AGENDA

British Geriatrics Society
Improving healthcare for older people

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Showing YOU care

The evolution of **education and training** in geriatric medicine

PLUS

- **Virtual Wards**
- Tackling overprescribing
- **World Falls Guidelines**

AGENDA
Publications information

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

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

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On the
AGENDA

President's *Message*

It was with great sadness that we received the news of the death of Queen Elizabeth II in September. During her 70-year reign as our Monarch, she epitomised a life of service. Her dependable fortitude in putting duty ahead of personal choice has been recognised in all four nations, the Commonwealth and across the world.

I was particularly struck by her message to the nation in April 2020 at the onset of the COVID pandemic, reflecting on her lived experience of adversity and encouraging us to move forward, positively supporting our communities. We have written a letter of condolence to His Majesty the King. As Prince of Wales, he has served as our Patron of BGS for many years, and we wish him a long and successful reign as King Charles III.

I am now approaching the end of my term as BGS President and wanted to reflect on the tumultuous past few years. When planning to take up this role, I had hope to influence and network with other speciality leads to improve training and education for all those caring for older people. I also aimed to broaden support for our members, embracing flexible working and enhancing our offer to develop future leaders. Our Society strives to continually build on the strong foundations of geriatricians by extending, welcoming and evolving into a truly multidisciplinary organisation, supporting all those who work in healthcare with older people. Our goal is to improve education and training, drive up standards in quality of care, build academic rigour into all that we do, and finally to influence policy in the delivery of healthcare for older people. It is an ambitious ask and we cannot let up in our efforts.

Presidency in the time of COVID has been challenging but I have been lucky to be able to contribute to the BGS and its influencing voice in important decisions on policy. It has been more difficult to build face-to-face networks, and as meetings and conferences return in person, this will doubtless be redressed. I am, however, proud of the ability of the BGS to adapt over the course of the pandemic with its emphasis on supporting our members caring for our patients.

It was salutary to read our previous President, David Oliver's column within the BMJ referring to the impact on his own personal health and career of the challenging period of the last 2 ½ years. I join with you all in wishing him all the best for a full recovery.

In the past couple of months, we have published two important documents:

Bringing hospital care home: Virtual Wards and Hospital at Home for older people

It is clear to all working in the NHS that to achieve our ambition of delivering more care closer to home, we need to build and develop our community resources. All four nations in the United Kingdom aim to offer Hospital at Home services for some older people living with frailty when they have an acute crisis. Our members asked us to provide clarity over the policy of introducing virtual wards in NHS England and within this document we review the evidence and provide tips for newly developing teams. Policy makers do need to understand that this is not a quick fix and will require a trained workforce and sustained funding. It will only succeed as part of a broader effort to build resources for post-acute care and rehabilitation in the community. The ideal model would also have emphasis on early intervention in the population to improve disability-free life expectancy and minimise the impact of frailty. You can read more about this new report on page 4 or by visiting **www.bgs.org.uk/virtualwards.**

The geriatric medicine workforce 2022

Workforce might be described as the elephant in the room and the lack of a robust workforce plan for the health and social care sector is a huge concern. We seek to understand our current medical workforce situation through this new report. Our analysis was based on the Royal College of Physicians (RCP) London census of all consultant physicians and higher specialty trainees. Please have a read and do all you can to influence those interested in training in our specialty in your own workplaces, through delivering medical and nursing student teaching and in your Deaneries. We have plans to meet at national level with Health Education England and NHS Scotland to encourage an increase in training numbers from medical students onwards. We will report on our next steps in this area in due course.

Don't forget that undergraduate health and medical students are eligible for free BGS membership, so please spread the message and help us to attract a new generation of geriatricians, nurses and AHPs to the specialty.

I want to finish with a list of thanks:

Firstly, to you all for the work that you do across the United Kingdom and beyond.

Secondly, to the superb BGS staff team who have been an enormous support to me as President and to wider membership across the pandemic, led by our Chief Executive Officer, Sarah Mistry.

Finally, a huge thanks to those members who are contributing to our society in many, many different roles and across the Trustee Board, all in voluntary capacities and without whose efforts we would be unable to deliver against our strategic objectives.

A special mention for the support given to me by the current President Elect Adam Gordon. Adam is well known to many of you and his energy and enthusiasm have been enormously helpful over this difficult period.

I know he will be an outstanding incoming President and I am also grateful that he will have the support of Professor Jugdeep Dhesi as she succeeds him as President Elect. The future of the Society is in great hands but in the meantime I hope to see as many of you as possible in person in November in London.

Dr Jennifer MA Burns
President, BGS
@Burns61Jenny

'Our goal is to improve education and training, drive up standards in quality of care, build academic rigour into all that we do, and finally to influence policy in the delivery of healthcare for older people.'

Incoming **BGS Presidents**

As Dr Jennifer Burns approaches the end of her term as BGS President, she prepares to hand over the reins to the current President Elect.

At a handover ceremony on the final day of the BGS Autumn Meeting, Professor Adam Gordon (*pictured left*) will formally take over from Dr Jennifer Burns as BGS President. He will serve in this role for a two-year term, until November 2024.

We invite all those attending the Autumn Meeting to join us for this special occasion, which will take place at 4pm on 18 November (London ExCel and online), and also to thank Dr Burns for her outstanding leadership of the BGS for the past two years, during an incredibly difficult time for both our members and for older people.

President Elect Elections

During the Summer, we held elections for the next BGS President Elect. Four oustanding candidates - Dr Jugdeep Dhesi, Dr Mark Roberts, Dr Emma Vardy and Professor Michael Vassallo - stood in the election, which was eventually won by Dr Jugdeep Dhesi (*pictured right*), who has since also become a Professor.

Professor Dhesi will take office in November 2022 for a two-year term, supporting Professor Adam Gordon as President. After this, she will serve a further two-year term from November 2024 to 2026 as BGS President, succeeding Professor Gordon in the role.

Bringing hospital care home

A first-of-its-kind BGS report examines the current landscape in terms of Virtual Wards and Hospital at Home services for older people and offers advice and experiences in setting up such a service in the community.

The BGS recently launched a new report, *Bringing hospital care home: Virtual Wards and Hospital at Home for older people*. This publication explores the potential benefits, limitations, and current scientific evidence to be considered when providing a safe, effective, and person-centred alternative to hospital inpatient care for older adults.

It also highlights how 'Virtual Wards' are being funded and implemented. It explains the various definitions of the term 'Virtual Wards' as used in different parts of the UK and describes the face-to-face care delivered by a multidisciplinary team, combined with some remote monitoring.

Alongside the benefits of treatment, hospital stays can expose older people to risks such as deconditioning, delirium, and hospital-acquired infections.

For some people, receiving hospital-level treatments and rehabilitation at home has the potential to reduce the likelihood of these associated conditions without negatively affecting patient safety or access to specialist healthcare professionals. Virtual Wards aim to provide urgent access to relevant blood tests, ultrasounds and hospital-level diagnostics.

This report summarises the current landscape on Virtual Wards and provides advice for decision-makers looking to set up such services for older people living with frailty.

Recent scientific research has provided some evidence that hospital-level care in an individual's home environment may improve their care experience and outcomes and deliver benefits for patients, carers and health and care systems.

The evidence base highlighting the potential benefits of Virtual Wards is growing but caution is needed when considering widespread implementation.

The report recognises that this type of care will not be suitable for all patients and not all older people with acute conditions will want, or be able, to be cared for in such a service.

'Honest communication with patients and families about how the service works and what to do if the patient's condition deteriorates is vital to operating a successful service.'

For some patients, hospital will remain the safest place for them to be. However, feedback from older people using existing virtual ward services shows that many people welcome the option of receiving hospital-level care in the comfort of their own home, supported by family care and visiting professionals.

Honest communication with patients and families about how the service works and what to do if the patient's condition deteriorates is vital to operating a successful service.

Dr Jennifer Burns, BGS President, commented: "In my work as a hospital-based geriatrician, I regularly see older patients who would potentially benefit from access to hospital-level care in their home environment. I welcome the initiatives to develop 'Hospital at Home' and 'Virtual Ward' models across the UK. It will be important to evaluate these, in the hope of strengthening the current evidence base. Virtual Wards for older people who need acute-level care will be a useful addition to the range of services available in community settings and, over time, will help to alleviate some of the pressure on hospitals."

View and download the full report at www.bgs.org.uk/VirtualWards

BGS Membership *Update*

Most of our members will be up for automatic renewal of their membership for 1 January 2023, so please keep a look out for your renewal reminder email during the first week of December.

Your membership will automatically renew but there will be a call for action to those who wish to apply/reapply for a discount and for overseas members to make payment for their membership fee.

As BGS membership is on a 12 month rolling membership model, not all our members will be renewing at this time but you will still receive a renewal reminder email around 30 days prior to your membership automatically renewing.

Membership fees have been frozen since 2020, and for 2023 depending on the AGM, there will be a less than inflation increase. This means most members will see their membership fee increase by no more than 2.5%. This equates to £3 or less for most BGS members.

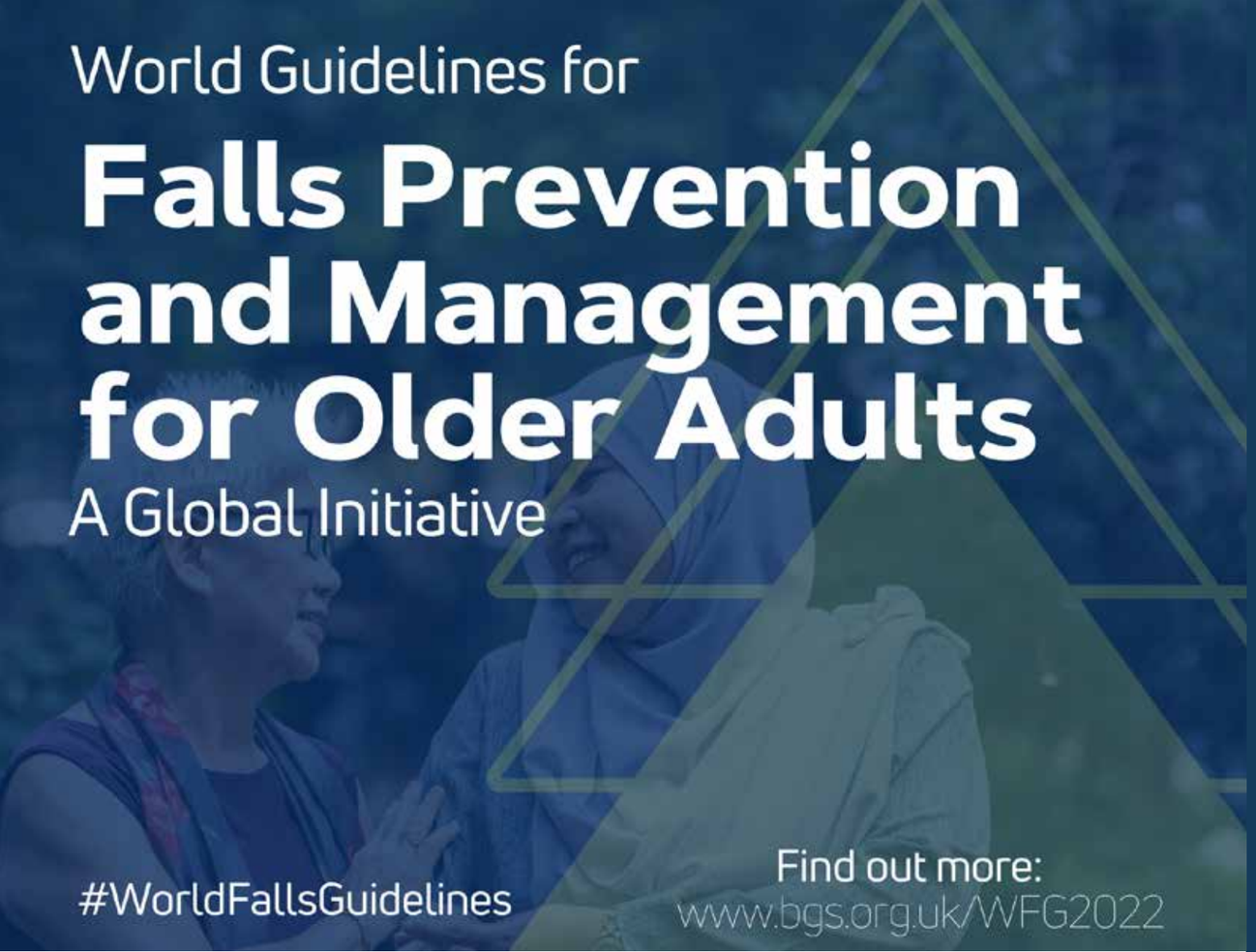
Please remember to keep your details up to date, and remind yourself of the membership discounts for parental leave, retirement and less than full time working patterns.

