AGENDA

British Geriatrics Society
Improving healthcare for older people

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Getting a move on

Mobilising *everyone* to make rehabilitation, reablement and recovery their business

PLUS

- **BGS event report**
- **SAS update**
- **Frailty language**

AGENDA
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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: **Dr Ruth Law, Dr Deb Gompertz**
Publishing and Production Editor: **Amy Brewerton**

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President's *Message*

This issue of *AGENDA* focuses on rehabilitation and intermediate care. A recent *Health Service Journal* article showed that, in England, 14% of NHS-funded community beds have no rehabilitation, reablement or recovery resource attached to them.

This means that – by their estimate – some 20,000 people a year move from the acute hospital setting to beds where they cannot access rehabilitation expertise. This state of affairs is replicated in the other UK nations, albeit potentially on a smaller scale. That this can happen in the third decade of the 21st century seems almost beyond belief – even if it won't surprise many of you reading this editorial.

Rehabilitation and reablement have always been at the heart of geriatric medicine. In the 1930s, Marjory Warren first left her indelible mark on healthcare by starting a process of comprehensive assessment and targeted rehabilitation for the older population at the West Middlesex County Hospital.

Subsequent randomised controlled trials and meta-analyses evidencing the impact of comprehensive geriatric assessment on outcomes ranging from mortality to functional independence, cognitive impairment and hospital admissions have had, at their core, a strong focus on rehabilitation.

Given how strong this evidence base is, how do we find ourselves in a situation where rehabilitation is not seen by policymakers, commissioners and leaders in the provider sector as a fundamental right for older people following an acute illness?

The answer is, I suspect, complex. For many it's in the category of "unknown unknowns" – people know to expect responsive primary care and good emergency care, but many fewer see rehabilitation as something they need or could benefit from. There is less outrage if a community service is understaffed or dissolved than if, for example, an emergency department is considered for closure. There are issues of resources following patients as we translate evidence into practice.

'People know to expect responsive primary care and good emergency care, but many fewer see rehabilitation as something they need or could benefit from.'

The original pilots of Discharge to Assess majored on comprehensive assessment and rehabilitation. Yet, in parts of the country, implementing this model at scale and pace has seen a focus on moving people out of hospital quickly without ensuring that community staff are available or equipped to meet them. Finally there's the issue of not enough staff in any part of the system – and a desperate lack if data to work out how many we need, or how big the shortfall is.

What can we do about this? First, we can start by outlining what good, evidence-based practice looks like. We did this, in part, through *Joining the dots: A blueprint for preventing and managing frailty in older people* (see **www.bgs.org.uk/Blueprint**) and have added to the detail through our recent publication of *Reablement, Recovery, Rehabilitation: Everybody's Business* (which can be found at **www.bgs.org.uk/Rehab**).

Secondly, we can proselytise widely about rehabilitation as one of the solutions to the health and social care system's woes. Ensuring that people have the opportunity to recover back to baseline functional status is not just the moral, ethical and decent thing to do – it also reduces readmissions and future healthcare resource use.

Thirdly, we can continue to campaign around the workforce needed for rehabilitation to work. Our call for more geriatricians seems, hitherto, to have fallen on deaf ears with NHS workforce leaders at a national level. We have also faced resistance in accessing the available data about the wider multidisciplinary workforce needed to deliver effective rehabilitation for older people across the health and social care system. We are, though, undeterred, and will continue to campaign in this space as we start our #ChooseGeriatrics workplan.

In the pages of this issue of *AGENDA* you'll read examples of the challenges facing those of us who believe strongly in older people's right to rehabilitation. You'll also read, in the spirit of this publication, examples of how expert practitioners who care and who want to make a difference are able to do so. If I can encourage you to do anything with this information it is to renew your determination to make rehabilitation everybody's business.

Wherever you work within health and social care we should not accept the status quo. We should, instead, campaign for the opportunity to make the difference we know it can, for the older patients we serve and advocate for.

Hopefully this issue of *AGENDA* can help you think about this with some helpful case studies and worked examples.

Adam Gordon
BGS President
@adamgordon1978

Dr Amit Arora to become next BGS President Elect

BGS is delighted to announce that Dr Amit Arora has won the recent member election to be the next President Elect.

Dr Arora will officially take up the role during the BGS Autumn Meeting on 20 November 2024. He will be supporting the incoming BGS President, Professor Jugdeep Dhesi, for a period of two years, and will then become President himself from November 2026.

Dr Arora is the creator of the highly successful deconditioning awareness and prevention campaign 'Sit Up, Get Dressed and Keep Moving!' Last year he led a follow-up campaign, 'Recondition the nation'. Both campaigns have been adopted by hospitals across the UK and abroad. He is credited with rejuvenating the term 'deconditioning' to describe the functional decline experienced by older people when they are not physically active, due to illness or disability.

Dr Arora is a Consultant Geriatrician at the University Hospitals of North Midlands and Associate Medical Director at Midlands Partnership University NHS Foundation Trust. He is currently the BGS Vice President for Workforce and was previously BGS Chair of the England Council.

He was previously a member of the Disability Living Allowance Advisory Board in England. He has served on a number of NHS England and Department of Health and Social Care committees, advisory bodies and working groups. He chaired the West Midlands Quality Review Service for people living with dementia and frailty, advising commissioners and provider organisations.

He is also the founding director of the National Frailty Academy which is providing free frailty training to all grades of health and social care workers. Dr Arora is clinical lead for the NIHR West Midlands Clinical Research Network. Dr Arora's research, editorials, reviews and national reports have appeared in more than 100 publications.

REPORT OUT NOW

BGS roundtable: Transforming care for older people

www.bgs.org.uk/Roundtable24

BGS has called on the Government, NHS organisations and the voluntary sector to take urgent steps towards transforming care for older people. Our new report is the result of a roundtable event held in June with England's Chief Medical Officer, Professor Sir Chris Whitty, and leaders from the NHS, social care, the voluntary sector and think tanks.

In 2023 Professor Sir Chris Whitty published his annual report *Health in an ageing society* and the BGS published its blueprint, *Joining the Dots*. These two publications set out the opportunities and challenges of an ageing population. They show how health and care systems need to change to delay the onset of frailty and disability, and how they can better cater for the needs of this user group.

The problems, and the solutions, are well known. The issue now lies with implementation, which was the focus of this roundtable discussion.

It covered five themes – the need for a skilled workforce, better use of data and technology, social care and housing, prevention and healthy lifestyles, and better integration of services. Our report makes ten recommendations of organisations across health and care.

We are grateful to all our participants for attending with a spirit of openness and collaboration, demonstrating a determination to make real changes to older people's healthcare. This was despite the event taking place during the pre-election period and some of our participants with roles in the civil service being limited in what they could say.

BGS has a crucial role in bringing together leaders from across sectors. We were pleased to convene this group of decision-makers who are well-placed to influence how older people are cared for in acute, primary, community and social care settings. We have committed to doing so again in early 2025 to identify where progress has been made and where work is still needed.

Professor Adam Gordon MBE, President of the British Geriatrics Society, said: "We are very grateful to everyone who participated in our event and for their commitment to transforming the design and delivery of older people's healthcare. We hope that our report captures the discussions and that those reading it can help to deliver our shared vision of improved care for an ageing population. Over the coming months, we will be using this report to engage with the new Government to ensure that they are as committed to improving healthcare for older people as the people at our roundtable are. The future of our health and social care system will be shaped by how well we care for an ageing population. We must get this right."

Professor Sir Chris Whitty, Chief Medical Officer for England, said: "Maximising the quality of health in older adults should be seen as a national priority - we can make very significant progress with relatively straightforward evidence-based interventions. We need to recognise and reflect in policy and medical practice where older people are concentrated geographically, maintain clinicians' generalist skills, improve mental health provisions and make it unacceptable to exclude older adults from research because of older age or common comorbidities."

Read the report in full at www.bgs.org.uk/roundtable24

Marjory Warren Lifetime Achievement Award Winner: Dr Firdaus Hirji Adenwalla

The BGS is delighted to announce that Dr Firdaus Hirji Adenwalla has been awarded the Society's prestigious Marjory Warren Lifetime Achievement Award for 2024. Named in honour of the founder of modern geriatric medicine, Dr Marjory Warren, the award is presented annually to someone who has made an outstanding contribution to the healthcare of older people.

Dr Adenwalla, a Consultant Geriatrician, qualified in Mangalore, India in 1989, before moving to Wales in 1998. In 2005 he was working in Neath Port Talbot Hospital at Swansea Bay University Health Board when he collaborated with the lead Advanced Nurse Practitioner, Annette Davies, to establish the Neath Port Talbot Acute Clinical Team. The team's aim was to move beyond traditional domiciliary care and provide Hospital at Home services for adults, particularly those living with frailty, a service that was one of the first of its kind in the UK. Dr Adenwalla and his team demonstrated that Hospital at Home services were a viable alternative to traditional hospital care. From the outset, the objective of the team was to provide timely, multidisciplinary care in the community. It was also one of the first to work with the ambulance service to accept patients directly from the 'call stack'. This achievement was recognised by the Bevan Commission as a 'Bevan Exemplar'. Their work with care homes during the Covid-19 pandemic won the BGS Eva Huggins prize.

At Neath Port Talbot Hospital, Dr Adenwalla collaborated with Afan Nedd Day Unit's Ward Manager, Lynne Hall, to develop multidisciplinary falls prevention clinics, rapid access assessments and the provision of urgent day-case blood transfusions and other intravenous treatments. The day unit worked closely with the Hospital at Home service to break down existing barriers between primary and secondary care. Since April 2024, Dr Adenwalla has worked as a Consultant Geriatrician in the recently commissioned 'Safe at Home Service' at Cardiff and Vale University Health Board, Wales. His role is to provide senior clinical cover supporting GPs and advanced clinical practitioners (ACPs), and to provide teaching and training for ACPs and nurses. He also works with management to develop and deliver a comprehensive seven-days-a-week Hospital at Home service.

Dr Adenwalla has contributed to BGS publications about community-based care for older people including 'Bringing hospital care home: Virtual Wards and Hospital at Home for older people', "No place like home" RCP report on Virtual wards and Hospital at home and Good practice guide for managing Covid 19 in Care homes. He is on the committee of the UK Hospital at Home Society. He has presented his work at National BGS and Ambulatory emergency care conferences. He brings his wealth of experience and expert insights to such reports, team meetings and education.

Professor Adam Gordon MBE, President of the BGS, said: "Dr Adenwalla is a great example of someone wholly committed to improving care for his older patients. Over many decades, he has innovated and developed services close to home, pioneering the Hospital at Home model. I am delighted we can reward his significant contribution to older people's healthcare in Wales with this prestigious award, recognising a lifetime of achievement."

Dr Adenwalla said: "This award is indeed a great honour, and I feel humbled that my colleagues find me deserving of this recognition. Over the years I have had the privilege of working with inspirational and committed healthcare professionals across the hospital and community. This award acknowledges their dedication and recognises the importance of Hospital at Home services across the UK."

BGS responds to Darzi Review

On 12 September, Professor Lord Ara Darzi published the report of his independent investigation of the NHS in England. The BGS welcomes this report and looks forward to working with the Government and other stakeholders as the NHS Ten Year Plan is developed over the coming months.

Lord Darzi's report on the NHS outlines many of the issues that our members tell us about every day. We particularly welcome the acknowledgment of the skills and commitment of the NHS workforce and the immense pressures that NHS staff face on a daily basis. We also appreciate Lord Darzi's appraisal of strengths and the pride we take in our NHS.

