# AGENDA

British Geriatrics Society
Improving healthcare for older people

Issue 90 | September/October 2023
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# A workforce in crisis

**Sharing frustrations and solutions for older people's care**

**PLUS**

- **Less than full time working**
- New frailty elearning
- **Challenges in acute inpatient physiotherapy**

AGENDA
Publications information

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## On the AGENDA



# President's *Message*

**The focus of this issue of *AGENDA* is workforce. This could not be more timely. Despite progress in Scotland, the Westminster government remains deadlocked with the British Medical Association (BMA) over doctors' salaries in England. We are in truly unprecedented times, as consultants and junior doctors prepare to walk out in unison for the first time ever.**

The NHS has been in existential crisis since the COVID-19 pandemic. What these latest difficulties serve to highlight is that this existential crisis is fundamentally about workforce. Of course it is. All care in the NHS flows through the staff that work within it. The NHS is stethoscopes on chests, hands on abdomens, wobbles steadied, bottoms wiped, hands held, shoulders lent, problems shared, plans made. Staff are the single biggest cost for the NHS, and its single biggest asset.

Goodwill among the workforce is, in my opinion, its second biggest asset. While for many, goodwill towards our political masters has been squandered in recent months, goodwill remains for our patients, and towards the National Health Service itself. A glance through the NHS constitution reminds us what we come to work for: a comprehensive service available to all; based on clinical need rather than ability to pay; underpinned by the highest standards of excellence and professionalism; with patients at its centre; and accountable to the communities we serve. We can deliver on these promises.

As recently as 2017, the NHS ranked first on the Commonwealth Fund's Scorecard for International Healthcare systems, which scores systems from ten high income countries on care quality markers, cost and equity of access. We had vied for top position since the first such report in 2004. In 2021 we slipped to fourth overall, but came second last for care outcomes. It feels like we've slipped further since.

'The increasing numbers of older people with frailty are frequently cited as a reason our health and social care system is in crisis. They are not. Rather, it is the failure of our health and social care system to provide frailty-attuned care that is the problem.'

As nervous as we are about the co-ordinated industrial action, this month and in months to come, we will get through it. It will be like Christmas day, albeit without the turkey and the carols, but Christmas days are safe in the health service. We should, however, be more concerned about the existential crisis that underpins industrial action, and the long-term effects of a failure to invest in recruitment, retention, development and support of the workforce. An agreement between the parties in the dispute would be a good first step back to being the best healthcare system in the world. Anybody that cares about patient care wants to see this resolved as soon as possible. The failure of the government to come to the negotiating table pushes that resolution further away and should be a source of concern to all of us.

So what can BGS and its members do while all this is going on? For starters, we can help set the narrative. The increasing numbers of older people with frailty are frequently cited as a reason our health and social care system is in crisis. They are not. Rather, it is the failure of our health and social care system to provide frailty-attuned care that is the problem. Given that the healthcare system is, largely, the people that work in it, the solution here lies substantially with workforce.

We need better systems leadership from people that know about frailty and multimorbidity. Our **#moregeriatricians** campaign, and accompanying publication (available at **www.bgs.org.uk/moregeriatricians**), laid out how to deliver the consultant geriatrician workforce to provide this. As we return from the summer leave period, we at BGS have lined up meetings with other professional organisations to work out how to build similar campaigns around the wider multidisciplinary team.

If we're successful in our demands for more training places, we'll need recruits ready to move into the posts. The incorporation of undergraduate training around ageing and frailty care across the healthcare disciplines is more important now than ever. The BGS recently updated its recommended undergraduate curriculum in ageing and geriatric medicine for medical students. We build on this further in this issue by with an article about how specialists in the Allied Health Professions can deliver the necessary competencies as part of their own undergraduate curricula.

As we grow our numbers, we need to ensure that expert multidisciplinary teams in care of older people go where they can deliver maximum impact. We need to juggle the demands of front-door frailty, complex discharges and community-based intermediate care, and newer initiatives including virtual wards and Hospital at Home. This will involve calculated and flexible deployment of existing resource, and retraining ourselves to work in new and exciting service models. It will also mean that other professionals – who are not members of the BGS – will need to do their fair share of frailty medicine. We need to work out the best way to train the wider workforce so that they know how to care for older people with frailty and also see it as their job to do so. We have started this process with a BGS frailty elearning module, now available to all for free (see page 9 for more information).

Maximising our workforce will mean delivering on our commitment to colleagues who want to work less than full time, and those who choose to work in Staff and Associate Specialist roles. We're likely to see an expansion in Advanced Clinical Practitioners (ACPs) and Physician Associates (PAs). In my own practice, I already work very closely with an extended team of ACPs, all of whom are friends and allies in the fight to improve care for older people. In some other specialties it seems as if tensions are growing between trainee doctors and these newer professions. In geriatric medicine, though, we have enough work and training opportunities for everybody. The heavy commitment of many geriatric medicine trainees to the acute unselected take, and the role that ACPs and PAs can play in sharing that burden, while also attaining their own training goals, is just one example of how carefully-calibrated multiprofessional training and service delivery can operate well for our specialty.

These are just a handful of the ways in which the BGS can help to influence resourcing, planning and deployment of the workforce for older people's care. We cover all of these topics, and more, in this issue of *AGENDA*.

These are complex issues and the team at Marjory Warren House are always happy to hear how we can be doing more to campaign both for the workforce we've got and the workforce we need. The NHS is the people that work for it. Getting these things right is essential if the BGS is to deliver on its mission to improve healthcare for older people.

**Adam Gordon**
BGS President
**@adamgordon1978**

## BGS President at **Number 10**


**On 13 September, BGS President Adam Gordon joined discussions with the Prime Minister, Secretary of State and other health leaders to talk about preparing the NHS for winter.**

Keep an eye on Twitter/X via **@GeriSoc**, as well as the BGS website, *AGENDA* and e-bulletin for further updates on any progress following these discussions.

# Calling out sexual misconduct in healthcare

**A recent report published in the *British Journal of Surgery* revealed the shocking extent to which female surgeons have suffered sexual harassment and abuse at the hands of some male colleagues. A toxic culture of sexism and misogyny, not just in surgery but within other specialties and health professions, has been highlighted as a major reason for such misconduct persisting unreported for so long. The BGS strongly supports a more equal culture in medicine and healthcare more widely. Sexist actions, behaviours and institutional factors contribute to the persistence of gender bias, and should not be tolerated anywhere, let alone in a health and care system so dependent on the commitment and competence of its workforce. As senior figures in medicine and healthcare call for urgent action to protect women workers and bring about long-overdue change, BGS Deputy Honorary Secretary, Dr Ruth Law, shares her own reflections and experiences.**

While there is much to be celebrated about the health and care workforce, it is important to take a moment to reflect on the challenges many of us face in our day jobs. We were horrified to read the recently published article on sexual harassment, sexual assault and rape by colleagues in the surgical workforce.[1] It concluded that sexual misconduct in the past five years has been experienced widely and is not dealt with adequately by accountable organisations. This follows the British Medical Association (BMA) survey last year on sexism in medicine, where 91% of women reported experiencing sexism at work within the past two years.[2]

> 'The inclusive culture and collaborative team approach is what attracts many of us to geriatric medicine, but we cannot be complacent as a specialty.'

As a privileged white woman, I am acutely aware I cannot comment with lived experience on the full intersectionality of the issues raised, but I have seen again and again the benefits of a diverse and inclusive workforce in delivering the best care possible for our patients. Working together to eradicate sexism encourages respect for women of all identities and backgrounds across the multidisciplinary team (MDT). This should also contribute to improving the experience of our female patients. A Kings Fund and University of York Report[3] in 2021 makes sobering reading in this regard; women of all ages are too often ignored, belittled or – most worryingly – put off seeking healthcare as a result of their experience of interacting with medical staff. Focus groups with women over 65 highlighted feelings of 'invisibility.'

I am fortunate to have worked alongside wonderful female role models and male allies who have offered me professional development opportunities but I am not immune to the systemic challenges facing women in clinical workplaces everyday. In 1907, RCP President Sir Richard Douglas Powell said 'Women ought not to be encouraged to enter a profession for which they were constitutionally unfitted' and at times it feels we have not moved far enough in the last 116 years. A recent survey amongst male and female medical registrars[3] found that our medical registrars are witnessing sexism, with 92% having witnessed or been aware of colleagues experiencing sexism in the medical workplace.[4] Despite compelling evidence that we are still promoted less often,[2] paid differently[5] and exposed to a spectrum of sexual harassment and abuse,[1] the reported experiences of women continue to be questioned and not believed. The bravery and persistence of our surgical colleagues in highlighting these issues should not be underestimated.

The inclusive culture and collaborative team approach is what attracts many of us to geriatric medicine, but we cannot be complacent as a specialty. This is a moment of profound internal reflection for our profession. We stand as allies with our colleagues in surgery, with whom we work closely every day in our liaison roles. We commit to building a workplace where the whole MDT starts and ends every day in an atmosphere of psychological safety and each member feels equally valued and able to speak up.


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**Dr Ruth Law**
BGS Deputy Honorary Secretary
**@Ruth_E_Law**




# *Age and Ageing* hearing conditions collection

**Curated collections of articles on specific topic themes are published periodically by *Age and Ageing*. The hearing conditions in older people collection, with accompanying commentary, can be accessed by visiting www.bgs.org.uk/AAAhearing.**

Hearing conditions such as hearing loss, tinnitus and hyperacusis are highly prevalent in the population and can severely impact communication and quality of life.

Hearing is affected by multiple factors, including heredity, noise exposure, age, sex, ear disorders and lifestyle factors. Globally, hearing loss affects over 80% of adults aged 80 years and older, is often experienced in combination with other long-term health conditions, and is a mid-life risk factor for dementia.

To form the themed collection, we searched *Age and Ageing* for articles on hearing conditions published from 2000 onwards. This resulted in 22 articles included within the collection.

They examined a range of important topics related to hearing healthcare and research, including noise-induced hearing loss, health service quality and safety, psychological and psychosocial consequences of hearing loss, and comorbidities of hearing loss.


All articles reported on hearing loss; there were no published articles with a primary focus on other hearing conditions such as tinnitus or hyperacusis, on the health of older people from the Deaf community, or on users of Cochlear implants, suggesting key gaps in knowledge and targets for future research.

**Visit www.bgs.org.uk/AAAhearing to access the full collection.**

# FORCE FOR CHANGE

**It is a pleasure and an honour to welcome you to this special workforce edition of *AGENDA*.**

When I applied to be a trainee registrar in geriatric medicine, one of the questions I asked was 'What are the biggest challenges in geriatric medicine?' The reply was 'There are not enough geriatricians and not enough people to look after older people; and if we don't get it right, this will become an even bigger challenge.' The challenge remains, but at the BGS, we are now focussing on it and doing something about it.

When I took up the role as BGS Vice President (VP) for Workforce, I was clear about where we needed to start and where we need to be. I am delighted to report that we have made immense progress on your behalf, and though you may not always have had the time to read them all, there are multiple reports around workforce that BGS has published or contributed to. These reports give us insights into the challenges and potential solutions, and we use these reports in influencing nationally. You can find out more about these reports on page 32. I would urge you to make yourselves familiar with some of them and use some of the insights and data to influence decision-makers locally and nationally.

If you can't find time to read all our reports on workforce I would suggest reading the headlines from the report *The case for more geriatricians* (**www.bgs.org.uk/MoreGeriatricians**). This publication has lot of data which you can also divide by region. We are happy to do a session at your regional meeting focusing on regional workforce data.

This process of producing these reports takes lot of thinking, developing, collecting data, triangulating, publishing and sharing with various stakeholders. I am immensely grateful to the wonderful team we have in the Workforce Committee and colleagues at Marjory Warren House without who none of this would be possible.

In the work that we are doing there is something for everyone - from medical students, Foundation Doctors, Internal Medicine Trainees (IMTs), Specialist Registrars (SpRs), Specialty and Specialist Grade (SAS) doctors, Consultants, GPs, Nurses, Therapists and Allied Health Professionals (AHPs). This reflects the true collaborative, inclusive and multidisciplinary nature of the BGS. I would like to take this opportunity to invite members from all professional groups - including students, Doctors, Nurses, Therapists, GPs, care professionals, social care, and the care home sector to consider joining the BGS Workforce Committee. We are specifically interested in greater representation from the devolved nations.

'We are leaders in our own right in our own workplaces, and I would encourage us all to support our junior colleagues, not least because they are the ones who will look after us in our older age.'

In the coming weeks we will be sharing findings from our recent Training Programme Director (TPD) survey and our membership survey focusing on workforce.

I was rather disheartened to note in the national media recently that two thirds of young medics plan to quit the NHS within two years of graduating. I hear this from many of the doctors I work with. This will have a large impact on our future workforce. We are leaders in our own right in our own workplaces and I would encourage us all to support our junior colleagues, not least because they are the ones who will look after us in our older age.