Member benefits

Don't forget to make full use of all the member benefits you are entitled to through your BGS membership. These include:

- Discounted fees for BGS events.
- Online subscription to our scientific journal *Age and Ageing* (available with most membership categories).
- The chance to network with other specialists and experts in the care of older people face-to-face and via our members' directory.
- Membership of various Special Interest Groups (SIGs) within the Society that focus on specific conditions, at no extra cost.
- Access to best practice guidance on topics such as diagnosing and treating frailty or commissioning services for care homes.
- A regular newsletter, e-bulletin and blog to keep you updated on the latest news and events.
- Entitlement to apply for a grant for relevant educational activities for eligible members.

Please contact membership@bgs.org.uk with any queries about your membership, or log in and manage your account online at www.bgs.org.uk



The World Guidelines for Falls Prevention and Management for Older Adults: A Global Initiative were published recently in *Age and Ageing*. These guidelines were developed by the World Falls Task Force, which assembled 96 multidisciplinary experts from 39 countries across five continents, with representation from 36 scientific and academic societies.

The World Guidelines for Falls aim to provide a framework and expert recommendations to healthcare and other professionals working with older adults on how to identify and assess the risk of falls. They recommend which interventions, alone or in combination, should be offered to older people as part of a person-centred approach.

Falls become increasingly common as we get older. People aged 65 and over have a 30% chance of falling at least once a year and this increases to a 50% chance of falling at least once a year in those aged over 80. Although some falls may appear to be minor evemts, the human impact of falling can be devastating for older people from a psychological and physical perspective. Falls can result in loss of confidence, loss of independence, pain, injury, depression and even death.

The Global Burden of Disease study reported nearly 17 million years of life lost from falls in 2017. The number of falls and related injuries is likely to increase, partly as the global population of older adults grows, but also because of the rising prevalence of multimorbidity and frailty. It is therefore highly significant that falls experts from across the globe have come together to agree and document guidelines for healthcare professionals to use in the prevention and management of falls.

Expertise and insights from falls specialists, scientific and academic societies, alonside patient and carer feedback, have contributed to an extensive three-year process, culminating in the publication of these peer-reviewed guidelines. The worldwide and multidisciplinary nature of this group of experts and stakeholders makes them truly groundbreaking and relevant for a global healthcare audience.

Professor Rowan Harwood, Editor of *Age and Ageing* journal, commented: "We are delighted to publish the 'World Guidelines for Falls Prevention and Management for Older Adults' in the British Geriatrics Society's academic journal, *Age and Ageing*. Publishing such guidelines for the benefit of clinicians worldwide in a prestigious, peer-reviewed journal brings them to the attention of a global audience, informing future policy, practice and commissioning decisions. Congratulations to the 96 contributing experts for this landmark publication."

Professor Tahir Masud, Past President of the British Geriatrics Society and part of the World Falls Task Force, added: "Along with multidisciplinary colleagues from across the field of geriatric medicine, I was honoured and excited to launch the World Guidelines for Falls Prevention and Management for Older Adults at the 18th International Congress of the European Geriatric Medicine Society on 30 October. We are privileged to be joined by world-leading expert clinicians, researchers, and academics for the launch and publication.

"Achieving a global consensus on best practice has the potential to transform the prevention and management of falls worldwide and to have a real impact on quality of life for older people."

Key messages from the new guidelines

Key message #1

The world's population is ageing. Falls and related injuries are increasingly common, making their prevention and management a critical global challenge.

Key message #2

Many falls can be prevented. Fall and injury prevention needs multidisciplinary management.

Key message #3

Engaging older adults is essential for prevention of falls and injuries: understanding their beliefs, attitudes and priorities about falls and their management is crucial to successfully intervening.

Key message #4

Managing many of the risk factors for falls (e.g. gait and balance problems) has wider benefits beyond falls prevention such as improved intrinsic capacities (physical and mental health), functioning, and quality of life.

Key message #5

Estimates of risk of future falls can be done by trained clinicians with simple resources.

Key message #6

Multifactorial interventions (i.e. a combination of interventions tailored to the individual), when delivered, are effective for reducing the rate of falls in high-risk community-dwelling older adults.

Key message #7

In care home and hospital settings, all older adults should be considered as high risk and a standard comprehensive assessment with multifactorial interventions should be considered.

Key message #8

Vitamin D supplementation to prevent falls should be reserved for those at risk of vitamin D deficiency.

Key message #9

Modification to the approaches for assessment and interventions may be needed for older adults with certain medical conditions associated with an increased likelihood of falling.

Key message #10

Application of some of these recommendations may need modification to meet the needs of older adults in settings and locations with limited resources such as Low and Middle Income Countries (LMIC)

View the World Guidelines for Falls Prevention and Management for Older Adults: A Global Initiative at **www.bgs.org.uk/WFG2022**

THE GERIATRIC MEDICINE WORKFORCE 2022

Read our analysis of the latest figures at
www.bgs.org.uk/GMworkforce22

A startling recent analysis from the BGS reveals that there are not enough healthcare professionals being trained to address the growing demands of an ageing population.

In Septmeber, the BGS published a report examining data collected by the Royal College of Physicians (RCP) on the consultant and Higher Specialty Trainee geriatric medicine workforce.

This data, which was collected between 2019 and 2021 as part of the RCP's annual workforce census, demonstrates the staffing challenges facing older people's healthcare. Despite the growth in medical student places, there are not enough specialist healthcare professionals being trained and retained to meet the needs of the population as it ages.

The BGS's geriatric medicine workforce 2022 report uses census data to give a snapshot of geriatric medicine consultants by age, gender and ethnicity. It calculates the number of consultants per head of the population, thereby highlighting parts of the country that are particularly poorly served in terms of senior expertise.

It shows that consultants and trainees in geriatric medicine are more likely to work less than full time than other specialties, and that they also undertake a larger share of general medicine roles in hospital than their colleagues in other specialties.

The overall shortfall of staff is revealed through the survey, showing that more than two thirds (68%) of geriatric medicine consultants report locum staffing vacancies within their Trust.

Nearly half said that they had unsuccessfully tried to recruit a consultant in the last two years. It takes an average of 16 years from entry to medical school to train a consultant geriatrician, meaning that even a substantial increase in the number of medical training places will take many years to make an impact on this shortfall.

The nature of the rapidly ageing UK population means the NHS cannot simply wait for new geriatricians to be trained. The BGS's new report advocates for practical solutions to be developed to support and empower the current workforce to care for the older population.

Such initiatives must focus on the recruitment, retention, development and support of the specialist multidisciplinary workforce across different care settings.

In addition to this, there needs to be encouragement, support and training of healthcare professionals from other specialities to look after older populations more effectively. Older people comprise the NHS's largest user group and, with the exception of those involved in child and maternity services, all healthcare professionals will be likely to care for older people more than any other population group. It is therefore vital that they have an understanding of frailty and other complex conditions that affect older people.

Dr Jennifer Burns, BGS President, said: "Our analysis of the Census data from the Royal College of Physicians confirms that there are not enough geriatricians for the current and future care needs of the older population."

"A substantial increase in the number of medical training places is sorely needed but will take many years to come to fruition. In the meantime, it is essential that there is planning and action to make the most of the existing workforce, and that healthcare professionals are properly supported after the gruelling years of the COVID pandemic."

Dr Amit Arora, BGS Vice President for Workforce, commented: "Care for older people is best provided through the expertise of a multidisciplinary team."

"The RCP Census data provides an illustration of the shortfall of consultants and higher specialty trainees in geriatric medicine and shows how working patterns are changing.

"If the NHS is to be prepared for the demographic reality of an ageing population, it must use a range of means to support the recruitment, retention and development of specialists across the different professions caring for older people and recognise the need to skill up the wider workforce too."

Are you involved in providing rehab?

The BGS is currently planning some work around the provision of rehab and intermediate care services and we need your help.

Please let us know if you are happy to be included on a list of BGS members involved in providing this type of care and would be willing to help us with this work in the coming months.

Members from across the multidisciplinary team would be welcome. If you are interested in being involved, please email Jo Gough at **j.gough@bgs.org.uk**

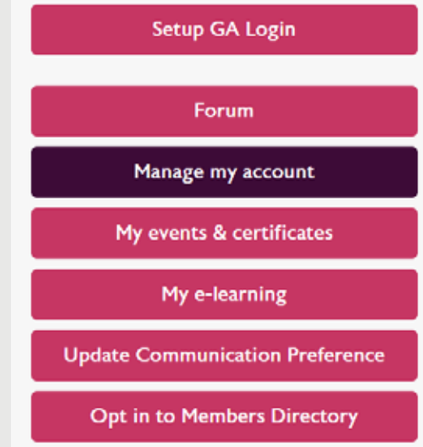
Join a BGS *Special Interest Group*

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

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

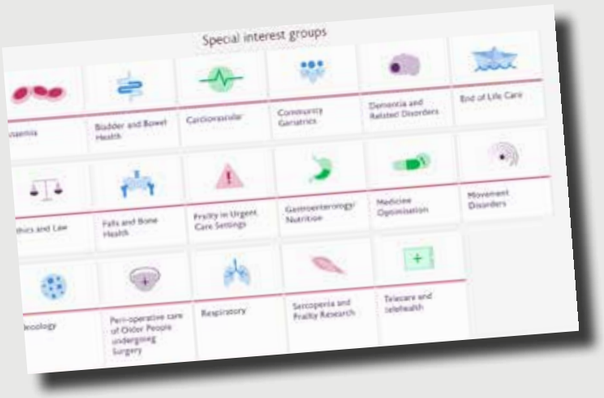
You can join a SIG via the BGS website in a few simple steps!

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



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

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



A NEW Geriatric Medicine *Curriculum*

The new Geriatric Medicine Curriculum was introduced earlier this year, which has implications for all Geriatric Medicine StRs, Internal Medicine Trainees and Foundation Year doctors who were not in ST7 in August 2022. Many trainees will doubtless have queries and challenges around exams, training and progression, and the BGS has assembled resources and information to help clarify the changes and support current and future trainees.

"The purpose of the Geriatric Medicine specialty training curriculum is to produce doctors with the generic professional and specialty specific capabilities needed to take overall responsibility for management of patients presenting with frailty, falls, dementia, delirium, stroke, declining mobility and functional impairment, polypharmacy and multiple co-morbidities. Such doctors will be qualified to practise as specialist consultant geriatricians, entrusted to deliver services for frail older people within hyper-acute, in-patient, out-patient and community settings. They will have the skills required to address the challenges of frailty, complex co-morbidity, different patterns of disease presentation, slower response to treatment, uncertain prognosis, end of life and requirements for rehabilitation or social support demanded by the demographic changes of population ageing. Doctors who complete training satisfactorily will be eligible for a CCT and can be recommended to the GMC for inclusion on the specialist register. At completion of training they will be capable of independent unsupervised practice and will be eligible for appointment as an NHS consultant."