Professor Adam Gordon MBE, President of the British Geriatrics Society, said: "Lord Darzi's report rightly describes insufficient long-term investment in buildings, community services and digital infrastructure, all of which have hindered efficient and joined-up care. Systems and services are not configured in ways that work for patients or healthcare professionals supporting our communities.

"As Lord Darzi rightly points out, the ageing population and the rise in multimorbidity pose particular challenges that were not envisaged when the NHS was established. However, the report fails to recognise the impact of frailty and cognitive impairment on many older people and on the health and social care system. Whilst Lord Darzi states that 1 in 8 hospital beds are occupied by patients waiting for social care services, it is disappointing that social care was considered out of scope for this review. We look forward to the Government delivering on their manifesto commitment of social care reform.

"There is nothing in Lord Darzi's report that will come as a surprise to our members - the problems in the NHS have been known for some time. However, the solutions are also known, as outlined in the report published from our recent roundtable on older people's care. We urge those developing the upcoming NHS Ten Year Plan to move forward from outlining problems and potential solutions and towards implementation. At BGS we stand ready to support with the expertise of our 5,000 members in improving healthcare for older people, the biggest user group of health and care services. If the system works for older people, it will work for everyone."

Lyndsey Dunn appointed Chair of the BGS Nurse and AHPs Council

BGS is delighted to announce that Lyndsey Dunn has been appointed as the next Chair of the BGS Nurse and AHPs Council. She will officially take up the role on 15 November 2024.

Lyndsey currently works as a Clinical Service Manager for Fife Health and Social Care Partnership and has 22 years' service with NHS Scotland. Her responsibilities include managing community flow, integrated discharge teams, community nursing and specialist services. She is currently Deputy Chair of the BGS Nurse and AHPs Council. Since qualifying from Edinburgh Napier University with a degree in Adult Nursing Lyndsey has worked as a Frailty Nurse in Acute Medicine, a POPS (Perioperative Care of Older People Undergoing Surgery) Specialist Nurse and as a Lead Nurse for Quality Improvement and Standards.Lyndsey has a special interest in the early identification and management of patients at risk of delirium and in person-centred discharge planning. She has presented her work at a number of prestigious national events and webinars. In addition, she was a key contributor to the recent BGS report 'Reablement, Rehabilitation, Recovery: Everyone's Business'.

Lyndsey Dunn commented: "It is a privilege and honour to have been elected as the next Chair of the Nurse and AHPs Council. I look forward to taking up the position in November and working with the BGS as we strive to improve healthcare for older people."

BGS announces two new Vice Presidents: Workforce and Education & Training

BGS is pleased to announce that Dr Claire Copeland has been appointed as its next Vice President Workforce. She will officially take up the role on 15 November. In addition, Dr Iain Wilkinson has been appointed as its next Vice President Education and Training, taking up the role from 7 October.

Vice President Workforce: Dr Claire Copeland

Dr Copeland is a highly experienced senior geriatrician and medical leader who for over 20 years has combined delivering excellent innovative care with service review, redesign and transformation. She has worked in acute and community care roles and brings an understanding of the multidisciplinary workforce which is so vital to sustainable care for older people. She is Deputy Medical Director for Primary Care and Community Services for NHS Highlands. This exposes her to the workforce challenges of remote and rural settings, as well as deepening her understanding of urban models. Her previous experience in Acute Services has helped shape and evolve her thinking around workforce, especially across the many interfaces that healthcare professionals caring for older people work across. She strongly believes that understanding the needs of local people by involving them in workforce planning can be incredibly powerful.

Speaking of her appointment, Dr Claire Copeland commented, "I'm thrilled to be taking up this important role on behalf of the BGS. Workforce planning for our ageing population has never been more critical. Only through shared understanding and collaborative multi-professional working will we be able to provide impactful and sustainable solutions to meet this need."

Vice President Education & Training: Dr Iain Wilkinson

Dr Wilkinson has been working as a consultant geriatrician in Surrey and Sussex Healthcare NHS Trust since 2014. His clinical interests include orthogeriatrics, acute geriatrics and Parkinson's disease. Currently Iain runs an acute ward, an intermediate care ward and a virtual ward, seeing patients across the whole spectrum of older people's care in the Trust. He also runs a weekly movement disorder clinic.

As a clinical leader, Iain has held a number of leadership roles since becoming a consultant. Initially he was joint Clinical Lead for the Kent, Surrey and Sussex (KSS) Academic Healthcare Science Network's hip fracture programme, working with teams across 13 acute trusts to develop neck of femur fracture care. He was then joint clinical lead for the Parkinsons UK South East Coast excellence network. He has been clinical lead for the Department of Medicine for the Elderly in East Surrey Hospital for four years and is also Clinical Director for Frailty. Iain is the clinical lead for the East Surrey Ageing Well group for Surrey Heartlands ICS.

Iain is a passionate clinical educator and has run simulation learning courses in hospitals and care homes. He developed e-learning courses for NHS (accessible through their e-learning for Health website) and established the very successful MDTea podcast, which has had over 500,000 downloads of educational content for multiprofessional teams caring for older people.

Iain was a Training Programme Director (TPD) for geriatric medicine within KSS for a number of years and is now TPD for trainees who require additional support. He has been a member of the BGS Educational and Training committee for a number of years.

Dr Iain Wilkinson commented: "I am really looking forward to taking up this role and continuing to develop the Society's multidisciplinary professional education and training. I am excited to work with the inspirational people in the BGS committed to the goal of ensuring healthcare professionals have the knowledge and skills they need to provide high-quality care for older people."

For more news and announcements from BGS, keep an eye on our news page at www.bgs.org.uk/policy-and-media

Treatment, Rehabilitation, Reablement, Recovery ...of the NHS?

BGS Deputy Honorary Secretary, Deb Gompertz, reflects on the future of the NHS, and considers whether principles of rehabilitation for older people could be equally applied to an ageing health service.

The new Health and Social Care Secretary, Wes Streeting, has described the NHS as 'broken.' Maybe, with his acceptance of it being damaged, we can move forward to rehabilitation, reablement and recovery - not only for the people and patients we look after, but also for carers and the workforce.

Some 76 years ago, the NHS was set up to meet the demands and needs of a very different population and environment to the one we are now living in. BGS members experience first hand the needs of a significantly ageing population, along with increasing multimorbidity, which intensifies workforce pressures on all levels. In addition to this, the effect of climate change is evident all around us – on a global level, wildfires, floods and heatwaves have already occurred in 2024, and the situation does not look set to imminently change. We need a sustainable, supported workforce, and novel ways of working to ensure longevity of the NHS.

'There is much to learn from other's successes and failures, not reinventing the wheel, and really importantly, listening to people and carers.'

Treatment: Care given for an illness or injury

With the health of the NHS acknowledged as a problem, we can now start 'treatment' and the process of repair. It is important that the new Government remember that to properly support the NHS, we need to support the people who work in the NHS. Maybe now there is an opportunity to reverse underfunding, improve recruitment and retention, and most importantly give staff the time to care.

Rehabilitation: Restoring something that has been damaged

I feel like we almost need time to pause and reset. We need to be able to move back from transactional person/patient interactions, and to be able look at people as a whole again. Social care must be included as part of generalist care. To achieve this, we must work together. Perhaps it is the system itself that has become too complex, not the people we look after. We need to work smarter and be more joined up with our services.

Staggeringly the King's Fund has estimated that 250,000 people out of the 1.2 million working in the NHS are also carers. These carers are often juggling work and advocating for their relatives, care coordinating in a system that is difficult to navigate round. They not only understand the limitations of what's there on offer but can add to the discussions on what could be done better and differently.

There is much to learn from other's successes and failures, not reinventing the wheel, and really importantly, listening to people/patients and their carers. There is a lot to learn from 'expert carers', who like expert patients, have real and meaningful lived experience and can provide a perspective often overlooked by policy and decision makers. We need to put a stop to unnecessary investigations, treatments and medications, instead focusing on prevention and reducing backlogs.

A recent BMJ 'Letter of the week' suggested reducing waste in the NHS could help deliver better health at a population level. The authors proposed that the £1 billion saved could be reinvested to improve health and prevent disease in a sustainable way.

Reablement: Relearn daily activities

Personalised care plans tell the story of people, patients, what really matters to them, and what is important to them. We need to value this information, and by providing IT platforms that capture these important details we can avoid people having to repeat themselves. People need to feel they are listened to.

Our IT systems need to talk to each other. Unless they can do this, we will continue to duplicate, waste time, devalue the people we look after, and frustrate the people doing the looking after.

We also need to try and stop over medicalising everything. Not simply a 'pill for every ill', but looking at alternatives that include prevention and social prescribing (including 'green' and 'blue' prescribing).

'Perhaps it is the system itself that has become too complex, not the people we look after.'

Recovery: A return to normal state of health, mind or strength

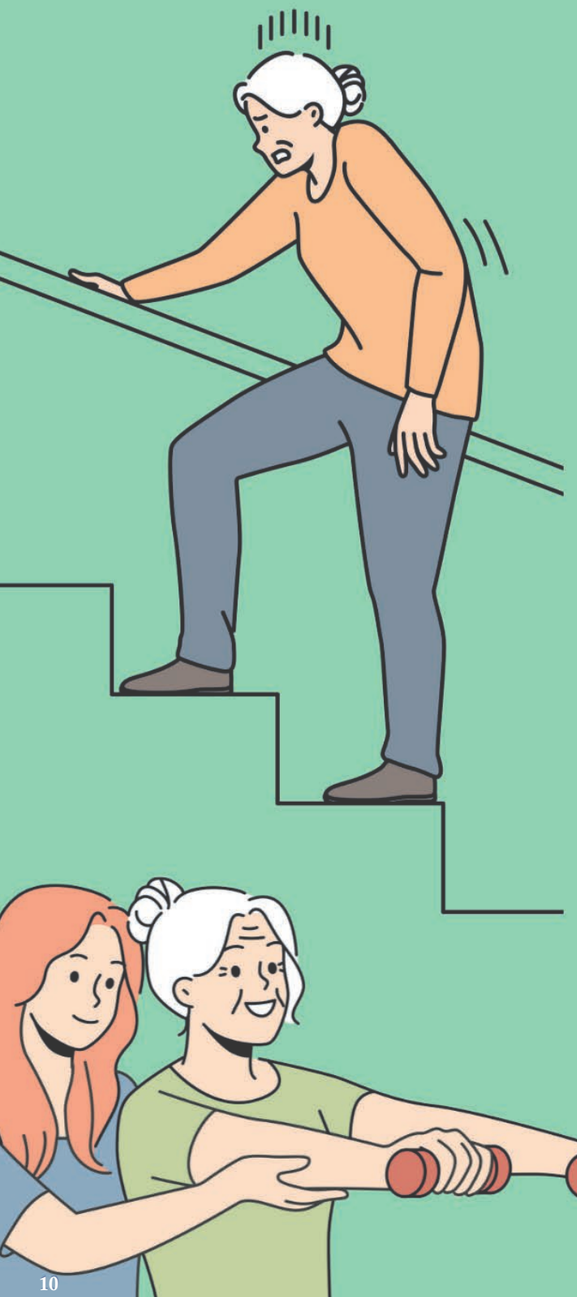
Following recognition of the problems we face comes recovery. Change invariably brings hope. The NHS in 76 years' time will look very different to the NHS now. Innovation and digital technology will no doubt enable constant change. But let's not forget Professor Andrew Elder (President of the Royal College of Physicians of Edinburgh) who at the BGS Spring Meeting 2024 said "the real power of technology is freeing hands to care." At the Royal College of General Practitioners (RCGP) conference in Autumn 2023, Lucy Easthope, a disaster planner, reminded us about moral injury and distress, and how real these were - and how as healthcare professionals we were rubbish at looking after ourselves!

