AGENDA

British Geriatrics Society
Improving healthcare for older people

Issue 95 | November/December 2024
ISSN 2754-4532

Be proactive

Prevention *and* early intervention *in* frailty

PLUS

- **BGS Autumn Meeting**
- Winter pressures
- **#ChooseGeriatrics campaign**

AGENDA
Publications information

Agenda is published every second month by:

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

Printed and distributed by Brown Knight & Truscott (BKT)

Images: Cover image: Adapted by Amy Brewerton. from Canva original. Other images: © Canva/BGS/Centre for Ageing Better.

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On the AGENDA

(Outgoing) President's *Message*

By the time you read this *AGENDA* editorial, we'll already have completed our November BGS meeting and Jugdeep Dhesi will have taken possession of the Chain of Office as your BGS President.

The chain doesn't get out often – at the BGS we don't stand much for pomp and circumstance. It is though, in some ways, a thing of wonder. Each link has the name of a Past President, going all the way back to Lord Amulree, the founding BGS President. A chain with the names of Past Presidents engraved on it is a fitting metaphor for the way that our mission to improve care for older people has been passed forward over the years, even as our knowledge and expertise in how to do so has grown.

Lord Amulree led the BGS from 1948 to 1973 – a quarter of a century – no doubt a reflection of an exceptional leader and campaigner. One wonders, though, if such a long tenure would be sustainable given the recent and current pace of work at Marjory Warren House. We recently completed our response to module six of the UK COVID inquiry. I was struck by just how much work my predecessors, Tash Masud and Jenny Burns, did along with the BGS staff team to campaign for older people at that time. Thirteen letters to senior policymakers and health leaders on everything from the composition of the Scientific Advisory Group for Emergencies, to availability of PPE, to care home testing, to workforce wellbeing; four detailed responses to government consultations; two meetings with government ministers; and a series of documents that helped shape how care took place during the pandemic, including our highly accessed guidance on COVID-19 in care homes. *Age and Ageing* contributed substantially to the growing body of published evidence in care of older people during COVID – with the team working around the clock to ensure they brought evidence forward as quickly as possible. All of our work drew upon a phenomenal body of work by the membership at a time when we faced unprecedented workplace stressors and demands. Thank you to you all.

'One of the highlights of working as BGS President is the opportunity to travel around the country to see, and learn from, the work that our members do.'

This pace has continued for the last two years. The pressure of work has been driven by two previously unsurpassed awful winters for older people in need of health and social care. We have seen the longest service delays, and the worst health outcomes, since current measures began. To those of us who have been in clinical practice for more than a decade, it feels at times that we can scarcely recognise the National Health Service as the one we began our working lives in.

Early in my Presidency, Jugdeep Dhesi (the now President) and I sat with the BGS team and decided we couldn't let this happen without putting up a fight. We've done what we could to seize every opportunity available. We've met with health and social care leaders across all four UK nations, two health ministers, a Secretary of State for Health, and a Prime Minister. We've banged the drum whenever we could on television, radio and in print media. We've attended two Labour party conferences. We've published three winter statements, our *Joining the Dots* blueprint, our workforce paper on **#moregeriatricians**, our guidance on Acute Care for Older People, our paper on *Reablement Rehabilitation and Recovery*, and our paper on *Smarter Data for Better Care*. We've strengthened relationships with Royal Colleges - particularly the three Colleges of Physicians but also the Royal Colleges of Emergency Medicine, General Practice and Psychiatry. We've hosted a roundtable on care of older people with Professor Sir Chris Whitty.

Recognising that our members need us now more than ever, we've launched our QI Hub and Research Hub. In addition to our highly accessed and highly rated frailty elearning module we have developed elearning courses on Delirium, POPS and oncogeriatrics, with continence to follow soon. We've provided hybrid conferencing technology to ensure that we offer the best possible CPD at our conferences, both for those who are able to attend in person and those unable to do so. We've committed to this model of conferencing going forward, with a view to sustainability and accessibility whilst also retaining the advantages of in-person attendance and networking.

One of the highlights of working as BGS President is the opportunity to travel around the country to see, and learn from, the work that our members do across the four nations and the full range of care settings from primary and community care, through care homes, to all parts of the hospital system. It is increasingly the case, wherever an older person living with frailty finds themselves in contact with the healthcare system, that there is a BGS member who has found a way to provide effective evidence-based care in novel and/or innovative ways. Because of differences in resource and staffing across the country it's not possible to deliver everything our patients might benefit from in every geographical location. Being able to share your work, champion the differences you make, and campaign for wider implementation is one of the biggest highlights of the role.

It feels like I'm leaving the BGS in decent shape to carry the fight forward. I know that Jugdeep will, with the rest of the top team, do just that. The BGS staff will continue to support in the exceptional way they always do. They will need the full expertise, energy and support of the membership as they do so. There is hope that a new Westminster administration provides some opportunities for substantial policy shifts that can help us deliver the care our older population need. But we will continue to need to campaign, and campaign hard, to make sure that policy shifts in the right direction.

Thanks for all your help these last two years. It has been an honour and privilege to serve, and I look forward to seeing what we can all do together to improve care for older people next.

Adam Gordon
BGS President (2022-2024)

Prof Ken Rockwood receives inaugural BGS President's Medal

The BGS President's Medal is a new award for 2024 to celebrate outstanding contributions to the healthcare of older people.

This year's winner is Professor Kenneth (Ken) Rockwood, Professor of Geriatric Medicine at Dalhousie University and Nova Scotia Health, in recognition of his significant role in enhancing the understanding of frailty in older people, including creating a Frailty Index.

Prof Rockwood's Clinical Frailty Scale is used to measure how frail a person is by considering the overall impact of their health problems. The more health issues someone may have, the more likely they are to face further challenges with illness or injury and the less likely they are to return to their former state after episodes of ill-health. This scale can help healthcare professionals understand how vulnerable a person might be and plan their care accordingly. Through his groundbreaking work, Professor Rockwood has helped bridge the gap between theoretical models of ageing and practical tools to improve clinical care and health outcomes in older people

Professor Rockwood was formally presented with the President's Medal at the BGS Autumn Meeting in London on Friday 22 November 2024 by the outgoing BGS President, Professor Adam Gordon.

BGS WELCOMES NEW PRESIDENT & PRESIDENT ELECT

The BGS is delighted to announce that Professor Jugdeep Dhesi is its new President, following a successful term as President Elect.

Professor Adam Gordon, who was BGS President from November 2022 to 2024, transferred the presidential chain of office to Professor Dhesi at the BGS Autumn Meeting at the Excel Centre in London on Friday 22 November.

Professor Dhesi's term of office as President will be two years. She will be supported in the role by President Elect, Dr Amit Arora, who will take over from her as President in November 2026.

About our new President, Professor Dhesi

Professor Dhesi is a consultant geriatrician at Guy's and St Thomas' NHS Foundation Trust and Professor of Geriatric Medicine at Kings College London. She is clinical lead for the award-winning Perioperative medicine for Older People undergoing Surgery (POPS) service and President of Age Anaesthesia Association.

Professor Dhesi has led the development of novel education and training programmes for medical and allied health professionals and established a research programme in perioperative medicine. This work focuses on improving quality of care for the high-risk surgical population, through fostering a collaborative and proactive approach.

She is also Deputy Director for the Centre for Perioperative Care, contributes to a variety of steering, advisory and guideline groups (NELA, RCoA, BGS and NICE) and is committed to influencing policy to improve health and social care for older people.

About our new President Elect, Dr Arora:

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 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.

Speaking of her position of President, Professor Jugdeep Dhesi, said: "I am delighted to be taking up the position of President at the BGS. I hope to progress the important work of influencing quality of care for older people, which has been led so impressively by Professor Adam Gordon over the last two years.

"I look forward to working with Dr Arora, the wider BGS leadership team and all our dedicated and hard-working multidisciplinary members to deliver sustainable improvement to the health care of older people living with frailty, multimorbidity and complexity."

Speaking of his position of President Elect, Dr Amit Arora, said: "I am absolutely humbled, honoured and delighted to have been elected to serve as the next President Elect of the British Geriatrics Society, and then to be its President from November 2026. I look forward to working further with the Society and our membership to build on its outstanding work to improve and transform healthcare for older people."

New BGS Oncogeriatrics elearning course FREE to BGS members

The BGS has launched a new elearning course, to help health and social care professionals to better support older people living with cancer.

Expanding the elearning offering, which already includes frailty, delirium and perioperative care, this new course provides CPD for those caring for older people with cancer, including geriatricians, GPs, nurses, allied health professionals and pharmacists.

The BGS's elearning platform currently has close to 12,000 users. The addition of the new Oncogeriatrics course, providing 10 CPD credits, is an exciting expansion of the CPD on offer.

The Oncogeriatrics content has been jointly developed by a geriatrician and an oncologist, to ensure that the content is up-to-date in terms of cancer identification and treatment, and specifically focussed on the care of older people.

The development of the course has also been supported by a wide range of professionals, including a nutritionist, occupational therapist, physiotherapist and pharmacists, ensuring that the content is accessible for as many professions as possible. The course starts with an introduction to oncology and builds knowledge through four modules, focusing on the patient journey. The course culminates with a discussion of two case studies.

This new elearning course is suitable for any health and social care professional who interacts with older patients with cancer. It is particularly aimed at professionals who deal with complex cases or who lead services (Tier 3 competency). This includes not only geriatricians and oncologists but also other health and care professionals with a high degree of autonomy in providing healthcare for older people. This includes acute-based medical staff as well as GPs, Advanced Clinical Practitioners, Pharmacists, Nurses and Allied Health Professionals.

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

- Oncology essentials
- Geriatric oncology
- Patient assessment
- The cancer patient journey

Successful completion of the course provides 10 CPD credits (from the Royal College of Physicians London). It will equip professionals with the knowledge to provide the best possible care for older patients living with cancer.

The course is free to BGS members, or £150 for non-members. Sign up by visiting www.bgs.org.uk/oncolearning

The BGS has partnered with the Royal College of Physicians London to offer healthcare professionals working with older people the opportunity to apply for the Diploma in Geriatric Medicine (DGM).

The DGM is an examination for those who want to demonstrate interest, knowledge and clinical expertise in the care of older people. Applications open on 6 January and close on 19 January with exams taking place across the year.

If you are a GP, psychiatrist, doctor undergoing specialty training, nurse, allied health professional or pharmacist, this examination may be right for you. Find out more by visiting: **www.bgs.org.uk/DGM**

#CHOOSE GERIATRICS

www.bgs.org.uk/choose

The BGS has launched its #ChooseGeriatrics campaign, which aims to ensure that the workforce caring for older people is fully and sustainably resourced, now and into the future.

Why #ChooseGeriatrics?

The population is rapidly ageing, and it is projected that by 2045, there will be almost double the number of people aged over 85 than there are today.

People are living longer than ever before, which is cause for celebration. However, it also means that more people are living for longer with multiple long-term conditions and complex health needs.

Now, more than ever, it is crucial that we attract healthcare professionals from across the multidisciplinary team to ensure that older people today and in the future can access the care they need, when and where they need it.

We will showcase the variety of roles within older people's healthcare and share stories and career journeys from a diverse range of our members. We will highlight the breadth of experiences available to professionals working in this specialty and the rewards they gain. Working in older people's healthcare is innovative, exciting and challenging, with opportunities in acute hospitals, primary care and community services. Through the campaign, we will also collaborate with relevant stakeholders to ensure that medical training is fit for purpose and that good candidates are able to find a rewarding career within geriatric medicine.

What is #ChooseGeriatrics?

#ChooseGeriatrics is a campaign that celebrates the variety, excitement and rewards of professional roles in older people's healthcare.

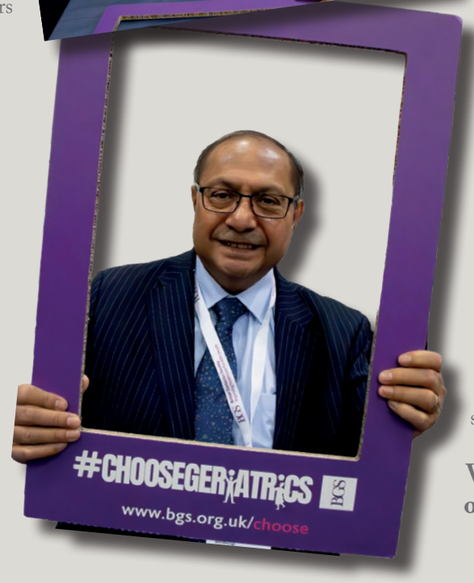
Over the next 12 months, we will share stories and career journeys from our members to highlight the diversity and flexibility of roles across the multidisciplinary team, so that people wishing to specialise in older people's healthcare can access the information they need to start on this journey and become part of the strong community providing high-quality care for older people.

We will also work with those involved in the recruitment of doctors to improve the match between people and jobs, helping to ensure that good candidates are able to find jobs in geriatric medicine and vacancies are filled across the UK.

'Working in older people's healthcare is innovative, exciting and challenging, with opportunities in acute hospitals, primary care and community services.'

All older people should have access to the care and support that they need, where and when they need it. But this requires a workforce that is fit for purpose. We aim to attract more people into older people's healthcare.

The population is ageing and currently there are not enough people with the skills needed to care for older people with increasingly complex needs. BGS members will help to promote the **#ChooseGeriatrics** campaign to the wider healthcare workforce, encouraging recognition of the needs of older people as those who use NHS services the most, and the rewards of careers specialising in their care.



How can I get involved?

We know that BGS members have already chosen geriatrics, so why did *you* **#ChooseGeriatrics**? We want to hear the personal stories behind careers in older people's healthcare. What motivates and inspires you? Has your career taken an unexpected path? What patients or situations stay with you, and provide a constant reminder about why you do your job?

At this year's BGS Spring and Autumn Meetings, some of our amazing members took the time to stop and share what they love about geriatric medicine, and why they find the specialty so interesting and rewarding. You can find out what they said by watching the video on this page. But this is just the beginning.

There are more than 5,000 members of our global BGS community, committed to delivering high-quality, person-centred care to older people across care settings and professions, in all four corners of the UK and beyond.

We know there are hundreds more stories still waiting to be told. Why not tell yours?

Why did you **#ChooseGeriatrics**?