Curriculum for Geriatric Medicine Training (2022), Joint Royal Colleges of Physicians Training Board

There were several driving forces for the recent changes to the Geriatric Medicine Curriculum. From a training perspective, there was a feeling that the existing curriculum was very tick-box based, and didn't offer the opportunity to holistically assess where a trainee was in their training journey. From a General Medical Council (GMC) perspective, there has been a general drive towards addressing generic professional capabilities. These capabilities are intended to more realistically reflect the educational basis of a training curriculum.

A final driver has been a demographic change in the patient base, especially older patients, who are more frequently presenting with multimobidity and frailty. This requires a broad base of training alongside specialty training.

What has changed?

The key changes in the 2022 Geriatric Medicine curriculum include:

- A move away from a 'tick-box' approach towards a more 'holistic' assessment of learning outcomes.
- A smaller number of capabilities in practice (CiPs), which sit alongside an updated and expanded set of generic capabilities (as required by all doctors and set out by the General Medical Council).
- The new curriculum for geriatric medicine higher specialty training is designed to be completed in 4 years of full-time training (plus an additional 6 months for stroke training if this path is chosen). However there is flexibility to complete it at a faster or slower pace as necessary.

All trainees who were not ST7 in August 2022 will be required to transition to the new curriculum.

Why do we need a new curriculum and why do we need to switch as existing trainees?

With the change in structure of physician training, including the introduction of internal medicine training (Internal Medicine stage 2 training replaced General Internal Medicine training as of August 2022), the length of time in higher specialty training has changed and this provided the ideal opportunity to revise the curriculum.

The old curriculum was devised in 2010 and the shape of geriatric medicine has changed hugely in that time. By taking this opportunity to modernise our curriculum it better represents the exciting new facets of geriatric medicine which have developed since the last curriculum.

There is also a drive from the GMC for all physicians to be competent in generic capabilities.

While we understand the change in physician training structure does not directly impact existing ST7 trainees we feel the new curriculum also reflects the increasing complexity of our patients and will better prepare all of our trainees for qualification as consultant geriatricians.

How will the new curriculum affect trainees and what are the big differences?

The new curriculum affects all trainees who were not in ST7 when the transition began in August 2022. As previously mentioned, the main difference for trainees in the move away from the current competency-based curricula to a holistic assessment of high-level learning outcomes. There are also changes in the way trainees are assessed, and these are outlined in more detail in the table on the next page.

The new curriculum has been designed to focus on trainees' competencies, and as such has a reduced administrative burden for trainees, and is based on the current needs of services and patients. It has been developed with a lot of input from trainers and trainees, including those from the BGS, and we believe it is a positive step towards ensuring trainees have the tools to be the consultants of the future.

E-portfolios and ARCP

You will not be required to re-link your pre-existing supervised learning events (SLEs) from the old curriculum to the new curriculum. At your first educational supervisor (ES) meeting, encourage your supervisor to refer back to the competencies you have already achieved, and these will also remain available to review in an archive version of your old e-portfolio.

Your efforts to keep the portfolio up to date so far will not be wasted, as this will now be used as evidence and to facilitate your progress to this point. This evidence will remain accessible, as all of your existing portfolio will be automatically transferred and can be easily accessed anytime.

There is now more flexibility in how you can approach courses, with the aim to complete competence of one generic skill per year. The order you complete these in is now optional but it may still fall in to a natural pattern, for example leadership and management in ST6 or ST7.

There is no major change in how the trainee needs to prepare for the ARCP. They still need to do an appropriate number of SLEs and workplace based assessments (WPBAs).

As the ARCP approaches, trainees need to arrange to see their ES to facilitate preparation of the ES report (ESR). They will have to self-assess the level at which they feel they are operating at for each CiP.

"Doctors in training will learn in a variety of settings using a range of methods, including workplace-based experiential learning, formal postgraduate teaching and simulation-based education.."

Rough Guide to Implementation of the Geriatric Medicine Curriculum (2022), Joint Royal Colleges of Physicians Training Board

Where can I find more information and support?

All trainee members of the BGS, at any stage in their training, are automatically enrolled in the BGS Trainees' Council. Through the Trainees' Council page on the BGS website and e-bulletin, you can access a wealth of resources, including FAQs, events, webinars, the BGS Forum and other networking events and opportunities, such as becoming a Trainee Representative on another BGS Committee or Council.

To find out more about the BGS Trainees' Council, visit www.bgs.org.uk/trainees.

To view the FAQs on the new Curriculum, including videos from recent webinars explaining the changes, visit www.bgs.org.uk/CurriculumFAQs.

Geriatric Medicine Curriculum 2022: Differences in assessment requirements between the old and new curriculum

	Old curriculum (2010)	New curriculum (2022)	Changes
Advanced life support	Valid throughout	Valid throughout	No change
Patient survey	To be completed in ST6 year	To be completed by ST6	Same requirement but more flexibility in when patient survey can be undertaken.
Multi source feedback	To be completed in ST4 and ST6	One per year	Increased requirement to each year
Multi Consultant Report	4-6 per year	4 per year	Reduced to previous minimum standard
Supervised learning events: ACAT	1 per year (for geriatric medicine, in addition to GIM requirement)	4 per year or 16 in total (for geriatric medicine, in addition to GIM requirement)	Increased from 1 to 4 per year
Supervised learning events: CBD and Mini-CEX	6 CBDs and 6 mini-CEX per year	8 per year (32 in total)	Reduced from 12 per year to 8 per year
Procedural skills	No geriatrics specific procedures	Competent to perform independently by CCT: • Dix-Hallpike test and Epley manoeuvre • Bladder scanning (bedside ultrasound procedure)	Two new competencies
SCE	Attempted in ST5/ST6 Passed in ST7	Attempted in ST5/ST6 Passed in ST7	No change
Teaching observation	One by PYA	One per year (4 total)	Increased from 1 to 4 in total
Training courses	ST4: Research ST5: Teaching ST7: Management and leadership	Courses in 4 core skills to be completed one per year but in no specific order: • Research • Teaching • Management and leadership • Good clinical practice	One additional course: good clinical practice. More flexibility in when these can be completed.
Teaching attendance	"Satisfactory"	50 hours per year or 200 hours total	Specific target introduced. Can be from regional teaching and relevant conferences eg BGS meetings
Quality improvement	One per year	Evidence of participation and leadership in QI activity throughout with at least 1 specialty related QI project to be completed and assessed with QIPAT by the time of completion of specialty training	Focus on one

THE *art & science* OF GERIATRIC MEDICINE

When it comes to prodiving the best possible care to older people, clinical excellence, teaching and research all go hand-in-hand, explains *Age and Ageing* journal Editor-in-Chief, Professor Rowan Harwood.

In a recent ***Age and Ageing*** 50th anniversary commentary, Roman Romero-Ortuno, Andreas Stuck and Tash Masud reflect on Bernard Isaacs' famous 'giants of geriatrics' to write about the 'giants of geriatric medical education'.

Geriatric medicine is broad, embracing prevention, acute, rehabilitation, long-term, community and end-of-life care. Almost uniquely, our skill set is broader than that of our parent discipline, internal medicine. We need to know about core medical specialties, but also about psychiatry, orthopaedics, urology, health policy and law. We work in teams, alongside nursing and allied health professionals, and social care practitioners, so we need to know about them too.

The unifying theme is improving function and quality of life for older people. But the means of getting there are diverse, which means a huge knowledge base. Geriatric medicine is an art as well as a science. The scientific evidence-base is solid, but context and individualisation are important as well.

At the same time, most medical and surgical specialties predominantly treat older people. Their practitioners need to know the rudiments of geriatric medicine, from delirium prevention, to taking account of multimorbidity, considering treatment burden, and the need for overt rehabilitation.

All this has consequences. Higher medical training in care of older people has to be wide. But we must also share our expertise with others. Like many evangelists for a cause, we should be keen to mould the views of the next generation and commit to teaching medical students and postgraduate trainee doctors. The public, politicians and businesses also need to know about ageing. Education is everywhere. And it needs infrastructure – curricula, institutions, regulation and advocacy organisations.

The whole world is ageing, and lower- and middle-income countries can benefit from lessons learnt by richer nations. Maw

'Geriatric medicine is an art as well as a science. The scientific evidence-base is solid, but context and individualisation are important as well.'

Pin Tan highlights the problems for developing economies of medical migration and the loss of healthcare personnel to richer nations. An innovative mitigation would be educational payback to local workforces, delivered by richer nations' practitioners and educationalists, using modern digital media to enable reach without an unacceptable carbon footprint.

The approach to training has changed over the years, as theories of adult learning have developed. But inspirational role-models have been an important feature of training in geriatric medicine. Delivering continuing education can be difficult, and some health professionals have few opportunities for postgraduate learning. Models of co-working can effectively spread expertise, as seen in orthogeriatric and peri-operative medicine, and the central role of education in models of old age liaison psychiatry. Against this we must balance the risk of de-skilling if liaison working estranges other specialties from addressing the needs of older people themselves. Some specialties such as emergency medicine and dentistry have embraced the challenge and developed their own age-attuned training initiatives.

Romero-Ortuno and colleagues propose investment, inspiration, integration and inter-professionality to be the new giants of geriatric medical education, which can help overcome the challenges. They emphasise the important links between the clinical, educational and research agendas.

It hard to imagine any centre of clinical excellence which is not actively engaged in teaching and research. The three elements are mutually supporting, none can thrive without the others. Together they form a powerful framework for taking education to the next level, and with it, ever improving healthcare services for older people.

Professor Rowan Harwood
Editor-in-Chief, Age and Ageing

View *Age and Ageing* online at www.bgs.org.uk

SAS Doctors in Geriatric Medicine:

The road ahead

Recent changes to the structure and career progression of Staff and Associate Specialist (SAS) doctors have implications for those working within this grade. BGS SAS Grade Lead, Somaditya Bandyopadhyay, and BGS Vice President for Workforce, Amit Arora, explain the changes and what this means for BGS members who might be affected.

Staff and Associate Specialists (SAS) doctors form an important and substantial part of the NHS workforce caring for older people. The year 2021 was significant for SAS doctors as the new contract opened up a 'specialist grade'. The new grade is similar to the 'associate specialist' grade that was abolished in the 2008 contract. This created a situation in which many SAS doctors had to stay as 'specialty doctors' in the 2008 contract, without a way to progress in their career, work more independently or, at times, develop their own autonomous service. The terms and conditions of the 'specialty doctor' grade were updated too in the new 'specialist grade'.

Who are the 'Specialty doctors'?

Specialty doctors are experienced doctors in a particular specialty who are not in training. This route is more often adopted by overseas qualified doctors for a variety of reasons. Specialty doctors should have full registration and a 'Licence to Practice' with the General Medical Council (GMC).

They should have completed at least four years of full-time postgraduate training (equivalent training gained on a part-time or flexible basis counts). Of those four years, there should be two years spent in a specialty training programme (or as a fixed term specialty trainee) in a relevant specialty is preferred. If they have never been in training, then equivalent experience and competencies are acceptable.

Our personal advice to specialty doctors is to engage in their annual appraisal, job planning and revalidation. It is important to organise colleagues' and patients' feedback at least once during the revalidation cycle (which is usually five years). Participation in internal and external continuing professional development (CPD) activities and maintaining a work diary are important too.