We must be compassionate as leaders and to ourselves, remembering good communication and listening skills. I see the joy in our day-to-day work and the value we bring to people we look after, and supporting people in training of all professions. I often remind myself of the starfish story (The Star Thrower by Loren Eiseley) which many of you may already be familiar with. In the story, thousands of starfish were washed up on a beach after a storm. A little girl is seen to be throwing them back in, one by one. After a while a man asked her why she was throwing them back when there were so many; her actions would not make a difference and seemed pointless. Her reply each time she threw one back as that it mattered to that one, and to that one. People on the beach joined in, and all the starfish were saved!

Deb Gompertz
BGS Deputy Honorary Secretary
@DebGompertz

REABLEMENT, REHABILITATION, RECOVERY:

EVERYONE'S BUSINESS



I am delighted that this edition of *AGENDA* features articles from BGS members who worked with me on our recent publication *Reablement, Rehabilitation, Recovery: Everyone's Business*. It was a pleasure to lead the expert multidisciplinary group of BGS members drawn from our Special Interest Groups, committees and Councils.

Thanks to all for bringing their insights from across the UK along with their personal passion and expertise. I am also very grateful to our external reference group of advocacy and professional bodies for their constructive advice, and to the BGS policy and communications team for their excellent support.

The report describes a continuum of reablement, restorative and recovery approaches that should be at the heart of health and care services at each system touchpoint, framing access to rehabilitation as a right for older persons. It builds on our BGS Blueprint and makes the case that rehabilitation, like frailty, is everyone's business. The report presents 12 key messages that are supported by international evidence, examples of practice and quotes from lived experience.

We launched the report in May, just weeks before Wes Streeting, the new Secretary of State for Health and Social Care, announced his formal policy position that the NHS is broken. BGS members who face the reality of that broken system daily may feel that is simply stating the obvious. But it means there is an immediate opportunity for us all to advocate for a concerted focus on rehabilitation for older people as a critical step in restoring our broken system.

Here I present a slightly shortened version of the 12 key messages in the report. I hope this helps you pitch them with confidence when you are in conversation with national, regional or local influencers!

- Invest in rehabilitation as a priority for more sustainable care - it improves lives, delays dependency, reduces demand and costs for acute and long term care.
- Rehabilitation should be integral to care plans in all care settings.
- Age alone should not bar access but the approach, intensity and pace of rehabilitation may need to be adapted for people with specific needs.
- Future research should address the gaps around older people who have been excluded from studies due to cognitive impairment or socio-economic or cultural inequalities.

'There is an immediate opportunity for us all to advocate for a focus on rehabilitation for older people.'

- Rehabilitation at home allows a clearer focus on practical, real-life goals based on 'what matters to me' conversations and activities that the individual enjoys.
- All staff in all care settings should prevent older people deconditioning by encouraging mobility and offering early active rehabilitation.
- Older people should have a personalised care plan that promotes enablement and follows them across transfers of care.
- Rehabilitation is everyone's business - all disciplines and partners should work together and with age-friendly communities.
- Education providers should support everyone involved to work together and at the top of their licence to increase collective capacity for reablement and rehabilitation.
- Rehabilitation environments should be fit for purpose and enable older people to achieve their social goals as well as undertake activities of daily living at home.
- Monitor and continually improve the quality, experience and outcomes of rehabilitation.
- Identify a senior officer or non-executive Board member with a specific role in assuring and continually improving the quality of rehabilitation services for older persons.

There has been overwhelming support for the report from across disciplines and across the UK. The only 'kick back' has been on our ability to balance current workforce constraints with a commitment to a right to rehabilitation for every older person who needs it. The key to squaring that circle is to have a creative and integrated approach to workforce – valuing and developing the capability of all who work with older persons in all settings.

Please share this report with clinicians and managers who are planning or commissioning hospital, community, housing or leisure services for older people.

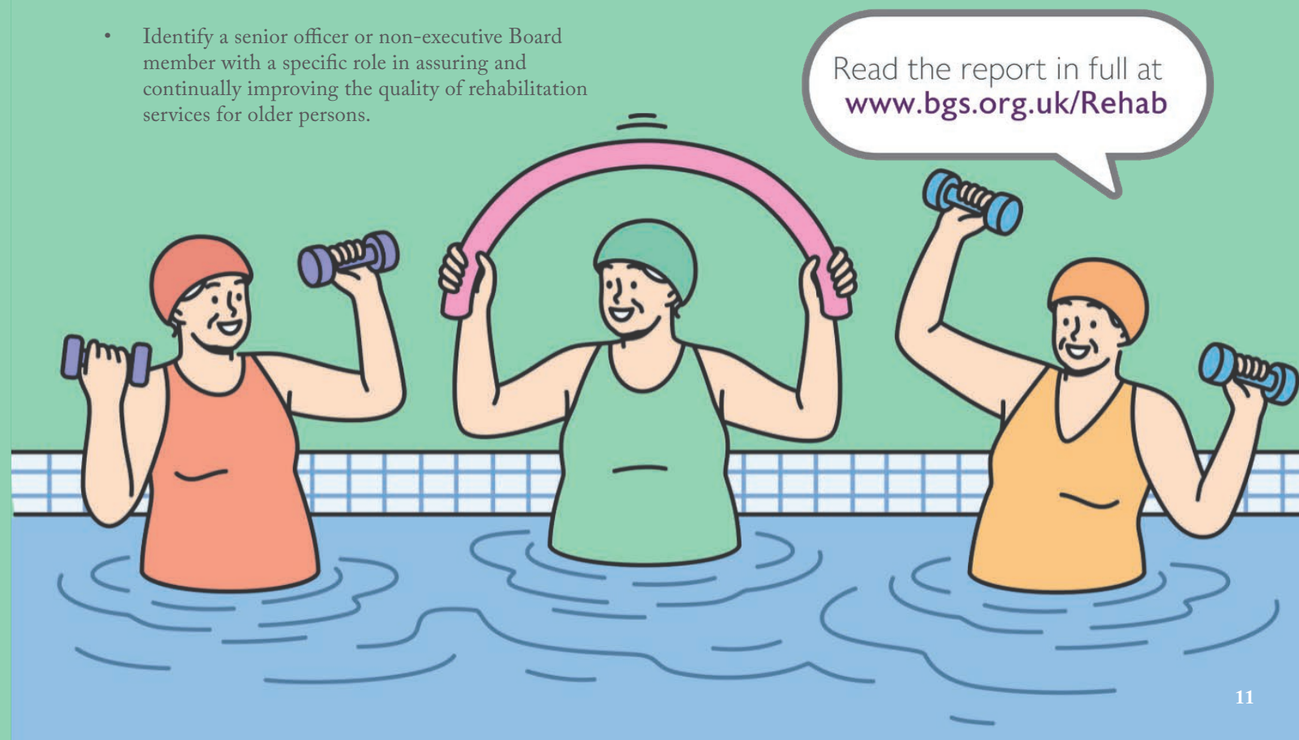
Tell them rehabilitation matters.

Convince them that rehabilitation for older persons is the route to sustainable care and support.

Encourage them to work together across health and social care disciplines, and with carers and community and voluntary sector partners to realise the right to rehabilitation for every older person.

Let's make it *our* business to position rehabilitation as *everyone's* business.

Professor Anne Hendry
Senior Associate, International Foundation for Integrated Care (IFIC); Director, IFIC Scotland; Honorary Professor, University of the West of Scotland; Lead Author, *Reablement, Rehabilitation, Recovery: Everyone's Business*
@AnneIFICScot



Minding all OUR business

The BGS publication *Reablement, Rehabilitation, Recovery* sets the challenge to make this area of care 'everyone's business.' Dr Alison Cowley, one of the allied health professional (AHP) contributors to the report, explains what needs to happen for this to be embedded into practice.

Who is 'everyone' and how can we enable and facilitate people to gain skills confidence to realise this mission?

Our working group started off with the circle of people involved in an older person's recovery (or even pre-habilitation) – including family members, therapists, nurses and medical staff. Teamwork works best when members take initiative based on the match of their skills to the needs of the individual, rather than professional hierarchies.

I have found this within my research in care homes; teamworking is best when nurses, therapists, care assistants and GPs share their knowledge of the resident and work towards goals for that individual. Team members can also learn from each other and we advocate for training in practice in care home and home settings, as well as the rehabilitation ward. Everyone can learn skills for caring for people with frailty, and there is even free online training available from BGS (see **www.bgs.org.uk/bgs-elearning** for more about this free frailty elearning course).

A risk of 'everyone's business' is that the patient's needs can be missed, especially when team-members are stretched. There are models of integrated workforce planning now that help to improve resource allocation across a place.

It was great to hear from one of our writing team who shared a story of a patient who had received rehabilitation from Intermediate Care Service in Fife. Following a stroke and early supported discharge, a community exercise group had rebuilt the patient's strength and confidence. Then talking

'A risk of 'everyone's business' is that the patient's needs can be missed, especially when team members are stretched.'

with a Local Area Co-ordinator helped the patient find new community connections. This emphasises the importance of continuity in rehabilitation; from clinic to community.

While we were writing about capacity and capability, we also considered infrastructure in the sense that our physical environment and our digital 'environment' are also important factors that enable successful recovery. Digital care records are an essential part of care and yet can sometimes be a challenge with team communications. Following COVID lockdown, many more people are familiar with remote consultations, and this may be more convenient for the patient rather than coming to rehab clinic. For patients who do need to be in the clinic, space is sometimes limited as hospital areas are redesigned (particularly seen with COVID pressures). A survey by Chartered Society of Physiotherapy found that 100 areas across UK reported loss of rehab space, so we need to make the case for re-establishing good facilities that encourage people's recovery.

I found it exciting seeing this report coming together and having the clarity of mission of rehabilitation and recovery. This fits perfectly into the bigger picture of the BGS blueprint document, *Joining the Dots,* in setting out the expectation of making high-quality, joined-up care a reality for older people across the UK.

Dr Alison Cowley (PhD)
Associate Chief Allied Health Professional Research & Innovation, NUH NHS Trust; Honorary Associate Professor, University of Nottingham, School of Medicine

Fit *to* function

Reflecting on the meaning of 'functional ability' in the context of rehabilitation, Professor Finbarr C Martin examines whether we need to raise our expectations of what older people could, should and might want to achieve.

You may have seen the recent BGS report, R*eablement, Rehabilitation, Recovery: Everyone's business*, which was inspired by the *Joining the dots* blueprint. One of the key messages, addressing issues on practical implementation, was a call for the person-centred approach to be understood. This doesn't simply mean the person in front of you in the here and now, but in the context of their lives as social beings.

"Relational and informational continuity, and coordination of care, are the essence of person-centred integrated care. Older people should have a personalised care plan that addresses their rehabilitation needs and is contextualised to their health trajectory, social circumstances and cultural norms. This plan should be iterative, following the patient across transfers of care, and promote continuous enablement as their needs change."

– Key message 7: Reablement, Rehabilitation, Recovery: Everyone's business

This hints at an individual's needs being broader than the usual notion of functional ability – personal activities of daily living (ADL) and instrumental activities of daily living (iADL). This is not news to clinicians, used to discussing personal rehabilitation goals with patients, but nevertheless when it comes to legitimacy of their efforts, for trial outcomes to assess effectiveness or for funders to justify costs, it is still these ADL functionalities and their links to dependency that generally trump any broader aspiration.

Thus when we hear "back to baseline" as a target, it usually refers to these functions, with the implication that this denotes success and moreover implies that it is the best we can expect – the "we" mainly meaning the clinician, but often also the patient. In so doing, we may be sidelining the aspirations (goals) for which enhancing ADL/iADL may be neither sufficient nor necessary.