Become an ambassador

As part of the **#ChooseGeriatrics** campaign, we are looking for enthusiastic BGS members from across the multidisciplinary team to become BGS **#ChooseGeriatrics** ambassadors!

Who better to advocate for older people's healthcare as a rewarding career choice than a current BGS member?

You have joined the BGS because you are passionate about the care of older people, so let's harness your enthusiasm to inspire other professionals to join the specialty.

To become a **#ChooseGeriatrics** ambassador,the only requirement is that you are a current BGS member.

As a **#ChooseGeriatrics** ambassador, your role would be to advocate for older people's care by spreading the word to colleagues, being active on social media, volunteering to attend career fairs and events, writing blogs or providing content for *AGENDA*. We may call upon you for other opportunities as they arise. We will provide you with all the information and materials you need, along with some special **#ChooseGeriatrics** goodies to help you spread the word. You will be supported by the BGS secretariat during the campaign.

Visit www.bgs.org.uk/choose to find out more and get involved.

12 Actions to help manage WINTER pressures

This guide, put together by the BGS Policy Committee, represents the core components of safe, high-quality care for older people that are transferable between care settings. Making these changes will help both the individual in front of you and the system around you. We hope they will also enable you to speak to colleagues and operational managers about the kind of services we need to preserve, even in the most challenging times.

Winter is traditionally a tough time in the NHS and we know that the overarching issues that continue to place pressure on our health and care services are not going to be solved before the cold weather hits. Indeed, for many BGS members the pressures are no longer seasonal. Older people use health and social care services the most, but our workforce and services remain under-prepared to meet their needs.

The 12 actions that follow are intended as a guide to focus our minds on the possible. We hope to encourage our non-specialist colleagues to join us as allies in providing the best care possible for this population in very challenging circumstances.

Across all settings

1 Encourage everyone in your service to equip themselves with the skills they need to care for older people with frailty, including generalist staff and those delivering other specialist services.

Optimising community care

2 Implement proactive care plans and advance care plans (known as anticipatory care plans in Scotland) in primary and community settings, especially care homes, to consider future health needs including end of life care. Those based in the acute setting may be able to do this as part of the discharge process.

Proactive care plans, centred around individuals' specific wishes for the future and preferred place of care, including advance care planning, can improve the use of available services. Care plans, once developed, must be shared with relevant family members and added to healthcare records to ensure that they are followed when necessary. Those updating healthcare records may also wish to ensure that next of kin details are recorded, especially for older people living on their own in the community.

Continuity of care in primary and community settings can also help to avoid admissions. For some patients who do need hospital treatment, attending hospital earlier in the day may mean that they can be treated by a Same Day Emergency Care (SDEC) service and avoid being admitted to hospital.

3 Encourage all people aged 65 and over, and all care home residents, to receive vaccinations against Flu and Covid-19.

In addition, people aged 75-79 will be offered a vaccine for RSV for the first time this year. Increasing vaccination uptake is considered to be a high priority to protect people from serious illness and support the NHS and adult social care.

Those working in the community can encourage patients to get the vaccinations that they are eligible for and share information with any patients who may be unsure. Those working in acute setting may have access to inpatient vaccination services which allow patients admitted to hospital to be vaccinated while they are there. Adding vaccination status to CGA templates or clerking proformas can help staff to identify patients who are not vaccinated and ensure that they are offered vaccinations. Health and social care staff should also ensure that they are vaccinated against winter illnesses, if they are eligible.

4 Get to know your local social worker with the aim of developing better connections between health and social care.

Forging strong relationships can improve quality of care and enhance individualised person-centred care. Working collaboratively around a common goal can lead to better outcomes in mental, physical and emotional wellbeing. You might achieve this by inviting your local social worker to your next team meeting or arranging shadowing between your teams to enable staff from both sides to understand each other's work better.

5 Make better use of technology available through social care to support people at home.

These might include smart devices that help people to carry out day-to-day tasks or devices to help healthcare professionals to monitor someone's health remotely. Digital apps can be used to help people to record daily pulse oximeter and pulse rate readings which are then automatically transmitted to the hospital digital care hub with abnormal readings triggering an alert and prompting a follow-up with the patient. One example of such an app is the MyCare24 app, used by NHS Airedale: **www.airedale-trust.nhs.uk/service/digital-care-hub/mycare24**

Community staff on routine home visits can ask to see a patient's medications and, if they have any concerns, can contact the primary care team who can then follow up with a full review. Medication-related complications are thought to contribute to up to 30% of admissions in older people.1 Deprescribing reviews should be completed as part of routine inpatient care for older people. Medication accounts for 25% of carbon emissions in the NHS2 so reducing unnecessary prescribing throughout the patient journey not only reduces the risk of medication-associated harm but also contributes to reducing the carbon footprint of the NHS.

Reducing hospital-associated harm

7 Seek to minimise use of temporary care environments (also known as 'corridor care') for older people – this includes 'boarding.'

Ensure frailty scores are included in any Trust policies or Standard Operating Procedures (SOPs) around the provision of care in a temporary setting to allow better risk stratification. Ensure bed management teams understand that these environments increase the risk of delirium, falls and pressure area damage for older people with frailty and that low National Early Warning System (NEWS) scores should not provide false reassurance in this cohort. Wherever an older person is cared for, continue to advocate for the key components of quality care outlined below. Trusts should consider how these can still be provided in temporary care environments.

8 Identify patients with frailty as soon as they arrive at the hospital through proactive use of the Clinical Frailty Score in triage.

The Acute Frailty Network have developed an app to help staff to determine a patient's clinical frailty score (CFS) and therefore ensure that the patient accesses appropriate pathways and care such as front door frailty services. Once a patient has had their CFS assessed, this should be recorded to make further decision-making easier.

9 Encourage older people in hospital to get up, get dressed and get moving to avoid deconditioning.

This is a real risk for older people in hospital – hospital inpatients have muscle strength reduced by up to 10% in the first seven days of admission.3 There may be voluntary groups locally who can support patients to move around safely in hospital. Welcoming carers and family members into the acute hospital setting can also help to avoid deconditioning as they can help their loved ones to get out of bed and mobilise.

10 Recognise and treat delirium as a medical emergency and prioritise its prevention and recognition.

The incidence of inpatient delirium in older people is around 20%.4 Systems should use the 4AT Rapid Assessment Test to identify delirium on admission and the single question in delirium (SQiD) at Board Rounds. Patients or their carers should also be asked 'what matters to you' to help to guide treatment decisions and ensure that the patient's needs are prioritised.

11 Prioritise pressure area care for older people who are admitted to hospital.

The majority of pressure injuries are hospital-acquired and they are associated with increased morbidity and mortality.5 Hospital-acquired pressure ulcers increase length of stay by an average of 5-8 days per pressure ulcer. There should be clear pathways for identifying patients who need pressure mattresses, ordering mattresses and ensuring that pressure mattresses follow patients if they are moved within the hospital. Processes should be in place for routine skin checks for older people in emergency departments and to regularly turn patients who are at high risk of developing pressure ulcers.

12 Consider whether older people could be treated in a Hospital At Home service as an alternative to hospital admission.

While hospital may be the best option for some older patients, it is a risky environment for many older people, especially when pressure on the system is at its highest. An older person who wants to go into hospital and can benefit from it should not be denied this option. However, most older people would prefer to avoid hospital admission if possible and evidence shows that for the appropriate patient population, hospital treatment can be provided in a home setting with comparable outcomes. Hospital At Home services are available in many parts of the country and provide a safe alternative to hospital for some patients.

For the full version of this article, which includes resources and links to help carry out these 12 actions, visit www.bgs.org.uk/12WinterActions

BGS WINTER 2024-25: TIME TO ACT FOR OLDER PEOPLE

www.bgs.org.uk/winterstatement2024-25

The BGS, supported by 23 organisations including six medical Royal Colleges, has expressed grave concerns about the impact of the winter months on the health and wellbeing of older people.

BGS members say that services are already critically overloaded in many parts of the country and have been so throughout the summer.

The government has pledged to transform health and social care but none of these promised improvements will be in place before winter.

The BGS is calling on the new government to act for the long term rather than with quick fixes that do not address root causes.

The BGS proposes seven evidence-based actions that will make a sustainable difference to older people's care across the UK. These aim to ensure that older people with frailty and multimorbidity are able to access the care they need over the winter months:

Services for older people living with multiple long-term conditions should take a coordinated and person-centred approach including the involvement of experts in older people's healthcare as appropriate. BGS's Joining the Dots Blueprint sets out what coordinated and person-centred care should look like for older people. This can reduce unnecessary investigations and medications, and support older people to make informed decisions about their future care, treatment and place of care. Effective implementation of proactive care to identify those in the community at risk of deterioration and early intervention can prevent ill health occurring or worsening. The BGS will shortly be publishing the evidence base to support NHS England's Proactive Care Framework and also a guide about the delivery of proactive care in primary and community care settings.

Investment in good quality healthcare support for care homes reduces avoidable hospital admissions. There should be continued efforts to implement Enhanced Health in Care Home models where it is possible to do so. These initiatives should focus on minimising inappropriate polypharmacy and discussing resident and family preferences about what should happen in the event of an acute healthcare crisis. The BGS has published guidance on the provision of healthcare in care homes in our Ambitions for change report.

Experts in older people's care must be included in Government and NHS policy planning. Older people are the largest group of people who use NHS services, accounting for 40% of hospital admissions and 62% of hospital bed days. Older people are also the fastest growing age group, with the number of people aged over 85 projected to double by 2045. The BGS has supported calls for the establishment of an Older People's Commissioner in both England and Scotland to advocate for the rights of older people. These roles already exist in Wales and Northern Ireland and have had a positive impact on older people's advocacy in those nations.

All older people with frailty should receive comprehensive multidisciplinary assessment as soon as possible after they arrive in hospital. This is often best achieved by dedicated services such as acute frailty units, or frailty assessment teams. Such teams can initiate early treatment to prevent deterioration and enable timely discharge to community services at home. We outline more about how to deliver such approaches in our guide to Front door frailty services.

There must be a focus on preventing, identifying and managing both deconditioning and delirium in hospital. Both are avoidable and are associated with increased length of stay in hospital and increased dependency on discharge. All hospitals should have a delirium policy in place as described in our Delirium Hub. Information on preventing deconditioning is available from the 'Sit up, Get dressed, Keep moving' campaign and the Reconditioning Games.

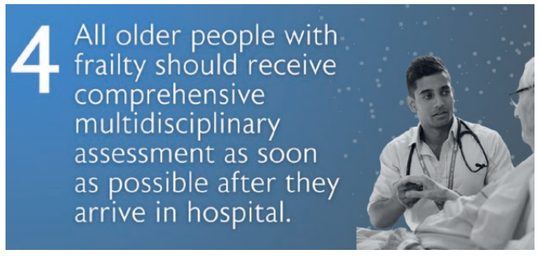
The government, and health and social care providers, must protect and preserve the right to rehabilitation for all older people who need it. Effective care for older people with frailty requires early mobilisation in hospital, rapid establishment of rehabilitation goals, and continued therapy input until their condition has stabilised. The right to rehabilitation means that older people must be supported by rehabilitation multidisciplinary teams wherever they receive care. Where delayed transfers of care to community rehabilitation services are unavoidable, rehabilitation should commence in hospital. Older people with rehabilitation goals should not be transferred to a care home or community bed without assurance of appropriate rehabilitation being available. BGS's *Reablement, Rehabilitation, Recovery: Everyone's business* report outlines what good quality rehabilitation looks like for older people.

There should be continued investment in a multi-professional urgent community response that provides both intensive short-term hospital level care at home through Hospital at Home and access to goal-oriented home-based and bed-based reablement and intermediate care services. These must work closely with ambulance, ambulatory care and same day emergency care services as an integrated local network. We have written more about this in *Right Time, Right Place,* our guide to urgent community-based care for older people and *Bringing hospital care home,* which outlines how virtual wards and Hospital at Home services can support older people.

The BGS and its partners will continue to campaign for transformation of the health and care services used by older people. Solutions such as spot purchasing beds or time-limited funding perpetuate a short-termist approach which is not sustained beyond a few months, after which the same challenges resurface.

A joined-up integrated system of care would deliver better health outcomes for older people. It would also unblock some of the ongoing systems problems the NHS faces, such as long waiting lists for elective care, delayed transfers of care and avoidable hospital readmissions. Now is the time to undertake systems transformation in readiness for the increased demands of an ageing population.

Our seven evidence-based actions for the Government:



For a downloadable version of this statement and a full list of the 23 organisations supporting it, visit: www.bgs.org.uk/winterstatement2024-25

Why should we BE PROACTIVE?

‘The problem we encounter is that, at times, being proactive just requires too much energy and mental space.’

Being proactive is more than just a service format - in many ways, it's more of a mindset, explains BGS Honorary Secretary, Ruth Law.

A couple of weeks ago, a sign appeared on the stairs up to our offices. For me, it summed up so much of what is wrong with the NHS at the moment. Waiting until things break before fixing them - if they are fixed at all. Like many people working in the NHS, I have learned to find creative solutions to the crumbling infrastructure we spend our days in.

I hold the office window open with a can of soup, I stir my tea with a knife, I have a bucket ready for the corner of the office where the roof leaks on a rainy day. These workarounds have become business as usual for most of us.

‘How long can we keep jumping over the wobbly stair before the whole flight collapses?’

We love labelling problems in the NHS, but how much time do we spend looking at root causes and pre-empting the issues before they arise? I understand this reactive approach to the management of our working environment is a consequence of funding and staffing constraints. Our estates teams are working hard to do their best with the resource they have to improve things But we know that when we don’t spend time on maintenance, things cost more to fix in the long run....how long can we keep jumping over the ‘wobbly stair’ before the whole flight collapses?

The danger of a continually reactive approach in all walks of life is that the cost is greater in the long run. This is true for the environments we work in, but is critically also true for our patients. Being proactive takes time to do well, but embracing proactive care - thinking ahead with our patients about their health and wellbeing - brings benefit in the longer term.

In geriatric medicine, this means identifying people living with frailty and intervening early to optimise their physical and mental health and environment but also to understand better what matters to them. This is the core of what the community MDT I work with does every day, and this deceptively simple work is highly skilled and time consuming to do well.