We were recently successful in our request to the General Medical Council (GMC) and the Joint Royal Colleges of Physicians Training Board (JRCPTB) to extend deadline for submission of CESR applications (under the old curriculum) for our SAS doctors. We could only do this because SAS doctors brought this to our attention. If there are similar issues you are facing and if you think we can help, do let us know.

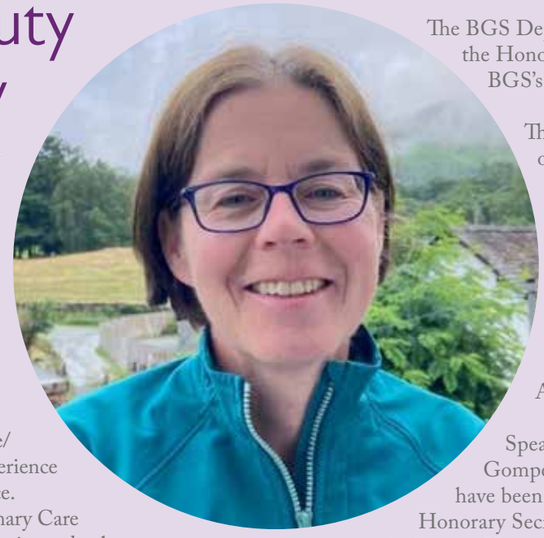
At the BGS Autumn Meeting on 22-24 November, there are several sessions on workforce topics, and I look forward to seeing many of you then.

**Dr Amit Arora**
BGS Vice President for Workforce
**@betterageing**



# **Dr Deb Gompertz** elected as next BGS Deputy Honorary Secretary

**The BGS is delighted to announce that Dr Deb Gompertz will be the next Deputy Honorary Secretary.**



Based in Somerset, Dr Deb Gompertz is a Complex Care/ Frailty GP with 16 years' experience as a partner in general practice. She currently works in a Primary Care Network across acute, community and voluntary sectors, supporting older people with complex needs.

Her past experience also includes working in A&E as an Acute Care GP. She joined the BGS as a member of the BGS GeriGPs group and is active in the BGS Community and Primary Care Group as its lead for anticipatory care. She has recently collaborated with the RCGP to establish a framework for GPs with an extended role in frailty and complex care.

Dr Gompertz will officially succeed the current Deputy Honorary Secretary, Dr Ruth Law, at the BGS AGM on 17 November. Dr Law will in turn succeed Professor Anne Hendry as Honorary Secretary. Dr Gompertz will become Honorary Secretary in November 2025.

The BGS Deputy Honorary Secretary supports the Honorary Secretary in overseeing the BGS's policy and communications work.

The Honorary Secretary is one of the BGS's most senior roles, serving as a member of the BGS Trustee Board and chairing the Policy and Communications Committee.

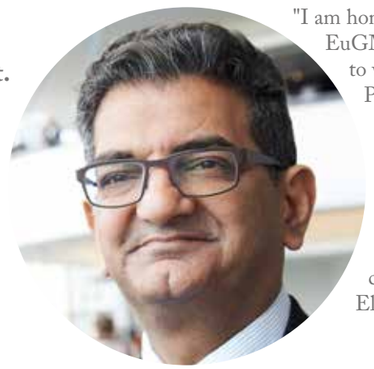
Dr Gompertz received the most votes from BGS members in an election held in July and August 2023.

Speaking of her appointment, Dr Gompertz said: "I am honoured to have been elected to the post of Deputy Honorary Secretary. I look forward to working with the next Honorary Secretary, Dr Ruth Law, over the next two years as I learn the ropes, and to collaborating with BGS members and staff to achieve better care for older people.

"I have found my 'tribe' within the BGS and it will be a privilege to influence healthcare for older people while supporting peers from secondary and primary care backgrounds."

# BGS Past President **Prof Tahir Masud** to become EuGMS President Elect

**The European Geriatric Medicine Society (EuGMS) has announced that Professor Tahir Masud is to become its next President Elect.**



Professor Masud, who held the position of BGS President from 2018 to 2020, will formally take up the post of EuGMS President Elect in January 2024. He will serve alongside the incoming President, Professor Mirko Petrovik, for two years before succeeding him as President in 2026.

EuGMS is the collaborating and co-ordinating organisation of the national geriatric medical societies in Europe. Its mission is to develop geriatric medicine in all member states as a recognised independent medical specialty, contributing to the care of all older people with age-related diseases.

Previous BGS Presidents who have also held the role of EuGMS President include Professor Finbarr C Martin (BGS President 2010-2012) and Dr Paul Knight (BGS President 2012-2014).

Speaking of his appointment, Professor Masud said:

"I am honoured and humbled to be elected as EuGMS President Elect, and look forward to working with Mirko during his term as President."

"During my time as BGS President, one of my priorities was to strengthen connections and share knowledge between geriatric medicine professionals internationally, and I am thrilled to have the opportunity to continue this work as EuGMS President Elect, and subsequently President."


# BGS Frailty elearning: **updated and free to all**

**The British Geriatrics Society has updated and relaunched its Frailty elearning course, which is free to all health and social care professionals.**

The BGS has updated its popular Frailty elearning course for 2023 and is relaunching it,with funding from NHS England. This CPD-accredited course is free for all health and social care professionals to access,until June 2024.

First launched in 2019, the updated course is part of a suite of frailty resources from the BGS. More than 2,000 learners have undertaken the course.

The frailty elearning course is suitable for any health and social care professional who provides care and services for older people living with or at risk of frailty.

It is particularly aimed at professionals who deal with complex cases or who lead services (Tier 3 competency), complementing the elearning in place for Tiers 1 and 2.

This includes not only geriatricians but also all health professionals with a high degree of autonomy providing healthcare for older people. Acute based medical staff, plus GPs, Advanced Clinical Practitioners, Pharmacists, Physician Associates, Nurses and Allied Health Professionals are elible. It is also open to care at home, care home staff and Social Workers leading services are also eligible.

The course is delivered via self-paced online distance learning and is broken down into four modules:

- Understanding and Communicating Frailty
- Identifying Frailty
- Supporting People Living with Frailty
- Building Systems Fit for Frailty

Successful completion of the course leads to 10 CPD credits (from the Royal College of Physicians London). It will equip professionals with the knowledge to be able to provide the best possible care for people living with frailty, including completion of Comprehensive Geriatric Assessments (CGAs).

Learners are able to choose the pathway best suited to their professional needs. These pathways are:

- Acute pathway
- Community pathway
- Intermediate care pathway.

The elearning course is presented in an engaging interactive way to suit different learning styles. This includes videos from leading experts, such as Dr James Ray, Emergency Medicine Consultant, National Clinical Advisor Fiona Wisniacki, National Clinical Lead of SDEC (Same Day Emergency Care) and leading experts in Geriatric Medicine including Professor Jugdeep Dhesi, Dr Adrian Hopper, Professor Finbarr Martin.

Professor Adam Gordon, President of the British Geriatrics Society, said:

"Around 10% of people aged 65 and over and a quarter to a half of those aged over 85 live with frailty, costing healthcare systems approximately £5.8 billion per year.

"It is therefore essential that the health and social care workforce is equipped with the skills and knowledge to care for people living with frailty.

"I am delighted that with the support of NHS England, the BGS has relaunched and updated this vital educational resource to help professionals improve their understanding of frailty."

Dr Adrian Hayter, National Clinical Director for Older People and Person-Centred Care, said:

"Professionals across health and care organisations are supporting older people living with frailty across many new pathways and settings. From Proactive care in General Practice to Urgent Community Response, staff are working with older people in their homes and in community settings.

"Patients are being identified at an earlier stage in Hospital Emergency Departments being further managed in 'Same Day Emergency Care' (SDEC) or acute hospital wards but more recently in Frailty 'Virtual Wards' (Hospital at Home).

"I'm glad that this updated resource is now free to all professionals and shall support the skills and competencies required by those who work on the front line to improve the experience and outcomes for older people."

**To access the elearning course, please visit www.bgs.org.uk/2023F-IF**


**The future of our workforce is with the students who will soon qualify as healthcare professionals. The experience of those students during their training, when working with older people and the professionals who care for them, will undoubtedly influence their future career decisions.**

This article reports on an event aimed at engaging and inspiring healthcare students to explore a career working with older people. We will also hear from healthcare students who have already developed a committed interest in geriatric medicine, and give some tips on how you can inspire the future generation of geriatricians and multidisciplinary colleagues.

## Quality improvement workshop for medical students

One of the BGS Trainees' Council's aims is to encourage more students to consider specialising in geriatric medicine. A one-day virtual event was organised in January 2023 to engage with student healthcare professionals.

The event was supported by members of the BGS team alongside the Trainees' Council, Clinical Quality Committee, and Education and Training Committee. It was felt that a quality improvement workshop offered something new, in addition to the careers and teaching events we are normally asked to support, and also had the potential for attendees to make a meaningful change for older people in hospital and the community as a result of their quality improvement initiatives.

Attendance was open to medical and Allied Health Professional (AHP) students, with registration via the BGS website, and the event was advertised online, social media and by word of mouth. We were delighted (and a little overwhelmed) to receive 130 registrations, with over 50 attendees live on the day.

The workshop used a combination of short presentations to introduce important concepts and tools for quality improvement, and worked examples of quality improvement projects conducted by medical students and interactive small group sessions themed around the 'geriatric giants'.

Ideas for quality improvement initiatives generated on the day included potential solutions for inpatient falls, polypharmacy medication reviews and delirium awareness. Attendees have since been invited to attend a 'follow up clinic' to further support their projects.

The feedback for the event was positive, with 100% reporting that they would recommend the workshop to their colleagues.

The BGS Trainees' Council plan on making this an annual event for healthcare students, so please look out for registrations when they open for our 2024 event, which will be made available at **www.bgs.org.uk/events**. If you would like to be involved in the national virtual event or we have inspired you to organise a similar local event then please get in touch with **trainees@bgs.org.uk**.



## Quotes from attendees

*"I'm hoping to get involved in a QIP in geriatrics soon – possibly about falls as this seems like a very important topic. The workshop made QIP seem more logical and showed that the process is quite straightforward, following certain cycles."*

*"I learned about the basics of QI. I was glad to see cross country similarity among the problems faced in care for older adults. Hoping to do some project on reducing polypharmacy."*

*"Anyone can do QI projects, it was really inspiring to see medical students who have done QIPs"*

## Inspiring a future generation of geriatricians

Have you encountered a healthcare professional student who is interested in geriatric medicine? Consider some of these resources to inspire and nurture their interest! **www.bgs.org.uk/resources/resources-for-trainees**

- Free BGS membership for students (**www.bgs.org.uk/join**)
- BGS events grants (**www.bgs.org.uk/grants**)
- BGS QI Hub (**www.bgs.org.uk/QIHub**)
- Local university geriatric medicine societies
- MDTea podcasts (**http://thehearingaidpodcasts.org.uk/mdtea-2**)

**We asked a number of students who have already decided they want to specialise in geriatric medicine about their experiences. We hope their stories show how important their experiences as undergraduates are, and how important you are as role models for inspiring students to be part of our future workforce.**

### **Grace:** First year medical student

**Tell us about any inspiring people that you have encountered during your clinical experience in geriatric medicine so far**

When shadowing a Geriatrician, we met a patient who was non-verbal and had very limited range of movement. The doctor demonstrated all of the qualities I wish to show when I become a Geriatrician and it was incredible. She held the patient's hand, and took extra time to ensure that the patient was told fully what the plan was, even though she could not respond. She treated this patient like a person, and a lot of other people would have just ignored her. The doctor went the extra mile, ensuring she had an end-of-life care plan in place and ensuring the patient's care home knew what was happening. The care and respect given by the doctor allowed the patient to maintain their dignity, and even though the patient couldn't speak, the instant bond between them and the doctor was so strong and inspiring. I've never wanted to be a Geriatrician more.

### **Shirsho:** Fourth year medical student, (Non UK medical school) interested in stroke subspecialty of geriatric medicine

**What is it about healthcare for older people that makes you interested in a career in geriatric medicine?**

Firstly, the challenge of complex multimorbid conditions. Secondly, deprescribing seems very fascinating to me, since physicians often earn a bad reputation for providing too many medicines and investigations. Finally, we all encounter many physicians and health professionals, from womb to tomb. By being someone providing end of life care, I can be one of the physicians having a final impact on someone's life, and support their family members too. With the population ageing worldwide, we need more geriatricians and I would be more than happy to be among them.

### **Anon:** Final year medical student

**Do you have any ideas about which subspecialty of geriatric medicine you might like to pursue?**

No, and herein lies part of the problem: there is lack of exposure to geriatrics as a whole, let alone subspecialties, to even be able to scratch the surface.