Terms and conditions for speciality doctors are available here: **www.nhsemployers.org/publications/terms-and-conditions-service-specialty-doctors-england-2021**

A new grade: Specialist

The Specialist grade is a new national grade for senior SAS doctors. This is available for all SAS doctors or non-trainee doctors if they satisfy the eligibility criteria that are laid out, and at the discretion of the employer. Doctors in the Specialist grade will be responsible for the patients under their care. A Specialist is an expert in a narrower field and will have the autonomy to work in their defined area of practice (as agreed locally). Applicants must meet a set of generic capabilities criteria to be eligible for this grade. However, these posts will be created at the employer's discretion, where a specific workforce need has to be identified. There is no automatic right to progress from the Specialty doctor grade to the Specialist grade. The appointment process should be open, competitive and transparent.

SAS doctors who identify their current role as closely aligned to the Specialist grade should create a document. The document should highlight the relevant parts of the generic capabilities framework that they relate to and explain in detail what these activities involve. It is important to complete the document, submit this to your line manager, review your job plan and negotiate.

Specialist grade resources and links

NHS Employers produced a webinar on the Specialist grades which can be found here: **www.nhsemployers.org/system/files/2021-06/SAS-reform-2021-webinar-slides.pdf**

Information on contract reform: **www.nhsemployers.org/articles/sas-contract-reform-2021**

Generic Capabilities Criteria: **www.nhsemployers.org/sites/default/files/2021-06/sas-paper-2-specialist-grade-generic-capabilities-framework-2021.pdf**

Specialist Grade Appointment Guidance: **www.nhsconfed.org/sites/default/files/2021-06/Specialist_grade_template_for_collating_entry_criteria_evidence%20%281%29.docx**

Roles and responsibilities of the specialty doctor, specialist and consultant: **www.bma.org.uk/media/4347/bma-specialty-doctor-specialist-and-consultant-roles-and-responsibilities-comparison-table-jul-2021.pdf**

'It is important to organise colleagues' and patients' feedback at least once during the revalidation cycle.'

Pay structure of the new specialist grade

The 2021 contract reform is a multi-year pay progression and would not be affected by pay recommended by the Doctors' and Dentists' Review Body (DDRB) and awarded by the government. This is unfortunate as this has led to a situation in which a significant number of specialty doctors did not move to the new 'Specialist Doctor (2021)' contract, as it could mean a pay cut for some of them.

Associate Specialists in national or local contracts also did not have any added financial incentive to move to the new Specialist post, as the pay scales are lower for the associate specialists who have already reached the top of their pay scales. There are no clinical excellence award (CEA) schemes or national clinical impact awards (announced in January 2022) for Specialist doctors. The SAS committee of the British Medical Association negotiated with the Department of Health and NHS Employers in June 2022 and reached an agreement that SAS doctors in old contracts wishing to transfer to the new speciality doctor contract will no longer face cut-off dates for their applications. This means, that if in future, the 2021 contracts are better paid (compared to the old contracts), then the opportunity will remain to declare the intention to transition to the new scale.

You can read more about this here: **www.nhsemployers.org/articles/contractual-right-transfer-2021-specialty-doctor-contract**

CESR, CCT and the route to become a consultant

It is great to have a new contractual 'Specialist' grade but what about progression to the consultant grade? Many SAS doctors have taken the CESR (Certificate of Eligibility for the Specialist Register) route in the past and have succeeded in obtaining CCT (Certificate of Completion of Training) to become consultants. CESR route is for doctors who have not completed a GMC-approved programme of training but have the knowledge, skills and experience equivalent to become a consultant. Doctors wishing to become consultants through the CESR route need to gather, prepare and submit the evidence themselves. Applications are bespoke and highly individualised as outside a training programme, doctors learn in a lot of different ways. Doctors should have full registration with the GMC and a 'Licence to Practice'.

The GMC has general information about the CESR route here: **www.gmc-uk.org/registration-and-licensing/join-the-register/registration-applications/specialist-application-guides/specialist-registration-cesr-or-cegpr**

Information specific to Geriatric Medicine is available here: **www.gmc-uk.org/registration-and-licensing/join-the-register/registration-applications/specialty-specific-guidance-for-cesr-and-cegpr/specialty-specific-changes-for-cesr-in-geriatric-medicine**

The NHS is drastically short of staff across all services and specialties. The lack of geriatricians is therefore part of a wider problem.

A recent parliamentary select committee report suggests that the NHS is now 12,000 doctors short (**https://committees.parliament.uk/committee/81/health-and-social-care-committee/news/172310/persistent-understaffing-of-nhs-a-serious-risk-to-patient-safety-warn-mps),** while the Royal College of Physicians (RCP) fairly recently mentioned that the NHS is woefully underprepared to cope with an ageing population (**www.rcplondon.ac.uk/news/rcp-warns-uk-facing-crisis-care-older-people**).

The same RCP document mentioned that 48% of consultant geriatricians in England are set to retire within the next 10 years, which means we have to act now. Successful CESR applicants can be a solution to the impending workforce issues geriatric medicine is about to face. Part of the solution could have been a standard path for eligible SAS doctors to do CESR applications, and if successful, to become consultants to prevent the crisis. This has not happened and some new changes (explained below) may have made the CESR route more difficult from 2023.

First of all, a new Geriatric Medicine curriculum has been introduced in August 2022. As a consequence of this, the window of opportunity for CESR applications with the old curriculum is closing fast. CESR application in the old curriculum cannot be made after 31st August 2023. The new curriculum has clinical internal medicine components as GMC mandated, and this is disappointing for some SAS doctors as not every department will have the resource, facility or the will to enable this to happen.

There is also a new method of assessment, which is 'Capabilities in Practice' or 'CiPs'. There has been no change to the workplace-based assessment methodology. There is apprehension that achieving competency in some of the components and gathering evidence would be difficult for many SAS doctors. This is primarily because these kinds of activities are not provisioned for in their job plans.

Often service priorities take precedence over other needs. The ongoing COVID pandemic has only exacerbated the already enormous pressure that doctors face. Study leave requests from SAS doctors are not always given the same consideration as given to trainee doctors. Study leave alone is generally not enough to achieve these competencies.

It would appear that unless specific measures are taken by individual Trusts, supported by senior colleagues and management, after 2023, the CESR applications may actually reduce in numbers. With the current workforce crisis, this may not have been a well-thought-out move, especially concerning the CESR route.

At present, to apply through the CESR route, MRCP (or equivalent) is desirable and qualifying the Specialty Certificate Examination (SCE) in Geriatrics is necessary.

It seems that in future, to take the CESR route, one has to have MRCP (or equivalent) and SCE (Geriatrics). This may affect the CESR application route as many SAS doctors may not like to go through those examinations.

There are some myths about the current CESR process which we can clarify here:

- At present, (until August 2023) one does not always have to be an MRCP (MRCP equivalent is enough) to be successful with the CESR application – but one has to have a strong portfolio in that case and have to pass SCE (geriatrics) exam.
- A person with MRCP/FRCP with a strong portfolio may not need to pass SCE and there is some scope for limited exemptions till August 2023 only.
- One has to have either MRCP or SCE – if one does not have either of those, the chance of success is very low. However, every application of CESR is different as the way we work and gather data is different.
- DGM (Diploma in Geriatric Medicine) or MSc (Gerontology) are not equivalent to MRCP or SCE (Geriatrics).
- Pure experience is not enough. One has to collect the evidence and demonstrate it in an appropriate manner.
- It is very difficult to give generalised guidance on what to do and what not to do. But there is no harm in trying – we can have a collective and collaborative approach toward learning and that's why we at BGS have taken this extra step to reach out.

Table: Comparison of Specialist Grade and CESR routes

	Specialist Grade	CESR route
Qualifying criteria	To be matched against Generic Capabilities Criteria	To be matched against Geriatrics Medicine Curriculum
Evidence collection	Doctors have to demonstrate that they fulfil the criteria	Doctors have to open an application process with the GMC. Evidence collection and upload takes about 12 months.
Progression	No automatic progression to a Specialist role from another middle grade role. Trust has to agree and fund to create a new Specialist post. This need to be filled in by open competition.	No automatic progression to a consultant role. Successful CESR applicants after obtaining CCT can apply for consultant posts. There is no guarantee of success in CESR applications.
Programmed Activity (PA)	10 standard PAs – at least 1 PA for continuing professional development.	As a consultant 10 standard PAs of which 2 PAs are for Supporting Professional Activities (SPA) including for continuing professional development (CPD).
Managerial, leadership roles; teaching, training, audit etc.	Specialists are not expected to carry out these roles, but they will be encouraged and given the opportunity to do so when appropriate.	Consultants are expected to carry out such (and wider) roles.
Link to current information regarding terms and conditions:	**www.nhsemployers.org/articles/new-specialist-grade-sas-2021**	**www.nhsemployers.org/articles/consultant-contract-2003**
Salary or Pay-scale (based on latest information)	£79,894 to £90,677	£88,364 to £119,133

Support and advice

For a few months now, we have been operating an informal unofficial BGS CESR Forum, a social network group for aspiring CESR applicants who are mentored by a few successful CESR applicants. The aim of the group is to learn from other people's experiences. Areas in which people struggle most – like maintaining a logbook - are discussed. Without guidance doctors struggle to know what material needs to go into a logbook, and how to best present the logbooks.

We also discuss if we should keep e-portfolios or keep paper records or not – the pros and cons. One of the most useful aspects are the examples/samples from people who have been successful, and this gives reassurance that following these examples may improve the quality of the data.

We are very happy to expand the group and share these experiences, and anyone who wants to become a member (or more importantly, a mentor) please get in touch by email at **somsuj.b@gmail.com**. We have some non-BGS members in the group too. Unfortunately we do not, however, have the acumen to help people who are applying for CESR in other specialties or people who wish to apply for a non-CCT specialty. In future we are looking to utilise the offical BGS forum to further expand this group.

We might wonder if the authorities should consider other routes for SAS doctors to demonstrate competency to become consultants. CESR route essentially scrutinises the submitted evidence against those of a doctor at the completion of an approved training programme. CESR cannot be the only route to achieve CCT. This route does not recognise that SAS doctors learn differently and have been working at a senior level competently and often without supervision. Sometimes it is very difficult for such senior doctors to demonstrate the evidence that is required. Surely it is time to consider other, different routes (other than CESR) for these high-performing SAS doctors to become consultants?

Therefore, a Speciality doctor can progress in two directions after obtaining some degree of seniority. One can either take the CESR route or the Specialist route. Both routes have some pros and cons. While it is impossible to compare every aspect of the two routes here is an attempt to compare the basics and the BGS is willing to be contacted by individuals for guidance.

But watch this space...

At the time of this article going to press, we are hearing of some changes regarding the CESR/CCST route via the GMC. We will clarify these details in a subsequent update when this information becomes clearer.

Somaditya Bandyopadhyay
BGS SAS Grade Lead

Amit Arora
BGS Vice President, Workforce

#AHPsDay

On AHPs Day (14 October) some of our amazing Allied Health Professional members shared what they value most about being part of the BGS community...

Jo Jennings
Advanced Clinical Practitioner

"One of the best things about being a BGS member is the discount you get on conference registration. The conferences are always **educational and inspiring**. The fringe sessions are a great way to take some well-deserved time out, indulge your creative side and sit and reflect."

"Being a member of the BGS community means I am part of a diverse group of clinicians. For me, BGS gives me the broad knowledge, **access to the most recent research** and multi-professional networking opportunities I need, as well as access to affordable development events."

Grzegorz Drozdz
Trust Falls Lead Practitioner/Senior Specialist Physiotherapist

"We have a fabulous network of MDT members, who are all looking to connect, and support each other to improve the care of older people, in whatever location you are working. You also get to contribute to national agendas around **supporting older people**."