This is why it's worth having a good look at the 2015 World Health Organization (WHO) model of healthy ageing, because this integrates an individual's physical and mental capacities (intrinsic capacity) with their environment in its notion of functional ability. In this model, healthy ageing is neither being able to run marathons, nor being free of disease, but defined as 'the process of developing and maintaining the functional ability that enables well-being in older age.'[1,2] And functional ability is having the capabilities that enable a person "to be and to do" what they have reason to value.

'More importantly... is the departure from individual-based capacity to focus on what it is feasible for an individual to be, or to do, in the social context of their life.'

This word - 'capabilities' - is central to this notion of functional ability, and as explained in a recent *Age and Ageing* commentary,[3] is based on a framework for evaluating wellbeing (or quality of life) which incorporates a theory of social justice and human rights.[4]

This all sounds like a bit of a mouthful, but as I understand it, there two key differences from the narrow view of function. Firstly in addition to meeting basic needs (food, hygiene, safe shelter, etc), the scope of each of the other domains of functional ability crucial in all humans' lives is explicit, albeit challenging to measure: the ability to move around; to build and maintain relationships; to learn, grow and decide; and to contribute to their communities. [1,2]

Secondly, and more importantly, is the departure from individual-based capacity to focus on what it is feasible for an individual to be, or to do, in the social context of their life - i.e. through their interactions with their environment in all its physical, social and cultural dimensions. So "to move around" is about being able to be in a variety of places, and is impacted (but not defined) by how far you can walk unaided. This highlights the external facilitators or barriers to functional ability and therefore wellbeing.

Again, this is not new in our multidisciplinary working. At its simplest, doctors and physios might focus on modifying intrinsic capacities of individuals, occupational therapists (OTs) on adapting the requirements of the specific activity, and social care on mobilising others to enable the capability.

What the multidisciplinary team (MDT) cannot do directly is modify the many other environmental constraints which impact the capabilities of a wider range of 'being' and 'doing'.

The potential of thinking in a way that is influenced by this model is that we identify where and when the physical, social and cultural dimensions of our environment are hampering the achievement of social justice and equity.

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Professor Finbarr C Martin
Emeritus Geriatrician and Professor of Medical Gerontology, Population Health Sciences, King's College London

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Rehabilitation IN Research

I am delighted to write my first column for the Agenda newsletter as the new Editor-in-Chief of *Age & Ageing*.

The journal is in fantastic shape thanks in no small way to the superb job my predecessor Rowan Harwood did for over five years. I appreciate the journal will be less familiar to many BGS members, especially the newer ones who only joined the society after the journal changed to being published online only. I am sure many of us miss the days when, once a month, the journal thudded onto our doorway floor. However, I recommend periodically having a look through the journal website. There is a helpful monthly 'Editor's View' article that summarises the most important messages in the previous issue, with links to the full article for those that want to see more detail. The journal has become arguably the most widely read and respected geriatric medicine journal in the world and it goes from strength to strength.

Taking on the role has made me reflect on the changing ways we practice geriatric medicine since I qualified. Rehabilitation practices may be perceived to evolve only slowly, but they have changed very considerably.

Long gone are the days of recommending convalescence and bed rest. I well remember therapist colleagues declining to see patients because they had delirium or were still receiving acute medical care. The perceived wisdom was that all the medical issues should be dealt with first. Then, when the doctors could do no more, the patient was deemed fit for discharge. More usually, since there was a good chance no one had bothered checking to see if they could get out of bed by themselves yet, the patient would then have to undergo rehabilitation.

'Rather than delirium being a contraindication to starting rehabilitation, rehabilitation and therapist input became the key intervention.'

That it is better to begin the process of rehabilitation and discharge planning from the moment of admission may seem obvious, but it was not 'the done thing' and medicine can be slow to adapt to new ways of working. A key instigator of change in my neck of the woods was when, in 2006, the BGS and the Royal College of Physicians jointly produced the first ever guideline on the management of delirium. The one intervention given the highest grade of evidence at the time was therapist and multidisciplinary team input. So, rather than delirium being a contraindication to starting rehabilitation, rehabilitation and therapist input became the key intervention overnight. It not only revolutionised delirium care, but all acute geriatric medical care, because we saw how early comprehensive geriatric assessment dramatically improved outcomes and reduced length of stay in practically all our patients, delirium or not.

Working as a multidisciplinary team, even in acutely unwell patients, is now the norm; though there are plenty of pockets of practice where services have not yet adopted this change, or do so in a disjointed way. This story shows the power of evidence-based medicine, and I am determined *Age & Ageing* plays a major role in improving the care of older people through publishing work that is innovative, clinically relevant, impactful and scientifically robust.

Much of the recent scientific literature has been dominated by COVID-19 and its effects, though this is gradually waning. We recently published an observational study of the outcomes in older people with frailty that required rehabilitation after contracting COVID-19. The good news was that for the large majority, outcomes were very good, even in the frailest groups. Our understanding of 'long COVID' is evolving and I have certainly been struck by the number of admissions to hospital I have seen with post-viral fatigue. Rehabilitation appears effective, not just to the point of allowing people to return home, but also in restoring their premorbid quality of life.

'Much of the rehabilitation-focused research we have published has attempted to test activities that are fun as well as therapeutic.'

What works and does not work in rehabilitation can sometimes be tricky to ascertain. Compared to pharmacological interventions, where the precise nature, dosage and indication of each one is very well defined, non-pharmacological therapies can be appear to be an unregulated jungle of interventions, often with multiple names for similar treatments, and totally inconsistent delivery. Perhaps it is no wonder they are notoriously under-utilised. A non-drug equivalent to the British National Formulary for such treatments seems to me to be badly needed. I am not sure if I will ever see that in my lifetime, but we recently published an article that may be a step in the right direction. It tried to classify the various interventions to allow greater clarity on what community-based complex interventions actually exist.

Incidentally, when speaking about this to a psychologist colleague of mine, she alerted me to the existence of 'The Matrix', which is precisely a florilegium of evidence-based psychological interventions, complete with training on their correct application and delivery. I believe it is only used in Scotland (and unlike the movie of the same name, does not feature Keanu Reeves), but otherwise, it seems to be an exemplar of what is needed more widely across the spectrum of non-drug treatments.

The other major challenge, even if we all agree that a rehabilitation intervention is effective, comes with implementation. With the usual concerns around staffing and resourcing, a major challenge can be ensuring the person is first willing to try it, and then stick with it long enough for the intervention to take effect.

Much of the rehabilitation-focused research we have published has attempted to test activities that are fun as well as therapeutic, from using computer-assisted exercises (exergaming) to dancing. A consistent theme is that, although exercise in most forms is the closest thing we have to a panacea, there remains a need to be person-centred and bespoke when developing individual rehabilitation plans.

No single intervention is likely to suit everyone and most effective non-pharmacological interventions are multifactorial in nature. Moreover, some outcome measures such as falls, are trickier to improve than others. This was neatly illustrated in a recently published systematic review and meta-analysis on the effects of dancing interventions on falls. They concluded dancing does not reduce falls.

I am not sure if we asked if that remained true after excluding dance routines with daring lifts – an editorial oversight!

Professor Roy Soiza
Editor-in-Chief, *Age and Ageing*

Age and Ageing journal increases rank in the Geriatrics and Gerontology category

***Age and Ageing*, the scientific journal of the British Geriatrics Society, has recently announced a Journal Impact Factor™ of 6.0, reflecting the continuing excellence of this flagship publication over the last year.**

As a result of this strong performance, the journal now ranks 7th out of 74 in the Geriatrics and Gerontology category, up from 10th out of 54 journals in this category. It remains the top clinical geriatric medical journal in the field. *Age and Ageing* received 3,272 citations in this time period, and recorded 5,085,683 article downloads, giving a "usage rate" of 2.5m article downloads per year.

Furthermore, *Age and Ageing* is an unusually prolific publication. While its contemporaries focus on a small number of highly cited articles, the journal continues to deliver a wide range of articles that prove useful for clinicians. *Age and Ageing* published 605 articles in the reporting window, of which 486 received a combined total of 3,272 citations, making us the journal with the most cited articles in our category.

Age and Ageing Editor-in-Chief, Professor Roy Soiza, said: "*Age and Ageing* has established itself as the world's leading clinical geriatric medicine journal, publishing a high quality and quantity of research that is novel and relevant to the healthcare of older people internationally.

"The COVID-19 pandemic caused some volatility in Impact Factor measures across the sector, but the journal's ranking reflects its high standing in the field. I am confident the Impact Factor will rise even higher in future as we continue to publish the very best clinical research into health and wellbeing of older people."

A little help *from our* friends

‘Across the UK, local third sector and social enterprise organisations are providing rehabilitation services to older people recovering from periods of ill health.’

The provision of rehabilitation for older people is a multi-agency endeavour and the third sector plays a vital role in both campaigning for better services across the country and in providing services at a local level. This article provides a summary of a variety of organisations and initiatives that exist across the UK with the shared aim of improving provision of rehabilitation for older people.

Campaigning across the UK

The BGS is a member of the Community Rehabilitation Alliance (CRA), a coalition of more than 60 charities and professional bodies across England. The CRA is convened by the Chartered Society of Physiotherapy (CSP) and aims to gain political commitment to delivering universal access to rehabilitation to meet needs and to improve the quality of rehabilitation through new models, better data collection, planning, commissioning and delivery of services.

The CRA have published best practice standards which are intended to be used as a basis for developing community rehabilitation services and aim to reduce the nation and regional variation in rehabilitation.[1] These standards are the basis for the rehabilitation recommendation in *Joining the Dots*[2] and are highlighted in *Reablement, Rehabilitation, Recovery: Everyone’s business*.[3]

CSP also convenes sister alliances across the devolved nations, looking specifically at the issues affecting access to rehabilitation in Wales, Scotland and Northern Ireland. The Right to Rehab Coalition in Wales has successfully secured funding for the allied health professional workforce and a ministerial commitment that rehabilitation space lost during the pandemic should be restored.[4]

‘Early outcomes were improved fitness, nutrition and stress, and people more able to live well with their cancer.’

The Right to Rehab Coalition in Scotland highlights the publication of the Government’s Once for Scotland approach to rehabilitation[5] and is committed to ensuring that the measures outlined in this document are achieved.[6]

In Northern Ireland, the CRA have been focused on engaging with the new Government and, prior to the last elections, influencing party manifestos.[7]

At local level

Across the UK, local third sector and social enterprise organisations are providing rehabilitation services to older people recovering from periods of ill health. While we cannot hope to provide a detailed account of all of these, we have showcased a handful here to demonstrate the type of services being delivered.

Move more live more: Age NI

Age NI Move More Live More programme, funded by Innovate UK, aims to improve activity levels, strength, balance and overall health and wellbeing and reduce falls so that older adults in Northern Ireland can get the most out of later life. It builds on their previous work with former Olympian, Lady Mary Peters, to promote the importance of maintaining strength and balance. The Age NI Move with Mary initiative is a series of five exercise videos catering for every ability.[8]

Living well with cancer in older age

The Cancer Older People’s Service at the Beatson, West of Scotland Cancer Centre, and Maggie’s Centre set up a Living Well with Cancer in Older Age Class, led by an exercise expert and supported by a frailty nurse specialist. Older adults can self-refer at any point in their cancer journey and staff can refer to support pre-habilitation or rehabilitation goals. Early outcomes were improved fitness, nutrition and stress, and people more able to live well with their cancer.[9]

Breathe Dance for Strength and balance

Staff at Guy’s Hospital, London offer an innovative dance programme as an alternative to exercise classes for older adults prescribed strength and balance physiotherapy. Co-designed with patients, physiotherapists and dance artists, the ten-week Breathe Dance for Strength and Balance programme is proving popular and showing promising results.[10]

Good Boost

Good Boost is a social enterprise delivering digital musculoskeletal supported-self management services in partnership with 140 leisure centres, swimming pools, community venues and charities. They offer ‘plug and play’ technology-enabled solutions to convert existing spaces and venues into opportunities for rehabilitation to promote wellbeing and manage health.[11]

For more case studies and examples, read our *Reablement, Rehabilitation, Recovery: Everyone’s business* report at www.bgs.org.uk/Rehab or visit the collection of video case studies from the BGS Autumn Meeting 2023 at www.bgs.org.uk/rehabcasestudies23.