**Do you have any concerns about a career in older persons' medicine? Are their any barriers to you pursuing a career in geriatric medicine?**

Aside from the general disinclination [in training] to provide us with explicit exposure to geriatrics in a focused context, the cultural position of geriatrics is also discouraging. It is seen as the 'next step' in the generic medicine route past GP, and indeed is being increasingly portrayed as GP by another name for a more limited population subset. This falsely presents geriatric medicine as a speciality less worthy of interest, and more as an inevitable path which we must resign ourselves to be shoehorned into. This reputation of geriatric medicine is unearned and inaccurate.

### **Hannah:** Final year medical student

**What is it about healthcare for older people that makes you interested in a career in geriatric medicine?**

I enjoy the holistic nature of geriatric medicine, where it is so important to work with other skilled professionals within a multidisciplinary team to manage all aspects of care, including physical, social, psychological and functional. Furthermore, I am academically intrigued by the complex interplay between physiological ageing and the manifestation of disease, and how they can be managed to improve overall quality of life.

**How can those currently working in geriatric medicine support you to continue your career with us?**

During my geriatric placement, we had fantastic teaching on frailty syndromes and diseases of ageing. To support my career in geriatric medicine, I would like a greater understanding of community geriatrics and the social care system.

**Dr Sarah True**
StR in Geriatric Medicine, University Hospital Coventry;

# Ready, steady, research!

**Getting involved in research early on in your career might feel like a daunting option, but the rewards can be huge. Dr Katherine Chin shares her experience as someone who chose to incorporate research at the early stages of career planning, and offers some tips to those considering the same path.**

In 2020 to 2022 I completed the Academic Foundation Programme (now called the Specialised Foundation Programme, SFP) with the University of Leicester. In the year that has followed I have been working as a research and teaching fellow in London. My hope is that others who are also at the early stages of their career will consider including research in their career planning, and that my experience may pique the interest of those who are sat on the fence, as well as those who are already convinced!

Although I am a medic, hopefully my experience will still be applicable to everyone within the geriatrics multidisciplinary team (MDT).

## Why did you decide to pursue an academic path?

To have an impact beyond the immediate patients I see, and for the variety research provides! I may be preaching to the choir here, but participating in research has encouraged me to think beyond the clinical case directly in front of me. It has meant that I am more aware of the wider issues and complexities with care for older people, and I feel empowered to think about how we can address these. I would really encourage those who are interested in research, even if just tentatively so, to consider the option of integrating research into the early stages of your career. With the current problems of staff burnout, I have found that research provides the variety in my work life to help keep that at bay. Although, at times, it can add to your workload, overall, having an academic element to my schedule has meant that I have felt part of a community and given me skills that are also applicable clinically.

‘With the current problems of staff burnout, I have found that research provides the variety in my work life to help keep that at bay.’

## What has been your experience of research so far?

I was an academic trainee during my foundation training, and I could not recommend it more. The SFP was a unique opportunity to have dedicated and protected time to complete a research project. That meant that during my working hours I had allocated time to focus solely on research and I also had access to academic supervisors who were able to mentor me and provide guidance, which was an extremely valuable aspect of the programme! It also gives you exposure to the mechanics of how a research team is run.

After I completed my foundation training, I started my F3 year at Guy’s and St Thomas’ as a research and teaching fellow within the Ageing and Health department. It has been an amazing chance to be fully integrated into a research team, to actively participate in the writing of grant applications, and to publish and present our work. Through the job, I have also had the experience of recruiting patients to studies. This has been great first-hand experience of consenting and monitoring study participants, and has demonstrated how trials need to be designed to be accessible to our older populations.

## Are there any tips for those in the early stages of their career and interested in research?

There are lots of things you could do to get an experience of research. For instance:

- **Get in contact with the Research and Academic Development Committee (RADC) of the BGS**. They will be happy to facilitate observers to the committee, or they can you let you know if a position on the committee becomes available. It is open to all members of the BGS. Drop the team an email enquiry if you are interested in getting involved or want to find out more (**j.gough@bgs.org.uk**).

- **If you are still studying, you could consider completing an intercalated degree or masters.** Although this does then extend your study and there are associated costs with it, it is a good opportunity to complete a research dissertation and to gain experience of numerous research skills.

- **Think about what projects you pick at university**, particularly any student-selected components. Some projects may be more amenable for development into a completed piece of work that is ready to present at conferences than others. If this is something that is important to you, you can always speak candidly to the supervisors and explore what options there are to presenting or publishing your work.

- For both those who have finished university and those who have not, **try contacting people who work in the academic field and express your interest to them.** Generally, people are happy to talk to someone who has shown that they are eager and enthusiastic. You may find that they have useful insight into what life as an academic is like, or you may even find that there are some projects you could input on. The BGS has a page showing different research centres across the UK (**www.bgs.org.uk/resources/research-centres**). Try browsing on there to see if there are any local academic geriatricians who you could contact. This page is in the process of being updated and will have more contact details soon.

- **Apply to a stand-alone job which includes research.** This past year as an F3 has been hugely valuable and has given me so much experience and insight into what an academic career may entail. I would recommend keeping an eye out for Fellow jobs!

- Check out the BGS research pages on the website. These are filled with tips about how to get involved in research.

- Keep an eye out for when the BGS mentorship scheme is open for new mentees - a notification will come around in the trainees e-bulletin. You will be able to specify if you have a particular interest in research and then hopefully you will be matched with a mentor who is also interested in academia.

## If I have no research experience, should I be put off?

Absolutely not! I had very little research experience when I applied to the SFP. I had completed an intercalated degree in Health Sciences, but this was not published or presented at any conferences. I think the important thing was that I was able to reflect on what I had done so far and apply that learning. Make sure you look at what each SFP deanery wants because they can vary considerably on how strict they are in terms of publications/posters etc. Good luck!

**Dr Katherine Chin**
BGS Trainees' Council, RADC Representative



# Launch of the DMT Academy

**Dunhill Medical Trust (DMT) has launched the Academy - a place for professionals across all career stages and disciplines to come together to share their knowledge through collaboration and networking and to provide a supportive place for the future leaders in the care of older people.**

DMT recognises the importance of creating and fostering networks of support, celebrating success and providing safe and supportive spaces to learn and explore solutions to the many challenges that exist in providing care for older people. Conversations with existing professional networks, membership organisations, the recently-formed BBSRC-MRC funded ageing networks and other groups have highlighted an appetite, not to duplicate existing networks, but to provide a forum for connecting people working in a range of professions and disciplines, to:

- Celebrate success, achievement and ambition in ageing-related research and evidence-informed practice
- Create a supportive place to find new collaborators, mentors and advisors
- Facilitate better understanding and foster relationships between academic and clinical researchers and community organisations working with older people
- Sustain existing and nascent networks longer term.

The Academy aims to provide a growing, searchable portal of researchers and evidence-informed community organisations with an interest in age-related research. By joining the Academy, members will have access to:

- Advance notice of future funding calls
- A platform for advertising job vacancies
- Professional development opportunities
- Content from experts to share best practice
- Networking and shared learning events.

## DMT Academy Excellence Awards

Academic and clinical members of the Academy will also be eligible for nomination for our excellence awards – two three-year awards of £40k pa each will be made to two researchers:

- One to an early/mid-career researcher: a “rising star”
- One to a senior leader in ageing-related research.

## Academy membership

Membership of the Academy is open to:

- Current, former and prospective DMT academic and clinical research award holders.
- Members of the UKRI-funded ageing across the life course interdisciplinary research networks
- Evidence-informed community organisations working with older people.

**For more information and how to join please visit: https://dunhillmedical.org.uk/academy**

# Creating a workforce fit to meet the needs of older people: Developing a Frailty Academy

**The Royal Surrey is a medium sized Acute Trust located in the Guildford and Waverley health and care system, serving a population of approximately 320,000 with the highest average age of death in England. In this article, Dr James Adams outlines his experience of developing a Frailty Academy to tackle the gaps in knowledge and skills in frailty, alongside developing innovative workforce plans.**

## Education is the silver bullet

"Education can be the silver bullet," quipped President Bartlett. I was a big fan of the West Wing, tuning into it in the late 1990s when I myself was deep in study at medical school. This idealistic take on tackling the inter-dependent failings on broader society stuck with me. Interestingly, I learnt none of the frailty knowledge and skills I now have during my medical education, building this experientially along the traditional medical training route.

But imagine a world where everyone knew urine dipsticks are probably not required in everyone over the age of 65, that UTIs aren't the unifying diagnosis for everything, that acopia isn't even a word at all and deserves banishment to the Geriatrics Profanisaurus.[1] What would Geriatricians and other frailty experts do if everyone knew how to complete the Clinical Frailty Score? That Neurosurgeons are unlikely to operate on someone living with severe frailty and small amount of intra-cranial blood? That the referral to them in the middle of the night probably made us feel better, rather than the patient? How do we build in pragmatism and clinical judgement, in addition to clinical knowledge of signs and long-term condition management and the latest evidence? With the capability to know the difference and when to apply each of them as part of a person-centred approach to co-ordinating care for the individual living with complexity in front of them. And so it was in 2020, with the publication of the *Skills for Health Core Capabilities Framework for Frailty* through Health Education England[2] that a generous donation landed in the Ageing and Health Department at our Trust. A local vicar had passed away and donated a large sum of their estate as a legacy donation to help support older people's care. What better legacy than to invest in a sustainable education and training programme in frailty?

**Figure 1. The eight strategic ambitions for the Guildford and Waverley Ageing Well Strategy**


## Drivers for change

We already knew the challenges. An ageing demographic, with ever increasing need to provide multidimensional, multidisciplinary person-centred care, large gaps in skills and knowledge to achieve this, and a shrinking pool of frailty experts to oversee this much-needed change. The *NHS Long Term Plan* enshrined in national policy the drivers for change in focus to co-ordinated, integrated care for older people outside hospital.[3] The *NHS Long Term Workforce Plan*[4] clearly articulates development of health and care professionals to work in multidisciplinary, integrated teams that respond to population health needs and effectively deliver care in communities, and there is a clear call for more Geriatricians from the BGS.[5] Within our local health and care system our analysis told us that 50% of all health and care spend was on older people living with frailty, but that we had poor understanding of frailty as a long-term condition, leading to large variations in care and quality. We also have problems in recruiting geriatricians and a lack of focus on developing 'frailty experts' in alternative roles to help us build capacity for Comprehensive Geriatric Assessment (CGA). This, in spite of the unequivocal evidence for CGA in improving both system efficiency as well as outcomes for our patients.[6]

With these factors in mind our Frailty Academy had three key aims:

1. Everyone in the Guildford and Waverley system to be aware of, and able to identify, frailty at a level appropriate to their role.
2. We start to explore population needs and work to establish appropriate capacity through innovative workforce models to meet this need.
3. To build a movement for change through development of an Academy and Faculty membership, enabling people to feel part of a community championing education relating to those living with frailty and complex needs.

## Think big, start small

The Guildford and Waverley Frailty Strategy was approved by the local Health and Care Alliance (now the ICB) in March 2022 (see Figure 1). One of the eight key strategic ambitions centred on workforce development and the Guildford and Waverley Frailty Academy was established as the vehicle to implement this change (see Table 1). Initial faculty membership included Consultant Geriatricians, a transformation programme manager, a project manager and an academy fellow. We set about aligning the core capability tiers to our strategy for local education and training delivery with the aim that everyone would be able to identify frailty and know what to do next when they encountered it.

We developed our Tier 1 content, uploading this to our Trust e-learning platform with over 500 people in the trust completing this in year 1. Through partnership working, our Tier 1 package was uploaded to South East Coast Ambulance e-learning platform with over 150 staff completing this to date.

There was a complete overhaul of weekly departmental teaching, traditionally only delivered to junior doctors, into a webinar series available to all and aligned to Tier 2 of the core capabilities framework to create Frailty Champions. With multiple vacancies at consultant level, the need to think differently to create a tier of frailty experts became paramount and the Faculty set about establishing internal Tier 3 training programmes.

## Going from strength to strength

Tier 1 workshops are system-wide with a diverse multi-professional audience, from receptionists in GP practices to care home staff. At the end of the Tier 2 webinar series there is a Train the Trainer workshop to create capacity within the system to generate frailty awareness. The Frailty Champions webinar series has a system-wide presence proving phenomenally popular with community nursing teams and GPs as well as with acute staff.

## Tier 3 frailty experts

In January 2023, three community-based and three acute-based trainee Advanced Clinical Practitioners in Frailty enrolled in a Frailty ACP training programme. The Academy has developed its own curriculum, workbooks, Local Faculty Groups, and yearly Annual Review of Competency Progression (ARCP) with robust governance. Each trainee has a dedicated educational supervision with regular objective setting and appraisal, completion of structured learning events and other formal assessments replicating Junior Doctor training. In addition there is a weekly teaching programme with a portfolio of education and training opportunities, including quality improvement methodology, simulation and case-based discussions.