Dr Esther Clift
Consultant Practitioner in Frailty

DID YOU KNOW?

Nurse and AHP members are eligible to apply for grants to attend BGS events for free! To find out more or to apply for a grant for an upcoming meeting, visit **www.bgs.org.uk/grants**

"As an AHP member of the BGS, I have been able to join a **multi-professional community** with a shared purpose and vision, allowing for networking, shared learning and access to a range of CPD and evidence-based resources."

Rachael Hosznyak
Advanced Clinical Practitioner (Paramedic)

British Geriatrics Society
Improving healthcare for older people

Join us

Group membership

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

The key benefits are:

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

Benefits **not** included in group membership:

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

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

How to join?

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

Developing a new *BGS Strategic Plan*

During the course of 2022, the BGS has been developing a new Strategic Plan to guide its work for the period April 2023 to March 2026. We have had excellent input, including discussions with BGS committees, a survey of members, workshops for the Board and for staff, and interviews with key stakeholders.

Many thanks to the 520 members who responded to our survey, which closed in June 2022. For a full analysis of the responses, please go to: **www.bgs.org.uk/strategysurveyanalysis.** The key messages from the survey reinforced our existing priority areas of clinical quality; education and training; research; and policy influence. In addition, respondents felt strongly that the BGS should do more to help address the current workforce challenges. This included working with others to campaign for a sustainable social care solution and a properly paid and supported social care workforce.

Members were proud of the BGS's multidisciplinary ethos, and urged us to do more to attract healthcare professionals into the field and the BGS community.

Free text responses accompanying the survey highlighted members' concerns about older people's health in light of the COVID pandemic - the risk of older people's healthcare being overlooked in the competition for NHS resources, and the risk of more older people with increased frailty through delayed interventions, deconditioning and fragmented services.

The call for the BGS to strengthen its policy and campaigning voice was echoed in a strategic planning workshop for the BGS Board, held in person at the end of July. Board members (*pictured*) felt that the BGS needed to speak up more powerfully for older people's right to high-quality joined-up healthcare. Solving some long-running challenges of patient flow and delayed discharge through alternatives to hospital admission, anticipatory care and timely rehabilitation, parity of pay and conditions for social care staff and more community-based services would better serve older people, as well as helping with NHS priorities such as reducing waiting lists and the backlog of elective care. The Board discussed how the BGS needs to go further in ensuring the voice of older people informed its work. In the absence of long-term planning for an ageing population by Government and NHS decision-makers, the BGS must be proactive in proposing realistic solutions to the workforce challenges and must help those involved in local, regional and national programmes and services to understand what good care for older people looks like and how it should be commissioned.

The consultations have provided incredibly helpful insights as we start to craft the new Strategic Plan and consider how to articulate the priorities for the next three years. The draft Strategic Plan will be shared with members two weeks ahead of our AGM. This will be held online at 1pm on Thursday 11 November. We will invite members to approve the Strategic Plan for 2023/26, giving us time to develop an Operational Plan for the first year (April 2023 to March 2024) and set out the budget that will underpin the Strategic Plan. Under our new President, Professor Adam Gordon, the Society will then ensure the Strategic Plan priorities guide the work of our committees and Councils, and of the staff team. We will publish the new Strategic Plan on the BGS website and communicate it widely to members. We will also provide a one-page summary, and an overview in the next edition of *Agenda*.

Thank you to all who have been involved in helping us to develop a Plan that takes on board what members want and value, responds to the urgent challenges of the operating environment and continues to build our community and positioning as the go-to place for expertise, information, education, research and insights on older people's healthcare.

Sarah Mistry
BGS Chief Executive
@SarahMistryBGS

Members of our Trustee Board met to discuss the future direction of the BGS

Learning to be kind

What happens when someone is rude to you at work, and does it really matter? George Coxon and Jane Brightman discuss civility and the value of learning to be kind to one another in the workplace, especially when times get tough.

The Civility Saves Lives website, run by healthcare professionals aiming to raise awareness of the power of civility in medicine, (**www.civilitysaveslives.com**) describes 'incivility' as being rude or unsociable speech or behaviour. It goes on to stress that this is as interpreted by the recipient. There are many examples of this, such as shouting, swearing, belittling, sending emails while in meetings, talking over others, rolling eyes or tutting at someone.

Crucially, the impact of incivility is big. It can reduce people's cognitive ability by up to 61%. People lose time worrying about the rudeness and avoiding the person who was rude. Their quality of work can reduce, and some take it out on the people they support, while 12% of people leave their role.

But worse than that, the impact spreads across teams and organisations, especially when people witness rudeness. It can leave those who are drawing on the care feeling anxious.

So, condoning and allowing rudeness (incivility) is just as bad as actually being rude.

George Coxon, Care Home Manager:

In 2019 I was lucky enough to be in the audience at the TEDX event in Exeter where Dr Chris Turner, a consultant in a busy NHS intensive care unit, spoke about the impact of incivility on his work and the need for us quite simply to be aware of how deadly rudeness in health and care settings can be.[1]

The word 'kind' has become a powerful part of modern dialogue in daily life and let's all applaud this – as long as it's accompanied by real life application, perhaps especially in health and care settings in these challenging times.

I have undertaken some short 'kindness huddles' with my staff in the care homes I own and asked about their experiences of people's rudeness and even asking if they themselves have ever been rude to others. The results have been poignant and important in drawing attention to this basic aspect of good care and good manners. I have written several pieces on reflections about care home life during the pandemic and about language and how we must be mindful of the importance of what we *say* as much as what we *do*.[2-4]

Each of these has a subtext of imparting a need for us to be the best person we can be when looking after those we are entrusted to care for. Dr Turner was humble and honest about how he - like many of us when operating in the (at times) busy and frenetic environments of high pressure and high risk - can be short, impatient, and intolerant of error when witnessing a failure to meet the high standards of care we aspire to. What do we do in those situations?

For me, it's exercising my very best in being understanding, following a pause and showing restraint in my instinctive response to whatever frustration that might have been triggered. We work in imperfect times with imperfect people, but as imperfect people ourselves, it doesn't mean we are lesser individuals not wanting to do the very best we can. We must, however, remember the central message from Dr Turner and the NHS guide on civility and respect,[5] that is to be kind, as rudeness can cost lives.

I asked my staff what key points I should include in the piece that Jane and I agreed to write together and here are some of the points they wanted me to emphasise:

'Treat people the way you would want to be treated' – Emily

'Try to be understanding even when someone gets it wrong' – Meg

'Working as a team with trust and respect is the key to kindness' – Jane

Jane Brightman, supporting social care from within the NHS and government:

Last year I was honoured to be asked to judge the abstracts for Quality Improvement South West. There were some excellent posters and one that really stood out (and went on to win) was based around civility in midwifery. I recall being really surprised about the topic, not having worked in health and missing out on the Civility Saves Lives campaign, I couldn't understand why we were needing to remind ourselves to be civil to each other.

Then I realised. It also chimed with some research I conducted last year exploring why people didn't consider social care as a career for them or had left the sector

Incivility (rudeness) within teams came up more times than I care to mention as a reason for leaving a role in social care.

That's shocking and really sad.

I experienced repeated incivility in a previous role, and it did make me leave. I am pretty sure the person didn't realise they were being rude, but they were, and I wasn't thriving. It was debilitating, I spent a lot of time awake at night mulling things over and I blamed myself a lot, what was I getting wrong? I know I didn't perform my best.

Which leads me onto - what can be done? Firstly, I highly recommend you take a look at the Civility Saves Lives website if you haven't already. It's packed with free resources which are admittedly very health focused but there's plenty we can learn from for social care on there.

If you are an employer, it's worth taking a fresh look at your policies and your induction and training programmes. Could you include some opportunities for teams to explore this together?

Managers and team members, we all have a role to play here - if you are reading this and are curious, why not start some internal conversations with your colleagues?

George Coxon
Director, Classic Care Homes
@CoxonGeorge

Jane Brightman
Assistant Director of Programmes, System Reform, NHS Transformation Directorate, NHS England
@TOMNetworkUK

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BGS pays tribute to **Her Majesty Queen Elizabeth II**

The BGS were deeply saddened to hear of the death of Queen Elizabeth II in September at the age of 96.

The Queen was the longest reigning monarch in British history, and the second-longest reigning monarch in the world.

As head of state for the UK and the Commonwealth, the Queen provided invaluable continuity and unity during her reign of more than 70 years.

The Queen will always be known for her unwavering sense of duty and devotion in a life of service to her people. She was patron to 74 health-related charities including the British Red Cross, Cancer Research UK, the Chartered Society of Physiotherapy, Guy's and St. Thomas' NHS Foundation Trust, the Royal Medical Benevolent Fund, the Royal College of Nursing, the Royal College of Physicians and the Royal Society of Medicine.

Dr Jennifer Burns, President of the British Geriatrics Society, commented: "All at the BGS were sad to hear news of the death of Her Majesty the Queen.

"Her enduring support for so many charities in the health sector is a resounding testimony to a life of public service.

"On behalf of our members, staff, and officers of the British Geriatrics Society, we would like to convey our deepest condolences to our Patron, His Majesty the King, and to the Royal Family."

Ordinary dying:

What can we learn from the death of the Queen?

While members of the public may have been shocked by the seemingly sudden decline in the health of Her Majesty the Queen which preceded her death aged 96, those accustomed to caring for people at the end of their lives, particularly older people, may have recognised the stages of 'ordinary' dying. Former palliative care doctor turned author, Dr Kathryn Mannix, sensitively illustrated this in a series of Tweets which we have reproduced with her kind permission.

The world has watched her live through the process of ordinary dying, and yet dying went unspoken, un-named.

Let's notice what nobody mentioned: we all saw the Queen going through the stages of ordinary dying.

As her body wearied, she needed to ration her energy, reduce her public engagements, delegate some tasks.

Energy runs out faster as the process progresses.

But her mind remained crystal-clear, her famous sense of humour was undimmed.

The changes began slowly.

Initially, we realised that she was less energetic year by year.

This is the stage of dying when life expectancy is usually still measured in years.

After Prince Philip died she was noticeably more tired, her public appearances less frequent, her energy less reliable.

Losing weight, walking with a stick: changing month by month, a stage that usually indicates life expectancy measured in months.

'She has demonstrated the phases of ordinary dying to us all. How dying is mainly living, after all. And how, in the end, we can all plan ahead, address the unfinished business in our lives, and die with symptoms well-managed.'

She began to make clear her wishes.

Charles' wife to be Queen Consort. The 2nd in line, William, to move to Windsor. Her dresser and special friend joined the Royal household as her daily companion.

I wonder what medical wishes she also sorted out.

Strength fading, she had tasks to complete. She was able to join in some, but not all, of the long-awaited Jubilee celebrations.

The country waited for a new Prime Minister to be appointed by her, with weeks to wait for that election.

She hung on.

Many people do this, living longer than expected in order to see somebody special, celebrate a last important occasion, hear longed-for news.

Something held her, something important to her own heart, waiting.

Once at her beloved Balmoral, the break with tradition in asking the outgoing and new Prime Ministers to attend her there was a sign that she was now too tired to travel.

All of us in palliative care recognised what was unfolding.

Yet dying remained un-named.

Missions all accomplished, arrangements within the family in place, Constitutional duties complete, her energy was spent.

Even as the family was gathering, it was clear that she was in the last stage of dying.

She has demonstrated the phases of ordinary dying to us all.

How dying is mainly living, after all.

And how, in the end, we can all plan ahead, address the unfinished business in our lives, and die with symptoms well-managed, even in our own bed if circumstances permit.

