.

Into the afternoon, a session on the biology of ageing and how this influences falls was chaired by Professor Michael Vassallo. Risk factors for falls in older people with multiple multimorbidities were discussed by Dr Pelagia Koufaki. Considering the available evidence, she concluded that "in the context of multimorbidity, a cardiovascular index implicated in the short-term regulation of blood pressure better predicts the number of falls over the next 12 months than frailty alone."

Thursday's Guest Lecture was delivered by Professor Dame Carol Black, who among a long list of achievements, accolades and past posts, is the current Chair of the Centre for Ageing Better, Think Ahead and the British Library, as well as an advisor to the UK Government on issues relating to age, health and employment. She spoke about the ageing workforce and the health implications of this both from an individual and a system-wide perspective.

Professor Dame Black highlighted the barriers to successful working in older age, including social determinants of health and workplace culture, and explained how good leadership was crucial to successfully embed wellbeing into an organisation. Talking about the importance of human needs versus tokenistic gestures, she warned that "we mustn't confuse these crucial, fundamental things with well-meaning interventions which are one-offs, and are really not based in evidence."

claire m @claireymck
Wise words from Dame Carol Black on how an institution should/could be like family and colleagues should give each other a break. Must recognise that we're all exhausted and will need to cross cover leave to get through this. No point in pretending nothing is happening. #bgsconf

This was followed by the President's Poster Round, where the top posters from the Spring Meeting were presented in three-minute vignettes by respective researchers. Topics covered included Parkinson's, frailty and sarcopenia.

Further poster presentations took place in Stream 2 throughout the day, on topics such as hip and knee arthroplasty, delirium and hospital at home services. Other highlights from this stream on Day 2 included a session on infection and sepsis, which looked at the new 2022 sepsis guidance from the Academy of Medical Royal Colleges.

A dedicated stream on stroke medicine ran during the afternoon in Stream 4, adding to a packed programme on this second day. Dr Michelle Dharmasiri gave a presentation on hyperacute care including thrombolysis and thrombectomy, while Professor Gillian Mead looked at new advances in rehabilitation post-stroke. "Early supported discharge and excercise training are effective but not widely implemented, and I believe that an exercise science approach may help with embedding knowledge into practice," Professor Mead explained.

Day 3: Tissue viability, rehabilitation and training curriculim

The final day of the Spring Meeting offered plenty of choice for delegates, with a huge number of sessions and workshops to choose from. Interactive sessions and breakout chats were held for Nurses, AHPs, Trainees and Retired Members, while a workshop on the Diploma in Geriatric Medicine (DGM) gave current and future candidates a chance to grill the examiners for tips and study advice for both the written and practical parts of the examination. A quality improvement workshop provided attendees the opportunity to ask questions and receive guidance on how to carry out their own project.

The morning slot on tissue viability was possibly not one to tune into over breakfast, but this popular session provided a fantastic interactive update on history-taking, examination and treatment of wounds in older people. A quiz on the visual presentations of wounds gave attendees a chance to show off their clinical observation skills, with many taking to the chat box to be the first to correctly identify the skin condition on screen. "I think we can all agree this looks quite unhealthy," observed presenter Dr Amy Ferris, speaking about an infected wound bed in what was perhaps the understatement of the day.

New BGS hybrid event platform

Participants of past BGS virtual meetings may recall using a platform called Swapcard to navigate events digitally. Hybrid events from the BGS are now accessed and hosted entirely within the familiar setting of the BGS website without the need to log into a seperate external site.

This move is designed to enhance the experience of both virtual and in-person event attendees as we move towards a 'hybrid' event model, with meetings delivered both virtually and physically at the same time. Some of the benefits of this new setup include:

Log and download your own CPD

By clicking '**Sign in for CPD today**' for each day you attend the meeting virtually, your attendance will be recorded and date stamped, allowing you to download your own CPD certificate from the '**My account**' section of the BGS website. Those attending in person will have their attendance registered digitally by BGS staff, and will also be able to download their certificates via the BGS website.

View and download invoices

When the time comes to reconcile your expenses, pay your bills or file your tax returns, you can simply log into the BGS website, navigate to '**My account**,' select '**My events & certificates**' and download invoices for any events or e-learning.

Watch content for 12 months after the event

With so much going on across numerous days and streams, it's easy to miss something you really wanted to see, regardless of whether you attend virtually or in person. You can access the full recordings of all events you are registered for at any time in the 12 months following the original broadcast.

Twitter and chat streams

The BGS website still supports live chat among delegates and presenters during the sessions, allowing interactivity between all participants and presenters. In addition, Tweets from the BGS **@GeriSoc** account are included in a feed on the event page, allowing you to fully immerse yourself in all the news, views and discussion from the event.