Sally Greenbrook
BGS Policy Manager
@SallyGreenbrook

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Yoga therapy in a rehabilitative setting

Improvements in functional and physical ability are often the focus of rehabilitation outcomes in older people. Yoga therapy has the potential to not only improve physical health, but offer benefits that enhance a person's overall sense of wellbeing.

What is yoga?

Within the field of geriatric medicine, we advocate for a comprehensive approach, placing the patient at the heart of what we do. It is this approach to patient care that is so well suited to the integration of yoga therapy. Yoga therapy is steeped in an ancient tradition that dates back millennia, and there is an increasing evidence base to support its application and integration into Western medicine.

Yoga originated in the Indian subcontinent with continuous evidence of its existence dating back to 600 BC.[1] The yoga of today, Modern Postural Yoga (MPY), was developed in India under British Crown rule in the 1800s and gave rise to a number of lineages. MPY has placed the Yoga Sutras of Patanjali at its philosophical core which provides a framework to self-realisation through eight steps. The first step offers ethics and observances which provide a way in which to engage in the world that is deemed to be beneficial to ourselves and others. Other steps include asana (physical postures), pranayama (breathwork), concentration and meditation.

Yoga therapy

The seeds of yoga therapy were sown in the 1920s, with scientific research to understand the physiological benefits in practitioners.[2] Today it has evolved into what the The International Association of Yoga Therapists describe as "the professional application of the principles and practices of yoga to promote health and well-being within a therapeutic relationship that includes personalised assessment, goal setting, lifestyle management, and yoga practices for individuals or small groups."

Yoga therapy works on multiple levels through a biopsychosocial-spiritual lens; and although it takes time, it is a non-invasive, complementary approach to conventional treatment. Yoga therapists are required to attain a thorough grounding in biomedical sciences, so as to work safely with all individuals. There are also training courses aimed specifically at qualified healthcare professionals.

Terminology guide

If you're not familiar with yoga or some of the terms used in this article, here are a few key definitions:

- **Interoception**: The ability to sense internal bodily sensations.
- **Proprioception**: Ability to sense the body position in space; through an action, self-movement and position.
- **Asana**: Physical poses in yoga
- **Pranayama**: Yogic breathing practises, including slow deep breathing and functional breathing.
- **Yoga class**: General practice, often fitness-oriented, little adaptation to the individual.
- **Yoga therapy session**: Individual assessments and practices tailored to the client(s) and specific concern(s). Therapeutic relationship, empowering self-care.

'What differentiates yoga therapy from physical therapy is that it is grounded within yogic philosophy which places an emphasis on the whole person.'

Yoga in the UK

Within the UK, the Yoga in Healthcare Alliance is working to make yoga more accessible, with NHS collaborations including social prescribing and online yoga for NHS staff.[2] The National Institute for Health and Care Excellence (NICE) supports the integration of yoga for varying conditions, such as high blood pressure, chronic primary pain and pelvic floor dysfunction.

It is important to emphasise that yoga is more than just movement. What differentiates yoga therapy from physical therapy is that it is grounded within yogic philosophy which places an emphasis on the whole person. While the physical nature of yoga is often the entry point, individuals often continue to practice because they notice improvements in others areas of their life.

As a Geriatric SpR, I had a hunch that yoga could provide benefit in the care of my patients - and more than a decade later, I am even more convinced. In this next section, I will review some of the key areas where yoga therapy has the potential to support in a rehabilitative setting.

Mobility

The most obvious benefits of yoga are those that result from movement, including strength, flexibility and balance. A recent systematic review looking at the effects of yoga on frailty, reviewed 33 studies which combined 2384 nursing home residents and community dwellers with a wide range of medical comorbidities.[3] The authors concluded that over inactive controls, there was moderate-certainty evidence that yoga led to an improvement in gait speed, lower extremity strength and endurance.[3] A 2012 pilot study[4] suggested that a minimum 8-week yoga intervention can lead to clinically significant improvements in balance and independence, and a meta-analysis of 6 studies with high quality methodology suggested that yoga led to a small improvement in balance and a moderate improvement in mobility.[5]

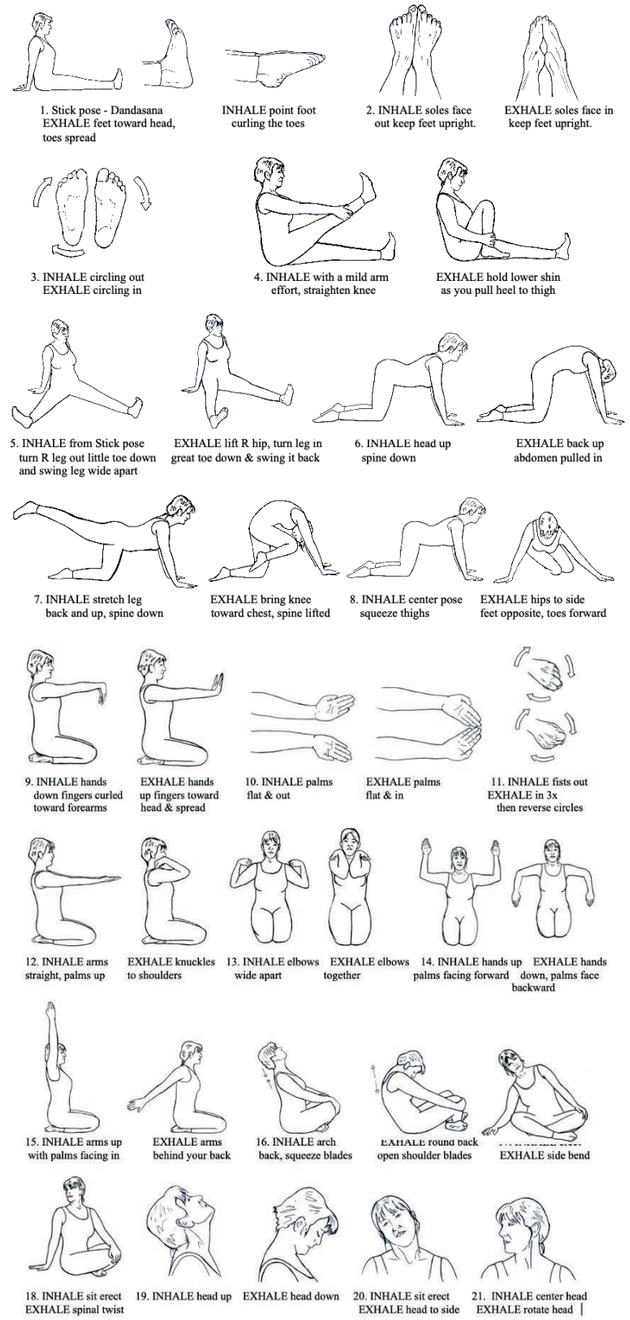
Fear of falling

There is a lot of empirical evidence and an increasing evidence base to show that in individuals with anxiety, depression and post-traumatic stress disorder (PTSD), yoga therapy can support individuals to better manage arousal and adapt to triggers and stimuli.[6]

The fear of falling in our patients is familiar to all of us. Over time, with patience and confidence building, patients can usually surmount this. But this is not always the case. With some so fearful following a fall, the consequence is an irreversible decline in function. In those who do attempt to mobilise, the degree of proprioceptive impairment is far greater than would be expected after a fall, thus suggesting a psychological element. This is further compounded if there is an underlying cognitive impairment present.

When an individual is aware and present with interoception, they are more able to process and integrate difficult feelings, experiences and emotions. They are also better able to manage fluctuations in the mind, such as uncertainty and

Figure 1: Joint Freeing Series



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fear of future and past events, which can contribute to significant distress. In turn, this allows them to be more present and focused, which is required for successful rehabilitation.

In order to develop interoception, yoga therapists work with proprioception through 'asana' (the positions of the body used in yoga). The smaller and slower the movement, the more beneficial. An example is the Joint Freeing Series (see Figure 1), which can be adapted to suit all patients.[7]

There are a group of individuals who have heightened interoception, such as those living with chronic pain. In such cases integrating work with nervous system regulation is key.

Nervous system regulation

Asana such as the Joint Freeing Series, in conjunction with 'pranayama' (the regulation of breath used in yoga), induce a relaxation response through enhanced vagal tone. It is known that those living with frailty frequently have an impaired autonomic nervous system, as evidenced clinically by reduced heart rate variability.[8] By enhancing vagal tone, we are supporting the body to down-regulate sympathetic drive, which in an anxious patient means we are creating the conditions for them to more optimally focus, concentrate and carry through new motor skills and learning. It has also been shown that slow deep breathing can increase orthostatic tolerance in individuals with orthostatic hypotension.[9]

Yoga nidra

Yoga nidra is frequently included in yoga therapy sessions. In yoga nidra, individuals are guided into a state between wakefulness and sleep, inviting ease, rest and relaxation. Electroencephalogram (EEG) monitoring shows that in yoga nidra, individuals are moving through alpha, theta and delta brainwaves. It is considered to be similar to hypnosis and has been applied in a range of conditions.[10] In a rehabilitative setting it can assist in memory and recall, aid sleep and support pain management. It has also been successfully used in those with anxiety and PTSD.

Final thoughts

Yoga therapy is grounded within a multi-dimensional philosophy, placing an emphasis on the whole person. It empowers individuals to use techniques to self regulate and self care, and offers an opportunity for self reflection. This can be an important first step in health behaviour change. As patients become more frail and approach the end of their lives, there may be a naturally arising desire to explore the deeper questions around the meaning of their life. Yoga therapy is perfectly placed to support individuals with these spiritual explorations, something that health professionals may not feel comfortable doing.

I believe yoga therapy can be viewed as the thread that can support someone through their whole medical journey, particularly within the context of a reductionist medical system. There are few healthcare professionals whose role is to hold space for someone to be who they are, in whatever way they wish to be, on that day. A yoga therapy therapeutic relationship is unique. It offers no diagnosis or cure. It simply adapts to the person, meeting them where they are, and is the very definition of whole person care. And in the context of rehabilitation, would be a positive integrative therapy.

Yasmin Bedi
Consultant Geriatrician and C-IAYT Yoga Therapist
Queen Alexandra Hospital, Portsmouth

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A new tool showing site-level, up-to-date emergency medical pathway data specific to older and frail patients has been added to the Getting It Right First Time (GIRFT) suite of resources supporting urgent and emergency care (UEC).

GIRFT has launched the SAMIT 75+ data tab to help improve services for older and frail patients. SAMIT 75+ is a new tab within GIRFT's existing Summary Acute Medicine Indicator Table (SAMIT) data tool, offering national comparative data for frailty at site level, all on one easy-to-understand page.

As with the SAMIT, only the most useful metrics have been selected for display to provide a deep understanding of a site's frailty service covering demand, flow and outcome for both the admission and recovery phases of care. Site data is shown benchmarked against all hospitals in England, and most metrics also show a hospital time series.

Each site's landing page also includes a GIRFT Elderly caRe Index (GERI) score, which ranks sites on their performance against three key patient metrics for medical pathway admissions:

- Discharge of frail patients over 65s in less than three days;
- Bed days utilisation for frail patients over 65 who stay in hospital longer than 21 days;
- Bed utilisation of frail patients over 65 with three or more admissions in a year.