The release of the NHS England document *Proactive care: providing care and support for people living at home with moderate or severe frailty* (published December 2023) validated the approach of many similar teams across the four nations, and the new BGS documents on proactive care provide further evidence to support a proactive approach to frailty care in the community.

The problem we encounter daily however, as we navigate the various challenges we face at work, is that at times, being proactive just requires too much energy and mental space. The BGS Autumn Meeting just passed offered a great opportunity to re-energise, reflect on this way of working, and consider how we can generate the momentum we need to practice this approach.

As Rachel Clarke, author and palliative care doctor reminded us in her excellent talk - no one can do everything, but everyone can do something. You may not work in a ‘proactive care service’ but how can you bring that proactive mindset to your area of work? Where are your metaphorical ‘wobbly stairs’ and how could you and your team do one small thing towards fixing them?

Perhaps look through our ‘12 actions to help manage winter pressures’ (see page 8 or online at **www.bgs.org.uk/resources/12-actions-to-help-manage-winter-pressures**) and identify one manageable action to focus on over winter.

There’s no doubt this winter will be tough but if we can allow ourselves to create a small amount of space now to think ahead and be proactive, we can use less energy feeling frustrated and conserve it for where it is most needed.

Ruth Law
BGS Honorary Secretary

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The BGS has published two new documents on proactive care, one focusing on the evidence supporting proactive care, and the other on delivery of good quality proactive care.

Be proactive: Evidence supporting proactive care for older people with frailty

This first publication provides evidence-based guidance to support healthcare professionals in implementing proactive care for older people with frailty.

Proactive care (previously known as anticipatory care) is one of the three strands of the Ageing Well Programme, as set out in the NHS Long Term Plan in 2019.

'There are many examples of excellent proactive care services across the UK which aim to slow the progression of frailty and offer personalised interventions so people can remain well for longer.'

In December 2023, NHS England published *Proactive care: providing care and support for people living at home with moderate or severe frailty* to support systems to implement proactive care locally. Extensive work went into producing this guidance from stakeholders across the health and social care sectors.

However, the final guidance published by NHS England was edited significantly, with much of the supporting evidence removed to create a succinct document. While it is disappointing that the original Ageing Well funding for 'anticipatory care' never materialised, nevertheless the NHSE guidance acts as a useful framework. BGS is now publishing the detailed evidence base supporting this guidance, with the approval of NHS England.

Be proactive: Evidence supporting proactive care for older people with frailty is intended to help healthcare teams across the UK to develop their own proactive care services, working with the voluntary sector and with social care providers. It will assist them in making the business case for early intervention to commissioners. The content is relevant to the whole of the UK, although this is based on an NHS England document.

Many BGS members across the country are already implementing proactive care services which help to delay the progression of frailty. These services are identifying and addressing older people's needs at an earlier stage, improving outcomes for the individual and reducing hospital admissions.

We hope that this document will help more people to make the case for proactive care services locally.

Be proactive: Delivering proactive care for older people with frailty

This guidance document explores how to deliver proactive care for older people with moderate to severe frailty in community and primary care settings. *Be proactive: Delivering proactive care for older people with frailty* is aimed at healthcare professionals, clinical leaders, commissioners and system designers seeking advice on how to implement services in their locality.

Building on NHS England's guidance, the new BGS publication outlines how to identify a target cohort, carry out holistic assessments, develop personalised care plans, work in a co-ordinated and multi-professional manner, and provide continuity of care to older people living with frailty.

It also outlines the importance of a flexible workforce, using shared care records, and implementing clear accountability and shared decision-making.

To support the delivery of proactive care, the publication makes eight recommendations requiring action from commissioners, policymakers, providers, and healthcare professionals at local, regional and national levels. This includes a call for national funding and contractual arrangements, investment in outcome measures, and a focus on training and development for proactive care.

There are many examples of excellent proactive care services across the UK, which aim to slow the progression of frailty. These services vary in size and structure, but all identify older people at risk of ill health and poor outcomes and offer personalised interventions so they can remain well for longer. The publication showcases a range of these services, and it is hoped readers will find the learning points useful.

The publication follows on from *Be proactive: Evidence supporting proactive care for older people with frailty*, which outlines the evidence for proactive care. This document may be used to build a business case, while the second document provides a roadmap for delivery.

BGS Delirium Hub: A comprehensive delirium resource

The BGS Delirium Hub links users to useful, practical and high-quality information on all aspects of delirium in older people.

Frequently misdiagnosed or under-diagnosed, delirium is a state of acute confusion. Characteristic features include difficulty concentrating, disorientation, difficulty with understanding or memory and personality changes, which can be immensely upsetting to both patients and their loved ones.

The causes of delirium are multifactorial and can often be a sign of an underlying physical illness. Raising awareness of the risk factors, signs and management of delirium among the wider multidisciplinary healthcare team is vital to help ensure that older people can access the support and care they need, reducing unnecessary distress for those affected.

The hub guides users through the topic of delirium, focusing on four key interlinked areas; an introduction to delirium; presentation, screening and treatment of delirium in specific settings; education and training; and current research evidence.

The BGS Dementia and Related Disorders Special Interest Group (SIG) led on the curation of the resource, which provides useful context and signposting to material from organisations such as BGS, Health Education England, Health Improvement Scotland, National Institute of Health and Care Excellence (NICE) and the Scottish Intercollegiate Guidelines Network (SIGN), as well as free-to-access papers from Age and Ageing and other globally-recognised peer-reviewed journals.

Visit the Delirium Hub on the BGS website at www.bgs.org.uk/DeliriumHub

Why *proactive care* matters

Dr Eileen Burns is a past BGS President, former NHS England Specialty Advisor, and was heavily involved in developing the recent BGS *Be proactive* publications. Here she sets out what proactive care actually is, and how it can affect older people's lives for the better.

Proactive care is a preventative service, now beginning to flourish across the UK. For those areas under its purview, NHS England published a guide to proactive care last year.[1]

BGS have since published two recent documents, one reviewing the evidence base for proactive care, the other giving useful guidance in setting up a service. These great publications are outlined on the previous two pages of this issue of *AGENDA*.[2,3]

So, what is proactive care? Who provides it and how can it be delivered when every part of the NHS is feeling the strain of increasing demand and budgetary increases which don't keep pace with that demand.

Consider Alice, a 79-year-old lady who lives in terraced house in a city. She has four long term conditions (cardiovascular disease, Type 2 Diabetes, arthritis and depression). She has had three hospital admissions over the last 12 months, and frequently speaks with '111' who almost always send an ambulance to assess her. She makes frequent calls to the GP surgery – she can't get used to the online system the practice now uses for appointments and she often gives up when she hears she's seventh in the queue on the phone.

Her breathing is slowly getting worse, and after the last two hospital admissions she has returned home feeling more anxious and less inclined to try to get up and leave the house.

Her daughter lives a 20 minute drive away, she works full-time and is finding the frequent phone calls her mother makes to her increasingly difficult to manage. Her boss has suggested that perhaps she should reduce her hours, but financially that's not an option for her.

How might proactive care offer Alice a different set of options?

Her GP practice uses the electronic frailty index (eFI) to identify a cohort of people with moderate frailty. They further refine the cohort using respiratory disease as their data indicate this combination of factors produces an increased risk of unplanned use of care. The cohort identified is then assessed clinically to identify their Clinical Frailty Scale (CFS) score. Alice is one of the cohort with a CFS of 6.

Alice is contacted by one of the integrated care team (Helen), who explains why they would like to visit Alice and discuss proactive care with her. Alice isn't sure about this but agrees to be visited. A nurse visits and discusses with Alice how she currently feels about her health status and her expectations and wishes for the future. She then uses an electronic document to initiate comprehensive geriatric assessment (CGA). Helen explains to Alice that she'll keep Alice fully informed regarding next steps and what Alice can expect to happen.

'Alice is delighted to say she's now a regular member of the knit and natter group - she gets a lift there from a volunteer driver who enjoys the drive as much as Alice does.'

Helen meets with the members of the neighbourhood team. A number of issues identified are:

- Polypharmacy, with some concordance issues, including practical issues related to Alice's use of her inhalers.
- Diabetic control: Alice is still convinced that she needs to keep her blood sugars very tightly controlled, resulting in several hypos, some managed at home, some resulting in hospital admission.
- Falls risks: Alice has become deconditioned and is afraid of falling
- Low mood: Alice doesn't feel her antidepressant is helping – she's been taking amitriptyline for several years.
- Constipation.
- Loneliness.

The team agree the following actions:

Rigorous medication review – diabetic meds reduced, amitriptyline slowly titrated downwards, support and education with inhaler use.

Physio and OT input to help Alice regain some lost mobility and reduce falls risk.

The voluntary sector member of the team engages with Alice and persuades her (after some initial resistance) to go to the local 'knit and natter' group - she takes Alice herself the first few visits to help her cope with a new social situation.

The team support Alice to apply for attendance allowance, and she is awarded the lower rate. This allows Alice's daughter to reduce her hours at work and spend more time supporting her Mum.

All the teams' interactions are documented on a shared clinical record so that they form an 'iterative' CGA, which is visible to primary, secondary and community health services.

Helen meets with Alice after two months. Alice is delighted to say she's now a regular member of the knit and natter group - she gets a lift there from a volunteer driver who enjoys the drive as much as Alice does. She feels less worried about falls, though she continues to be cautious and finds the extra stair rail and toilet adaptations really helpful. She feels more in control of her medications and especially in how to use her inhaler. She also says she feels the breathing techniques she's been taught if she starts to feel breathless have really helped her. She tells Helen that her bowels are much better since the changes in her medication. At least for now, she feels her mood has improved so that she wants to try without an alternative antidepressant.

Alice's GP hasn't been contacted about her since PC started to interact with Alice. The team have made the practice aware of the difficulty Alice has had in using the online system, and they have agreed to note this on her records and to ensure her daughter is recorded as a trusted individual for Alice. Alice called 111 once when she felt breathless, but declined the offer of an ambulance, opting rather for an out of hours GP response. This resulted in reassurance and an antibiotic prescription. The electronic record sent a 'task' to the team to alert them that Alice has had an exacerbation, and they review her the next day. She is referred to the Hospital at Home (H@H) service who visit the same day, and support Alice over this exacerbation. Once she's stable again H@H let the PC team know.

Alice and her daughter are delighted with the input from the team. The team have broached Alice's views about her future health and she and the team have developed her advance care plan.

Lastly, the team members are all delighted that they can see real change for Alice from their interventions - an assessment of job satisfaction for the team is overwhelmingly positive, and sickness absence is at an all time low.

Hopefully this example helps to illustrate how proactive care can reduce demands on the health and care system, improve patient's quality of life, and staff satisfaction.

The two BGS documents on proactive care describe the evidence base for the service and some practical advice on setting up a service, which are thoroughly recommended for those setting up services.

Dr Eileen Burns MBE
Former BGS President and former NHS England National Specialty Advisor

References

1. NHS England (2023). Proactive care: providing care and support for people living at home with moderate or severe frailty. Available at: www.england.nhs.uk/long-read/proactive-care-providing-care-and-support-for-people-living-at-home-with-moderate-or-severe-frailty
2. BGS (2024). Be proactive: Evidence supporting proactive care for older people with frailty.
3. BGS (2024). Be proactive: Delivering proactive care for older people with frailty. Both available at: **www.bgs.org.uk/ProactiveCare**

Proactive care IN PRACTICE

Examples from across the UK

As part of our *Be proactive: Delivering proactive care for older people with frailty* publication, BGS members and colleagues shared examples of proactive care services currently operating across the UK. Here we highlight a few of the featured services to understand more about how they were set up, as well as some of the things they learnt along the way.

North Devon Anticipatory Care

Overview

Torridge Health Primary Care Network and Barnstaple Alliance Primary Care Network launched a proactive care pilot in 2023 supporting older people living in their own homes with frailty and medical complexity.

How does the proactive care pathway work?

People are identified from the Community Matron caseload and referred to the weekly Anticipatory Care multidisciplinary team (MDT) meetings. The Community Matrons review their caseloads weekly and refer the following people:

- People who have had frequent hospital admissions or are thought to be at high risk of admission.
- Those who are falling or at risk of falls.
- People with medical complexity.
- Those who wish to remain in their own home but are struggling to manage.
- Those with polypharmacy.
- People nearing the end of life.
- Those with behavioural and psychological symptoms of dementia (BPSD).
- People who need input from multiple teams.

For each person being referred to the service, Community Matrons complete a WHO-5 wellbeing score and ask the person, "What matters most?" The individual is then discussed at a weekly virtual MDT meeting. MDT members include community therapy professionals, older person's mental health professionals, dementia support workers, community matrons, social care professionals, pharmacists, social prescribers, GPs with extended role in geriatric medicine, falls rehabilitation nurse, and a care co-ordinator. At the MDT meeting, a problem list is created, and a plan is made to address each individual problem. Following the MDT, different team members take on responsibility for actioning different aspects of the plan, including a medication review, and a timescale for follow-up is agreed. When a person is discharged from the proactive care service, they are sent a letter summarising their ongoing care plan.

How was the service set up?

When proactive care (formerly anticipatory care) was initially announced as part of the NHS Long-term Plan in 2022, Dr Fiona Duncan was already running a successful weekly Care Home MDT meeting as part of Enhanced Health in Care Homes model, and this model was adapted for the new proactive care service. There was close engagement with the local community matrons, GPs and other MDT members when developing the service model. Existing MDT relationships were built on to create a new MDT for older people with frailty living in their own homes, with medical complexity. There was anticipatory care pump priming funding available from the Integrated Care Board (ICB) and this was used to test the service as a pilot in a single Primary Care Network (PCN) in North Devon, which later rolled out to a second PCN.

Impact

The following outcome measures were used:

- Before and after WHO-5 wellbeing scores.
- Testimonials: older people, carers and healthcare professionals.
- Personalised medication reviews.
- Before and after surveys of Community Matron job satisfaction and support.
- Numbers.
- Over 70 older people have benefited from the service and had medication reviews.

Testimonials from older people

"I feel the input from the MDT really made me feel listened to and supported."

"The MDT helped me to now have my prophylactic antibiotics which have helped my chest infections reduce – I feel this would have been a slower process if I did not have the input from the MDT".