Attending in person

Those who choose to attend the event in person will still be able to enjoy networking opportunities, social meet-ups and real-life refreshments as they return to face-to-face meetings, in addition to the post-event digital benefits outlined above. You will also be able to engage with the event sponsors, and will hopefully benefit from a change of scenery as you settle down for a day of uninterrupted learning with like-minded clinicians outside of your usual working environment.

For more information on our hybrid events, including FAQs, visit: www.bgs.org.uk/events/hybrid-event-faqs

BGS President, Dr Jennifer Burns, was joined by President-Elect, Professor Adam Gordon, BGS Honorary Secretary Dr Anne Hendry, BGS Nurse and AHP Council Chair, Dr Esther Clift and the Demitting Chair of the GeriGPs Group Dr Maggie Keeble for a panel discussion reflecting on the current status of older people's healthcare. They discussed issues such as workforce, models of care in the acute and community setting, and how services are coping and recovering from the pandemic. "One solution doesn't fit all across the whole country," mused Professor Gordon, "and where geriatrician resource is thin we have to be even smarter about how we use it."

Pandemic recovery was also a theme over in Stream 2 where much of the day was dedicated to rehabilitation. Talking about rehabilitation potential, Dr Alison Cowley reiterated the importance of person-centred care, reminding the audience: "Ask patients what's important to them. Are we setting the right goals and the right outcomes that they aspire to?" Dr Esther Clift also discussed exercise benefits and its uptake in older people.

Reflecting on the end of what is planned to be (future pandemics permitting) the final online-only BGS national meeting, Dr Jennifer Burns thanked all the speakers, moderators and delegates for making the event such a success. Praising the enthusiasm of the new BGS Community and Primary Care Group, she also cited the session on dementia and technology in addition to a talk about working with a disability as some of her stand-out moments of the conference.

We look forward to joining you in person in London (or virtually) on 16-18 November for the BGS Autumn Meeting.

Amy Brewerton
BGS Publications & Website Editor
@Amy_Brewerton

One of the first BGS meetings to be held in a fully hybrid format was the BGS Scotland Spring Meeting, hosted both online and in person in Glasgow on 6 May. Former Chair of BGS Scotland, Dr Patricia Cantley, reflects on her first experience of a hybrid meeting and what she gained from the day.

As I set the alarm for a ridiculously early hour, I wondered whether I should have opted to join the Scottish BGS Spring Meeting online.

I reminded myself how much I enjoy such educational meetings in person, gritted my teeth and duly set off for Glasgow on Friday morning. I was not disappointed. Indeed, as I enthused to my husband on Friday evening, I think that may have been one of the BEST medical education events I've been to. And trust me, over several decades, I've attended a lot!

'I was joined by friends and colleagues I hadn't seen in person for well over two years - and in some cases actually know best through online contact. It felt very special to be back in the same room again.'

As it turned out, I was the first delegate to arrive, and so, as class swot and Twitter enthusiast, I grabbed my place in the front row to make the most of the 'back in the flesh' experience. Soon I was joined by several of my friends and colleagues, some of whom I haven't seen in person for well over two years - and in some cases actually know best through online contact. It felt very special to be back in the same room again.

The educational quality of the meeting was superb. Check out the hashtag #BGSConf on Twitter for a full account, but the Lanarkshire team had created a stunning programme for us.

We kicked off with some general medical updates. Dr Marie Freel took us through some common endocrine problems, addressing many of the knotty issues we wrestle with on a day to day basis, and then Dr Alice Radley gave us an excellent round up on advanced kidney disease in older age.

Before coffee, we were treated to a masterclass on improving the care of patients with delirium by Lyndsey Dunn, our Deputy Chair of the Nurses & AHPs Council. Her enthusiasm was palpable and infectious.

Dr Graham Ellis is something of a superstar these days in his role as Deputy Chief Medical Officer for Scotland, and we were privileged to hear him talk in person about the Health and Care Strategy for Older People.

Although preaching to the converted, his congregation listened avidly. Now it's in our hands to contribute our own views.

There were great presentations from Dr Lindsay Whyte on preventive care for frail people in a community setting and several others spoke in the poster and platform sections on identifying frailty and managing it across both community and hospital settings. Dr Pam Seenan told us of the work of her team in Oncogeriatrics and the need to get the balance between perceived kindness to patients with this awful disease while at the same time encouraging more physical activity and mental and physical rehabilitation. The scope of our specialty becomes ever wider.