The SAMIT 75+ data is current (only around six weeks old) and is refreshed monthly, making it the most up-to-date view of a service available. The tool uses mainly routine hospital data, meaning some metrics – including the Hospital Frailty Risk Score, which is used for identification of frailty – depend on the quality of coding. While most users will see their own hospital, national data is also available to those with a national role.

GIRFT's national report for geriatric medicine was published in 2021, based on deep dive visits to trust teams across England. It showed that approximately 4,000 patients per day are admitted with frailty in England. The quality of frailty care was an important reason for unwarranted variation between trusts.

More recently, GIRFT has been reviewing the UEC pathway with trusts – again finding frailty to be a central source of unwarranted variation. However, that variation is now linked in part to the effectiveness of frailty recognition and care in acute hospitals and in the wider system. Metrics are provided within SAMIT 75+ to address quality and effectiveness of care both in hospital and the wider system.

GIRFT review visits have shown that current models of care in the UEC pathway for patients living with frailty can produce poor outcomes, often linked to hospital acquired deconditioning. SAMIT 75+ shows the resource in % bed days used by long stay older patients living with frailty (an average of 50% but up to 80% at some sites), pointing to the need for more effective and higher value care for these patients.

Dr Adrian Hopper, GIRFT's clinical lead for geriatric medicine, said: "Frailty is a big issue for the NHS, one which affects services across the care pathway, from colleagues in the ED and hospital wards through to those working in care homes and the community. The SAMIT 75+ has been developed by clinicians for clinicians, helping to cut through the noise of other data tools and allow a 'helicopter view' of how a service is performing at a hospital site level.

"We'd urge those working in UEC specialties to make regular use of both the SAMIT and SAMIT 75+ – alongside the metrics in the Model Health System which take a trust view – to gauge performance and highlight gaps which might be impacting on the delivery of a service."

A GIRFT webinar is planned for 22 October 2024 (12.30pm) to showcase the SAMIT 75+ tab and hear from teams making use of the data. Visit https://bit.ly/SAMIT75 to register. Feedback on the SAMIT 75+ tab is welcomed - please email adrian.hopper@gstt.nhs.uk.

Event Report

The BGS Spring Meeting returned to the Vox in Birmingham on 22-24 May for an unforgettable three days offering a mix of social and educational opportunities, connecting like-minded colleagues with a shared passion for improving health in older people.

Programme highlights included streams on topics such as dementia, falls, continence, ethics and respiratory care, while lively sessions on policy, education and training offered space to reflect on the external landscape. Attendees also had ample opportunity to relax and connect with friends old and new, with a wide variety of professional meet-ups and friendly social events against a backdrop of the East Midlands countryside.

Day 1: Dementia, nutrition, continence and clinical quality

Kicking off the conference in his customary efficient and effusive style, BGS President Professor Adam Gordon welcomed more than 950 delegates back to Birmingham, joining either in person or online, giving a whistlestop update on BGS's latest activities, including recent reports on workforce and rehabilitation. Among the many recent achievements of BGS and its members, he updated the audience on the many policy developments that the Society has been involved in behind the scenes, such as giving evidence to the Senedd Health and Social Care Committee inquiry into support for chronic conditions in Wales, and the publication of NHS England documentation and guidance with a focus on frailty.

Starting the day's clinical sessions over in Stream 1, the theme of brain health was first on the agenda, with Professor Dorota Religa from the Karolinska Institut talking about brain health services. The stream moved onto nutrition and dementia, with the results of a trial looking at the effects of a protein-enriched Mediterranean diet on cognition in older adults. Early stage findings from the study suggest such a diet could improve nutritional status and diet quality among older adults that are at increased risk of under-nutrition and cognitive decline. "This means that we could intervene early," she explained, "and take a pragmatic dietary approach to prevent under-nutrition in community-dwelling older adults." The importance of positive eating and drinking experiences, good hydration and dietary modulation were discussed in subsequent morning sessions. The role of speech and language therapists as part of the multidisciplinary team supporting people with dementia to achieve good nutrition and quality of life was also highlighted. Dr Lyndsey Collins explained that "communication

'Clinical quality posters on topics including virtual wards, clinical frailty scales and hospital-acquired pneumonia wrapped up the first afternoon.'

difficulties carry a high disease burden that can contribute to isolation, one of the biggest risk factors for dependence. Speech and language therapy is a key intervention that can help people live more independently."

Bladder health and continence were on the schedule for Stream 2, with topics such as the ageing bladder, overactive bladder (OAB) and stress incontinence discussed in the opening sessions. Professor Adrian Wagg, Chair in Healthy Ageing at the University of Alberta, advised that "antimuscarinic agents are an effective treatment for OAB in older adults - don't stop them just because they're an anticholinergic!" Karen Guerrero, a Urogynaecologist from Glasgow, reinforced the message that management of stress urinary incontinence should "assess the whole patient and not just the bladder." Subsequent speakers addressed nocturia, dementia, and pelvic organ prolapse.

The role of deprescribing and medicines reconciliation was a focus of the first morning session over in Stream 3, with Louise Organista and Dr Tamasine Grimes giving an overview of evidence and best practice. This was followed by platform presentations on data on mortality from Parkinson's and Motor Neurone Disease, and a poster lightning round on topics ranging from delirium to falls to pain management.

Lunch was served in the bright foyer space and exhibition hall, giving delegates some much-needed time to relax and stretch their legs while catching up with colleagues and exhibitors. Informal meetup points for professional groups within the BGS membership were scattered around the venue, helping attendees to meet and network with like-minded colleagues.

The BGS Trainees Council provided some light-hearted entertainment in the form of a 'frailty circuit' challenge, where volunteers were encouraged to don equipment intended to mimic the effects of ageing and race each other to perform a series of tasks (see image below left). The winner of this challenge across the whole three days was Laura Davey, a GP from South West England.

The afternoon's sessions continued the morning's themes. In the dementia stream, a panel made up of researchers, old age psychiatrists and geriatricians discussed novel treatments for Alzheimer's disease, debating whether further infrastructure changes are needed ahead of the approval and administration of novel treatments. This was followed by talk from Professor Liz Sampson and Dr Nathan Davies about nutrition for people with dementia at the end of life and the importance of person-centred care and conversations. "Sometimes people don't realise you can have alcohol!" said Dr Davies. "It's fine, it's hydrating – it is allowed."

Elsewhere, the continence session turned to the topic of UTIs, with Dr Bob Yang, Consultant Urologist from Berkshire, explaining how antimicrobial resistance is throwing into question the value of prescribing antibiotics for this condition. Over in the third stream, trainees gathered for a masterclass in how to prepare for the Specialty Certificate Exam in Geriatric Medicine (SCE), with support, advice, revision tips and example questions. Clinical quality posters on topics including virtual wards, clinical frailty scales and hospital-acquired pneumonia wrapped up the first afternoon.

Day 2: Respiratory illness, medical ethics and research

The second day began bright and early with a policy breakfast session led by BGS Policy Manager, Sally Greenbrook. With the general election having been called the previous day, the session focused on the BGS's priorities for an incoming Government, setting out 10 priorities for older people's healthcare on a policy level.

The respiratory stream in Vox 1 & 2 began with a look at the ageing lung, along with an overview of asthma and chronic obstructive pulmonary disease (COPD) in older patients. This was followed by a session on respiratory viruses, focusing on respiratory syncytial virus (RSV) and COVID. "If this talk had been given in 2019, it would be

a very different presentation," said Dr Guy Hagan, Consultant in Respiratory and General Internal, alluding to the fact that older adults are now at much greater risk of both viruses, accounting for a rise in hospital admissions.

Elsewhere, the session of medical ethics and law delved into some of the thorny legal and moral issues that present themselves through the course of caring for older people. Barrister Alexander Ruck Keene KC discussed deprivation of liberty from a legal standpoint, looking at confinement, consent and imputability in the context of care homes, hospitals and home-based care of older people. "The right to life versus the right to liberty is a complex issue," he explains.

Chief Executive of Age UK, Caroline Abrahams, gave a presentation on the rights of older people in social care. "Older people's rights within the social care system are, I think, routinely denied," she explains, citing complexities around resource allocation, funding, and local authority rationing.

Issues around medical fitness to drive were also addressed, with Dr Lynne Hutton, Consultant in Rehabilitation Medicine, highlighting that almost three-quarters of people of 70 hold a driving license, making this a pertinent wider-societal issue. She explained how to assess individuals for their fitness to drive. "It's really important that when we're doing assessments, we're focusing on impairments rather than 'good' or 'bad' driving skills," she explains. Guidance from the General Medical Council (GMC) on fitness to drive and medical confidentiality were highlighted by Helene Hillier.

The research session over in stream 3 looked at data and evidence around delirium, before moving onto findings from the home-based extended rehabilitation for older people (HERO) trial. "When it comes to interventions, we are always trying to balance what we know works with what might be delivered in the NHS," explained Professor Vicki Goodwin, Professor of Ageing and Rehabilitation at the University of Exeter, highlighting the challenges of translating research into practice.

A lively President's Poster Round saw the top ten submitted abstracts presented in three-minute slots, covering a diverse array of topics such from elearning to racism to body mass index. Delegates attending in person also had the opportunity to browse posters and submit questions on large interactive screens, via an innovative platform which online attendees could also access from their own devices. Various prizes were awarded for the best posters and abstracts from the conference, details of which can be found on the facing page.

A keynote address from invited guest lecturer Professor Janet Lord introduced the concept of geroscience, a relatively new discipline concerned with age-related morbidity. Presenting a fascinating overview of research on lifestyle interventions and their influence on inflammation and biological actions of ageing, she stated "it has to be a lifelong approach," when talking about the role of prevention in age-related disease.

As the day's educational agenda drew to a close, delegates were invited to join an informal drinks reception, where Age and Ageing outgoing Editor-in-Chief, Professor Rowan Harwood, was thanked for his time and commitment during his term of leading the journal. "Rowan made Age and Ageing a vehicle for real-time learning during the COVID pandemic," said Chair of the Editorial Board, Finbarr Martin. "He turned the COVID nightmare into a positive learning experience, and we have a lot to thank him for." The good feelings continued, as the drinks flowed and attendees took some time to relax and reconnect with like-minded colleagues. Delegates were invited back later on in the evening for the ever-popular conference dinner, a sold-out event with a three-course meal and dancing late into the night.

Day 3: Falls, artificial intelligence, education and training

As delegates trickled back into the Vox and online for the final day, there were a few bleary eyes from those who attended the previous night's dinner. Fortunately, the flexibility of the hybrid conference format meant that even those who couldn't face arriving the 9.30am start could still keep up with the morning's sessions online from the comfort of their room.

'When it comes to interventions, we are always trying to balance what we know works with what might be delivered in the NHS.'