"Input from the MDT has helped to stop my falls and dizziness, I have not had any falls since input from the MDT and this has made a huge impact to my everyday life and I have gained confidence again!"

Testimonials from community matrons

"His wife has been concerned about his mood and his mental health. She has welcomed discussions about her husband starting antidepressants and conservative interventions to address this. In addition she worries about 'all of his medication.' She is very pleased that this has been looked at and a plan to reduce blood pressure medication has been made. She feels she is involved with decisions about her husband's care and reassured that her husband's problems are being discussed in depth with a GP and community pharmacist, during what has been a very difficult and emotional time, for her and her husband."

Testimonials from GPs

"Through the multidisciplinary Anticipatory Care MDT, my patient's addiction to over-the-counter medication was identified. With the teams support the patient now has better control of their medication which is reducing the need for clinical input at both a primary and secondary care level. There is incalculable benefits to the patient and the savings from reduced A+E attendance and hospital admissions"

Future of the service

Proactive care continues to run in North Devon, but there is sadly no recurrent funding for this. The service plans to apply for further funding to continue this invaluable work. They will be measuring ongoing success by looking at numbers of people having personalised medication reviews and the impact of Anticipatory Care on unplanned hospital admissions.

'There is a wide range of tech and IT that can be used for case identification, but you can end up identifying vast numbers of patients that are then unmanageable in practical terms.'

Top tips

- **Keep case identification simple and manageable: there is a wide range of tech and IT that can be used for case identification, but you can end up identifying vast numbers of patients that are then unmanageable in practical terms. In North Devon, most very complex older patients with frailty living at home are under the care of the community matrons, so this was an ideal ready-made pool from which to identify cases.**
- **Investing time in an MDT meetings saves time overall: all professionals in a single place and can often skip lengthy individual referral processes. Use this as an incentive for team members to engage and attend when building your MDT meeting.**
- **Keep MDT meetings structured: focus on the problem list, "what matters most" and medications. Keep to one hour to maintain concentration and focus of team members.**
- **Use the MDT meeting as a tool for education and peer support: we have encouraged education and upskilling of colleagues as part of this service. Fiona Duncan (who chairs the MDTs) gives weekly teaching and updates at the MDT and the feedback on this is very positive. Education and teaching are great incentives for the MDT members to attend each week.**
- **Keep 'what matters most' to the older person at the heart of your plans.**

Moreton and Meols PCN and Wirral Community NHS Foundation Trust

Overview

The Wirral peninsula is geographically small, with a population of 330,000 spread across large towns and rural areas. Its residents experience stark health inequalities and differences in life expectancy. Particularly on its more densely populated east side, practice and PCN populations are overlapping and interwoven. In Wirral, local and national data showed clearly that those with higher levels of frailty are already the greatest users of primary, community and secondary care. They are also most likely to need unplanned care, which may be avoidable with better proactive care. Working across the PCN and community teams, the Wirral's proactive care programme aimed to bring together teams who were already supporting those with higher levels of frailty and chronic disease, where personalised, proactive, holistic assessment and care planning could improve their quality of life and potentially reduce unplanned care demands. This meant the community trust's frailty nurses and matrons working as part of an integrated PCN team.

How does the proactive care pathway work?

The team identifies people with clinically identified moderate and severe frailty. However, this is not exclusive and people with mild frailty are also supported where there are additional complexities that will benefit from a CGA approach. People are identified via referral from practices and community teams. The pharmacy team receives discharge notifications from the hospital, and these are reviewed to identify those who should be seen by the team. Risk stratification, using data in the primary care record is also used to identify people who may benefit. The pathway from referral or identification via risk stratification begins with a triage review using relevant information available from both the GP and community trust health records. This gives a picture of past and current needs and service involvement. After a phone call with the patient to confirm details, including starting to understand what is currently of most importance to them, the initial visit will be from the lead clinician. The comprehensive geriatric assessment (CGA) and care plan is completed over a series of visits (current average 3-4), with non-registered clinical staff doing some of the follow-ups if appropriate. The referral and triage process is managed by the team's care co-ordinator. As patients with ongoing complex care needs require continuity and holistic care, the whole team, including the community trust-employed staff, use the GP patient record for their clinical documentation. As planned review is part of the CGA process, the service uses a shared patient tracker to support both immediate care coordination and future planned follow up.

How was the pathway set up?

The development of the combined Ageing Well, Living Better Team was a joint project between Moreton & Meols PCN and Wirral's community trust. It was the product of several months' development and exploration of cohorts, activity, barriers and gaps to be overcome. It was finally enabled with a one-off six month funding agreement by the community trust for additional resource to enable proof of concept without taking resources from, or disrupting, the community trust teams working beyond Moreton & Meols. The combined core team is made up of people working for the community trust, PCN, and the hospital trust. The team consists of six members of staff, including registered and non-registered clinicians and administrative staff, who look after 30,000 patients.

'As patients with ongoing complex care needs require continuity and holistic care, the whole team, including the community trust-employed staff, use the GP patient record for their clinical documentation.'

Several key building blocks that have supported the way the team works were:

- The information sharing agreements and access to PCN practice EMIS systems that was granted to the community trust staff
- The design and build of the patient tracker (an Excel-based tool on a shared Teams channel, accessible to PCN and community trust staff) and the customisation of assessment and care plan templates in EMIS
- The development of EMIS searches to support drawing together information for triage, and for risk stratification
- Co-location of the team in a PCN building
- Evaluation
- The service holds regular meetings with the team with an aim to monitor the service, assess success, implement improvements, and gather feedback from staff.

Impact

Removing barriers to good care

The service uses a shared primary care system which allows all staff in primary care practices to see proactive care interventions, saving community trust time which was previously spent writing letters and avoids formal referrals. The close co-ordination across the team also avoids duplication between PCN and community trust staff and allows for better communication.

An improved offer

The extended team at PCN level brings together a range of advanced skills and experience, resulting in more support without needing to request action from a GP. Initially, there was concern that a more proactive approach would need more GP input. However, the opposite has been the case and using a sample of 100 patients, GP and nurse appointments have reduced by 10% following the frailty team's input. The team supports individuals who are "just about managing" but do not have support available, which should result in fewer care crises. The service expects to show, after 12-24 months, a reduction in A&E and unplanned admissions.

Better staff and patient experience

This more proactive, person-centred and closely coordinated way of working has increased job satisfaction. One team member said, "*I love my job. This is what I came into nursing for.*"

Similarly, patient feedback has been positive. A family member of one patient said: *"Brilliant. I felt for the first time in a long time that I was getting support in managing her at home and keeping her at home for as long as possible."*

Next steps

The success of the model in Moreton and Meols has resulted in the community trust aligning all matrons, frailty nurses, and related staff to PCN footprints. This will enable the model to be co-developed with each PCN in Wirral. At this stage, this does not involve additional funding beyond what is already allocated for the existing community trust teams and the ARRS roles in the PCNs. The integrated team uses this resource better than parallel teams.

Top tips

The following aspects worked particularly well:

- **Explicitly building a 'team of teams' across PCN and community services has been essential for making the most of collective resources. Doing this with the team, recognising that it takes time and won't be perfect straight away, has been critically important.**
- **A CGA-driven process has been invaluable in supporting holistic, person-centred assessment and care planning.**
- **Co-location of PCN and community staff.**
- **A single referral pathway and one point of care co-ordination removes duplication, and the care coordination extends to building relationships and knowledge across and beyond the PCN to health, social care, community and voluntary sector services.**
- **Pooling PCN and community resources, which included advanced clinical practitioners and prescribers, means that more work can be kept within the team, who are less likely to need GP input.**
- **Sharing a single clinical system with the same assessment and care plan templates makes information available to the wider practice teams. This promotes assessable, continuous information across GP and ensures QOF related information is captured in one place.**
- **Retaining access to the community trust system has widened the information available to support good triage, whilst also making onward 'referrals' to community services quicker and simpler. Bringing together the PCN and community team members' knowledge of their respective organisations has been very beneficial.**
- **A shared patient tracker supports planned review and helps align planned CGA review to chronic disease reviews.**
- **Using simple risk stratification, run monthly, to identify a number of people expected equal to any capacity left after referral demand has been met means full utilisation of the team's capacity.**
- **Monthly reporting to individual practices about their patients who are being actively supported by the team supports coordination between GP and PCN teams, whilst practice-level activity reports demonstrate the work of the team and highlight the benefit of referrals from practices.**

Islington Proactive Ageing Well Service

How does the proactive care pathway work?

The Proactive Ageing Well Service (PAWS) strives to see patients with moderate frailty in the community for a proactive, preventative CGA with the ambition to keep them well at home. They work with other medical services who screen patients for frailty using the Rockwood Clinical Frailty Score (CFS) and provide service with the patients' details so that they can arrange a holistic assessment within their home. The services that screen patients for frailty include GP practices, district nurses, community therapy teams, older age mental health services, community heart failure teams and the acute hospital Emergency Department teams at the Whittington. All patients with a CFS of 6 will be proactively assessed by the team in a systematic way. They do not need to have any acute or new problems: the only criteria are that they are CFS 6 and have not had a CGA in the last year.

How are people supported?

Patients are seen by a multidisciplinary frailty team within their home for a holistic, patient-centred comprehensive geriatric assessment, where issues are identified, a care plan is developed, and referrals are made to appropriate services. The service recognises that a lot of people are living with moderate frailty and trying to support themselves, but this is not formally identified, diagnosed and managed. As a result, these patients are only diagnosed once they have severe frailty and starting to use acute and community services. The service aims to see these patients proactively with the objective of intervening early and hopefully slowing or halting the progression of frailty and the consequences of this.

How was the service set up?

In 2014, Whittington developed a community frailty service called the Integrated Community Ageing Team (ICAT), who undertake comprehensive geriatric assessments for patients in their home and support the local care homes. The ICAT team primarily see patients with severe frailty who are referred with a range of complex frailty issues.

In 2017, a group of GPs in Islington in North London were given some money to develop services that they felt that their patients would benefit from. They felt that proactive frailty assessments would be helpful and approached Whittington Health NHS Trust to support them with this, and the PAWS team were set up. The success of this project resulted in the service being rolled out across the borough. They have recruited a multidisciplinary team, including a frailty nurse, physiotherapist, pharmacist, Age UK navigator,

'The service aims to see these patients proactively with the objective of intervening early and hopefully slowing or halting the progression of frailty and the consequences of this.'

and administrator, supported by a consultant geriatrician and a specialist GP in frailty. They work together with the Islington GP federation, who have developed a service level agreement with all local GP practices to allow access to EMIS GP records and document our assessments on EMIS.

What difference has been made?

Patients

Patients are often trying to manage in the community and have not presented to services yet. This holistic assessment allows them to raise their concerns and provide early support from health services, social services and charitable organisations. Without this service, the patients would not have had any assessment, or possibly disjointed care. The patients are often identified with a range of frailty syndromes and will have evidence-based interventions to support them. An example of this is where patients are having falls - they will have a multidisciplinary falls assessment, a pharmacy review and screening/treatment for osteoporosis. This service provides joined-up care for patients with clear communication with general practice and community services. This ensures that the patient's concerns and treatment are available for other services, and this reduces duplication.

Staff

The community and primary care teams that are seeing patients with moderate frailty now have a pathway to enable these patients to be seen. Prior to this, they would often recognise frailty but were unclear of the best way to support the patients proactively. For the PAWS team, it is incredibly rewarding to assess patients and provide a holistic assessment within their home. They are frequently seeing cases where patients have been struggling to manage on their own and are extremely grateful for the interventions.

The team is a collaboration between an experienced clinical MDT, Age UK Islington and the local GP Federation. This level of integration ensures that all the patient's needs are considered within one team, and they are not working in silos.

For services/system

This service is an example of implementing proactive care as outlined in the NHS England Proactive Care guidance from December 2023. The North Contral London ICS were ahead of the curve when they commissioned this service in 2017. It has been used by NHS England as an exemplar of proactive care.

'It is incredibly rewarding to assess patients and provide a holistic assessment within their home... patients struggling to manage on their are extremely grateful for the interventions.'

Although the primary aim of the service improving patient care and wellbeing, the service recognises the importance of proactive, preventative work on the wider NHS and social care systems. By identifying frailty early, the objective is to reduce the patient's morbidity and mortality and in turn reduce need for hospital admissions and social care. Examples of this include reducing polypharmacy, assessing for falls and osteoporosis, diagnosing dementia at an earlier stage and ensuring a multidisciplinary intervention, and recognising social isolation and increasing community support for patients to promote wellbeing and reduce low mood.

Outcome measures

- Since 2021, the service has assessed over 1200 patients with moderate frailty.
- They identified a wide range of issues and referred over 500 patients to other services. Examples include audiology, community dentists, bladder and bowel services, charitable organisations and the memory team.
- The service has started evaluating the accuracy of the referring teams Clinical Frailty Scoring.
- One of the challenges the service experienced was finding a robust way to evaluate if proactive interventions have reduced acute hospital presentations and need for social care.

Patient story

Mr X is a 77-year-old man that was identified by the emergency department in a local hospital as likely to benefit from a CGA. He was given a CFS score of six and attended the emergency department on a few occasions in recent months with a urinary infection and blocked catheter. His medical history included heart failure, impaired vision and benign prostate hypertrophy with an indwelling catheter which was inserted in the last year. The patient's goal was to remove the catheter, improve mobility, and help with activities of daily living to improve function. After his initial assessment, he was discussed in the weekly MDT meeting with the consultant. A care plan was developed to include a physiotherapist assessment to improve confidence, urology referral, medication review, social service referral, and advanced care planning. Mr X remained on the service caseload until the care plan was completed. He had an allocated key worker within the team to oversee his care and liaised him and with all appropriate clinical and social care teams. On the completion of his care a timely discharge letter was completed. A copy was sent to Mr X and his GP. Outstanding actions for Mr X and GP included advice around future referral to talking therapies should Mr X want this in the near future.

Funding

The service has received recurrent funding for this project and staff are now permanent. This is crucial as non-recurrent funding makes it significantly harder to recruit and retain high quality staff.

'By working with the patient to understand what was most important to them and by tailoring intervention plans using shared decision-making tools, the aim is to develop a model which is sustainable and meaningful to the practitioner and patient.'