In a similar vein, the Royal Surrey has its own Geriatric Medicine rotation offering experience and training towards Certificate of Entry into the Specialist Register (CESR) for our seven specialty doctors. This mirrors specialty training in Geriatric Medicine with rotations through front door frailty, same day emergency care, Hospital at Home, community integrated care hub (including movement disorders), frailty units, stroke services and Orthogeriatrics.

## Creating a workforce fit for the future

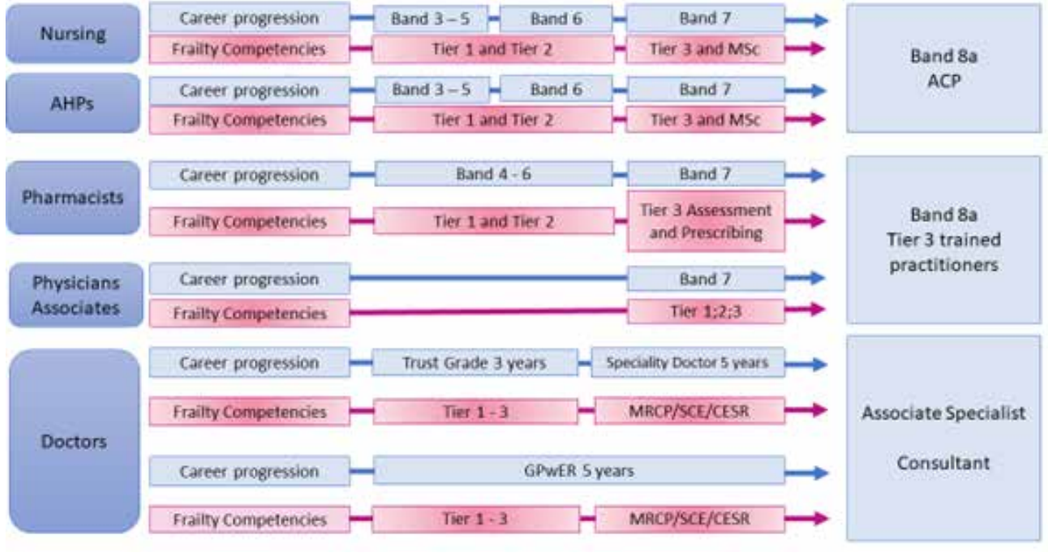
Development of neighbourhoods are a priority focus for delivery of the Fuller Stocktake,[7] building on the conceptual model of primary care networks articulated in the *NHS*

**Table 1. Details behind ambition six of the frailty strategy:**
***Staff have the skills and knowledge in frailty to provide the best care for our older population***

| | |
|---|---|
| Developing our frailty academy to support our people plan | We are developing our frailty academy to provide consistent high quality education and training for our workforce aligned to the core capabilities framework. We want to invest in our people and help develop their knowledge and skills. |
| Supporting our people living with frailty and their carers | We will ensure people living with frailty or those who are vulnerable have access to the right education and training in order to live well and age well. We will support carers and families in understanding frailty and recognising frailty crisis. We will ensure both people living with frailty and their carers have knowledge of local services to help support them and single points of access for contact. |
| Upskilling our general workforce | We will make sure our general workforce has the right training and feels equipped to provide high quality care for older people living with frailty. This training will be aligned to the Tier 1 and Tier 2 training of the core capabilities framework. |
| Developing specialist skills and frailty experts | We will understand the demand for Comprehensive Geriatric Assessment using population health management principles to identify the workforce need for frailty experts. We will map opportunities for developing Advanced Clinical Practitioners across the whole pathway of frailty care and train individuals to Tier 3 of the core capabilities framework. We will work with primary and secondary care to support development of Geriatricians and GPs with a special interest in frailty. |
| Creating multiagency workforce initiatives | We will explore joint posts, rotational schemes and cross-provider working between our Alliance partners. We will understand barriers to integrated working and professional development in our Allied Health Professions workforce. We will help maximise opportunities with Primary Care Networks through the use of ARRS funds and ensure these staff have the same access to frailty academy support. |

*Long Term Plan*. The drivers for this change bring a focus on population health management, risk stratifying cohorts of high risk patients and forming multidisciplinary teams built around their needs. Building capacity for CGA should reduce variation within local populations and provide economies of scale in order to achieve outcomes outlined in the national Ageing Well strategy (Anticipatory Care and Enhanced Health in Care Homes). The Academy was successful in a workforce innovation bid from the Surrey Heartlands Integrated Care System, designated as a pioneer project. The bid seeks to align the academy with emerging neighbourhood teams, to embed training and education in frailty and to scope development of frailty experts capable of meeting the needs of complex patients, risk stratified through PHM (Figure 2). It also looks to test innovative new portfolio roles through three educational fellows in voluntary, community and social enterprise organisations, adult social care and allied health professionals (Table 2). This expansion will enable us to explore the education and development needs of un-registered staff in particularly in the care sector, and most importantly those living with severe frailty.

**Figure 2. Our frailty people plan, career progression for everyone towards becoming a frailty expert**




## Where we are and next steps

After two years of trying, evolving, transforming and building, we absolutely know President Bartlett was right. Education can be the Silver Bullet, but equally recognising the needs of our local populations and older people, aligning our education and training programmes to meet their needs, can lead to sustainable change in the quality of care and outcomes we deliver. They can also influence workforce planning, recruitment and retention and some of the biggest challenges that we face in the NHS. As I write the Academy has touched well over a thousand individuals in our health and care system but we recognise the hard work has only just begun. Alongside our educational fellows, we are building an army of frailty attuned health and care practitioners capable of spreading Tier 1 training, we are expanding our Tier 2 access and we absolutely have the ambition to create the appropriate number of Tier 3 roles capable of meeting the needs of our local populations.

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Chair Guildford and Waverley Frailty Academy


**Table 2. Frailty Academy Educational Fellows and their areas of focus**

| Generic to all fellows | AHP | VSCE | ASC |
|---|---|---|---|
| • To undertake Tier 1 and Tier 2 Frailty Academy training<br>• To be supported in Quality Improvement training and developing project management skills<br>• To be an active Frailty Academy Faculty and Steering Group member. | • To use an A3 approach to understand the current state of AHP workforce challenges across Guildford and Waverley<br>• To map existing AHP vacancy in frailty across system providers<br>• To develop a collaborative approach to AHP vacancy in frailty across the system working with providers to improve recruitment and retention<br>• To understand barriers to AHP integration across the pathway of care for older people requiring multidisciplinary intervention<br>• To learn from high performing systems on their approach to AHP recruitment, retention and development<br>• To establish and lead an AHP-led programme to prevent deconditioning in inpatient units. | • To use an A3 approach to coproduce educational products, projects and programmes of work to help support older people, their carers and families in their understanding of living well, ageing well and dying well<br>• To understand current existing and available education and training for this cohort<br>• To work with the voluntary sector to embed Tier 1 and Tier 2 training where relevant in VSCE organisations<br>• To work with key stakeholders in neighbourhood programmes of work to test coproduced educational materials at a neighbourhood level. | • To use an A3 approach to understand the current state of social care workforce challenges across Guildford and Waverley, with a particular emphasis on unregistered staff in care homes, private care providers as well as local authority<br>• To work with unregistered staff to explore their needs and preferences for education and training specific to the pathway of care for older people<br>• To understand the opportunity for potential certification/ registration relating to older people's care and develop appropriate education and training to enable staff to achieve a recognised qualification. |

# FROM PHYSIOTHERAPY TO ADVANCED CLINICAL PRACTICE

**Ian Tyrell's interest in helping older patients was ignited early on in his physiotherapy journey. Here he explains how this passion led him to pursue a path in Advanced Clinical Practice.**

Initially, when I started out in my career, I had thought I would specialise in musculoskeletal or sports physiotherapy, but older people's care kept calling me back. As a physiotherapist there is a great deal of weight placed on understanding the patient, exploring their goals, and a collaborative attempt at reaching those goals. Some of the most successful patient stories I have are due to really exploring the history of patient and using that to enhance their rehabilitation.

The complexity of caring for older people is another reason I became so fond of it. Numerous systems all adapting to the pressures of ageing and a careful balance needed to ensure optimisation - like the fine-tuning needed for the precision and performance of a Formula 1 car.

As my physiotherapy career continued, I was faced with a desire for progression, but often found a glass ceiling. The only option available to me and many of my colleagues was to remain as a clinical band 7, or to lose our clinical skills and become a manager, which did not interest me.

Luckily at that time, a new 'Front Door Frailty' service was developing in our Trust. It focussed on prioritising older people who needed a full holistic assessment directly in the emergency department with the aim of them returning home. At this time I was encouraged by my Advanced Nurse Practitioner (ANP) colleagues to enhance my skills by doing some masters modules including physical health assessment and non-medical prescribing. Being able to assess a patient fully from a medical point of view, and continuing onto assessing their mobility and social care needs, was far more fulfilling for me. Also it meant that an older person, particularly one with cognitive impairment, would only have to see one clinician, which can help lower the risks associated with delirium.

The team supported me in gaining a trainee Advanced Clinical Practitioner role where I was able to undertake a masters as well as work across the older adult wards. I was able to bring my skills as a physiotherapist, including diagnosis of musculoskeletal conditions and management of respiratory conditions, alongside an in-depth knowledge of community pathways to the team. This helped me to integrate well, improving the service we offered to the patients we treated. I have gained skills in venepuncture, cannulation and wound management that I would not have gained had I not been given this opportunity.

Prior to taking the role I was concerned that I may not be accepted as a competent clinician due to being a physiotherapist by background. However throughout the last four years of working as an ACP I have been made to feel like a valued member of the team. I have never had a bad experience when dealing with specialists - they have been warm, welcoming and always gracious with their time and in sharing their knowledge.

The role is rewarding albeit challenging. The ability to utilise all four pillars of advanced practice in terms of clinical work, audit, leadership and education means the workload is varied, but is all focused on improving the care of older people, which is my passion. The transition to an ACP has expanded my knowledge and skills base but also made me better equipped for any other roles in the future. It has also helped me in developing myself both personally and professionally and helping the current workforce challenges by increasing my skills base.

**Ian Tyrell**
Advanced Clinical Practitioner, University Hospital North Midlands NHS Trust



# Less than full time: Shifting the culture

**'The NHS in crisis' is a headline that many of us have become used to reading and hearing over the past few months. Stories about waiting times for appointments, procedures and beds have become commonplace. Staff are overworked and overstretched, and rates of sickness and of those leaving are at an all-time high.**

Between 2011-2018 over 56,000 staff left the NHS citing 'lack of work-life balance' as the main reason for doing so.[1] The NHS is haemorrhaging workers and cannot afford to lose any more.

Flexible working and Less Than Full Time (LTFT) working has become much more recognised over the past few years. With the start of 'category 3' LTFT working in a number of training specialties, where trainees can apply to work at 80% for 'lifestyle reasons', many more are taking up the opportunity to work hours which provide them with a better work-life balance. The pandemic and the high rate of burnout and stress which working through COVID-19 caused has made people re-evaluate their work, lives and the value they place on their time. This, along with an increase in the numbers of people suffering from post-COVID ill health (physical or psychological) has meant that finding ways to make flexible and LTFT working more accessible and more accommodating has become even more important than it already was.

In the NHS People Plan and the British Geriatrics Society Workforce statement,[2] a call for flexible working and LTFT working to become embedded in NHS culture recognises that the idea that people working in these ways must become more accepted and available. It was, and still is in some places, unfortunately not uncommon for LTFT workers to experience negative attitudes and discrimination, or made to feel like they do not pull their weight.

However, if the NHS is going to stop the rapid flow of workers choosing to leave and improve both recruitment and retention then recognition that people need a better work-life balance, and the ability to balance working as well as fulfilling other commitments outside of work, is of upmost importance. Surely a doctor working at 60% or 80%, who is far less likely to suffer from burnout and more likely to enjoy job satisfaction, is better than that person choosing to leave the NHS altogether and take their skills elsewhere. With all of this in mind we looked at job adverts nationally over the past two years for Consultant Geriatricians. We looked at how many of these were advertised as being flexible, LTFT or open for negotiation. We then compared this to how many trainees in Geriatrics as of August 2022 were in-post as LTFT.

Across all specialties, the number of substantive consultants working LTFT rose from 6% in 2004 to 25% in 20213. However, out of 1,083 Consultant Geriatrician jobs, advertised between 2019-2021, 89% were advertised as being for a full time contract (≥10 PAs). Only 21 (1.9%) were advertised as being LTFT and 28 (2.6%) as being 'negotiable'. Seven (0.64%) were advertised as being for flexible working, or flexi-time.