We ended with some updates from SCoOP, the audit work on the variation around Scotland in the care of Older People. Check it out online (*see box, right*) - it's interesting stuff. There is no judgment offered, but there are certainly lots of questions!

The mood of the meeting was upbeat, not just in terms of the subject content (spoiler: staying active is a good thing!) but in terms of the joy in the room at being back together.

It was a hybrid meeting, and the chairs made it a priority to bring in questions from the audience at home as well as those at the tables in the hall. Indeed many who were present in person still chose to submit their questions via the online function rather than make the self-conscious walk to the microphone.

It feels a long time ago when we realised in March 2020 that our usual Scottish meeting would not be able to take place. It was my last one as Chair, and I remember how we hastily put together the first online offering from the BGS. It was a short evening meeting, and I recall setting up the iPad in the conservatory to have a panel discussion with colleagues on the early effects and impact of the COVID pandemic. The online meetings are certainly a lot more sophisticated now!

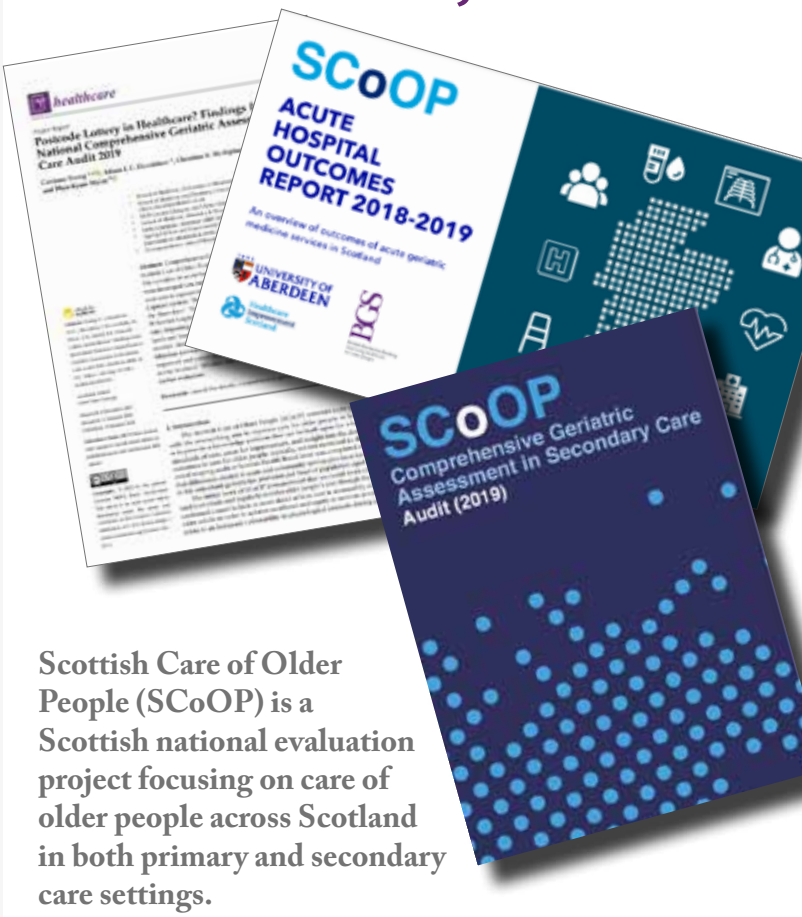
The hybrid option is clearly very popular, and indeed my colleagues back at work are all hoping to 'attend' using the playback option over different days. It's a green and sustainable option for many people, and means less time away from work. I too have used the online facility for the UK-wide meetings and I hope they stay on the menu as we go forward in our new ways of working, living and educating ourselves.

For me, though, this time was about the personal touch again. Seeing people, mingling at lunchtime and catching up on their news, both professional and otherwise. Old friendships were renewed and new ones were made. Indeed two of the best presentations were from medical students, Maddie Pritchard and Catriona Young.

The future looks to be in safe hands.

Dr Patricia Cantley
Consultant Geriatrician, NHS Borders
@Trisha_the_doc

Scottish Care of Older People (SCoOP) Project



Scottish Care of Older People (SCoOP) is a Scottish national evaluation project focusing on care of older people across Scotland in both primary and secondary care settings.

SCoOP has the following overarching aims:

- To evaluate the variation in service provision for older people who require health and social care in various settings to serve as a driver for standardisation and improvementof care across Scotland.
- To provide benchmarking tools for various care aspects of older people in Scottish NHS health and social care setting to support improvement work in services across Scotland.
- To provide a health intelligence and knowledge transfer hub for service users , health care providers and policy makers through annual evaluation cycles.