Top tips

The following aspects worked particularly well:

- **Identifying the right patients: initially, the service used the Electronic Frailty Index (eFI) from GPs to identify patients with moderate frailty for assessment. However, eFI often over-estimated the level of frailty. Therefore, the service sought the support of NHS community colleagues to ask them to undertake a Clinical Frailty Score on suitable patients. Crucially, with a data sharing agreement, these teams do not need to consent a patient for a referral or complete a referral form. They only have to provide us with their NHS number.**
- **Data access: having access to the patient's primary care health records and being able to write onto the GP's notes has been crucial to the service. The data sharing agreement with GP practices means the service doesn't have to get explicit consent for each patient, so this reduces the administrative burden.**
- **Collaborative approach to patient-centred care: the principle of developing a service that combines primary care services, community services and charitable sector has been invaluable as it ensures shared learning and clear communication that allows the service to think of the patient a whole.**
- **Frailty education: When seeking support and engagement from other services, the service found that it was helpful to start with some frailty educational events for the teams so that they were more confident with identifying frailty and the potential interventions that will support patients.**

Beeston, Middleton & Hunslet Frailty Team

Summary of service

The Beeston, Middleton & Hunslet Frailty Team aims to deliver personalised frailty assessments for patients with severe frailty, who live in their own homes. Every patient is eligible to receive an annual face-to-face holistic frailty assessment or review, and an ACP overview which incorporates personalised care and support planning.

Compliance is measured against the Leeds enhanced frailty scheme by ensuring the patient has an annually reviewed personalised care and support plan, a recorded falls risk assessment, an up-to-date RESPECT form, an advanced care planning discussion, a structured medication review and a Dementia CCSP (annual health check) when appropriate. The team also hold in-house multidisciplinary meetings which ensures every patient is discussed by the MDT. Complex patients are nominated for discussion at a locality-based case management meeting, with consent, to explore opportunities for collaborative working. By working with the patient to understand what was most important to them and by tailoring intervention plans using shared decision-making tools, the aim is to develop a model which is sustainable and meaningful to the practitioner and patient.

How does the proactive care pathway work?

To identify the original cohort, searches were run on SystmOne to identify any patient over 65, coded with severe frailty or with a Rockwood score of seven or more. The searches are repeated every three months to ensure the team have an up-to-date cohort. Additionally, a search for Electronic Frailty Index 0.36+ is also completed. All patients with the relevant coding have been verified using the CFS tool. Three patient pathway models have been developed for frailty assessments (newly coded severe frailty), annual reviews (existing caseload), and six-month reviews (2nd annual review caseload permitting) incorporating the comprehensive geriatric assessment and personalised care principles. Each model incorporates a Frailty Social Prescribing Link Worker, Healthcare Assistant or Occupational Therapist home visit to complete information gathering, a personalised care planning stage, and an ACP remote overview. Each patient is booked into an in-house frailty MDT meeting to give clinicians and patient facing staff an opportunity to discuss the outcome of the assessment or review and to plan for follow up actions. A PCN pharmacist also attends the meeting to align their structured medication reviews to the caseload.

How was the service set up?

The PCN identified a clinical lead ACP to head up the team and further recruitment under the ARRS scheme was conducted. An Occupational Therapist was recruited into the strategic frailty leadership role and skills set analysis enabled existing PCN staff (Registered Nurse Associates) to be incorporated into the team as Frailty Care Co-ordinators. Formalising ideas into a quality improvement plan enabled a clear plan for implementation. This involved:

- The development of a 'frailty appointment prompt sheet' to be used for preparation before the visit and to prompt questions during the appointment.
- Implementation of weekly 'huddle' meetings to discuss frailty updates and quarterly team-based meetings to evaluate good practice and areas for development.
- Monthly 1:1 meetings to discuss performance, individual development, patient-based discussions, reflections and achievements.
- Compiling a frailty team resource library, whereby patient facing staff can 'make every contact count' by offering advice and signposting to other relevant services, that may not fall within their remit of practice.
- Reviving the locality case management meetings, previously run by the community neighbourhood team, by offering to co-produce them. The aim was to facilitate conversations about complex mutual patients who access multiple health and social care services

and third sector organisations with a view to having a joint approach to intervention and avoid unnecessary duplication.
- Having oversight of all developments by a PCN clinical lead who fed back to the PCN executive team.

Patient example

David is an 89-year-old man who lives alone. His daughter and granddaughter visit regularly to help with jobs around the house, but he is otherwise independent. David has hypertension, AF, vascular dementia, and severe frailty. Before intervention from the frailty team, David's only social contact was from his daughter and granddaughter. The rest of the day he spent watching TV. His daughter and granddaughter are unable to spend as much social time as they would like with David due to other commitments. They raised concerns about his appetite and weight as he forgets to eat if not prompted. There was an element of carer strain detected with David's daughter. In terms of "what matters" to David, he loves watching horseracing on the TV, he used to go to art classes in his younger days, and he likes to talk but doesn't have anyone to talk to. A referral was made to a local social club to help reduce isolation and to provide respite for his daughter. The service also researched food delivery options and discussed this with David and his daughter to offer a solution for regular meal provision. David has joined a social group, and he attends every Tuesday to play bingo, have lunch and talk to other people. Through the social club, he now has meals on wheels delivered three times a week.

Lessons learnt

Working within a newly formed multi-disciplinary team reinforced the importance of skill set analysis. It quickly became clear those with an unregistered or non-clinical background required an enhanced level of support and supervision. The service has since developed forums whereby staff engage in peer support, have regular patient-based supervision, and they are currently looking to extend this offer by developing a core supervision meetings.

Top tips

- Review processes regularly and if things aren't working as well as anticipated, don't be afraid to go back to the drawing board.
- Having a team-based approach helped to identify and analyse problems within the patient pathways and enabled the service to make changes quickly with minimal disruption.
- Develop resources to help your team gather the information you need for holistic assessments, which is particularly helpful for those with non-clinical backgrounds.

The full versions of the 20 case studies that accompanied our report can be found at www.bgs.org.uk/proactivecasestudies.

With thanks to the above contributors for allowing us to publish their examples, and also to Dr Tara Verity who collated the full case studies.

Hearing & thinking

Scientists have long observed a link between untreated hearing loss and dementia risk. In a Special Report from the Global Council on Brain Health (GCBH), new research is highlighted that underscores the connection between hearing and thinking.

By way of background, the GCBH is an independent collaborative of scientists, health professionals and policy experts from around the world working in areas of brain health related to human cognition. The GCBH is convened by AARP (American Association of Retired Persons - a non-profit organisation in the United States representing nearly 38 million members) and provides evidence-based recommendations for people to consider incorporating into their lives.

The GCBH report, *Hearing Matters for Brain Health,* strengthens the case for addressing hearing loss. Studies have shown that adults with significant, untreated hearing loss were more likely to experience a substantial decline in cognitive abilities including memory, thinking, and learning than adults with intact hearing.

The GCBH believes that greater screening and treatment of hearing loss is an opportunity to strengthen brain health and promote cognitive well-being, communication and social engagement. This is a critically important message for many millions of older adults who are at the greatest risk for both hearing loss and cognitive decline.

Those who do not address their hearing loss are allowing an array of risks into their lives. Untreated hearing loss increases the danger of social isolation, loneliness, anxiety, and depression, which all can greatly reduce the quality of a person's life.

The GCBH encourages people to do what they can to protect their hearing, evaluate their hearing ability, get screened periodically, and address any potential or existing decline.

Top tips on hearing for brain health

The following may be useful to help older people protect their hearing:

1. **Know that hearing supports good thinking and brain health.** Besides simply hearing better, a great reason to protect and correct for hearing loss are the benefits to your mind and overall health. You can take simple actions to help your hearing, and in most cases, you can effectively treat hearing loss. For more information, go to: **www.aarp.org/health/conditions-treatments/hearing-resource-center**

2. **Establish a baseline hearing test and get hearing checked periodically.** The World Health Organization recommends that adults age 50–64 should be screened every five years, and starting at age 65 every 1–3 years. Screenings should be more frequent for individuals who are regularly exposed to loud noise or other risk factors.

3. **Recognise warning signs of hearing loss.** Do you often ask people to repeat themselves? Do you find it increasingly difficult to follow conversations in a crowded room or restaurant? Do family members frequently ask you to turn down the television? You may feel that people are mumbling when they are actually speaking clearly. Ringing or buzzing in the ears, known as tinnitus, may be another warning sign.

4. **Protect ears in noisy environments.** The best safeguard is to avoid exposure to loud noise, according to the National Institute on Deafness and other Communication Disorders. That can be difficult in a noisy world. Protection may be advisable if you are attending an auto race, fireworks display, sports game, rock concert, loud social gatherings, or other blaring events. At such times, you can use hearing protectors – wearable devices such as discreet earplugs or earmuffs – to reduce the volume that enters your ears. The earlier you protect yourself, the better. But it's never too late to begin.

5. **If hearing declines, take action as soon as possible.** Many people avoid doing so, and even those who seek help wait an average of seven years and sometimes a lot longer. But there is a price for procrastinating. Quality of life is undermined in the meantime, and with the passage of time, there may be less likelihood that a medically treatable hearing loss (not a typical age-related decline) can be improved.

6. **Be aware that uncorrected hearing loss may undermine emotional wellbeing.** If it becomes hard to hear others and participate in conversation, you may pull back from friends and other social connections. That is a path toward loneliness and isolation, which can be extremely harmful.

7. **Research before purchasing a hearing device.** Hearing aids come in different forms. Behind-the-ear devices are generally more powerful, have more features, and are often still very discreet. Smaller devices (in-the-ear and in-the-canal) may be impossible for others to see, but may have less power. Finally, some over-the-counter devices resemble earbuds, but may be intended for part-time use. Depending on your needs and knowledge, it may be wise to consult a hearing professional before buying a product over the counter.

8. **If a hearing aid is needed, make sure a hearing aid is used.** A separate category of hearing products known as personal sound amplification products is designed for consumers, such as birdwatchers and hunters, who wish to amplify sound in certain situations. Unlike hearing aids, they are not regulated and are not built to compensate for hearing loss. A hearing aid should say 'hearing aid' on the box.

9. **Watch out for scams.** Soon after hearing aids became available over the counter, reports began to emerge of shady sales practices including misleading labels, promises of miracle cures, a lack of trial periods, and inadequate customer support. Consumers should look for established brands and research products online to see if there have been complaints. Read the product's label, review the company's website, and look for information about trial periods, returns, and customer support.

10. **Don't allow stigma to get in the way of hearing better.** Know that hearing loss is very common in ageing, and it nothing to be ashamed of. With hearing aids, for most people, hearing loss is no longer something you just have to live with. In a positive sign, a majority of adults surveyed by AARP – 53% said they do not consider hearing difficulty a sign that they are "getting old," and an even larger majority – 64% – said they would not be uncomfortable being seen wearing a hearing aid.

For the complete GCBH report, including recommendations and practical tips, visit www.GlobalCouncilOnBrainHealth.org

Lindsay R Chura, PhD
Chief Scientific Officer, Global Council on Health
Summarising the 2024 report,
Hearing Matters for Brain Health

NHS London Frailty Clinical Network and the Health and Care in Community teams have joined forces with clinicians and commissioners across the region to understand and address unwarranted variation in the provision of proactive community frailty services across London. This included a review of the mapping of current service provision and of the evidence gathered, which resulted in the agreement of minimum core and gold service standards for London.

All London boroughs should aim to have a service that can fulfil the minimum core standards recommended for proactive community frailty. The more detailed gold standards can provide a framework for quality improvement if resources allow. This will support people living with frailty and prevent avoidable admissions and adverse events, keeping more people happy and healthy at home for longer.

Why this was needed

NHS priorities are shifting. As the population grows, the focus is now on proactive care, particularly for the increasing older population and those living with frailty. The aim is for all boroughs in London to offer a proactive community frailty service which meets core service standards, to help prevent hospitalisation and adverse events, keeping patients living with frailty safe and well at home for as long as possible.

The primary users of health and social care in the UK are older people. As the population in the United Kingdom increases in age, so do the number of people living with frailty and complex comorbidities.[1,2]

Evidence shows us that people living with frailty are at higher risk for adverse events, hospitalisation, institutionalisation and death.[3] Preventing these events while focusing on quality of life and wellbeing must be prioritised.[4]

‘People living in deprived areas of London...experience poorer health and higher levels of frailty.’

Frailty identification

The first step to managing frailty is to identify it using an evidence-based tool such as the Clinical Frailty Scale (CFS). Once frailty is identified, if clinically relevant, a holistic person-centred assessment such as the validated comprehensive geriatric assessment (CGA), should be commenced by a clinician with specialist training. It is important that a community frailty service exists to cover the proactive part of the frailty pathway, keeping people happy and healthy at home for longer.[5-10]

Frailty intervention

Research shows that earlier frailty intervention leads to better outcomes. Regardless of stage of frailty, older people have better outcomes with a comprehensive geriatric assessment (CGA).[11]

The main constraint for community frailty service development is strongly linked to limited resources. To prevent people from moving into the severely frail and most dependent state, it is recommended that services focus on preventing the deterioration of people with mild or moderate frailty to prevent and/or delay this deterioration.[12]

People living with moderate frailty benefit most from personalised proactive interventions as this can reduce progression of frailty and preventable use of acute services.[13]

Deprivation and health inequalities

People living in deprived areas of London, especially those who also belong to a minoritised group, experience poorer health and higher levels of frailty.[14,15] Evidence shows that only half of older adults living with frailty receive appropriate healthcare interventions.[16] A community frailty service mapping exercise completed by the NHS England London Frailty Clinical Network, shows that unwarranted variation exists across the capital, with services lacking in some areas of high deprivation.

Seven boroughs do not have a proactive community frailty service, and those that do, have quite varied offers. This has identified a geographical health inequality that needs to be addressed.

Minimum core and gold standards for London

All London boroughs should aim to have a service that can fulfil the minimum core standards recommended for proactive community frailty. The more detailed gold standards can provide a framework for quality improvement if resources allow.