BGS Spring Meeting 2024: Prize Winners

Best clinical quality platform presentations (joint winners)

Mind the HAP - an initiative to improve the diagnosis, management and prevention of Hospital Acquired Pneumonia on Elderly Care

Charles Mclaren

Patient Experience and Outcome Measures in Virtual Wards at Swansea Bay University Health Board

Alexandra Burgess

John Brocklehurst Prize for best clinical quality poster

A Pilot Project Implementing a Dysphagia Screening Tool For Femoral Fracture Patients

Dolcie Paxton

Elizabeth Brown Prize for best platform presentation

Effect of long-term care insurance in a pilot city of China: Health benefits among 12,930 disabled older adults

Lijun Zeng, Yue Zhong, Yuxiao Chen, Mei Zhou, Shaoyang Zhao, Jinhui Wu, Birong Dong, Qingyu Dou

Eva Huggins prize for best nurse/AHP poster

Physiotherapists' perspectives of barriers and facilitators to effective community provision after hip fracture

Jodie Adams

Richard Dodds memorial prize

A Novel Frailty Specific Same Day Emergency Care (SDEC) Score ? An Initial Retrospective Validation Cohort

Alexandra Burgess

Fergus Anderson Prize for best scientific presentation poster

Barriers perceived by medical students when considering a career in geriatric medicine

Grace Fisher

For upcoming abstract deadlines and submission information, visit www.bgs.org.uk/abstracts

The topic of syncope and falls set the scene for the main hall, with sessions looking at fainting, and driving implications for those with a history of syncope or transient loss of consciousness. Dr Lara Mitchell, Consultant Geriatrician from Queen Elizabeth University Hospital in Glasgow, advised on when to refer patients onto multidisciplinary colleagues. "In the end, it's all about realistic medicine and shared decision-making," she concluded. "What matters is what matters to our patients."

The education stream saw the launch of the UK Geriatric Medicine Educators Collaborative (GMEC) with an hour-long interactive workshop. Grace Pearson, Ellen Tullo, and Rebecca Winter discussed working together to improve undergraduate education in geriatric medicine. Elsewhere in this session, the topic of artificial intelligence and virtual reality as training modalities was explored, and the results of a recent BGS survey of Training Programme Directors shared.

Good oral health and the impact of dental disease on quality of life of older people was highlighted in the session ominously titled 'journey through the GI tract'. After a quick bathroom break, the stream turned to the topic of geroscience, with Professor Lynne Cox, Associate Professor of Biochemistry at the University of Oxford, looked at biogerontological research with a direct clinical application.

The Marjory Warren Guest Lecture was delivered by Professor Andrew Elder, President of the Royal College of Physicians Edinburgh. His fascinating talk, entitled 'The Artificial Doctor,' examined the emerging relevance of artificial intelligence (AI) in medicine, and the potentially conflicting outcomes for older people's care. Imagining a world where an AI assistant might work with clinicians and help them diagnose issues in their patients more quickly, he highlights that 'artificial' intelligence is only as accurate as the human data it relies upon. "The real power of technology," he concludes, "is in freeing human hands... to deliver actual care."

A lively and interactive multidisciplinary panel discussion on falls and syncope wrapped up the afternoon in stream 1, with a mixture of pre-prepared and audience-contributed case scenarios discussed from different professional and clinical perspectives. Meanwhile, a Nurse and Allied Health Professionals' Community of Practice session focused on the importance of kindness in leadership, offering space to reflect and connect over this frequently-overlooked topic. The final session in stream 3 looked at the Diploma in Geriatric Medicine (DGM), a qualification awarded jointly by the BGS and the Royal College of Physicians (RCP) London. The talk summarised the DGM and provided an overview to changes to the clinical exam.

Closing the meeting, BGS President Elect, Professor Jugdeep Dhesi, thanked delegates, speakers and moderators for coming together in Birmingham and online, as she invited all in attendance to join us once again for the BGS Autumn Meeting on 20-22 November in London.

Visit www.bgs.org.uk/Autumn24 to register today!

BGS

Spring Meeting 2024

22-24 May 2024
Birmingham & Online

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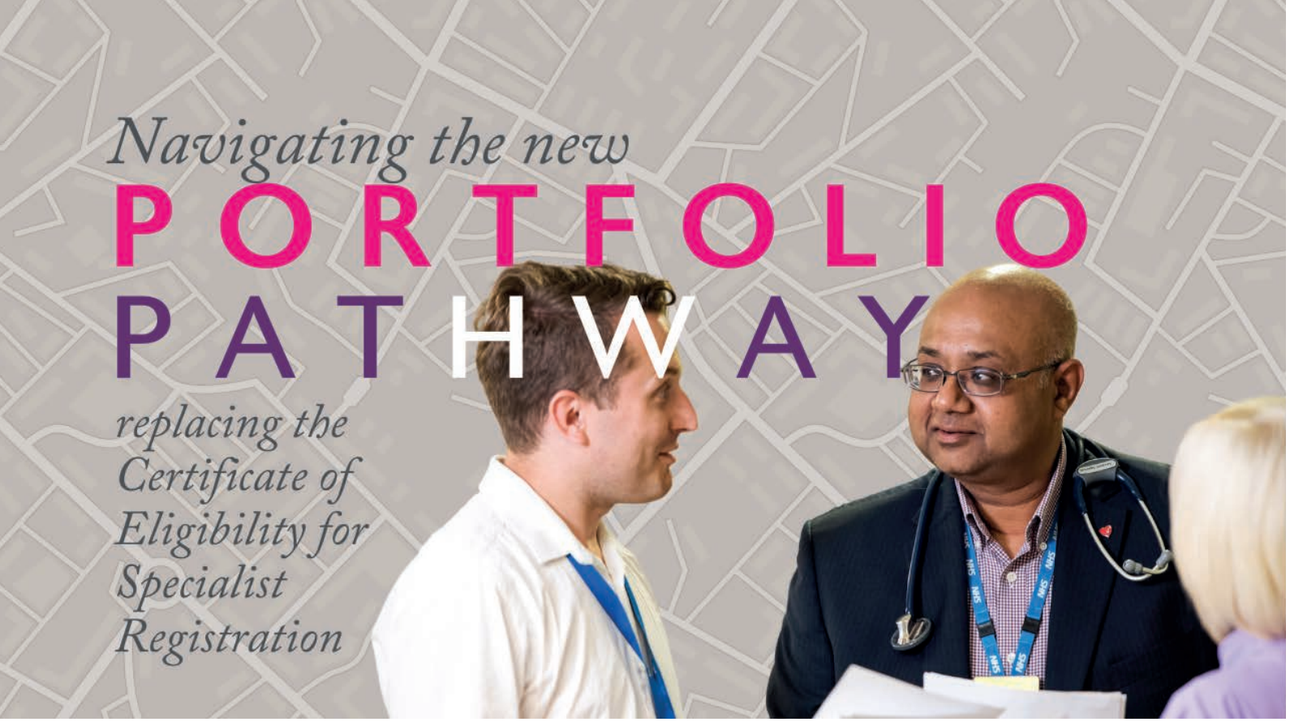


Navigating the new PORTFOLIO PATHWAY

replacing the Certificate of Eligibility for Specialist Registration

From November 2023, the Certificate of Eligibility for Specialist Registration (CESR) route for Specialist and GP registration changed to the new Portfolio Pathway. The article below offers some clarifcation and answers to common questions about this new pathway.

The old pathway: The CESR route to CCT

The old route, Certificate of Eligibility for Specialist Registration (CESR), was the route to entry into the Specialist and GP Registers for those doctors who have not followed an approved training programme. The Specialist Register is a list of doctors who are legally entitled to accept honorary, substantive, or fixed term consultant posts in the NHS and is maintained by the General Medical Council (GMC).

Previously known as 'CESR' and formerly 'article 14' (of the General and Specialist Medical Practice – Education, Training and Qualifications order of 2003), this was an equivalence-based approach. The applicant had to provide evidence demonstrating 'equivalence to a CCT', therefore the depth and breadth of competencies outlined in the relevant certificate of completion of training (CCT) curriculum.

Applications were judged against the GMC-approved curriculum with reference to the Specialty Specific Guidance (SSG) as well as the GMC's generic guidance of evidence to support a CESR application. The application was made through the GMC. Once the GMC had accumulated what it considered to be a satisfactory range of evidence, it forwarded the application to the faculty at the Royal College of Physicians for consideration. However, this changed in November 2023.

The new route: The Portfolio Pathway

CESR was changed to Portfolio Pathway from 30 November 2023. Doctors now must demonstrate that they have the Knowledge, Skills, and Experience (KSEs) required to practise as an eligible specialist in the UK. The emphasis has shifted from 'equivalence' to 'knowledge, skills and experience.'

Comprehensive information is available on the General Medical Council (GMC) website. The GMC website also has comprehensive advice on current application process (Geriatric Medicine). For applicants in Geriatric Medicine, a new curriculum has been in place since 2022. Anyone aspiring to apply in Geriatric Medicine through portfolio pathway should use the SSG.

A new system however brings its own uncertainties, questions, and rumours, especially as candidates will now be awarded dual Certification in Geriatric medicine and General Internal Medicine. The BGS Autumn Meeting 2023 had a session in which Rose Jackson, Specialist Applications Team Co-ordinator, Registration and Revalidation Directorate, General Medical Council provided advice and guidance on CESR. Most of the discussion was on CESR process as it was the existing pathway at that time. The talk covered some information on the future Portfolio Pathway as well.

The questions from the floor and online were mostly on the new pathway, which was yet to be announced. Since the Autumn Meeting, more candidates have had experience of submission, and this has resulted in further questions. We collected the questions, organised them and identified a few themes. We met up with Faye Macdonald on 28 May 2024 for advice and guidance on Portfolio Pathway in Geriatric Medicine. We have prepared a summary of the discussion below.

Qualifications: Is MRCP an essential requirement for GIM curriculum? What relevant overseas qualifications could be included?

Answer: MRCP has never been, and it still is not a mandatory requirement. If a candidate can demonstrate through the evidence to GMC and structured reports by the referee that they match the competencies, then MRCP is not necessary. Various MD or overseas qualification can be comparable if the evidence maps to the competencies and that could be verified. GMC may not be keen to give a list of qualifications as there may be many and a list would end up in excluding an equivalent degree. The onus to prove competencies lies with the candidate. Specialty Certificate examination (SCE) in Geriatric Medicine is highly recommended.

Will the CMT/IMT portfolio count if one OPT OUT from national training programme & wants to take the Portfolio Pathway route?

Answer: CMT/IMT evidence can be included. There is no time frame regarding how old the evidence is. However, 50% of the overall evidence must be with in the last 5 years. Any older evidence has less value.

Applicants will have to remember that only CMT/IMT evidence will not be sufficient to demonstrate GIM competencies Match the evidence against the SSG.

Acute specialty takes – can this be evidence from geriatric inpatients, geriatric outpatients, and front door frailty – or do the doctors need a "block" of time in a sub-specialty to achieve competencies?

Answer: Acute unselected take patients could be from any time in one's career but 50% evidence needs to be in last 5 years. When putting evidence together in the logbook, they can be grouped into in-patient/out-patient etc. No specific time was mentioned; however, it is advisable to follow the SSG.

DOPS procedures – Could you tell us the minimum number needed (i.e. we need to do 1 or 5 or 10 for signing off)? Can a consultant or supervisor sign off competencies without stating how many procedures the applicant has done or without a logbook?

Answer: Please refer to the SSG – DOPS need to cover each procedure highlighted. There needs to one summative DOP for all GIM requirement. If DOPS are signed off by someone who is not doing the structured report for GIM part, then he/she needs to mention clearly that individual is competent in each DOP.

'A new system however brings its own uncertainties, questions, and rumours, especially as candidates will now be awarded dual Certification in Geriatric medicine and General Internal Medicine.'

Stay up to date with the latest information on the Portfolio Pathway

We have a dedicated page on our website with all the latest information on the Portfolio Pathway, which will be updated with any additional questions and answers as we receive them. Please visit www.bgs.org.uk/PPGM2024.

We also have a page with information and resources specifically for Specialty and Associate Specialist (SAS) doctors, which can be found at www.bgs.org.uk/sas-grade-members

Do we need to show evidence of doing 80 clinics (as mentioned in the new curriculum ARCP checklist)? If it is 80 clinics, then do they need to be in 12 months, 24 months – or over 5 years?