We found that out of the 585 Geriatric Trainees in England, 216 (37%) were LTFT. This ranged from 23% in South East London to 50% in Severn and the West Midlands Deaneries, with trainees working a range of hours from 50% whole time equivalent to 80%. Trainees working at 80% made up the largest group.

There are a large number of trainees working LTFT for a variety of reasons. This, along with the huge increase in the number of consultants working LTFT across all specialties, demonstrates the need for the NHS and geriatrics to become more open to adapting to more of their staff working in different ways. The low number of consultant jobs being advertised as being negotiable, flexible or LTFT may be a barrier to some to applying, and may result in the loss of good candidates. While we know that there are often a lot of behind-the-scenes discussions and meetings prior to applying for a consultant job, where issues such as working LTFT may be discussed, if the NHS is to truly embed flexible and LTFT working in its culture then all jobs should be advertised as being open for negotiation.

If we can improve this and ensure we are all open minded to this approach at consultant level, then maybe these culture changes can filter through to other workforce groups and allied healthcare professionals, ensuring that this way of working is truly normalised and embraced across the entire NHS.

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BGS Trainees' Council Members

# Connecting, reflecting, and moving forwards in identifying the current challenges faced by acute inpatient physiotherapists

**Findings from a recent survey by AGILE, the professional network for physiotherapists working with older people, revealed worrying trends in the depletion of inpatient physiotherapy resources for older people.**

Frailty awareness and understanding has recently been thrust into the spotlight.[1] Frailty is common, affecting more than one in ten community-dwelling people aged over 65, and up to half of the population aged over 85.[2,3] Frailty costs UK healthcare systems £5.8 billion per year.[1,4]

Around 47% of people over 65 years admitted to hospital are affected by frailty.[5] Physiotherapists play a pivotal role in the management of frailty within these acute settings by supporting hospital flow, carrying out detailed assessments with a patient-first focus as part of Comprehensive Geriatric Assessment (CGA), and supporting the enablement focus of inpatient wards through early rehabilitation. The Chartered Society of Physiotherapy (CSP's) 'right to rehabilitation' campaign has further advocated a voice for all patients to recover well. However, is the workforce available to deliver equitable services to all patients?

As our understanding of frailty has grown, so has the surge in changes to frailty pathways for acute hospital settings. Developments such as NHS@home, virtual wards, and community initiatives are all focused on supporting people to remain in community settings, thus preventing hospital admissions for older adults. This has significant benefits in reducing pressures on acute hospitals as well as on the recovery and wellbeing of patients. However, patients remain in our acute beds, and those 'front door' changes have impacted the complexity of patients requiring admissions to acute trusts.

In today's modern frailty pathways only the most medically and socially complex patients are admitted. Most would agree this is the goal, ensuring patients are where they need to be and preferably in their own environment, away from the potential harm of hospital-acquired deconditioning, and infection risk of an admission. These system changes do, however, have wider implications for workforces in these clinical settings.

While working with patients, clinicians often describe how to provide full holistic care, but assessments vary from patient to patient with regards to time. The interplay of multiple long-term conditions increases the complexity of patients requiring physiotherapy assessment. General opinion suggests an increase in complexity of our patient group; however, this has not been formally measured. More traditionally, outcome measures in this population have been focused on function, however, these scores can be generic and do not truly reflect the MDT skills required to manage such patients.

To learn more about the challenges faced by acute inpatient physiotherapists working with patients with frailty, a scoping survey was sent to all AGILE (the professional network for physiotherapists working with older people) members in 2021. Fifty-six people responded to the survey. The results highlighted variation in key areas, such as supervision structure, ranging from weekly to every four months and variation in the process of patients being accepted onto therapy caseloads; some teams performed blanket reviews on all people over the age of 75, some teams received referrals, and some teams reviewed all patients on their ward.

We asked "*Do you feel that your team is adequately staffed to support patients in your care living with frailty?*" - 77% of respondents (n=28) either disagreed or strongly disagreed with this statement; 6% (n=2) neither agreed nor disagreed; and 17% (n=6) agreed with the statement. This survey provided initial evidence to demonstrate that therapy staffing in acute frailty required further investigation.
A follow-up survey was shared with the aim of creating a consensus statement. Of the 69 people who responded, 77% did not feel able to provide an adequate service to people living with frailty. Results varied between community, emergency department, and acute inpatient settings.

'Recent statistics from the CSP indicate that the NHS is losing 15% of its physiotherapy staff each year and almost half of new graduates will leave the NHS within five years.'



- 60% (n=38) of physiotherapists working in a community setting felt unable to provide an adequate level of service
- 80% (n=10) of physiotherapists working in emergency departments felt unable to provide an adequate service
- 100% (n=21) of physiotherapists working in an acute inpatient setting felt unable to provide an adequate level of service.

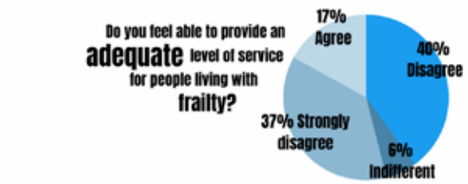
Neurorehabilitation units utilise the Rehab Complexity Scale (RCS)[6] to classify patient need, based on criteria including therapy staff, medical interventions and nursing care. It was suggested that this scale could be used in wider settings including care of older people.[6] This scale also considers the cognitive needs of patients, which is important given the number of people living with dementia who are admitted to this clinical area. The RCS score is individualised to each patient and is more sensitive at picking up variable demands on different MDT members in supporting the patient holistically, and represents a snapshot of the clinical area at one given time.

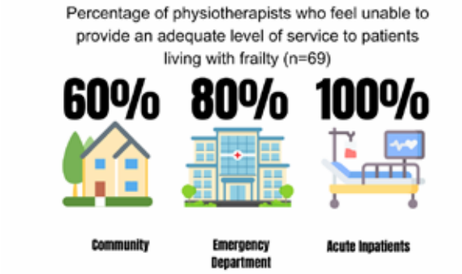
In 2022, to capture an overview of the national picture of complexity for acute hospital patients in medical divisional bed bases, AGILE invited members to undertake a snapshot audit. The aim was to identify the numbers of patients with frailty on one acute hospital ward in a week and their rehabilitation needs (using the RCS).

Staff at six NHS Trusts from across the UK completed the audit. The median Clinical Frailty Scale (CFS)[7] score of the patients on their wards was six. Most patients required two to three therapy disciplines to provide the daily therapeutic input they needed to recover and leave the acute setting. However, each day, on average only 50% of the patients received their required therapy input. Most respondents indicated a shortfall in the expected number of therapy staff versus actual number of therapy staff on the ward each day. From discussions with the teams involved in the audit, they described a workforce supported by high numbers of rotational staff with a high turnover rate due to caseload; unprecedented demand for physiotherapy input, and issues with mental health and wellbeing working in a high pressured, chronically under-resourced clinical area. These workforce challenges are not just ringfenced to physiotherapists; all allied health profession (AHP) groups report challenges at local level.

One of the biggest challenges affecting physiotherapists working in acute hospital older persons medicine is the ability of its workforce to be able to proactively respond to the new needs of this changing patient cohort. Recent statistics from the CSP indicate that the NHS is losing 15% of its physiotherapy staff each year and almost half of new graduates will leave the NHS within five years. Physiotherapists working in older persons settings report no changes to workforce numbers in years, sometimes decades. This is challenging considering the rise in average CFS scores and rising time demands on stretched resources. Frailty as a specialism within physiotherapy is relatively new, compared to other more established specialisms such as neurorehabilitation and respiratory care. Often these more established areas attract staff due to well-supported workforces, because of benchmarking targets supporting data

## Findings from the AGILE survey





for business cases (e.g. SNAP targets where therapy input directly impacts scoring). Unfortunately, acute inpatient medical wards do not have safer staffing ratios, standards to benchmark against, or wider audits to contribute to. As a result, and highlighted in the discussions held with AGILE, staff often feel overwhelmed with demand and unable to explore innovation, new ideas, and react dynamically due to overstretched resources and ever-expanding bed bases.

One area of current focus is supporting education and knowledge building in the future workforce i.e. physiotherapy students and international recruits.[8,9] Supporting a diverse and skilled workforce is a key priority for AGILE as well. Too commonly undergraduate programmes lack programme content about frailty, which is present in every area of physiotherapy practice. There needs to be more focus on promoting older persons' care as an area of specialism and supporting students and international recruits to join networks to further enhance knowledge of the variety of skills which can be learnt working in these clinical areas. Alongside this is growing the evidence base for the benefit of physiotherapy interventions for older people and frail adults. It is hoped that this, alongside highlighting current workforce challenges, will enable a change in perspective for acute trust leadership, promoting a review of pathway changes and the impact on all allied health professionals delivering care within them.

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# Offender health:

## Increasing nurses' frailty knowledge in prisons

**We are all familiar with the global ageing population. Prisons are not immune. Over the last 10 years in England and Wales, prisoners over the age of 60 have increased by 82% - and by an incredible 243% since 2002.[1]**

We tend to define the 'older adult' as someone over the age of 65, and indeed the Clinical Frailty Scale (CFS) is validated for use in the over 65s. However there is no universally recognised definition for an older adult in prison. The literature varies from 45-70 years old. His Majesty's Prison and Probation Service have adopted the age of 50 to define an older adult, suggesting that they may have the healthcare needs of a 60-year-old non prisoner.[2] The evidence base is building to suggest that people who have spent considerable time in prisons, coupled with the typical wider determinants of health often associated with prison population, expediate the ageing process.

In 2013 a Justice Committee inquiry, *Older Prisoners*,[3] explored the challenges posed by an ageing population. In 2020 a further inquiry was published; *Ageing prison population*,[2] echoing findings from the previous report. While there are silos of good practice across the country to address the findings there, is still a long way to go, with Age UK[4] calling for a national strategy for older prisoners.

In 2022, working in partnership with colleagues at Nottinghamshire Healthcare Foundation Trust, we identified four nurses who had been appointed as frailty

'His Majesty's Prison and Probation Service have adopted the age of 50 to define an older adult, suggesting that they may have the healthcare needs of a 60-year-old non prisoner.'

leads in prison healthcare teams who would be suitable to study a professional certificate in Frailty at Nottingham Trent University.

Delivering education in relation to the older person living with frailty to offender healthcare nurses requires an appreciation of not just the environment in which care is delivered, but the struggle of custody, and caring to be non-judgmental and recognition of the importance of boundaries.[5]

Reflecting on the delivery of education to nurses from offender health who undertook the frailty modules, there was an acknowledgement of these limitations. Other issues highlighted included limited time and resources to undertake a frailty assessment for persons identified who meet the criteria to be in the category. There were also challenges around space for gait and mobility assessments, time for any discussion on mental health issues, access to physiotherapy services and services that can be accessed in the community but not by the offender community, plus district nurse support and occupational health. Often because it is logistically difficult to get specialties to support the offender health service.

‘Following a discussion in class with the nurses who had experience of working in prisons, it was understood that the prison regime ultimately determines whether someone can attend an appointment.’

Nurses anecdotally reported that they can have 900 inmates as a prison population to undertake annual health reviews, with limited time to complete this health assessment. Often this assessment is undertaken by Healthcare Assistants using a tick box form with little room for objective review. Time to talk to offenders is limited, therefore any health issues cannot be discussed in detail. Some did not see themselves as leaders of healthcare within the professional multi-disciplinary structure of the prison to initiate any meaningful change, even though this was identified within the rationale for them attending the course. Learning and discussion about use of Comprehensive Geriatric Assessment (CGA) was well received, but then came the question of how to design a format and implement it into their area of practice, given the constraints of the working environment.

Some taught sessions incorporated student collaboration to allow sharing of their experience of practice in this unique setting, as well as to network with other practitioners from acute and community-based care settings also within the 'frailty' umbrella. They were able to reflect on their own practice, and in some instances debrief from some scenarios that stood out for them.

We have found over the cohorts of students that the richness of the multi-disciplinary team, along with people coming from different clinical areas and backgrounds, lends itself to students developing a better understanding of each other’s roles in a person’s health and care journey.

One student who had worked in a fracture clinic had previously made assumptions that patients from prisons were not turning up for their appointments through choice, however following a discussion in class with the nurses who had experience of working in prisons, it was understood that the prison regime ultimately determines whether someone can attend an appointment. There are several reasons that may prevent someone from attending an appointment; if there are not enough prison staff to accompany the patient, a security incident occurs on the day, or someone calls in sick. The non-attendance reason is rarely communicated with healthcare staff.

There has been a clear benefit to the nurses who have studied. With the increasing ageing population in prisons, organisations providing healthcare services should consider how they will support workforce and service development to meet the needs of older people. However with the absence of a national strategy and funding this will likely come with significant challenge.