Minimum core standards

1. Includes all eligible patients (not limited to acute only)
2. Holistic review (ie. CGA)
3. Core team is multidisciplinary (≥3)
4. As a minimum include those over 65 living with frailty; however, consider flexibility depending on local needs
5. Not limited to housebound or severe frailty
6. Access to geriatrician, consultant, or senior frailty specialist
7. Accept referrals from all health and social care providers
8. Home visits as standard
9. Clear and concise referral form
10. Create a Universal Care Plan (UCP)
11. Output is a personalised care and support plan, using an accessible shareable digital tool.

Gold standards for quality improvement

1. Engage with services across the frailty pathway
2. Patient records viewable by all services
3. Multidisciplinary team to aim for: doctor (consultant, GP with Special Interests), physician associate, advanced clinical practitioner, nurse specialist/practitioner/ community matron, pharmacist, physiotherapist, occupational therapist, social worker, mental health professional, community navigator, dietician
4. Capacity and demand correspond to local population/ deprivation
5. Develop local pathways for acutely unwell patients
6. Offer patient self-referral if appropriate
7. Provide an advice line for referrers
8. Work with local communities
9. Agree local outcome/process measures.

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BGS Autumn Meeting

Event highlights

The BGS Autumn Meeting 2024 took place on 20-22 November at ExCel London and was streamed live online to hundreds of viewers. Over 600 delegates joined in person across the three days at the Platinum Suite in the ExCel, right in the heart of the London Docklands area. Around 600 participants joined online, using the virtual platform to view sessions and take part in discussions and Q&As in real time. In addition to the main conference sessions, attendees also had the opportunity to take part in the social programme, enjoying a drinks reception with canapes, plus networking meetups for SAS Grade, Trainees, Nurses and AHPs, Researchers and Workforce groups.

Day 1: Community and Primary Care, Stroke, AI, Wellbeing and Clinical Quality

The conference started with an opening address by demitting BGS President, Professor Adam Gordon. As well as highlighting news and recent accomplishments from the BGS, he invited participants to maximise the opportunities for connection and information sharing. "Please do make the most of this time," he said, "coming together as a group and harnessing the social networking opportunities, as well as the academic and clinical ones."

Stream 1 sessions started on the topic of Proactive Care in Community and Primary Care. Dr Tom Downes, National Clinical Director for Older People, spoke on the three shifts set out in the new government's ten-year plan: sickness to prevention, analogue to digital, hospital care to community. He then highlighted the benefits of proactive care from a patient and staff experience and cost perspective.

Past BGS President, Dr Eileen Burns, then provided a summary on proactive care, why we need to implement it and how can it be implemented with additional funding. "There's a real moral imperative to do this," she said. She drew attention to the recent BGS publication on 'Be proactive: Evidence supporting proactive care for older people with frailty' which further outlines why proactive care is needed. Dr Adrian Hayter, RCGP Medical Director, wrapped up the session with a talk on care closer to home, and how community and primary care can integrate more. "The main thing is that we systemise it; we make it everyone's opportunity."

Over in the second stream, talks focused on stroke and cerebrovascular disease. Professor Chakravarthi Rajkumar, Consultant in Geriatric and Stroke Medicine from Brighton, set the scene for the day with updates on developments in stroke care. He then handed over to Professor Martin James, a Consultant Stroke Physician from Exeter, who presented on the new UK clinical guidelines for stroke and the importance of delivering evidence-based care.

Dr David Hargroves, National Clinical Director for Stroke Medicine, shared seven key innovations in stroke care, finishing with how robotics could help support the workforce. "Workforce is our greatest problem but our biggest opportunity," he explained.

Professor David Werring, a Professor of Clinical Neurology from London, spoke on intracerebral haemorrhage: challenges in aetiology and management. "I think we are genuinely entering a new era of potential treatability and prevention for this devastating condition," he remarked.

Stream 3 started with an AI and MedTech in Geriatric Medicine 'Dragons' Den' inspired session. Professor Emma Vardy (Remote monitoring), Dr Rose Penfold (Predictive analysis) and Dr Atul Anand (AI and Large Language Models) pitched ideas for an AI or MedTech approach which could offer promise to geriatric medicine in the future. A panel of 'Dragons' - Dr David Attwood, Professor David Oliver and Dr Zoe Wyrko – were faced with a tough decision to pick a favourite, ultimately deciding that the supply of (fake!) bank notes provided should be invested equally between the three presenters.

Elsewhere, Community and Primary Care sessions continued in Stream 1. Dr David Attwood, a GP and Associate Medical Director of Livewell Southwest, summarised whether proactive care with iCGA could improve survival in care homes. He suggested that iCGA in a community-based setting can reduce CGA down to ten minutes, which saves MDT time. Dr Matthew Dolman, Chief Clinical Information Officer, and Helen Rostron, an Occupational Therapist from Somerset, then presented on their use of BRAVE AI to deliver targeted personalised care in Somerset. They found that BRAVE AI can ultimately help reach those who are living with frailty and complex multimorbidity and give them the opportunity to plan for the care they want, both now and at the end of life. To round off the morning's Community and Primary Care talks, Dr Deb Gompertz and Dr Tara Verity, members of the BGS Community and Primary Care Group, presented on the new BGS report *Be proactive: Delivering proactive care for older people with frailty*. "We need to educate each other," reinforced Deb.

In the Stroke session, Professor Francesco Mattace-Raso, Professor of Geriatric Medicine from Rotterdam, talked about the use of anticoagulants in older patients. He concluded that healthcare professionals should not be reluctant to use them, but some form of stratification is needed to target the therapy. Dr Riyaz Kaba, a Consultant Cardiologist and Cardiac Electrophysiologist from London, then spoke on the recent advances and guidelines in the management of Atrial Fibrillation, followed by Dr Fiona Humphries, Consultant in Stroke Medicine and Geriatric Medicine at UCLH, presenting on transient retinal ischaemia, highlighting how retinal events are the ocular equivalent of ischaemic stroke and should have the same work-up.

A moving workshop on moral injury and healthcare professional wellbeing took place over in Stream 3. In-person and online attendees had the opportunity to share their experiences of moral injury and discuss support mechanisms.

On the continued theme of Community and Primary Care, Dr Dan Harman and Dr Anna Folwell from the Jean Bishop Integrated Care Centre shared how the Centre is meeting the needs of people living with frailty. This was followed by GP, Dr George Winder, and Proactive Care Practitioners, Joanna Quigley and Rebecca Long, all from Seacroft PCN, sharing their experience of proactive care from a Leeds Integrated Neighbourhood Team (INT).

Delegates then heard three masterclasses on Community and Primary Care. Dr Sean Ninan, a Consultant Geriatrician from Leeds, shared a rundown of top tips for community clinicians. Mental Health ACP, Jennifer Stone, from Berkshire, looked at delirium and community management lifelines, while Nurse Consultant, Becky Hyland, from Wiltshire, presented her masterclass on 'Heart Failure at Home - Remote Monitoring in a Community Heart Failure'.

Stream 2 moved onto the further developments and guidelines in stroke medicine. Professor Mike Okorie, Professor of Clinical Pharmacology from Sussex, talked on hypertension in stroke patients. Professor of Neurology, Pankaj Sharma, from London, spoke on the BRAINS study which looks at Ischaemic stroke in South Asian patients. The BRAINS study found that people of South Asian origin were on average eight years younger at the time of their first ischaemic stroke, despite being less likely to smoke or drink to excess and having a lower BMI. To finish the stroke sessions for the day, Ms Chandrika Kanraj spoke on her experience of caring for a stroke patient, which led to her being a member of the NICE stroke rehabilitation committee.

In stream 3, Dr Alexandra Burgess, a 2023 BGS Rising Star Award winner, gave her presentation on the clinical quality work at the frailty service at her hospital, and the importance of the MDT and community care in these services. "By doing clinical quality improvement projects, you can make a difference," she said. The stream then welcomed Professor Caroline Nicholson, a Professor of Palliative Care and Ageing from Surrey, speaking on the voice of older people with frailty and how this can influence clinical practice.

The last session for stream 3 was the NAHP Community of Practice workshop on the Diploma of Geriatric Medicine (DGM) which looked its benefits, the exam setup and top tips.

As the first day drew to a close, the final session was presented by Dr Rachel Clarke on 'The power of story in medicine'. Rachel - a palliative care doctor from Oxford with a background in journalism - is the author of *Breathtaking*, an account of working as a healthcare professional during the first months of the COVID-19 outbreak. *Breathtaking* was adapted into a TV series which aired in February 2024. Rachel spoke about the importance of being interested in people's stories as a doctor. As she describes in her own words, "Medicine is the marriage of science and humanity - we have to understand our patient's story in order to be a good doctor."

Day 2: Comprehensive Geriatric Assessment, Mental Health and Research

Thursday got underway with another packed morning programme, which focused on comprehensive geriatric assessment (CGA), research and mental health. In the CGA session in Stream 1, Professor Jugdeep Dhesi, incoming BGS President, opened the session with an overview of the value of getting CGA right. Spanning primary and secondary care settings, she outlined how to identify people who might benefit from CGA, and the current barriers to implementation. "Nobody's actually sitting back and looking at the whole patient and thinking about what's going on,"

she explained, "and of course that translates into hospital-acquired conditions like delirium, deconditioning and acute kidney injury."

The theme of multidisciplinary working was continued in the talks that followed, with Dr Nikola Baty elaborating on the role of different professionals within the multidisciplinary team, and Nurse Consultant Helen Hurst elaborating further on the area of kidney care. "Being able to identify people with frailty has enabled further discussions," she concluded. Later on, experts from continence, oncology and perioperative care of older people (POPS) services also gave their perspectives.

The President's Poster Round gave delegates the opportunity to hear from authors of meeting's top submitted scientific abstracts, as judged by the BGS Clinical Quality Committee and Research and Academic Development Committee. Outgoing President Adam Gordon was joined by Vice President Research, Miles Witham, as they posed questions to presenters on topics such as Type 2 Diabetes, emergency laparotomy, delirium and decision-making following a cancer diagnosis.

A parallel session on mental health over in stream 2 examined the complexity of comorbid depression and dementia. Dr Amanda Thompsell, National Specialty Advisor for Older Adults' Mental Health at NHS England, explained how recognising depression in older adults could make a difference to their overall wellbeing. "There is a real stigma, with older people often not wanting to use the term 'depression'," she cautioned.

Issues and advice around prescribing antipsychotics for people living with dementia were highlighted by Professor Suzanne Reeves, Professor of Old Age Psychiatry and Psychopharmacology at University College London. Catherine Sinnamon, a PhD Student at Queens University Belfast, contributed some patient and carer perspectives, concluding that "there is a need for more targeted education and support" for carers with regards to decision-making.

Later on, Age UK's Joint Head of Health Influencing, Tom Gentry, spoke about how older people's mental health is overlooked and under-valued. "Older people are on the margin of policy and practice when it comes to mental health", he said, adding that "there are lots of opportunities to promote good mental health that are completely missed."

The third concurrent stream of the morning was a joint symposium with the Association of Academic Geriatric Medicine (AAGM) on small vessel disease. Clinicians from Exeter, Edinburgh and Boston (USA) summarised some of the latest research in this area.

Later on, the winner of the BGS 2023 Rising Star Award for research, Oly Todd, presented his work on the biological underpinnings of blood pressure in later life, and how this evidence can be used to inform clinical practice. "There's potential to use patient data alongside patient narratives and patient involvement," he said, adding "I think that's really exciting."

The afternoon's Guest Lecture was delivered by Professor Chris Whitty, Chief Medical Officer for England, who gave a welcome overview of his 2023 annual report, *Health in an ageing society.* He highlighted the demographic challenges of an ageing population with a higher life expectancy, particularly among those in the most deprived areas, where people are living more of their lives in poorer health. "The more we can delay disease," he explains, "the shorter the period is going to be between the onset of disease and the upper band of mortality."

A platform presentation lightning round followed, covering topics as diverse as stress urinary incontinence, technology in dementia, exercise in nursing homes, and vascular ageing. The day was rounded off with an opportunity to network with colleagues with some much-needed drinks and nibbles.

Navigating New Horizons: Reflections on the BGS Autumn Meeting from Chair of the Nurse and AHP Council

I recently had the pleasure of attending the BGS Autumn Meeting in London as Chair of the Nurse and Allied Health Professionals (AHP) Council. This experience not only enriched my professional journey but also showed the importance of collaboration within our healthcare community.

As I reflect on the event, I am filled with gratitude for the connections made and the vibrant discussions that took place.

The significant in-person presence was wonderful to see; the large turnout reinforced the notion that our collective voice is stronger when we come together. The energy set an inspiring tone demonstrating a shared commitment to advancing our professions and improving patient care.

Day 1: Diploma in Geriatric Medicine

The conference commenced with a relaxed and informal introduction from myself and our new Deputy Chair, Dr Susanne Arnold. We encouraged attendees to actively invite new members to join the BGS and to share pressing issues they would like our leadership team to address. It was invigorating to see so many familiar and new faces, all eager to engage and contribute to our discussions.

Our community of practice session, facilitated by Jo Jennings, our England Council representative, Angeline Price (member of the NAHP Council and the BGS Deputy meetings Secretary) and Esther Clift, our demitting Chair, sparked engaging discussions about the Diploma of Geriatric Medicine (DGM). This session was significantly enhanced by informative presentations grounded in lived experiences, allowing participants to connect on a personal level and fostering an understanding of the challenges and triumphs faced when undertaking DGM.

One of the standout features of this session was the diverse representation of healthcare disciplines; nurses, physiotherapists, occupational therapists and pharmacists, brought their unique perspectives and expertise to the table. The conversations reflected the multifaceted nature of older people's healthcare, and many people expressed enthusiasm for pursuing the DGM.

Day 2: Inspirational leadership in research

The highlight of day two was an inspiring President's poster round featuring Angeline Price and Lucy Lewis, whose presentations emphasised the critical role of research in advancing our practice and the benefits it brings to patient care and professional development. Their presentations demonstrated the importance of evidence-based practice, inspiring attending to explore ways to incorporate research into their own practices.

Day 3: The value of moderation

On the final day, it was refreshing to witness the prominent presence of nursing and therapy professionals playing a moderating role throughout the conference. This visibility showed the value of our disciplines in shaping discussions and fostering collaboration.