Dying in plain sight, camouflaged by briefings about 'mobility issues' and medical advice to 'rest.' Because like anyone else, the Queen was entitled to some privacy about her health, and to die away from the public gaze.

But we all saw the process.

Rest in peace, Ma'am.

What can we learn?

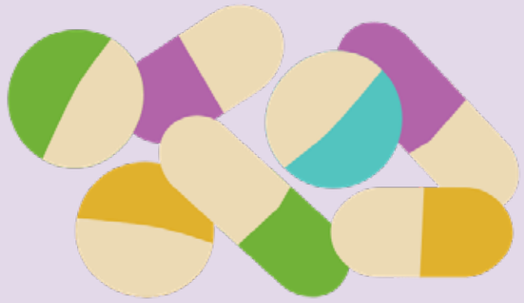
That dying is inevitable, recognisable, describable, and that we can prepare for it. The Queen had clearly planned ahead.

That at the edge of life, we can still enjoy love, and peace, and companions.

That we need to get familiar with dying.

Kathryn Mannix
Former Palliative Care Doctor and Author
@drkathrynmannix

Working with geriatricians to support implementation of the **National Overprescribing Review**



Following publication of the National Overprescribing Review report in September 2021, Tony Avery was appointed NHS England's first National Clinical Director for Prescribing, to provide clinical leadership to implement the recommendations from the review. He explains how geriatricians, GPs and prescribers working with older people are expertly placed to support this process.

Overprescribing is when people are given medicines that they don't want or need; it's a global problem with worrying consequences. Overprescribing causes harm to patients physically and mentally, as well as wasting vital NHS resources. It can also lead to preventable hospital admissions, even premature deaths. Wasted medicines also have a negative impact on the environment and do not support the NHS commitment to be carbon net zero – medicines and medical devices represent about a quarter of the NHS's carbon footprint.

Protecting the NHS, saving resources and improving patient care have become even more important following the COVID-19 pandemic. The review estimated that 10% of items prescribed in primary care may not be necessary. Furthermore, in 2010 it was estimated £300 million of NHS prescribed medicines are wasted each year and 12 years on, this figure may have doubled. It's a serious issue and we are keen to tackle it. Of course, we recognise that medicines do people a lot of good and we don't want to take away medicines that are effective. As geriatricians, you are well-placed to help us address this issue of global importance which has a major impact on older people.

The problem of overprescribing is set to continue as people are living longer with multiple conditions and their care shared between different clinicians and services. Evidence shows that older people are more likely to experience overprescribing because of multimorbidity, but in primary care we sometimes fail to deprescribe when those medicines become problematic. There are numerous examples here which geriatricians will be familiar with, including problematic use of analgesics, anticholinergics, antihypertensive medication, diuretics and psychotropic drugs. Also, drugs for secondary prevention with high 'Numbers Needed to Treat' may be futile, or unwanted, as people reach the final stages of their lives.

Older people particularly at risk from overprescribing include those from ethnic minority communities, those living in areas of high deprivation and those with a learning disability.

We are taking important steps at a national level to reduce overprescribing, through implementation of the National Overprescribing Review report: *Good for you, good for us, good for everybody: A plan to reduce overprescribing to make patient care better and safer, support the NHS, and reduce carbon emissions*. The report recognises that overprescribing is a complex issue. Following extensive consultation with patients and clinicians, the review makes the following recommendations to achieve long term sustainable reductions to overprescribing:

- Working with patients, carers and the system to tackle overprescribing.
- Improving and implementing prescribing processes, reviews and guidance.
- Using digital technologies to address overprescribing.
- Improving data for feedback to clinicians and commissioners to guide prioritisation and monitor success.
- Updating training and development to reflect the growing understanding of overprescribing.
- Assessing and supporting system action to address the carbon impact of unnecessary prescribing and medicines waste.
- Strengthening the evidence base for overprescribing and enhance the process of getting evidence into practice.

Its recommendations emphasise the importance of giving people choice and control over the way their care is planned, through shared decision making as a collaborative process between a patient and clinician, and the greater use of structured medication reviews (SMRs) and social prescribing.

The aim is to ensure that a patient's medication is appropriate to their needs and working well for them and to deprescribe where appropriate. We recommend that SMRs take at least 30 minutes with an emphasis on shared decision-making.

Better electronic communication between primary and secondary care, to ensure key medicines information is passed on, is paramount, and the technical barriers have largely been overcome so that in coming years this communication will become much easier with all clinicians having access to patients' current medication records. The report also recommends a focus on alternatives to medicines where appropriate, such as physical and social activities and talking therapies, building on the substantial investment in workers and social prescribing in primary care.

Much of the activity to implement the National Overprescribing Review will take place in primary care, but geriatricians are very well placed to support this given their extensive knowledge of therapeutics in older people; their focus on what matters for the patient, and their experience in (and confidence at) making deprescribing decisions. As a GP, I have been extremely grateful to local geriatricians who have helped give me the confidence I lacked in making deprescribing decisions, often with marked improvements in quality of life for patients.

Therefore, I'm keen to see geriatricians expand their work in supporting clinicians in primary care (mainly GPs and pharmacists) with the challenges of deprescribing, particularly for patients with highly complex medication regimes. In some parts of the country there are already dedicated facilities whereby GPs and primary care pharmacists can obtain such expert advice from geriatricians, clinical pharmacologists and/or specialist pharmacists. This can range from advice and guidance based on a referral, to a case-conference type approach allowing for discussion between the healthcare professionals (and sometimes the patient). In addition, I'm aware that the NHS Specialist Pharmacy Service has developed a number of deprescribing resources to support these discussions along with their 'On the Couch' series of webinars which allows healthcare professionals to discuss broader issues with subject matter experts on all aspects of prescribing. I would like to see dedicated services being set up in each ICS area (in England) as I think this could bring substantial benefits in helping colleagues in primary care with difficult (de)prescribing decisions.

A specific example of where geriatricians can help is through the Academic Health Science Network Polypharmacy Programme, which is being rolled out across England between 2022 and 2024. Recognising that many GPs and primary care pharmacists lack confidence in making deprescribing decisions in patients with complex medication reviews, the programme includes action learning sets where geriatricians have an essential role in helping participants build their knowledge and confidence around deprescribing through discussion of real-life cases. Further details of the programme are available at **https://tinyurl.com/AHSNpp**, including contact details if you wish to find out more about participating.

The implementation of the National Overprescribing Review gives an opportunity to put the brakes on the rise we have seen in medication taking over the last few decades. Geriatricians are extremely well placed to provide local and national leadership, along with support for primary care colleagues, to help ensure that we get the balance right when prescribing for older people; avoiding unnecessary or problematic medication while also having 'what matters to the patient' at the heart of all that we do.

Professor Tony Avery OBE
National Clinical Director for Prescribing, NHS England

The BGS Anticipatory Care Blog Series aims to promote the importance of anticipatory care for older people and the benefits of early intervention. The arguments for anticipatory care were set out in the NHS Long Term Plan and we are hopeful that it should remain a key strand of the Ageing Well programme in England.

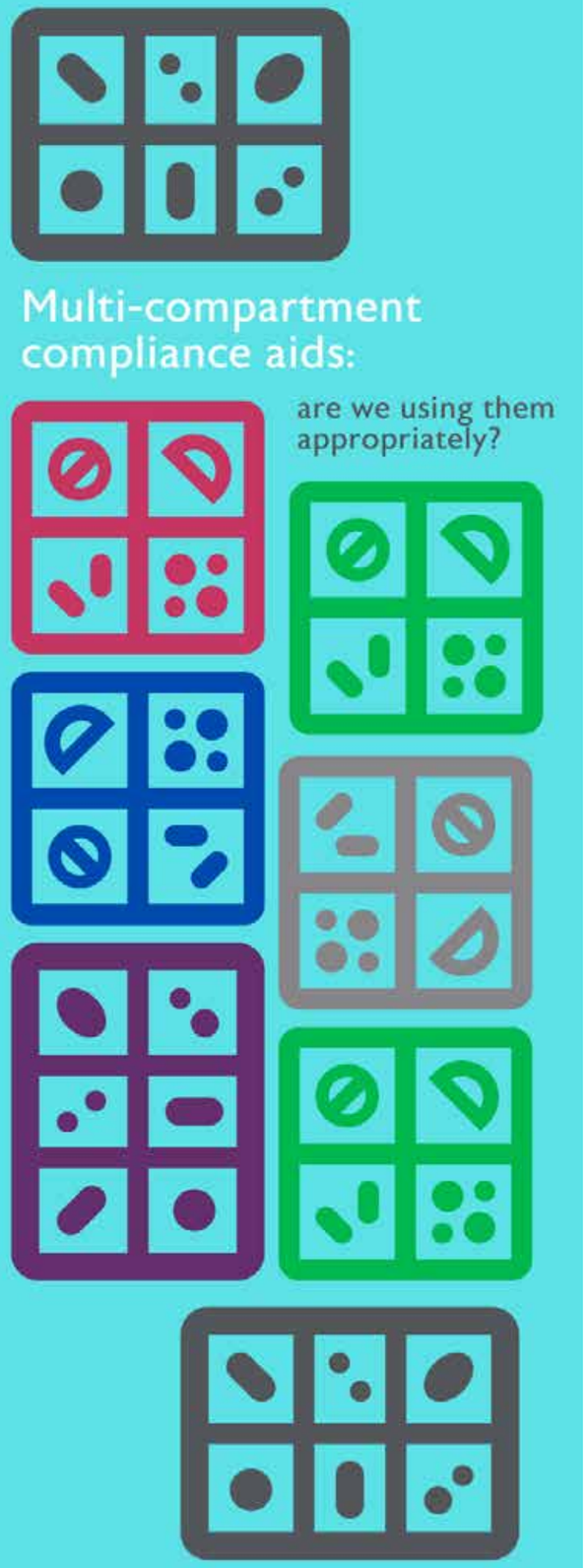
The COVID pandemic and decisions about resourcing within NHSEI have delayed this programme. The BGS has therefore published this blog series as a reminder of the importance of proactive care for older people. We have invited a range of authors to write about their experience of providing anticipatory care to older people living at home or in other residential settings. We hope these blogs will demonstrate the value of early interventions with older people in terms of supporting healthy behaviours, keeping frailty at bay and slowing decline.

Underlying all the blogs is the fundamental argument that early intervention improves health and wellbeing outcomes, reduces the risk of other care needs and saves money downstream, by reducing the need for more expensive care.

Blogs in this series include:

- **Moving beyond the crisis: Anticipatory care for older people** by Adam Gordon
  www.bgs.org.uk/AntCare1
- **The NHS can't stop you from growing older, but it can support you to live an independent and active life for as long as possible** by Liz Lawn
  www.bgs.org.uk/AntCare2
- **Person-centred care in action** by Jennifer Farren
  www.bgs.org.uk/AntCare3
- **Anticipatory Care for Older People and the benefits of Early Intervention** by Deb Gompertz
  www.bgs.org.uk/AntCare4
- **Anticipatory Care Matters** by Anne Hendry
  www.bgs.org.uk/AntCare5

You can view all the blogs in this series by visiting www.bgs.org.uk/AntCare



Multi-compartment compliance aids (MCCAs) are sometimes used to assist with medication-taking and enable adherence. They are not standardised and multiple variations in design exist. Different brands can be provided by pharmacies and hospitals within any locality. They can also be called monitored dosage systems, dose administration aids, dosette boxes or blister packs. Typically, they have compartments for morning, lunch, afternoon and night-time doses over a one-week period.