It is also important for academic staff, when designing educational opportunities to support increase of knowledge in relation to care of the older person, that we recognise the diverse range of professions and working environments and ensure learning objectives and teaching methods are inclusive of these.

**Further information about the frailty modules at Nottingham Trent University can be found at www.ntu.ac.uk/course/social-sciences/pr/frailty**

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**Nicola Payne**
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**Geeta Bhaggan**
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## **Charlotte Orford:** Practice Nurse, HMP North Sea Camp, Nottinghamshire Healthcare NHS Foundation Trust

**Briefly describe your job role:**
Working as a Practice Nurse in a prison setting is vastly different to working in a regular GP setting. We still see patients in clinic to triage, assess and refer to the appropriate services. However, we are primarily a nurse-led service and only have GPs come in three days per week. Duties within the prison setting also involve attending emergency calls where the prison request our attendance. A code is voiced out over the radio such as a ‘Code Blue’ or ‘Code Red.’ The nursing team would attend promptly with emergency equipment and medications. We would assess the situation and make a clinical decision on whether the patient needs admitting to hospital or whether this could be managed within the prison. Aside from the Practice Nurse role there are opportunities to take the lead in other areas including long term conditions - Diabetes, Respiratory etc - and any additional clinics such as Older Adults and Falls Assessments.

**Why did you want to study frailty?**
I am the Lead Nurse for Older Adults and Falls so I chose to study the frailty modules to gain more knowledge and understanding - especially since over half of the prison population at NSC are over 50, with some of those patients presenting with frailty syndromes. There is a large increase in the ageing population and there are a high number of historical sex offences now being sentenced. Therefore, Frailty will become more prevalent in an Offender Health setting.

**How has the training made a difference to your practice?**
I now have a better understanding of frailty and how to take a thorough history from the patient when completing a falls assessment. I have the awareness of how certain syndromes can overlap and how these can affect the patient’s overall health and wellbeing. Studying the frailty modules has enabled me to expand my critical thinking and to look at the wider picture when assessing a patient. My confidence has increased following studying and I believe this will benefit my overall practice as an Older Adult Lead Nurse.

## **Diana Buck:** Practice Development Matron, Offender Health, Nottingham Healthcare NHS Foundation Trust

**Briefly describe your job role:**
My role involves teaching staff from secure settings and the wider Trust, offering clinical shadowing opportunities., as well as offering clinical expertise and advice, and acting as a role model. It also includes ensuring quality assurance and identifying training needs, providing mentorship, clinical supervision and professional support and guidance. I have involvement with service delivery and system and process reviews, promotion of collaborative and integrated working.

**Why did you want to study frailty?**
As we are an ageing population, prisons are no exception to this, and prisons are receiving more elderly patients for their first sentence. Frailty is now much more visible within the prison setting.

**How has the training made a difference to your practice?**
Awareness, understanding and recognition of the frailty syndromes. I have delivered two face-to-face teaching sessions to staff on frailty which were well received. I will continue to offer these sessions to all staff. We have identified Lead Nurses for all long term conditions and now for the older person, falls and frailty. Additionally I am in the process of developing some competencies for nurses regarding frailty.


**The Diploma in Geriatric Medicine (DGM), awarded by the Royal College of Physicians (RCP), is an examination developed collaboratively by the RCP and the British Geriatrics Society.**

It is designed for individuals who want to demonstrate their knowledge and expertise in the healthcare of older people. GPs and old age psychiatrists, together with some doctors undergoing training in geriatric medicine, have been the main candidates for the DGM over recent years. Since 2021, the exam has been opened up to nurses, allied health professionals, pharmacists and physician associates (on the managed voluntary register).

### What is the DGM?

The DGM is a credential that recognises the in-depth critical understanding, clinical knowledge and skills required in the field of geriatric medicine to provide expert care for older people. Candidates sit two examinations: an online knowledge-based assessment, and a clinical exam, currently taken in person at the RCP’s Examination Assessment Centre in Liverpool.

### What is involved?

The DGM is a two-part assessment. Part 1 is a single paper consisting of a 100-question, best of five, online knowledge-based assessment, sat on a single day. Part 2 is a clinical assessment which takes place at the RCP’s bespoke assessment centre in Liverpool. The clinical assessment comprises four stations - history-taking skills; Comprehensive Geriatric Assessment (CGA); communication skills and ethics; and clinical examining skills.

### What will I gain from the DGM?

The DGM has been created specifically for healthcare professionals who are not specialist geriatricians to help demonstrate their knowledge and expertise in the care of older people and in particular the management of frailty. It offers external recognition as part of your continuing professional development.

### How and when do I apply?

Applications for the 2024 Part 1 examination open on 8 January 2024 and close on 21 January 2024. For more information about applying, visit **www.bgs.org.uk/DGM**.

# HOSPITAL AT HOME

## WORKFORCE CHALLENGES & OPPORTUNITIES FOR TRAINEES

**I have been fortunate to work as a Specialist SAS Doctor in a Frailty Hospital at Home team for many years and we have recently welcomed Trainee doctors into our team. Integrating them into our team of SAS Doctors, Advanced Clinical Practitioners, Therapists, Nurses and Pharmacists allowed me the chance to reflect on the challenges of adapting their current hospital-based training to this new model of care and the challenges and joys observed along the way.**

Development of the team has been both challenging and rewarding in equal measure, and working in a Frailty Hospital at Home team brings many benefits to the workforce; it offers a chance to work creatively and provide continuity during an episode (and often subsequent episodes) of illness. Patients choose their place of care and welcome you to join them, balancing the relationship with clinicians to allow management plans that are truly co-developed with the patient. The constant change of venue brings opportunity for activity and fresh air; while movement out of the hospital opens communication channels across multiple organisations. However, there are many other Cs that contrast with that list and require thought; there are challenges (physical and emotional) and a great deal of support required to work courageously with curiosity in community settings.

Members of a Hospital at Home team require a dizzying mix of attention to detail alongside the ability to work flexibly. Prior to the home visit, it is necessary to gather information on recent investigation results, medications and clinic letters as they may not be accessible in the person's home. However, this is often balanced by the need to remain curious on arrival, as the context discovered may be far from that described at the point of referral. Detail is needed before going onto complete a holistic assessment and it is important to understand what a patient's goals for care are so that management plans are developed in this context. There is a need for clarity and transparent discussion regarding risks and benefits of a Hospital at Home approach and the patient's ability to weigh this up needs to be evaluated. The patient and their family are central to their care and therefore details, such as checking medications against the repeat medications, are key so that those being started and omitted can be clearly identified. There has to be a discussion about the next points of communication and consideration of the next incoming clinician or family member/carer. It is important to pause at the end of a visit and check all parties have the information they require; the equivalent of returning from the ward station to the bedside to clarify queries. You have to feel at ease with the final plan; you may not be visiting daily, so trust passes to the patient and you have to accept that it may not be perfect.

'The constant change of venue brings opportunity for activity and fresh air; while movement out of the hospital opens communication channels across multiple organisations.'

There is a need to adapt to multiple environments within one shift and variety is the norm. This starts from when a clinician takes on a role within Hospital at Home, as they are often adapting training skills developed in a primary or secondary care setting. There is a joy in relying on clinical skills and bedside investigations to come to a diagnosis, but there is a need to balance this by sharing any clinical uncertainty and risks. Often guidelines are worked with and adapted, sometimes because of environmental constraints, but also during the process of working towards a patient's goals. There are alternating modes of working within community teams, requiring autonomous clinicians who can then come together within a multi-disciplinary team to coordinate a response and review plans from another viewpoint. The need to work collaboratively extends across many organisations and within one shift links need to be extended to care agencies, care home staff, families, wardens, paramedics, primary and secondary care.

Working in a Hospital at Home model distorts time; there are both pauses and periods of intense activity. An initial home visit to manage an acute illness may take hours, but this is in contrast to the ED admission, clerking, post take ward round and ward stay you are avoiding. Conversely, patients that focus their treatment escalation plans on community management often get to know the Hospital at Home team over multiple episodes and even complex situations may be managed quickly. A prolonged pause in initial home visits and the investment in bedside diagnostics, examination and candid conversations can save time for the whole system at a later date. Time also has to be invested in new team members and induction periods need to be prioritised. An induction can require months as many clinicians come from an acute setting with limited exposure to community contexts or an understanding of services available.

Remote monitoring of vital signs offers another chance to grow Frailty Hospital at Home teams, but is just one example of the technology that already compliments the multidisciplinary team. For it to add to the team's resources, remote monitoring is only useful if the trend of vital signs for that patient is appreciated, if their escalation plan is clear should vital signs change, and if combined with softer signs that may herald a deterioration. There is a careful balance required between using the clinicians' resources well and not overwhelming patients, carers and families with yet more tasks. It should generate the right response at the right time rather than just increase concern. Importantly, remote monitoring is needed alongside other hands-on support with important daily tasks important to promote recovery such as nutrition, hydration and rehabilitation.

So, in summary the 'big C' challenges of developing workforce within a Hospital at Home model are the need to work with courage, creativity, constant change, candid communication and curiosity. The opportunities for trainees within a Hospital at Home are vast and yet we are only just starting to see this being explored within the new Geriatric Medicine curriculum.

**Dr Amy Heskett**
Specialist SAS Doctor, Community Geriatrician & Clinical Lead for West Kent Urgent Care Home Treatment Service

# Risks, dogs, car sickness and keys: **Trainee reflections**

### IMT training in a community setting:
Dr Conrad Witek

**I was quite apprehensive to start working in the community. As an internal medicine trainee, I was at home in my familiar surroundings of the hospital. Unsurprisingly, I learnt a great deal. No CT scanner, but I had my stethoscope and pretty much everything else I could need in the boot of the car. No more writing plans in the notes for the nurses to follow, and a lot more doing - drawing up intravenous antibiotics, picking the Amlodipine out of a dosette box and even emptying the odd catheter bag.**

The first task I quickly learned was the skill of actually finding your patient. Gone was the convenient "bed 12", and instead crawling along in first gear, squinting at front doors.

I'm as big a fan as anyone for a lovely house name, but what happened to a good old fashioned house number? Wait, that one's got a key safe and a handrail outside the front door - surely it must be this one!

There's an innumerable number of funny stories, but a lot of the humour comes from the day-to-day quirks that you'll miss if you don't take a step back every so often. Trying to stay cool in a crisis during the hottest day of the year (not helped by Mrs Smith, who has the heating on all year round). "No, I would not like a nice hot cup of tea, but thank you very much for the kind offer" I say, as I untangle the ECG leads with one hand and pet her overly enthusiastic dog with the other. To top it off there's a nosy neighbour who has suddenly decided to start re-arranging their bins outside. I'm sure they're about to sustain a neck injury from the angle that they're peering over the front hedge.

Jokes aside, what a privilege it is to step into our patients' homes and care for them in the real world, outside of the augmented reality of a hospital with its artificial fluorescent lighting. Allowing them to be treated in the comfort of their own homes - and even more importantly die in the comfort of their own homes. It wouldn't be possible without such a dedicated team. No job too big or too small, from cannulas to clearing up the kitchen to collecting a prescription.

What did I miss about the hospital? Not much really. Your day is infinitely better driving through the countryside where you don't have the bells, buzzers and bowel movements of an inpatient ward (I should counter this with the fact that I have not worked in the community during the depths

of the British winter, where I expect my answer may be a little different). Not only is it great fun, it's a big part of the future of geriatric medicine.

Just make sure you don't get car sick before you apply for the job!

## Out of programme for clinical experience:
Dr Julianaa Raghu

**I am a SpR in Geriatric and General Medicine in South East London and have spent two years out of programme for clinical experience (OOPE) with the West Kent Home Treatment Service.**

Having spent all my training in hospital, two years in the community was very daunting to begin with, but I have learnt so much in this role - skills which I can transfer into my training role in the hospital. I found that the level of risk at home is higher than in hospital. Our patients are at risk wherever they are, and therefore you have to carefully share this risk with the patient and their families, which is something I did not appreciate while working in hospital.

I learnt very quickly that the best patient care involves working closely with the acute hospitals. The care provided at home is more patient-centered, as you are guided by the patient; however, in hospital, patients can find themselves on a conveyor belt of investigations and sometimes feel that they do not have a choice.

In hospitals you have everything close to hand, but this is not the case in the community. You have to really rely on your clinical judgement to make decisions, which is something hospital training does not prepare you for. There are a lot of training opportunities with weekly huddles, and you have the chance to train and support a wider workforce including the trainee Advanced Clinical Practioners.

The unknown can be scary, so having early exposure to community geriatrics is vital. I only knew about this service as I did this job as a Core Medical Training (CMT) rotation, so this exposure gave me an idea of what the job entailed. I feel that without early exposure it is difficult to recruit to the specialty.