The experience of moderating offers valuable learning opportunities. It allows professionals to sharpen their communication skills, develop critical thinking abilities, and gain a deeper understanding of the topics at hand. By taking on these roles, nursing and therapy professionals are not only showcasing their expertise but also reinforcing the importance of leadership within our fields.

Conclusion: A call to action

This conference was a profound experience that reinforced the significance of community, research and collaborative practice in our professions. The connections made and the knowledge shared will undoubtedly have a lasting impact on our work moving forward.

As we carry the momentum from this conference into our daily work, let us advocate for innovations in practice, support one another, and ultimately ensure that our patients receive the highest standard of care.

Lyndsey Dunn, Chair, BGS Nurses and AHPs Council

Day 3: Movement Disorders, Intensive Care, Loneliness and Visual Impairment

The final day started with another morning, with movement disorders, intensive care and loneliness all on the programme. Parkinson's specialist occupational therapist, Clare Johnson, began the Stream 1 sessions focusing on strategies to support people with non-motor symptoms of Parkinson's Disease. "Education as early as possible for patients" was a high priority as she shared practical tips to optimise care.

This was followed by Dr Boyd Ghosh, a Consultant Neurologist, speaking on the updates to diagnosis and treatment of Progressive supranuclear palsy (PSP). Talks then moved to focusing MDT and end of life care aspects of movement disorders. Specialist speech and language therapist (SALT), Caroline Bartliff, gave an overview of the SALT role in managing older adults with Parkinson's, before Dr Claire Morris presented on end of life care and deprescribing in Parkinson's Disease. Claire highlighted that end of life care and medications can vary depending on if a patient is dying from or with Parkinson's.

Over in Stream 2, intensive care was the focus of the day, starting with talks linked to admission and treatment of older adults. Intensive care medicine consultant, Dr Daniele Bryden, opened with the challenges and enablers of providing quality critical care for older people. "We need to refine really what a good outcome is for a patient cohort that is an older patient," she said when referring to the challenges.

Later on, post-discharge and patient perspectives became the focus in Stream. 2 Kate Tantam, a specialist ICU sister from Plymouth, shared the story of a patient whose rehabilitation post-ICU focused on upper body strength, as what mattered most to her was being able hold her baby grandson. This person-centred approached enabled her to fulfil her wish of holding the baby, rather than focusing on things that did not align with her personal goals. Other examples of good person-centred care were shared in talks on delirium and on communicating with patients.

In Stream 3, the first session looked at loneliness and social deprivation in older adults. Professor Charles Marshall, Professor of Clinical Neurology and Consultant Neurologist from London, presented on dementia risk in diverse populations and the roles of ethnicity and deprivation. The need for more participation of underrepresented groups in research was highlighted, "So that we can start to understand the biology of these risk differences better and start to address the inequalities that we see."

Dr Kathryn Price and Dr Jamie Henderson continued

'The afternoon's Guest Lecture was delivered by Professor Chris Whitty, Chief Medical Officer for England, who gave an overview of health in an ageing society.'

‘The panel discussed what’s changed in the health policy environment, what we’re looking forward to, and where BGS sits in the policy landscape.’

the session with their talk on intergenerational befriending involving a case study on the Griffin Community Trust in East London. “We know there’s a u-shaped curve with isolation and loneliness affecting younger people and then older people, so connecting these two groups tries to address this problem,” Kathryn explained. Platform Presentations and a Lightning Round followed in Stream 3, with delegates hearing more quickfire presentations from authors who had submitted scientific abstracts.

As the morning sessions drew to a close, all delegates then joined Stream 1 for the Trevor Howell Guest Lecture, presented by Professor Ken Rockwood who spoke about meeting the challenge of frailty in four numbers. Through the talk, Ken looked at why frailty challenges contemporary healthcare, steps to improve older people’s healthcare and the significance of the four numbers. He outlined how “frailty is not a disease, but it profoundly influences disease expression.”

Delegates stayed in Stream 1 to see the Professor Adam Gordon’s BGS presidency come to an end as he handed the Chain of Office over to incoming President, Professor Jugdeep Dhesi. In her inaugural speech as BGS President, Professor Dhesi thanked Professor Gordon for his work at the BGS and promised to build on all that he has achieved.

Angela Conlan, project Lead at Oxford Health Arts Partnership, received the BGS Special Medal 2024 for her work on the ‘Creating with Care’ project, while Dr Firdaus Adenwalla, a Consultant Geriatrician from Wales, was presented the Marjory Warren Lifetime Achievement Award 2024. Adam described how there had been “an outpouring of love, affection and admiration” from the BGS Welsh Council towards Dr Adenwalla. Following the conclusion of the guest lecture, Professor Ken Rockwood was presented with the BGS President’s Medal, which is awarded in recognition of an outstanding contribution to the healthcare of older people.

The final afternoon saw Stream 1 shift to a policy session chaired by BGS Policy Manager, Sally Greenbrook. Demitting BGS President, Professor Adam Gordon, incoming BGS President, Professor Jugdeep Dhesi, and BGS Policy Vice President, Dr Ruth Law, discussed what's changed in the health policy environment over the last few years, what we're looking forward to in the next few years and where BGS sits in the policy landscape.

Over in Stream 2, the intensive care theme topic continued with a live MDT case study session on complex older laparotomy patients. Experts in anaesthesia, surgery, intensive care and geriatrics all formed a panel discussion the case studies. Elsewhere in Stream 3, representatives from Guide Dogs UK led a workshop focusing on visual impairment in older adults and what healthcare professionals can do to support older patients outside medication and surgical options.

As Friday afternoon’s sessions came to an end, as did the BGS Autumn Meeting for 2024. New BGS President, Professor Jugdeep Dhesi, delivered the closing address the mark the conclusion of the three-day event. She commented on the importance of using the experience of the conference to motivate delegates moving forward. “It’s been a really great three days, certainly for me personally, and I hope that everybody else in the room has also had lots of fun, feels reinvigorated by all the stories of best practice, the things we can be doing out there, how to do them, and also making links with people that you can go and visit and learn from as well.”

Megan Harrison
BGS Communications and Marketing Co-Ordinator

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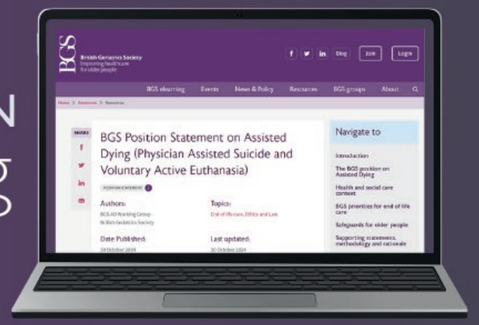
Photos: Emily Garner, BGS Interim Communications Manager

Highlights from Adam’s Presidency

As Professor Adam Gordon MBE handed over the chain of office to new BGS President, Professor Jugdeep Dhesi, we take a look back at some of his standout moments as BGS President.

TAKING A POSITION ON Assisted Dying



On Friday 29 November 2024, MPs in Westminster backed proposals to legalise Assisted Dying (AD) in England and Wales in a historic vote paving the way for a change in the law.

As politicians agonise over the Terminally Ill Adults (End of Life) Bill, the rest of us are left contemplating what this could mean for our professional work, ourselves and our families. If it becomes law, the bill will give some terminally ill people in England and Wales, the right to die at a time of their choosing, subject to safeguards and protections. Elsewhere in the UK similar bills are before parliaments in the Isle of Man, Jersey and Scotland. Whatever the final outcome in Westminster, it seems inevitable that legalised AD will be coming to the UK soon.

A long debate

This latest move seeking to legalise AD is preceded by much debate, with ground now shifting towards greater respect for those choosing to die. Almost a century ago, doctors, lawyers and theologians established the British Voluntary Euthanasia Society (now called Dignity in Dying) to advance debate on whether it could ever be right for someone to be assisted in procuring their own death. However, in 1961 section 2(1) of the Suicide Act made it a criminal offence in England and Wales to encourage or assist the suicide of another person. In 2006 The House of Lords blocked Lord Joffe's bill to remedy circumstances where the needs of a person with unbearable suffering could not be met by palliative care. Debate at this time was divided between respecting a right to choose to die and access to better palliative care.
In 2009 the law on assisted suicide was clarified following challenge by Debbie Purdy who sought exemption for her husband from prosecution if he helped her to die. It was ruled that while all cases would be investigated by the police on the basis assisted suicide is illegal, discretion would be exercised, implying legal action would be unlikely against people assisting suicide for a person with a settled and informed wish to die. However, the next year, the MSP Margo Macdonald sought to legalise assisted suicide through the Scottish parliament with the End-of-Life Assistance Bill and this was heavily defeated by 85 votes to 16.

In 2014 Tony Nicklinson and others sought a Court declaration that current legislation on assisted suicide was incompatible with their privacy rights under article 8 of the European Convention on Human Rights. The Supreme Court decided against such a declaration, instead indicating that Parliament is the most appropriate forum to consider changes in the law on this issue.

Several Private Members' Bills in both the House of Commons and the Lords have subsequently failed to legalise either assisted suicide or voluntary euthanasia including the Assisted Dying Bill (No 2) 2015 tabled in the Commons by Rob Morris MP, defeated on a free vote by 330 votes to 118 and the Assisted Dying Bill (HL) 2021-22 tabled in the Lords by Baroness Meacher which did not proceed.
Earlier this year the Social Care Select Committee report on Assisted Dying /Assisted Suicide paved way for the current debate. It concluded that for many, the priority was the pursuit of high-quality end of life care to achieve a good, compassionate death with as much agency and choice as possible, though there are a variety of ways of achieving this.

BGS and assisted dying: Key points

- **The BGS is currently opposed to the legalisation of Assisted Dying (AD) in the UK and Crown Dependencies.**
- **Many members are not confident that effective safeguards could be developed to protect older people with complex needs from harm.**
- **However, a significant minority of members are supportive of legalisation of AD in the UK and many members are undecided.**
- **Given this diversity of views, political caution should be exercised, and expert advice must be sought from those with significant stake holding in caring and advocating for older people.**
- **The BGS will respond to shifting attitudes among its members and stakeholders over time by reviewing its current position on the issue.**
- **Any future UK legislation must respect the choices of professionals who object to direct participation in AD.**
- **Irrespective of a change in the law on AD, shortcomings in health and social care for older people with complex needs, including specialist palliative and end of life care, must continue to be addressed.**

The current BGS position

Recognising that its own position on AD was out of date, the BGS convened a working group over the summer in 2024, to review its previous opposition and develop a new position statement. What clearly emerged during the process was the diversity of thought, finely balanced argument and need to retain nuance whilst providing clarity for the avoidance of doubt among stakeholders.

The working group was assembled from interested members who generously contributed their time and expertise. They were especially keen to ensure that the views of the wider BGS were sought actively to ensure true representation of the wider society. Regarding such a personalised matter, it has been important to maintain consensus while being open to the voice of dissent.

From outset, the group agreed how much this issue matters to our colleagues. In geriatric medicine we are perfectly used to dealing with the many legal, social and economic issues impacting on providing effective health care to people with complex needs, meaning our day jobs require an effective grounding in ethics and law. Yet this issue does feel somewhat different, perhaps because of the values we all hold professionally, but more so because of the commonality and finality of death for all of us. This issue is strikingly personal in a way that prevents abstraction and othering. Over the course of five working-group meetings there was palpable, collective passion, mutual respect, humility and shared professionalism to get this right for both the BGS and for the people we care about. While expressing a wide range of opinions, members sought to bring well researched evidence and structured argument to the table in ways that made this task considerably easier. If nothing else, the final output from the work retains authenticity, and the group believe it is broadly representative.

Membership survey

To enable the current BGS position statement to be representative, a survey was distributed throughout August 2024 to all members for anonymised response, utilising a pragmatic design to sample respondent views on specific key thematic issues. The survey was not intended to be a membership referendum, nor was it an academic research exercise. The necessary limitations of its content and methodology do not however detract from its utility. In addition, free-text responses from members were sought, received and considered carefully when drafting the new position statement. The importance of hearing from colleagues who shared their thoughts, expertise and in some cases highly personal and impassioned experiences cannot be underestimated.

Most importantly the group wanted to understand respondents' views on whether the BGS should be supportive or opposed to legalisation of AD to gauge the level of support or dissent.

A total of 775 responses were received (15.5% of BGS membership), a high response rate for a survey of this kind. It sought views on two aspects of AD: 1) Physician Assisted Suicide (PAS), involving the provision of a lethal substance for a patient to take themselves, and the subject of current proposed legislation; and 2) Voluntary Active Euthanasia (VAE) involving professional administration of a prescribed lethal substance on request to bring about death. This enabled the group to discern something about respondents' comfort with their professional proximity and involvement in assisting in the death of a patient.

Half (50%) of respondents were personally opposed to legalisation of PAS and over half (55%) were opposed to legalisation of VAE. Of note, a third (33%) were supportive while one sixth (17%) were undecided. However, 60% responded that the BGS as an organisation should be opposed to legalisation of PAS, suggesting that personal views and values on the issue are somewhat distinct from the collective values represented by BGS.

When considering their willingness to engage in the process of PAS, half (52%) of respondents were not willing and half (50%) were not confident that effective safeguards could be developed.

Despite its methodological flaws, the survey conveyed a clear sense of both personal and professional opposition by BGS members to legalisation of AD, unwillingness to engage in the process of assisting death and lack of confidence in the development of effective legal safeguards. However, a significant minority were either supportive or undecided and this cannot be ignored.

Despite overall BGS consensus on opposition presently, the process of formulating a new BGS position has extracted a level of dissent among some colleagues, largely rooted in respect for patient autonomy and choice. This must be respected and is not dissimilar to the political debate playing out among parliaments across the UK.

Moving forwards on AD

It seems likely that as with many countries across the world, the UK is now on the threshold of legalising assisted dying. The BGS is currently opposed to this, but whatever the outcome of legislative processes, we must always be prepared to respond to shifting societal norms and values. As professionals invested in providing the best possible health and care outcomes for older people, we must respect the choices and freedoms of our patients and work with, and within the law, wherever we work.

In the meantime, the BGS will necessarily remain firmly involved with this debate. Wherever we go next with AD, those invested in caring and advocating for older people will remain committed to promoting real choices about their health and care outcomes, respecting autonomy where this persists, and supporting a comfortable and dignified end of life when this happens.