MCCAs may be recommended for people with polypharmacy, which has led to increased use among older people, sometimes without consideration of alternative strategies. This can increase workload and has resource implications for pharmacy teams, if they are tasked with dispensing into MCCAs. Some pharmacies have recently suggested limits to the number of people they continue to supply with an MCCA.[1] Could such decisions disadvantage older people? This article considers the pros and cons of MCCAs with the aim of encouraging discussion that could lead to a BGS position statement regarding their appropriate use.

MCCAs are a controversial subject. The Royal Pharmaceutical Society (RPS) recommends that use of original packages of medications is the preferred option unless a specific need has been identified.[2] Older people are individuals and have differing needs and support structures. People may live in their own home and self-administer medications, or they may have assistance from either informal or formal carers. This is also true for some people who live in care homes and continue to self-administer. When a problem is suspected with medicines administration, a professional assessment is required to find the best solution for an individual. This process should be patient-centred and involve other relevant people (e.g. prescribers, pharmacists, pharmacy technicians and carers).

Adherence problems and solutions

Adherence to a medication regimen requires the capability (e.g. memory, dexterity and swallowing ability), motivation and opportunity (e.g. access). Motivation may be affected by the perceived need for medicines, belief that the benefits of medications will not exceed burdens (including adverse effects) or the medication rationale not being concordant with personal goals, beliefs and values. Reduced ability to self-manage medications may be detected by carefully establishing current adherence. Addressing problems with adherence depends on the contributory factors (see Table 1). The first stage is medicines optimisation based around shared decision-making and a structured medication review. Deprescribing, including reducing the number of medicines and how often medicines are taken, can reduce the need for support. There has been recent focus on overprescribing in the NHS.[3] With medicines cited as the primary or contributory cause of hospital admissions for older people, for 16.5% of unplanned admissions, there are significant opportunities to reduce this burden by timely and effective interventions.[4]

For medicines considered essential following medication review, a range of strategies have been suggested to assist with medication adherence barriers, listed in Table 1.

Table 1: Medication adherence barriers and possible solutions[5]

Problem	Effect	Possible solutions
Medication not wanted i.e. due to adverse effects, ineffective or not aligned with personal goals, beliefs and values	Medication not taken	Medicines optimisation/ deprescribing
Medication not needed e.g. symptoms resolved, new diagnosis, limited/ reduced prognosis	Therapeutic burden	Medicines optimisation/ deprescribing
Complex timing and/or number of tablets	Therapeutic burden	Medicines optimisation/ deprescribing
Visual impairment	Can't read medication container labels	Large print labelling
Cognitive impairment (mild-moderate)	Forget to take or take too much	Medication administration charts, reminder alarms, smart phone apps
Cognitive impairment (moderate-severe)	Forget to take or take too much	Administered by a carer
Reduced dexterity	Can't open packaging. Can't use specific formulations (e.g. eye drops, topical therapies or inhalers).	Easy open lids or cap gripper.s Specific compliance aids (e.g. Autodrop®, Haleraid® long-handled applicators or carer support).
Impaired swallow	Can't swallow large tablets	Pill cutter/ crusher, liquid formulations

MCCA use

MCCAs should not be an automatic choice but some cases, after consideration of other adjustments, they will be appropriate. A summary of potential advantages and disadvantages of MCCA is shown in Table 2.

Table 2: Potential advantages and disadvantages of MCCA use

Potential advantages of MCCA	Potential disadvantages of MCCA
• Supporting patient independence • Simplifying the consumption process • Acting as a memory aid • Improved adherence • Possibly reduce administration errors • Enabling others (e.g. care agency staff) to be involved • May reduce time and training required for social care staff.	• Only suitable for some types of medication • Loss of autonomy / knowledge about individual drugs • Loss of original packaging • Don't tackle intentional non-adherence • Could introduce their own dispensing errors • Increased cost • Pharmacy resource implications • Difficulty with regimen change • Delays to hospital discharge • No child-resistant closure • 'Over the counter' medicines not included.

The decision to use an MCCA should be patient-centred. Their primary purpose is to support independence in self-administering medications. MCCAs are sometimes requested by care providers, including care homes, in order to make medication-taking supervision simpler and quicker. This is not patient-centred. When MCCA use is recommended, it is not always a long-term need and should be reviewed regularly. This should occur after transfer to a new care setting or after medicines optimisation leading to significant deprescribing. NICE found that evidence supporting interventions to increase adherence is inconclusive[6,7] and the NHS does not fund MCCAs.

MCCAs have limitations. Not all medications can be administered from them. They are only suitable for regularly-taken, solid, oral medications at a consistent dose. Examples of when this is not possible are shown in Table 3. These restrictions can lead to older people having additional medications not within the MCCA in around

'When a problem is suspected with medicines administration, a professional assessment is required to find the best solution for an individual. This process should be patient-centred and involve other relevant people (e.g. prescribers, pharmacists, pharmacy technicians and carers).'

Table 3: Medications less suitable for use in an MCCA

Problem	Examples
Variable dose	Warfarin
Non-oral route	Insulin Liquids Inhalers Eye drops Patches Topical therapies
Specific administration requirements	Oral bisphosphonates
Complex timings	Co-careldopa / co-beneldopa With or after food, e.g. aspirin
Variable time	'As required' medicines

40% of cases, which adds complexity.[2] In some cases of polypharmacy there may be too many pills for each compartment, necessitating multiple MCCAs. There is concern that some drugs may be affected by removal from their original packaging, such as through moisture or sunlight exposure. Medications have to be placed within an MCCA and checked by pharmacists, which takes time, has resource implications and could introduce errors.[8] Medications should not be stored in an MCCA for more than eight weeks.

MCCAs can affect autonomy and act as barriers to treatment during transfer of care. They tend to disassociate people from their medications as they become mixed together and not individually recognisable. Knowledge of each medicine can be lost. Information leaflets, including possible adverse effects, are not usually kept with the tablets. They also create inflexibility in dose adjustment. MCCA are a barrier to making acute changes to medicines in general. They commonly cause delays in getting medicines changed in community for acute events, for example in acute kidney injury, decompensated heart failure or after falls. There is a risk to patients who were previously non-adherent but then suddenly become adherent because they are started on a MCCA (if medicines optimisation and close monitoring is not done at the same time).[9] MCCAs do not help adherence if the problem is poor motivation to take medications. They are also unlikely to help people with marked cognitive impairment beyond forgetfulness. Automated MCCAs can deskill individuals and carers, and associated prescription ordering patterns may mislead clinicians to incorrectly assume adherence, which can present clinical risk.

Summary

Numerous problems can act as barriers to taking medications as prescribed. Assessment is required for each individual case. A range of adjustments is available to support medicine taking. MCCA use is one adjustment, suitable for some people, which can enable a selected group to be more independent. MCCAs have some potential advantages but these must be weighed against disadvantages. There is a risk that they will be used to free up social care resource but at the expense of, equally vital, pharmacy resource. A greater emphasis on medication review to simplify the regime may provide more benefit for people with reduced adherence. Concerns about MCCA include problems with transfer across care settings, inflexibility and drug stability. MCCA use may be initiated without proper assessments to meet the needs of carers or care homes and some people have difficulty in using them. They can create disassociation from treatments – people have a right to choose which medications they take, and for which goals, or there is a risk that MCCA become a form of restraint. All of these issues add to the debate about the appropriate use of MCCA. The BGS has the ability to act as an advocate for the best interests of older people. Is it time for a consensus position statement on this topic?

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Henry Woodford
Chair, BGS Medicines Optimisation SIG

Anne Bentley
BGS Community and Primary Care Group Pharmacy Sub-Group Lead

FRINGE benefits

With the BGS Autumn Meeting returning to a physical location at the London ExCel from 16-18 November (with the added option to attend online), our ever-popular Fringe sessions will once again offer attendees the chance to indulge their creative side, think outside the box, and enjoy some much-needed downtime. Here's a taste of what you can expect - we can't wait to welcome you back!

The Fringe Room will be a space to refresh, relax and refocus during the Autumn Meeting. Come along and join in an activity, catch up with a colleague over coffee and cake, or just take a quiet pause. This is your space to unwind.

Wednesday 16 November

Science Museum for the Future

It's the year 2122. A visitor at the Science Museum is looking at a display on geriatric medicine over the past 150 years. What objects might they see? Whose voices might they hear? What words might they read?

Imagine you are creating a museum display, what would you put on display to represent your experiences of working in geriatric medicine, including during the COVID-19 pandemic?

Come and visit the Science Museum booth run by Selina Hurley, Curator of Medicine, with printed-out photos of your objects, or come and add words to the mood board.

Towards the end of the conference sessions on Wednesday 16 November, we will imagine a display, thinking about what it might look like, what common themes there are, and what we'd want people to know. It will be a glimpse into how displays and exhibitions are made. There will a chance to virtually explore some of the museum's collection in an object quiz. The Science Museum has world's largest medical galleries featuring more than 3,000 medical artefacts, striking artworks, interactive games and immersive experiences that bring the history of medicine to life. The Science Museum also cares for around 100,000 from Sir Henry Wellcome's museum collection and is constantly adding to their collection. Come along, be creative, and what you suggest might one day find a home at the Science Museum.

History of Geriatric Medicine Roadshow

Don't miss your chance to see some items of historical interest preserved in the BGS library and archive, and to meet our Honorary Archival Librarian, former BGS President Mike Denham, to discuss the display and ask him any questions you might have about the history of BGS.

Thursday 17 November

Film Club

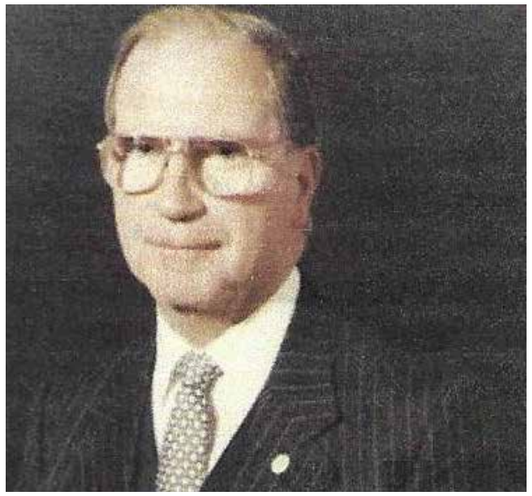
If movies are more your thing, come and join us for a screening of a film relating to ageing and older people's healthcare. There will be a chance to speak to the creators and ask questions - and who knows, if you feel particularly inspired, maybe next year we will screen your film!

Friday 18 November

BGS Book Club: #geribookclub Live!

Calling all book lovers! The BGS Book Club will be live at the BGS Autumn Meeting. Whether you work with older adults, care for them, or are approaching advancing years yourself, we invite you to join a lively discussion around themes such as the representation of older adults, cognition, death and dying, and societal attitudes towards ageing. At the time of print, the book title was still to be confirmed, but keep an eye out for further announcements.

Register for the Autumn Meeting and enjoy your special BGS Member discount!
Visit www.bgs.org.uk/Autumn22



Obituary: Dr John LC Dall OBE (1929-2022)

Dr John LC Dall OBE, O. St. J., MD, FRCP (G&E) was President of the British Geriatrics Society from 1990-92 as well as a powerful advocate of modern geriatric medicine in the UK and internationally. He died on 17 June 2022.

John Lamont Cameron Dall was born on October 15th 1929 in Glasgow. His parents were Janet and Robert, a commercial traveller. He was educated at Hutcheson's, a local boys' grammar school, and Glasgow University, graduating in medicine in 1953.

After completing two house posts, he was a medical officer in the RAMC, finishing his National Service in 1956. In 1957 he married Lilian Margaret (née Gibson), an anaesthetist, with whom he had two daughters. One followed him into the medical profession. He was appointed to various junior posts at the Victoria Infirmary. He passed the MRCP(G) and MD examinations in 1962. At this stage he considered his career was in cardiology.