The new geriatric curriculum has a lot of emphasis on community geriatrics, and if it is a part of a 4–6 month rotation trainees can meet their curriculum requirements and do not have to do any extra time. This post could also be incorporated into the General Medicine role, and trainees would be able to get workplace-based assessments completed, as it is still general medicine, and trainees are still leading an acute unselected take.

‘Community geriatrics not only involves reactive care, but also has a focus on proactive care, through which we raise the banner of preventative medicine and plan for the patient’s future.’

As part of the NHS Long Term Plan, every area should have a two-hour urgent community response (UCR), so the future workforce needs to be leaning more towards working in the community. Consultants in the hospital are looking to the community for support and GPs are looking for the next step up for support. We are in demand, although it may not look like it.

I don't know what the answer is, but from my own experience, I think if trainees had early exposure to the specialty - being mandatory, as a fixed rotation - then the workforce could adjust to being able to spend more time in the community.

Community geriatrics not only involves reactive care, but also has a focus on proactive care, through which we raise the banner of preventative medicine and plan for the patient’s future. It involves a lot of transferable skills between primary and secondary care, and therefore provides a valuable experience for trainees whose training is primarily hospital-based. I have thoroughly enjoyed my two years with the West Kent Home Treatment Service and I cannot wait to utilise the skills I have learnt in my future ongoing career.

## The first shift in community geriatrics:
Dr Amy Radcliffe

**Starting my first shift in community geriatrics, I was unsure what to expect. Outside the familiar sterile walls of the hospital and without the reassurance of imaging, bloods and regular observations, I initially felt out of my depth.**

However, I quickly adapted, learning both clinical and non-clinical tips and tricks; the skill of subtly checking whether the seat was damp before you sat down in a patient’s home, and dodging over-enthusiastic pets (try changing a catheter in sterile conditions when a chihuahua is trying to lick open leg wounds!)

Imagine my shock when, after deciding that IV antibiotics were indicated, I had to proceed to try and draw up the antibiotics myself – the Advanced Clinical Practitioner subtly laughing in the corner as I fumbled about with a giving set that I had not done since medical school OSCEs.

However, as my confidence and experience grew, I began to enjoy the freedom and variety of community medicine. One of my most poignant experiences was after reviewing a very polite patient at home, who was mildly confused with a complex surgical background and had acutely deteriorated. The decision was made to admit to the local hospital as per the patient’s and his wife’s wishes.

A week or so later, during my acute medical on calls at the hospital, I was called to review an agitated aggressive patient on the ward - and, yup, you’ve guessed it - it was the same patient. This previously extremely polite and pleasant man



‘Although we all know, and tell patients and families, that sending patients into hospital can cause or worsen delirium, to witness the stark deterioration first hand was very humbling.’

was now floridly delirious, pulling out cannulas and spitting at members of staff. After spending over 60 minutes trying to manage the situation, I reflected that although we all know, and tell patients and families, that sending patients into hospital can cause or worsen delirium, to witness the stark deterioration first hand was very humbling.

On the other hand, the positives of making a diagnosis with very limited investigations and the satisfaction when this is confirmed and the patient has improved, is much greater than you ever experience in the hospital. It is a real privilege to be invited into people’s homes and to see a glimpse of their lives and listen to the stories they have to tell.

Community medicine is similar to being a medical detective: using your skills to form a likely diagnosis but without the large comfort blanket that the hospital provides. I feel that as a medical trainee, this has been an invaluable experience, particularly dealing with risk and identifying which patients are appropriate to send in vs those who would be more appropriate to treat at home.

As we continue to see an ageing population that is becoming increasingly frail with complex co-morbidities, community medicine is a rapidly growing specialty that currently medical trainees have very little exposure to.

## Experience as a medical student:
Shona Mitchelmore

**I first started seriously considering a career in geriatrics when I was in third year of medical school. I was on a general medical ward, and I accompanied a geriatrics registrar to see a lady in her late 80s with dementia who was a so-called ‘social admission’.**

Although it would have been easy to have just written ‘medically fit for discharge’ in her notes and moved on, the doctor I was with helped her sit up in bed, refilled her water jug and drew her attention to the beautiful view out of the window. This was the first time I had seen that medicine could be like this and it excited me about medicine in a way that I had not experienced since I started university.

It was a little while after that that I first came across the field of community geriatrics and the Hospital at Home movement. For me, it made perfect sense, an opportunity for older patients to receive quality medical care while staying in their own homes and avoiding the pitfalls of a hospital admission. It was in the BGS magazine *AGENDA* that I first heard about the West Kent Home Treatment Service; I read an article from Dr Amy Heskett about her experiences working as a SAS doctor in the community and realising that that Home Treatment Service is down the road from where I grew up, I reached out to Amy and we arranged a week of shadowing.

I did not really know what to expect and I was quite nervous that I might not actually like community geriatrics after having told everyone that that was what I wanted to do! I needn’t have worried though; I found a deep satisfaction from caring for older adults in the community. I loved the balance of managing acute medical issues in the context of frailty, with the added twist of being in people’s homes and juggling dysfunctional key safes, narrow country lanes and enthusiastic dogs! It was certainly a challenge and required more flexibility and willingness to cope with uncertainty than with hospital, as you can never be fully sure what you are walking into.

Furthermore, although having access to point of care tests helped to quickly rule in and rule out differentials to aid in decision making, not having imaging meant relying more on the clinical picture and accepting a higher level of risk that the diagnosis might not be correct, and also that patients might deteriorate at home. It is a fine line to walk but one I found exciting and stimulating.

Although I found that doing home visits across half a county meant a lot of time spent on the road, and this could be frustrating and draining (particularly for someone who gets car sick!), I found it so rewarding simply seeing the look on people’s faces when we said that they did not have to go into hospital. Although some older patients may feel more comfortable being cared for in hospital, for a large proportion, it is a place that they fear that they will go into and never come out again. Not an unreasonable fear, particularly in the wake of the COVID pandemic.

It was satisfying to be able to care for them at home and to put measures in place to ensure that anyone looking after them in future would know what their wishes are. It was also affirming just how happy everyone tended to be to see you! One of my favourite memories was of a lady in her 80s with mild cognitive impairment who lived alone and had had a fall. I did all the history, examination and investigations (very exciting for a medical student - my normal role on placement was to open and close curtains!) and she was delighted to have someone to talk to and so pleased when she could do something correctly and help me with the examinations. She kept telling me ‘what a lovely lady’ I was, and told me to ‘drop in for a cup of tea’ any time!

Although working in the community can be daunting, I felt that I learnt a lot about pragmatic, caring decision making which is defined by the patient and their needs and that the community is not a controlled environment - and you have to be prepared to accept a bit of chaos.

### BGS Community and Primary Care Group

For more information and resources on working in the community or primary care, or to get involved in BGS work in this area, visit **www.bgs.org.uk/CPCgroup**

# Shaping our workforce agenda: Q&A with BGS Vice President for Workforce, Dr Amit Arora

**One of the strategic aims of the BGS is to support recruitment, retention and development initiatives that increase numbers of specialists in the care of older people and help existing staff to have the appropriate skills and support to deliver good care for older people in the right place at the right time. The BGS Workforce Committee oversees activities in this area. In this question and answer session, the BGS Vice President for Workforce, Dr Amit Arora, highlights the work that is being done to help strengthen and celebrate the workforce providing care for older people.**

## Tell us about the role of the BGS Vice President for Workforce

Although the workforce challenges in the NHS have been there for a while now, they have been increasing recently and are rightly receiving more attention. The BGS recognises that if we are to provide the right kind of care for older people, we must have the right kind of skilled workforce, with the right kind of attitude towards older people. There needs to be a focus on the multidisciplinary team that care for them. This is important nationally but also locally where consultants and other senior members of the team need to be supported to take those strategic leadership roles in developing such a workforce. One of the roles of the BGS Vice President (VP) for workforce is to influence this both within the BGS membership, but also outside of the BGS. This includes the Government and NHS leadership across the four nations, the Royal Colleges, General Medical Council (GMC) and other relevant agencies and organisations. We have been very successful in doing this so far.

One of our first goals was to identify workforce as a separate, bigger, strategic entity and situate it as one of the key priorities in the new BGS strategic plan. I took on the role in November 2021 and we quickly set up a brand new workforce committee and agreed a workforce work plan. The committee members come from across the multidisciplinary team, with geriatricians, consultants, GP members, junior doctors, Specialty and Associate Specialist (SAS) doctors, trainees, nurses, therapists and a medical student representative, and representation is sought from all four UK nations. The committee works to an agreed strategy, an annual work plan and links with all other Vice Presidents and senior officers in the BGS and beyond. The committee develops surveys, analyses them, produces reports and disseminates them to inform the members. We also inform and influence other organisations across the four nations. We support our members in issues related to recruitment, retention, education, career progression, development support and wellbeing. We also proactively seek responses to any queries form relevant bodies and feed into consultations and responses to workforce-related issues when these are brought to our attention.

## What do you feel are the biggest workforce challenges faced by BGS members

The key challenges for the workforce are that the population is ageing, and we don't have enough people in healthcare, domiciliary care or social care to deal with the growing demand in this complex area of work. Hence, we have a depleted and exhausted workforce across medicine, nursing and therapy as well as in social care - and these are all essential parts of effective and safe care for older people. If one of these is in deficit, the others can't function as efficiently. This then builds up pressure on the NHS because of frequent hospital admissions, delayed discharges, deconditioning, readmissions, waiting lists and potentially suboptimal care.

The information that we've analysed from workforce surveys by the Royal Colleges show there aren't enough doctors, there's a lack of consultants and lots of unfilled vacancies. For example, we noted that in Scotland, 40% of appointment panels did not go ahead because there were no applicants and the ones where there were applicants, some of them could not go ahead because either the candidate was not suitable, or inappropriately qualified, or the applicant withdrew the application. We've seen the same kind of picture in Northern Ireland.

Care of older people and related services are expanding – not just in acute care, but also in the community, with virtual wards, acute care at home, and care-home services. There is also expansion within the acute hospital, with more elderly care wards, orthogeriatrics and trauma and surgical geriatrics, etc. Because of the diversified roles that geriatricians are now adopting, like acute medicine and stroke, we need more geriatricians to do the core work of caring for older people with frailty, and this is highlighted in our recent report *More geriatricians* which can be found at **www.bgs.org.uk/moregeriatricians**.

## Can you give us a sense of what the BGS Workforce Committee is currently focusing on?

We've got a detailed workforce committee work plan with four key elements to it. First is recruitment, second is retention, third is expanding the skills base and the fourth is sharing solutions.

In terms of recruitment, as part of this we have been analysing the Royal College of Physicians (RCP) census data for 2021 and 2022. You can read our full analysis of the Royal College of Physicians (RCP) London consultant census here: **www.bgs.org.uk/GMworkforce22**. Following the 2021 census we met with the RCP and agreed with them to add some specialty-specific questions related to geriatric medicine, which arose from experiences and discussions with BGS members.

The RCP has been extremely helpful in producing specialty specific questions based on the regional distribution. We are building a relationship with the Royal Colleges and are in discussions about more questions for the 2023 survey. At the same time, we've also been busy in doing our own membership workforce survey for 2023, and we hope to share results from this soon.

To better understand the issues around recruitment, we also want to increase the information that we obtain from the Deaneries and the Training Programme Directors (TPDs), so we've developed the TPD survey, the results of which will also be available soon. We are asking for more geriatricians, which includes more training numbers for geriatric medicine, but are also focussing on how to attract more students, junior doctors and IMGs into the speciality. Similar work is happening in the field of retention, expanding the skill base and sharing solutions.

The BGS are also working hard to influence decision makers in the NHS and the Government through our various networks and working closely with organisations like NHS England, Department for Health and Social Care, Royal Colleges, GMC, and Community Rehabilitation Alliance to name but a few.

We have good representation from trainees in the speciality in our various workstreams and we value this immensely as our trainee registrars are the future of our speciality. We are also developing work around attracting doctors not in training posts, Medical Training Initiative (MTI) colleagues, SAS colleagues and medical students. This is in addition to engaging and attracting nurses and other allied health professional team members. At the BGS Spring Meeting we had special sessions dedicated to workforce that included SAS doctors and retired doctors' groups. We intend to do more solution-focussed sessions on workforce for future conferences. This special workforce issue of the BGS newsletter *AGENDA* is part of this initiative on workforce. So, we have been very busy but we also recognise that there is no overnight solution to the workforce challenge.

## What about International Medical Graduates (IMG) and SAS doctors?

A vast majority of our members and non-members who work with in geriatric medicine are IMGs and work in various SAS roles. The BGS is very supportive of SAS group of doctors, who form one of the biggest sections of the workforce of non-consultant geriatricians.