Answer: The evidence needs to be in total from one's clinical experience but at least half of the clinics need to be recent in last 5 years. Regarding the number of clinics from different specialties, it is best to read the Speciality Specific Guidance (SSG) very thoroughly.

For SLEs/CBDs/ACATs/OPCATs – do they need to show 'progression' of a candidate from level 2 to level 4 over the years?

Answer: They are not required to show progression of individuals. They are essential to show that the applicant can work independently. If at any point in the previous 5 years, one reached level 4 – then it is accepted. Hence the CiPs in SSG can be collected in one year if people are working prospectively (e.g. an/a IMT/CMT taken portfolio pathway to progress rather than National Training program) or retrospectively (e.g. someone is working as SAS or locum consultant over last 5 years).

Will there be new forms for SLEs/ACATs/OPCATs? The current forms do not have levels 2 or 3 or 4 competencies.

Answer: The assessors should mention that candidates can work independently, there is no need to specifically write 'at level 4' if this is not an option on the form.

Could you give a summary of the required time spent/ cases seen to achieve competencies in specific areas? Do these have to be at level 3 or 4? Do we need to produce logbooks?

These four specific areas are:

- Stroke
- Palliative care
- Old age Psychiatry
- Community Geriatrics

Answer: There is no defined number, but entry in the logbook helps demonstrate the breadth of experience. However, it is important to remember, logbooks alone are not enough – there may be need for other evidence to achieve competency.

(GMC representative did not mention any minimum number of patients needed for Stroke, Palliative care, old age Psychiatry, or Community Geriatrics).

How do we count months for colleagues in flexible (less than full time – LTFT) posts?

Answer: The best advice is to look into 'of clinical practice' references. It is likely that for LTFT – 5 years' worth of clinical experience is mandatory. For example, if someone is working LTFT at 60%, they need at least last 8 years of experience. For someone who is LTFT at 80%, they will need 6 years of experience. The total experience should be equivalent to approximately 5 years of clinical experience.

Sometimes referees are unsure about the pathway. Is there any teaching/help for them?

Answer: GMC does courses for referees: **www.gmc-uk.org/registration-and-licensing/employers-medical-schools-and-colleges/information-for-referees-and-verifiers**

How many referees are necessary?

Answer: GMC will need 3 referees/verifiers – one has to be clinical director/head of service or educational supervisor who knows the process and is familiar with the entire curriculum and evidence. One colleague from Geriatric medicine and one for General Internal Medicine (GIM) is necessary.

We hope that this information will be helpful for doctors planning to apply in Geriatric Medicine through the Portfolio Pathway. We appreciate there will be many more questions and confusions which need to be addressed.

Do please ask questions as we will be meeting GMC advisors from time to time and will be sharing their responses with you. For further information, please ask any of the authors of this paper.

Dr Amit Arora
BGS Vice President, Workforce
@betterageing

Dr Somaditya Bandyopadhyay
BGS SAS Lead
Somaditya.Bandyopadhyay@nhs.net

Dr Saniya Naseer
saniya.naseer@ouh.nhs.uk

Language & perceptions in frailty

How we talk about ageing affects how people feel about ageing. A recent guide from the BGS highlights preferred language when referring to older people in a health context, compiled to help healthcare professionals, academics and authors avoid language that might be deemed unacceptable or inappropriate when describing the health of older people.

In its simplest form, growing older is an accumulation of life. Each of us travel on this gradual journey every single day, and most of us hope to continue to do so, until such a point as our bodies or minds become unable to sustain the processes essential for living.

Age is a universal state of being, and older people are not 'other'. We all have an age, which is ever-changing, and the longer we exist, the greater that age is. Age is one of the few things that unites us all, independent of all other aspects of our identities, yet it can also affect us physically and mentally, positively or negatively. As healthcare professionals, our own narratives around ageing set the tone for us all, and how we view the ageing of ourselves and others.

'Age is a universal state of being, and older people are not 'other'. We all have an age, which is ever-changing, and the longer we exist, the greater that age is.'

It is a personal privilege, and a medical triumph, to live in a body that is sustained in its function as we age. But perhaps the ultimate goal is to live in a body that can continue to exist, in the context of a society that enables that body to achieve all the things that the person inhabiting it wishes to do, for as long as possible and without avoidable suffering.

For those at the upper end of the age spectrum, the notion of living well, feeling well, and having your needs met becomes even more important. Nothing lasts forever, as they say, and the human body of course is no exception.

While there are indeed ways to delay, reduce or even avoid the effects of frailty as we age, each person's genetics, history, needs, wishes and goals are unique, and the interplay between all these things becomes increasingly complex the longer our lives play out.

There is no shame in frailty. A person with frailty has lived a life without frailty. And just as they were supported when they learnt - with wonder and joy - how to achieve things in their first years of life, they deserve be supported to find similar meaning in what they can achieve in their final years of life, too. To quote John F Kennedy, "It is not enough [...] to merely to have added new years to life - our objective must also be to add new life to those years."

‘There are many negative and diminutive words or phrases relating to older people, and their usage contributes to a pervasive cultural narrative that ageing is something to be feared or ashamed of.’

A change in cognition, too, can alter personal and public narratives of ageing and the light in which this is viewed, irrespective of the wishes of the person to whom it is happening. Cognitive changes with advancing age can be mild and expected, or more severe and ultimately lead to a diagnosis of, for example, dementia. The public narrative of such conditions is one of fear. Misconceptions and stigmas around the conditions are prevalent. Any diagnosis can affect mental wellbeing, with older individuals at risk of loneliness, depression and anxiety. The effect of ageing on cognition and mental wellbeing should therefore also be handled with respect and care, and language use considered.

The BGS strongly believes in the ethos of person-centred care - treating older people as individuals, and tailoring support around what matters to each unique person. Older people are more than their age, their health conditions, or what they can no longer do. Age is not a condition to be treated, but rather a transient stage of the lifecourse that is no more or less meaningful than any stage before it.

Talking about older people as people is a good first step in framing conversations and discussions about ageing. Our choice of language around ageing reflects how we perceive it, and it is important that we try our best to get this right. There are many negative and diminutive words or phrases relating to older people, and their usage contributes to a pervasive cultural narrative that ageing is something to be feared or ashamed of. Just like age, frailty is a spectrum, and there is no such thing as a ‘typical’ older person with frailty.

It is important too, that we consider that while these people may cross our paths as a consequence of their experience of ageing, additional facets of their identities may also be referred to with inappropriate and outdated language. The relationship between ageing and these identities is often profound, and acknowledging these represents another important aspect of person-centred care.

We have put together a guide to help people select language that is both age-positive and clinically accurate when talking or writing about older people. It discourages dehumanising words such as ‘elderly’, instead preferring terms such as ‘older people.’ It also sets out how to frame frailty as a condition that someone is living with, rather than an adjective to describe or define a person. We also offer additional suggestions for how to approach language around some minority groups within the ageing population.

Like people at any other stage of the lifecourse, older people are individuals with diverse backgrounds, values, priorities and lifestyles. Altering the language used to describe older people and their experience of health or illness may also help to reframe some of the imposed stigma around the universal process of ageing, and ultimately help people to enjoy living longer lives.

Professor Terry Quinn
David Cargill Chair and an Honorary Consultant Physician in Geriatric and Stroke Medicine, School of Cardiovascular and Metabolic Health, University of Glasgow; Senior Editor of Age and Ageing journal
@DrTerryQuinn

Dr Jodi Watt
Postdoctoral Research Assistant at the School of Cardiovascular & Metabolic Health, University of Glasgow

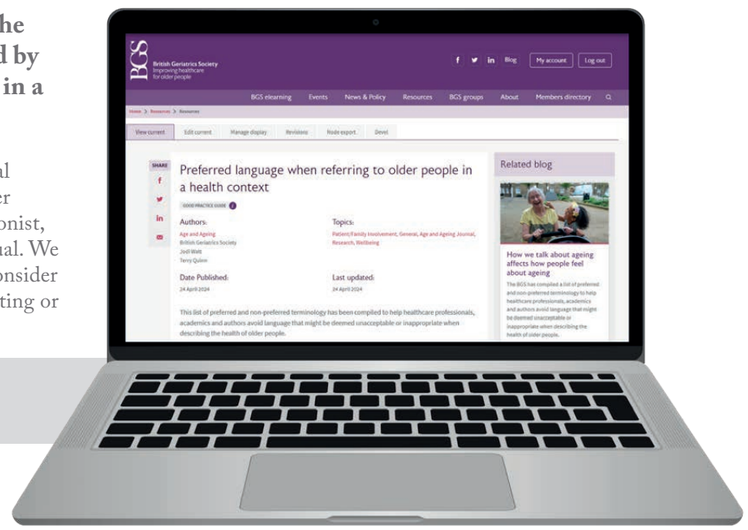
Amy Brewerton
BGS Publications & Website Editor
@Amy_Brewerton

Access the frailty language guide in full

Healthcare professionals specialising in the care of older people are well placed to lead by example when describing this population in a person-centred, fair and accurate way.

Language used to describe the health status, medical history and other social or clinical attributes of older people should be free from judgement, non-reductionist, and reflective of the lived experience of the individual. We strongly encourage all healthcare professionals to consider the preferred terminology outlined below when writing or talking about older adults under their care.

Access the guide at
www.bgs.org.uk/languageguide



AGENDA

Vacancies *and notices*

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

Vacancies: Trainees Council

BGS Trainees Council is comprised of 25 of the Society’s trainee members from across the UK. The co-chairs sit on the Trustee Board and the council support BGS committees, advocate for trainees, organise the trainee conference and much more.

Current Trainees Council Vacancies

All posts are 2 years in duration and trainees join our hybrid Trainee Council meetings 3 times a year.

- Policy and Communications Committee (PACC) Representative
- Sustainability Representative
- Less than Full Time (LTFT) Representatives (2 vacancies)

If you would like to apply for any of these roles and would like to know more about what’s involved please contact Mark Stewart via **M.Stewart@bgs.org.uk**. The deadline for all applications is Friday 18 October at 5pm.

Vacancies: Region officers and volunteers

Region officer roles provide a great opportunity for BGS members to help create a supportive and collaborative local environment for fellow healthcare professionals specialising in the care of older people. View all current roles at **www.bgs.org.uk/regionops**

Notice of BGS Annual General Meeting (AGM) 2024

The BGS Annual General Meeting (AGM) will be held via Zoom on Friday 15 November 2024 at 1pm.

If any BGS members wish to raise a resolution, please contact the CEO’s office without delay at S.Mistry@bgs.org.uk. Members will receive a formal notice of the AGM on Friday 1 November, with a link to the agenda, papers and instructions on how to register for the Zoom meeting.

Upcoming BGS Meetings
Visit www.bgs.org.uk/events for more

- **BGS Leadership and Management Course**
  2-3 November, Nottingham
- **Geriatrics 4 Juniors (G4J) 2024**
  9 November, online
- **BGS Autumn Meeting 2024**
  20-22 November, London & online
- **BGS Frailty and Urgent Care Meeting 2025**
  14 March, Glasgow & online
- **BGS Spring Meeting 2025**
  9-11 April, Belfast & online
- **BGS Trainees in Geriatric Medicine Meeting 2025**
  15-16 May, Leeds & online

BGS

Autumn Meeting 2024

20-22 November

ExCeI London & Online

FLEXIBLE ATTENDANCE OPTIONS

IN PERSON, ONLINE & ON DEMAND

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ADMIT ONE

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FULLY FUNDED PLACES

AVAILABLE TO ELIGIBLE BGS MEMBERS

Programme highlights:

- Primary and community care
- Movement disorders
- MDT working
- Health promotion and healthy ageing
- Stroke

View programme and register at www.bgs.org.uk/Autumn24