It is a joint initiative set up in late 2016 by three key partners: Health Improvement Scotland, the British Geriatrics Society Scotland Council, and the University of Aberdeen as the lead Academic Institution, with representatives from other Scottish Universities with Clinical Academic Departments in Geriatric Medicine.

You can access all the latest data, reports and analysis from the team behind SCoOP via the BGS website: www.bgs.org.uk/scoop

Dr Richard Dodds

It is with great sadness that we report the death of Dr Richard Dodds on 25 May 2022.

Richard was an immensely talented clinician and academic, and an active and generous contributor to the BGS community.

He will be sorely missed by all who knew him, and his death is a great loss to the world of geriatric medicine.

Richard's partner, Dr Chris Smith-Duque, has sent details of the funeral which is to be held at 1pm on 7 July in Woking.

Please contact Jo Gough at **j.gough@bgs.org.uk** for more information if you would like to attend.

The BGS will publish a full obituary in the next edition of *Agenda* and on our website. Please also see the blog about the London Marathon, which Richard was to have run in September 2022.

Five geriatricians who are members of the BGS and EuGMS will run the marathon in memory of Richard, raising funds for Age UK.

Age and Ageing 50th Anniversary commentary series

To mark *Age and Ageing's* half century, we have commissioned a series of 24 topical commentary pieces to be published throughout the anniversary year. These come from leading international thinkers and explore major issues in geriatric medicine. The commentary pieces published so far include:

- **Why illness is more important than disease in old age**
  Marcel Olde Rikkert, René Melis, Alan Cohen, Geeske Peeters
- **Healthcare for older people in Asia**
  Jean Woo
- **Inappropriate prescribing: hazards and solutions**
  Mirko Petrovic, Denis O'Mahony, Antonio Cherubini
- **The giants of education in geriatric medicine and gerontology**
  Roman Romero-Ortuno, Andreas Stuck, Tahir Masud
- **Geriatric medicine and health care for older people in Australia**
  David Le Couteur, Leon Flicker, Sarah Hilmer
- **Geriatric emergency medicine—a model for frailty friendly healthcare**
  Simon Mooijaart, Christopher Carpenter, Simon Conroy
- **Healthcare for older people in lower and middle income countries**
  Maw Pin Tan
- **Refashioning the uneasy relationship between older people and geriatric medicine**
  Desmond O'Neill
- **Clinical trials in older people**
  Kaisu H Pitkala, Timo E Strandberg
- **Healthcare for older people in Central and South America**
  Luis Miguel GutiéRrez Robledo et al.

All of these articles are Open Access, meaning they are free to all, regardless whether they are BGS members or journal subscribers. We hope you will enjoy and share this special series of articles as the journal reflects on more than five decades worth of research and evidence in older people's healthcare.

Links to all these articles, along with other featured content from the journal, can be found at: www.bgs.org.uk/AAAjournal

Vacancies and training

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

British Geriatrics Society
Improving healthcare for older people

Autumn Meeting 2022

16-18 November 2022, London & online

The **BGS Autumn Meeting** will return as a 'hybrid' virual and physical event on **16-18 November 2022** in what promises to be another fantastic three days.

The Autumn Meeting 2022 will cover latest evidence and updates on topics including **community and primary care, end of life, stroke, continence** and **endocrinology,** as well as the latest scientific research and the best clinical practice in healthcare of older people.

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

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

BGS vacancies and notices

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

BGS Junior Regional Rep Vacancies

We are currently seeking junior regional representatives to provide a Trainees' perspective on the following BGS Regional Councils:

- Northern
- North Thames
- Oxford
- South East
- South West Thames
- Trent
- Wessex
- West Midlands

For more information, email **trainees@bgs.org.uk** or visit **www.bgs.org.uk/BGSvacancies**

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**.

Notice of election for BGS President Elect

The Society is delighted to announce there we will soon be holding an election for the incoming BGS President Elect.

The candidates will be announced on 28 June when voting opens via the BGS website.

Voting will close on 22 July.

The winner will take office from November 2022 for a period of two years. On completion of the term as President Elect, the post-holder will succeed the incumbent BGS President and serve in this position for a further two years.

Further details will be communicated to members in due course, including manifesto pledges and voting links. Keep an eye on your email inbox for updates or check **www.bgs.org.uk/current-elections.**

EuGMS LONDON 2022

18TH INTERNATIONAL CONGRESS

SEPTEMBER 28-30

Better together: Multidisciplinary team working

EuGMS
European Geriatric Medicine Society
Fostering geriatric medicine across Europe

BGS
British Geriatrics Society
Improving healthcare for older people