We have an active SAS group. Many SAS doctors wish to proceed to Certificate of Completion of Specialty Training (CCST) to become consultants; there are some who may want to do this in future, though are not there yet; and finally there are some who wish to stay as SAS doctors. We try to support all these colleagues in whatever way they wish to shape their careers. For example given the introduction

## Key workforce publications from the BGS

**The case for more geriatricians: Strengthening the workforce to care for an ageing population**
www.bgs.org.uk/MoreGeriatricians


This report is intended to start the conversation about the workforce needed to provide high-quality care for the ageing population with increasingly complex needs. It explains why training, recruiting and retaining geriatricians should be a priority, estimates how many geriatricians are needed to provide safe and effective care for older people, and outlines some of the structural barriers that currently prevent recruitment. It concludes with six calls from the BGS for Governments across the UK.

**The geriatric medicine workforce 2022**
www.bgs.org.uk/GMworkforce22


This report looks at data collected by the Royal College of Physicians on the consultant and Higher Specialty Trainee workforce. It paints a stark picture of the challenges facing older people's healthcare.

Older people's healthcare is delivered by a multidisciplinary team across primary, secondary and community settings, and increasingly specialist expertise is needed to contribute to care closer to home. In order for the older people's healthcare workforce to be adequately resourced, we need to consider the whole workforce and ensure that older people are placed at the centre of workforce planning.

of specialist doctor grade we informed the wider BGS membership in an article for *AGENDA* about the changes.

And to give them their due recognition with the GMC, for example, we have been recently successful in getting them a two-month extension for the CESR application in the in the in the pre-2023 pathway. These are small steps but contribute towards a better future for colleagues. We are also linking in with the Royal Colleges of London, Edinburgh and Glasgow to support the work on attracting doctors on the Medical training Initiative Scheme into the specialty. BGS are supporting these colleagues on screen/off screen as well as in through official channels.

## What are the priorities for the wider multidisciplinary team?

The BGS Nurses and AHPs (NAHPs) Council is the representative group for these professions, and the Chair of NAHPs Council sits on the Trustee Board, who are involved with the highest level decisions at the BGS. We are trying to obtain some more data around workforce for this sector, as it is not routinely produced as it is for consultants. We are keen to support our multidisciplinary team colleagues in their career progression, from Advanced Nurse Practitioner (ANP) to Advanced Clinical Practitioner (ACP), enhanced practitioner and consultant practitioner roles. We particularly value this particular part of the workforce because of the essential work that they do both in hospital and outside of hospital.

The BGS is proud to have a diverse multidisciplinary membership base, and while there are currently more doctors, the numbers of members from other professions are steadily increasing. This is encouraging and means we can we all learn from, complement, and support each other in achieving the BGS aim of 'Improving healthcare for older people'.

## What about the work around expanding the skills base for non-specialists?

As mentioned earlier, this is within the workforce plan, and involves increasing the well of skills within the NHS. BGS has developed new frailty e-learning modules for doctors and senior nurses in Tier 3. The BGS also co-awards the Diploma in Geriatric Medicine (DGM) exam which is designed for non-specialist clinicians who want to evidence their expertise in frailty and healthcare for older people. We are working to attract more healthcare professionals to participate in this examination, and it is now open to nurses and AHPs as well as doctors.

In addition, we aim to work closely with various teams and organisations like the National Frailty Academy, who provide education and training to non-registered staff (for example domiciliary care or health care assistants) for Tier 1 and Tier 2 training. We hope that all these will contribute to the expansion of these portable and transferable skills base in due course and will also help them in their career progression.

## Can you tell us more about how the BGS is sharing solutions to workforce issues?

At the recent Trustee Board meeting we had a special workforce session in which we discussed the four key areas of recruitment, retention, expanding the skills base and sharing solutions. This was split into three main groups – doctors, nurses and AHPs, and non-specialist workforce numbers.

We also hope that this issue of *AGENDA* will give members the opportunity to share and learn from colleagues, and find out how others are thinking creatively to cope with some of the current workforce dilemmas.




**A Certificate of Eligibility for Specialty Registration (CESR) is intended for doctors that haven't been through a national training program but have gained the expected level of experience to become a consultant in that speciality. The process involves compiling evidence of relevant experience equivalent to a doctor in a national training scheme and independently submitting this evidence to the General Medical Council (GMC).**

There is good evidence from workforce surveys that the East Midlands has a lower number of geriatricians per capita compared to other areas of England. In response to this and looking for ways to adapt training to meet local candidates needs, University Hospitals of Derby and Burton (UHDB) NHS Trust have developed a thriving CESR training programme, with three consultants appointed from this scheme to date.

To support the trainees during their training, one of our consultants has taken a lead, and meets with our trainees on a regular basis to monitor their progress and mentor them.

Dr Hannah Street has recently completed her training and has been appointed as a consultant in the Trust. She reflects on her training via the CESR route:

"Following completion of Core Medical Training (CMT) and on entering a speciality training scheme it became apparent that travelling across the region to different hospital sites for placements was going to be extremely difficult due to personal circumstances. I was at a crossroads in my career, knowing that I wanted to continue to train and progress, but feeling that remaining in training in medicine wasn't going to be compatible with my life. I had no doubt that I loved medicine and was passionate about Geriatric Medicine as a specialty.

"I was made aware of the CESR process at this point and the department created a specific CESR trainee job role/plan. This included stroke medicine, palliative care, continence clinics as well working on the wards. There are also plenty of managerial and research opportunities that are available within this role that help to ensure that a well-rounded wealth of experience is achieved prior to applying through the CESR route. Being established in a department that are aware of your training needs means that your senior colleagues are able to support you along the way and can advocate for you at the submission point of CESR to the GMC. The biggest driver for me throughout the CESR pathway has been the colleagues that I have had the opportunity to work alongside.

"The knowledge and skills they impart, as well as the exhibiting such passion for the speciality is something that I feel has helped to enrich this journey more than anything. It has confirmed to me that their values are in line with mine and that the qualities they exhibit on a daily basis are how I want to practice.

"The key points to consider when thinking about taking the CESR route are: are you in the right environment/hospital and do you have the useful links to ensure that all aspects of the curriculum can be fully covered? Having an awareness that everything you do needs extensive evidencing from the start is key, as collecting the documentation as you go along will help the application. Being proactive and organised makes the process smoother and the final submission of the CESR portfolio less challenging.

"Having a good understanding of the curriculum means that it can be possible to allocate time periods to focus your attention on different curriculum subjects that need addressing.

"Focussing your job plan around set allocated times in the week where different activities are completed can also set out expectations for your job plan with your department. This can then help them to be able to support you in achieving the competencies and experience required. There are numerous aspects of speciality medicine that needs evidencing and having the foresight to organise these into manageable sections with an appropriate time frame in mind will help you progress. Due to the nature of acquiring a CESR all the evidence is presented at the end of the process, but this has to thoroughly cover the breadth of the syllabus in detail. The quality of the evidence submitted must be high and is meticulously checked prior to submission to the board for consideration. Showing that you have, throughout the process, been reviewed and developed in your practice with supervisor reports will help to reflect clearly the experience you have gained. This regular contact with senior supervisors will also aid them in their ability to them provide the consultant reports that are requested as part of the CESR submission process."

There is extensive information on the GMC website about the CESR process as well as courses on applying through CESR route from the Royal College of Physicians.

# I have retired!
## What next?

**After 40 years of NHS service and 30 years as Associate specialist in Medicine with interest in care of the elderly medicine (Functioning as an Independent clinician), SAS member Dr Sandip Raha retired in June 2022. Here he describes what retirement means to him, and how he continues to share his passion and expertise in Parkinson's disease with new groups.**

There was a discussion about retirement planning at the BGS Spring Meeting in Edinburgh back in May, highlighting how ill-prepared senior clinicians can be for this milestone in life. Often they are so engrossed in their clinical responsibilities, that working becomes a second habit and it is difficult to give up or even contemplate leaving.

I retired and came back part time (three days a week) in 2017 and fortunately my Health Board in Wales agreed with everything I had planned in terms of returning. This included days of the week I proposed to work, days in clinic, and I agreed to no on call or ward commitment. Although, like many others, during the peak of the COVID-19 pandemic in 2020 I did work briefly on the wards for three months, with trepidation.

Since full retirement I have been developing and practising my love of clinical life - Parkinson's disease and management with patients in India. I spent three months in India last winter, lecturing about Parkinson's disease and frailty to clinicians in Kolkata, rural Bengal and to the local population in the local language. My mission is to raise awareness of this chronic neurodegenerative disease and its understanding in India, especially in my home state of Bengal (Kolkata).

I have been doing online and WhatsApp consultations on many of my Parkinson's patients for last three years and it has been very much appreciated and acknowledged. Most of these consultations are voluntary. During my stay in India, I did see some of my patients face-to-face in ad hoc organised clinics (outside hospital). Most of my patients and family find the 30-45 minute consultation time especially useful, and unlike anything they can get locally from neurologists.

My clinical practice in India is facilitated by my registration with the medical council of India, which goes back 42 years! Once you are registered there with your primary qualification you have lifelong registration. I recently found my registration certificate online from 1978!

I am still a Royal College of Physicians (RCP) Fellow and BGS Member, as well as registered with the General Medical Council (GMC), including CPD updates.
Other clinical interests during my last visit to India included raising awareness of frailty in medicine and geriatric medicine to young scientists and clinicians at Indian Institute of Medical research in Jodhpur, Rajasthan (Northwest India), where I was guest speaker for an afternoon workshop. It was encouraging to see young professionals under guidance of senior clinicians, professors and scientists keen to understand and develop concept of frailty and its outcome in older adults.

I hope that I stimulated them to work on older population in villages of Northwest India to measure frailty and follow outcomes, to quantify health care needs in future for this group of over 65s, which may help in planning health care in future years, when the Indian Council of Medical research advises the government on health needs and policy.

I hope to continue this work as well as my clinical interest in Parkinson's disease on my future visits to India.
I have recently also joined as external assessor for a new online Diploma / MSc course on stroke care being launched by Buckingham University, UK.

I keep myself busy in local Indian community work of festivals, celebrations and art events in Cardiff among people of Indian origin which has been my love for last 30 years.

So, keeping brain and community involvement is the key for me in addition to reading, walking, holidays with my wife. Things you always wanted to do but kept in backburner can be burnt now!

**Dr Sandip Raha**
Retired Care of Elderly physician, Cwm Taff Morgannwg University Health Board, Bridgend, Wales
**@sandipRh**

### Join the BGS Retired Members' Group

If you're retired, thinking about retirement or want to connect with our network of retired BGS members, please email **m.stewart@bgs.org.uk**. The group holds regular virtual meet-up sessions, organises social gatherings and trips away, and has its own quarterly email newsletter.






### BGS Meetings in early 2024: Save the date

- **Yorkshire and Northern Region Spring Meeting**
  **6 February 2024**
- **South East and South West Thames Region Spring Meeting**
  **22 February 2024**
- **Wessex and South West Region Spring Meeting**
  **8 March 2024**
- **Movement Disorders Meeting**
  **15 March 2024**
- **East Anglia and Thames Valley Region Spring Meeting**
  **19 March 2024**
- **BGS Spring Meeting 2024**
  **22-24 May 2024**

### Notice of AGM

The BGS AGM 2023 will take place online at 1-2pm on Friday 17 November. Joining details and papers will be made available closer to this date.

### Vacancy: Deputy Honorary Meetings Secretary

**Self-nominations are invited for the post of Honorary Deputy Meetings Secretary, to take office from November 2023.**

**The Honorary Meetings Secretary and Deputy Honorary Meetings Secretary work together to produce meetings and plan the Society's strategy for conference provision for the future. The successful applicant will take up the role of Deputy Honorary Meetings Secretary for 2 years followed automatically by the role of Honorary Meetings Secretary for a further 2 years.**

Nominations should be sent to the incumbent Meetings Secretary (via email to the Director of Learning and Professional Development at **g.collingridge@bgs.org.uk**) by 27 October 2023. For a full description of the role and responsibilities, see **www.bgs.org.uk/vacancy-deputy-honorary-meeting-secretary**

### New BGS Deputy Honorary Treasurer

We are delighted to announce that Dr Divya Tiwari is to become the Society's new Deputy Honorary Treasurer. She will join the BGS Finance Committee, working with Dr Liz Lawn who takes over as Honorary Treasurer from Professor Sarah Goldberg in November.
Divya is a Bournemouth-based Consultant Geriatrician and has previously served as BGS Meetings Secretary. She will take up the post of Deputy Honorary Treasurer at the AGM on 17 November.

BGS

# Autumn Meeting 2023

**22-24 November**

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## Programme highlights:

- OncoGeriatrics (in association with The Royal College of Radiologists and The International Society of Geriatric Oncology)
- Primary and community care
- Urgent care of older people
- Orthogeriatrics
- Safe prescribing

View programme and register at www.bgs.org.uk/Autumn23