However, the views of Professor Noah Morris, influential head of the University Department of Materia Medica and Therapeutics helped to change his mind. Morris was a determined proponent modern medical care of the elderly with its powerhouse based in Stobhill Hospital, Glasgow. John decided that his future lay in this field. It is noteworthy that three of the first professors of geriatric medicine had all worked in Morris' department.

Between 1962 and 1967 John was appointed to senior clinical appointments in general and geriatric medicine in Glasgow and Paisley, before becoming a full-time geriatric physician at the Victoria Infirmary, Glasgow in 1967, where he later became its medical director. The geriatric unit, later renamed the Mansionhouse Unit, was the first standalone specialist unit in Scotland, opening in 1972 with its day hospital following the next year. It was much visited and attracted doctors keen to follow John's example. He was a fine clinician, teacher, mentor and published widely. His approach to the care of older people helped to ensure that geriatric medicine became an accepted career choice.

He became a stalwart advocate of modern geriatric medicine in the UK. He was very active in the local Scottish branch of the British Geriatrics Society (BGS), influenced policy in the BGS and various national committees. His contacts with pharmaceutical companies enabled him to organise national and innervational conferences. He was elected President of the British Geriatrics Society 1990-1992.

John rapidly made an international impact. He was appointed visiting professor/lecturer in Canada, Hong Kong and Japan and was advisor to the Government of Singapore. From 1978 he developed an increasingly strong influence in the International Association of Gerontology (IAG). In 1981 he was secretary of its clinical section (Europe), was president of the section in 1985 and President of European National Congress (IAG) in 1987.

He retired from clinical practice in 1992 but continued to work for the NHS as Chairman of the Board of Management of the Victorian Infirmary NHS Trust until 1996 when he fully retired.

He was awarded an OBE for services to geriatric medicine, was appointed to the Order of St. John and awarded an honorary Doctorate of the University of Ottawa for his work in helping in the development for services for older people.
He was a likeable man with great charm and personal integrity. He much enjoyed golf, being a member of Royal Troon and Pollock golf clubs. However, he never went on to won the BGS Golf Cup. He died peacefully, aged 93, in the Queen Elizabeth University Hospital, Glasgow on 17th June 2022.

Dr Michael Denham
Former BGS President (1992-1994) and
Honorary BGS Archivist

Dr Dall's legacy

The family of the late John Dall have donated a generous sum of £10,000 to the BGS, which will be used to fund the BGS's annual Rising Star Award for Research.

The BGS confers two Rising Star Awards per year. One is for research contributions that have translated into, or are in the process of being translated into, improvements to the care of older people. The other is for clinical quality or a work project that demonstrates that the nominee has improved the care of older people with frailty.

Dr Dall's family felt a donation towards the Research award would be in keeping with their father's support for the next generation, as well as his passion for innovation.

The Clinical Quality award is funded from a donation by the family of the late Dr James 'Jim' George, former BGS Vice President for Clinical Quality, who died in 2017.

Tribute to Professor Davis Coakley

Professor Davis Coakley MD, FRCPI, FRCP London, FRCP Edin, was regarded as one of Ireland's greatest geriatricians and scholars and was President of the Irish Gerontological Society (IGS) from 1990-94. He died on 25 September 2022.

Professor Coakley, a fellow of the Royal Colleges of Physicians of Ireland, London, Edinburgh and Glasgow and Honorary Fellow of Trinity College Dublin, was one of Ireland's most respected physicians and medical academics, who championed the development of geriatric medicine throughout the country. As a direct result of his initiatives, physicians in the specialty now form the largest subspecialty in medicine in Ireland.

Awarded entrance university scholarships, he attended University College Cork, where he achieved first place in medicine in his final examinations in 1971. Even as a medical student, his enthusiasm for writing prevailed, as editor of College Literary Magazines and the Irish Medical Students Journal. His love of and talent for writing flourished lifelong. After postgraduate training in Cork, Dublin and Cardiff, he was appointed senior lecturer in geriatric medicine in the University of Manchester, returning to Dublin in 1979 as consultant physician in St James's Hospital and senior lecturer in Trinity College Dublin. In Cardiff he worked with Professor MS Pathy and Dr FL Willington. In 1996, he was appointed to a personal chair in medical gerontology in Trinity College Dublin, the first such academic appointment in the country. He went on to establish the first department of medical gerontology, a department that is home to many of Ireland's PhD, MD and Master graduates in the specialty and many of whom shared outpourings of sorrow, gratitude and respect after his death. Under Davis's stewardship the department continued to grow and increase its academic posts, enabling Ireland to command a leadership role in research in ageing and a new build institute at St James's Hospital, Mercer's Institute for Successful Ageing.

At Trinity College, Davis held many senior positions on committees and boards over the years. As Director of Postgraduate Education and Dean of Health Sciences, he initiated Trinity's membership of the prestigious Eurolife consortium, and he developed the first masters in Geriatric Nursing. In 2018, he was awarded the University College Cork Medical School medal. Davis influenced important infrastructure preservation which meant a great deal to him,

such as the acquisition of the AIB Bank on Foster place, in collaboration with then provost Tom Mitchell; and the preservation of the birthplace of Oscar Wilde at 21 Westland Row, now a successful creative writing centre. Typical of his attention to detail he oversaw the refurbishment of Oscar's birthplace in the style of the 1850s. He then invited Merlin Holland, Oscar Wilde's only grandson, to Dublin for the opening of the refurbished building. Merlin and Davis became firm friends and Merlin travelled a number of times to Ireland thereafter.

He also initiated preservation of the old anatomy building at Trinity College, raising awareness of its importance as the only intact surviving anatomy school in Great Britain and Ireland and of its future potential as an anatomy museum. The museum is now an established project in the college. Davis was passionate about history and literature and as such was the longest running trustee of the beautiful Edward Worth library at Dr Stevens' hospital, now carefully refurbished and open to scholarly readers and researchers. He was also librarian for the Dun's library, a collection that represents 250 years of medical education and advancement in Ireland. Both libraries meant a great deal to him.

He was a longstanding member of a number of societies including the British Geriatrics Society (serving in the BGS Pharmacology and Therapeutics Section), the Irish Geriatric Society and Association of Professors. He published over 150 scientific papers and 18 books on medical science and on historical and literary subjects. Two of his medical books were deemed "significant landmarks in the development of geriatric medicine and pioneering volumes in their field." He discovered the importance of ocular microtremor in consciousness and neurodegeneration during his MD thesis work in Cardiff and persisted with this research which has just recently translated into a new technology. His beautifully illustrated book *The Anatomy Lesson: Art and Medicine* informed a successful exhibition of Irish anatomical art at the National Gallery.

He will be dearly missed by those of us so privileged to have worked with him and learned from his reflective, sincere, intelligent, altruistic, purposeful character, his remarkable interpersonal skills and his ever wit and roguish sense of humour. Thank you, Davis.

Regius Professor Rose Anne Kenny
Trinity College Dublin
President, Irish Gerontological Society

Richard Matthew Dodds: A rising star of Academic Geriatric Medicine

Dr Richard Dodds was a much-loved, generous and active member of the BGS community, and a winner of the Rising Star Award in 2020. He died on 25 May 2022.

Dr Richard Matthew Dodds was an immensely talented clinician and a rising star in the world of academic geriatric medicine. After qualifying from St George's Hospital Medical School where he was awarded a first-class intercalated degree in medical genetics, he completed his foundation training in London. In 2009 he moved to Southampton to pursue a career in academic geriatric medicine and was awarded a Wellcome Trust Research Training Fellowship to complete a PhD at the MRC Lifecourse Epidemiology Unit. His PhD research - defining normal ranges for hand grip strength across the life course has had huge impact – it is highly cited and has had a major influence on international guidelines for the diagnosis of sarcopenia.

After his PhD Richard returned to clinical work in Wessex and completed higher speciality training in Geriatric Medicine. His keen intellect, modesty and commitment to taking a meticulous and kind approach to the care of patients, families and colleagues placed him in great demand as a prospective consultant colleague on the south coast. However, Richard instead took the opportunity to move to Newcastle, joining the newly established AGE Research Group led by his PhD supervisor and mentor, Professor Avan Sayer. The next few years saw a steady stream of influential papers on the epidemiology of sarcopenia, and Richard was at the heart of a rapidly expanding theme of translational ageing research at the NIHR Newcastle Biomedical Research Centre. His growing reputation was celebrated by the British Geriatrics Society who bestowed their Rising Star Award on him in 2020. Richard continued to contribute to clinical work as a consultant geriatrician and was an inspirational teacher and mentor to students and junior colleagues in his academic role. Richard also had numerous external responsibilities and was an industrious and supportive secretary of the UK Academic Association of Geriatric Medicine.

Richard enjoyed being outdoors – whether running, skiing, climbing or walking – and he shared these passions with Chris, his partner of 12 years. Richard planned to run the London Marathon this year, fundraising for Age UK with colleagues from the European Academy for Medicine of Ageing with whom he had spent many happy days training to be a future leader of academic geriatric medicine. Chris will now take on this challenge in Richard's place. Work did not prevent Richard enjoying a varied and active social and family life with Chris, his mother Kay, sister Alison and her family and his many friends and colleagues. For so many of us, Richard embodied the qualities of the doctor we would want looking after us in our old age.

All who knew Richard will miss his intellect, modesty, welcoming approach, his smile and consistently positive attitude, his sense of empathy, and his kindness and willingness to spend time asking and listening. Richard leaves his partner Chris, his mother Kay, and his sister Alison.

This obituary was first published in The BMJ: www.bmj.com/content/378/bmj.o2253 (with permission).

Running for Richard

In Spring 2022, five European geriatricians, all connected through the European Academy of Medicine of Ageing (EAMA), decided to commemorate the European Union Geriatric Medicine Society (EuGMS) congress being held in London by running the London Marathon. One of these geriatricians was Richard Dodds.

Early fundraising plans had been led and co-ordinated by Richard, but in late May 2022 as training got underway, we all received the devastating news that Richard had died suddenly.

Richard was a passionate runner, and firmly believed in the value of the work undertaken by Age UK. The team were honoured when his partner, Dr Chris Smith-Duque, said that he wanted to take Richard's place in the marathon and continue the fundraising work. The team also included Dr Johannes Trabert from Frankfurt, Dr Carly Welch from Birmingham, and Dr Melanie Dani from London. This inspirational team of European geriatrician runners successfully completed the London Marathon on 2 October, and so far they have raised in excess of £14,000 for their cause. It's not too late to donate to the JustGiving page set up by the team and help support the important work of Age UK by visiting **www.justgiving.com/team/europeangeriatricians**

BGS AGENDA

Vacancies *and notices*

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

Junior Representative Vacancies

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

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

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

Update your details!

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

Notice of Annual General Meeting (AGM)

This year's AGM will take place on Friday 11 November 2022 at 1pm via Zoom.

The BGS AGM is an important opportunity for members of the Society to vote on key resolutions and proposals, such as approval of the BGS Strategic Plan for 2023-26 and the revised membership fees for 2023.

The papers for this year's AGM will shortly be available to download from the BGS website at **www.bgs.org.uk/AGM**.

Please register your attendance at the AGM in advance if possible.

You need to be a current BGS member to view the papers or register your attendance.

BGS

Autumn Meeting 2022

16-18 November 2022

ExCel London & Online

TAKE A SEAT!

ATTEND IN PERSON OR ONLINE

The BGS Autumn Meeting 2022 is being held as a hybrid event, giving you the choice to attend physically or virtually. View the programme online and register today!

www.bgs.org.uk/Autumn22