To view BGS's new position statement on assisted dying in full, visit www.bgs.org.uk/positionAD

Prof Martin Vernon and Dr Andrew Stanners
Joint Chairs, BGS Working Group on Assisted Dying

Ageing & Frailty

Standards for the care of older people in Scotland

The variation in the provision of healthcare for older people is well documented,[1] and data from Scottish Care of Older People, one of the BGS' national audits (www.bgs.org.uk/scoop), suggest that health inequalities exist in Scotland.[2,3]

Joining the dots: A blueprint for preventing and managing frailty in older people,[4] sets out how organisations taking on responsibility for integrated health and social care services can organise their services to best meet the needs of the older people within their communities. The document puts an emphasis on promotion of wellbeing, integrated responses, proactive care planning and support at all stages transition from health to death.

Healthcare Improvement in Scotland published Standards of Care for Older People in Hospital in 2015 with a focus on hospital setting. In reviewing these standards there was a strong desire to extend the scope and to include all health and care settings where older people might seek or receive care. The new Ageing & Frailty Standards for the care of older people in Scotland 2024[5] were published in November 2024 and provide a benchmark for progress towards nationally consistent and integrated frailty services that put people and their rights at the centre, in line with the BGS blueprint.

The conceptual framework of these new standards stems from the fact that older people living with frailty are among the most vulnerable in our society. They can be at risk of harm if we do not understand and address their needs, or if our systems and services are inadequate, ineffective or poorly coordinated. However, frailty is not an inevitable consequence of ageing. If frailty, or likelihood of frailty, is identified early, it can sometimes be prevented, reversed or slowed down. Coordinated multiagency care supports and enables people experiencing frailty to remain as independent as possible.

Within this context, the ageing and frailty standards for older people in Scotland were developed by a multi-professional and multi-agency group of experts. They were informed by current evidence, best practice recommendations, national policy and were cocreated with key stakeholders and people with lived experience from across Scotland. Eleven distinct standards were developed, each with a rationale explaining why it is important, a list of criteria describing what is needed to meet the standard, what the standard means if you are an older person living with frailty, a member of staff or an organisation delivering care. There are also examples of what meeting each standard would look like in practice. The rest of this article draws out some of the key points within each of these 11 standards.

Standard 1: Identification of frailty - Organisations have systems in place to identify older people living with frailty at the earliest opportunity.

This means it is expected that both health and social care staff are trained appropriately according to their role to recognise frailty within the population that they are providing care. Early identification enables prompt access to referral and/or assessment, so that people receive the care that they require.

Examples of what meeting this standard might look like include:

- System-wide use of clinical risk stratification, frailty scores and electronic Frailty Index (eFI) in relevant settings;
- National, regional and local improvement work on frailty screening tools and processes; and
- Identification flowcharts and decision-making tools based on screening outcomes.

Standard 2: Assessment and future care planning - Older people living with frailty experience coordinated multidisciplinary support that is responsive to changes in their life, health and care.

The comprehensive geriatric assessment has been highlighted as best practice for assessing frailty, though it is recognised that other assessments may be used. The whole assessment process aims to empower the older person who is at risk of frailty or living with frailty to be as fully engaged and involved as they can be with regard to their health and social care. Understanding personal choices and priorities for care should be central to any decisions about treatment or care. There should be a single care plan for all health and social care providers which is shared with the person and those they choose to share.

Examples of what meeting this standard might look like include:

- Use of tools and frameworks to support shared decision-making during care planning;
- Use of person-centred plans created and shared digitally where possible; and
- Accessible language in all documents and communication including the use of communication aids and tools as appropriate.

Standard 3: Unpaid carers and care partners - Unpaid carers and care partners are valued, supported and trained to continue providing care.

This standard acknowledges the role of unpaid carers and care partners and the challenges they may face when caring for an older person with frailty. It emphasises that they will be listened to and treated with respect as part of the care team. Their own needs will be assessed, documented and met as much as possible, and they will receive information about care options, and what might happen in the future.

Examples of what meeting this standard might look like include:

- Evidence of good documentation of any unpaid carers and care partners within the clinical notes of an older person with frailty;
- Informal update of training and resources for care partners; and
- Evidence of staff training and uptake of training on power of attorney.

Standard 4: Keeping active - Older people living with frailty are supported to keep active to maintain and improve mobility, independence and function.

The focus is on prevention and provision of support that is needed to be able to keep active for frail older people. The person will be supported, encouraged, and enabled to be as mobile and independent as possible, including when they are in hospital. It is also expected that they will have a care plan to reduce the likelihood of falling; and if they had a fall, they will be offered appropriate support and rehabilitation.

Examples of what meeting this standard might look l ike include:

- Creative approaches to introduce meaningful activity for the individual;
- Established multiagency pathways to physiotherapy, occupational therapy and rehabilitation; and
- Pathways in place to trigger a comprehensive review of potential reasons for falls.

Standard 5: Nutrition and hydration -Older people living with frailty are supported to eat and drink and receive specialist input if required.

Good nutrition is essential for healthy ageing. The emphasis of this standard is on respecting an individual's personal choices and requirements about eating and drinking. They will be supported to meet their needs including enough time to eat and drink, access to equipment that they may need to eat and drink, access to dietary advice after an appropriate assessment. They will be supported if they have difficulties with eating, drinking or swallowing. They will be supported to maintain good oral health.

Examples of what meeting this standard might look like include:

- Protocols for nutrition and hydration screening and assessments;
- Evidence of pathways for equitable access to specialist nutrition and hydration support; and
- Measures to ensure adequate nutrition such as protected mealtimes, alternative menus to allow choices about food and drink, and referral pathways to dentistry.

Standard 6: Bladder and bowel health - Older people living with frailty receive early assessment and proactive management of bladder and bowel issues.

Bladder and bowel health is closely linked with frailty. Staff are encouraged to discuss bladder and bowel function sensitively and in supportive manner. It is expected that all health and social care staff are trained (according to their role) to identify, proactively manage, and treat/refer as appropriate anyone with a bladder or bowel problem. People will be provided with continence products that are right for them if they need them.

Examples of what meeting this standard might look l ike include:

- Evidence of routine enquiry about people's bladder and bowel issues;
- Referral pathways to specialist continence teams; and
- Evidence of treatment and management plans for bladder and bowel issues.

Standard 7: Medicines management and review - Older people living with frailty are prescribed medicines which are safe, effective and person centred.

This standard sets out the good practice that is expected regarding use of medicines in frail older people. It is expected that people are supported to understand what their medicine is for and any side effects they may experience. They will have the opportunity to discuss the risks and benefits of any medicines. Their medicines will be reviewed if there are changes in health, life or care. The people who care for the person will have the information and guidance they need to support the person with medicines.

Examples of what meeting this standard might look like include:

- Evidence of structured polypharmacy reviews with appropriate documentation and coding;
- Evidence of pathways and processes for medicines reconciliation; and
- Use of electronic systems and other systems and processes for example Hospital Electronic Prescribing Medication and Administration, Medication Administration Recording and Requesting.

Standard 8: Living and dying well - Older people living with frailty are empowered to live well throughout their life, maximise enjoyment and die comfortably.

Older people should be enabled to live well with frailty and received the support and care they need for daily activities and things that are important to them, including maintaining

social networks and contact with their local community. They will be supported in ways that matter to them in case of deterioration in health, and if they are dying, they will be cared for in ways that are comfortable and safe, with the people that matter to them close by.

Examples of what meeting this standard might look like include:

- Use of mental wellbeing screening and scores to measure effect of wellbeing support interventions;
- People having early discussions about palliative care and information about care and treatment options when they are dying; and
- Update of staff training including bereavement support relevant to their roles and adoption of the Scottish Bereavement Charter.

Standard 9: Mental health and mental wellbeing - Older people living with frailty have their mental health needs addressed.

This standard focuses on the importance of mood, mental health and psychological state of the person being recognised, assessed and addressed when they receive health and social care. Specifically, there should be timely access to specialised mental health care when this is required.

Examples of what meeting this standard might look like include:

- Referral pathways to mental health treatment;
- Implementation of mental health standards; and
- Consistent screening of mental wellbeing and mental health conditions.

Standard 10: Sudden deterioration and immediate care - Older people living with frailty who experience a sudden change in their health can access timely, coordinated and consistent support.

One of the focuses is on timely access to health care and social care if the person becomes suddenly unwell. There should be an appropriate assessment and treatment/support in line with their preferences or known wishes. It is also emphasised the need for the person to be involved in decisions about whether to stay at home or be admitted to hospital, i.e. care in the right place for them.

Examples of what meeting this standard might look like include:

- Protocols and pathways for a responsive assessment of care needs following a sudden deterioration;
- Evidence of a community-based 'urgent care team' who can assess people quickly in their own homes 7 days a week; and
- Evidence of a dedicated frailty unit which has enough capacity for the population it serves.

Standard 11: Care in hospital - When in hospital, older people living with frailty receive safe, effective and person-centred care.

This standard covers any other aspects of care including continuing care of acute illness, elective care and any services provided by community-based hospital teams e.g. hospital at home services. The focuses being that the person is cared for in a right clinical environment, importance of safely maintaining their independence, proactive discharge planning, regular review of delayed discharges and the person being kept informed about their progress and discharge plan, including any changes to their medicines and future care plan made during the admission.

Examples of what meeting this standard might look like include:

- Data related to number of people in hospital waiting for discharge;
- Data related to reasons for delayed discharge; and
- Audit of proportion of people who have an up-to-date future care plan at point of discharge.

With the publication of these standards, it is envisaged that we will work towards a transparent, person-centred, seamless health and social care system in Scotland through multi-professional, multi-agency working in collaboration with the older person who is frail or at risk of frailty.

The standards should encourage national consistency in the quality of care that people receive, regardless of where they live. Organisations can use the standards to self-assess their services, develop learning, and plan improvement. While some of the standards may seem aspirational it is hoped that they will be a catalyst for change, and that by working together to achieve these standards older people living with frailty will be able to receive early and proactive care that is right for them.

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Phyo Kyaw Myint
Professor of Medicine of Old Age

Paul Baughan
General Practitioner

Angela Conlan wins BGS Special Medal for her creative work with older people

TheBGS awards its Special Medal each year to someone who has made an outstanding contribution to promoting the health and wellbeing of older people. It recognises non-clinical professionals who have gone the extra mile through their work or volunteering to support older people.

This year's winner is Angela Conlan, Project Lead at Oxford Health Arts Partnership, which brings creative arts to older people in community hospitals, helping to ensure they can live fulfilling lives.

One of Angela's notable contributions is her 'Creating with Care' project, a collaborative project supported by the Oxford Health Charity, Oxford Health NHS Foundation Trust and University of Oxford. The project delivers a variety of arts interventions to patients in community hospitals including dancing, live music and painting. These activities bring therapeutic joy into a clinical setting.

Angela recently completed an Arts Impact Measured service evaluation of the 'Creating with Care' project, which found that patients who interacted with artists showed an improvement in mood and an increase in positive emotions from 29% to 94%. The activities facilitated the sharing of memories, and participants' engagement with the artists, family members and staff has built a sense of community and connection.

Angela is passionate about reducing inequity in the provision of artistic rehabilitative services for housebound older people. She is planning further research on improving older people's access to treatment, therapy and rehabilitation in their own homes.

Angela was awarded her Special Medal at the BGS Autumn Meeting. Speaking of her award, she said:

"I am honoured to receive this medal in recognition of my work at the Oxford Health Arts Partnership. I have seen firsthand the incredible impact that creative health projects bring to older people in hospital settings, and it is wonderful that the value of these activities has been recognised in this way."

Rising BGS Star Awards 2024

The BGS is delighted to announce the winners of the Rising Star Awards for 2024. The prestigious annual BGS Rising Star Awards are awarded to people who show exceptional promise in their research or clinical quality work and have the potential to be leaders within the field of healthcare for older people.

The awards were open to all medical practitioners from the wider multiprofessional workforce including doctors, nurses, allied health professionals and pharmacists.

Research Award Winner: Dr Peter Hanlon

Dr Peter Hanlon is a GP and a researcher with a special interest in healthcare for older people.

Peter's research focuses on the management of long-term conditions in people living with frailty. He has published over 74 papers (34 as first or senior author) focussing on frailty, social vulnerability and multiple long-term conditions. He is a mentor to students and healthcare professionals interested in the care of older people and is currently developing an independent programme of work focusing on frailty and chronic illness.

Over the next five years, Peter's priority is to develop his skills and networks, as well as to secure additional funding, to deliver research that directly informs the care and management of frailty in older people within a primary care setting.

Speaking of his award, Dr. Peter Hanlon, said:

'I am absolutely delighted to have been awarded the Rising Star for Research and am very grateful to the BGS for the honour. Being part of the BGS has provided great opportunities to engage with and learn from people with a shared passion for the care of older people across multiple disciplines.

'This award will help me to develop my research seeking to inform the management of people living with frailty and long-term conditions in primary care.'

'Being part of the BGS has provided great opportunities to engage with and learn from people with a shared passion for the care of older people.'

Clinical Quality Award winner: Jacqui Holmes

Jacqui Holmes is the Operational Lead for Inpatient Physiotherapy at Kingston Hospital and currently leads improvement projects aimed at preventing deconditioning across Kingston and Richmond NHS Foundation Trust.

She advocates for innovative, evidence-based approaches to reduce hospital inactivity and immobility which prevents acute deconditioning, enhances patient outcomes, and transforms hospital culture through the Eat, Drink, Dress, Move (EDDM) project.

Over the next five years, Jacqui aims to successfully embed the EDDM project across London, with the aspiration that it will be adopted nationally as a quality improvement programme to tackle frailty and acute deconditioning.

Speaking of her award, Jacqui Holmes, said:

'I am incredibly proud and deeply honoured to receive the British Geriatrics Society Rising Star Award for Clinical Quality. This recognition not only draws attention to the important issue of tackling frailty and acute deconditioning but also highlights the vital role and capabilities of Allied Health Professional (AHP) leaders in driving innovation and quality improvement in health care for older people.

'I hope this empowers more AHPs to use their voice to lead positive change. I am especially grateful to use this opportunity to showcase the Eat, Drink, Dress, Move Project which encourages a multidisciplinary approach to promoting activity, mobility and holistic care to prevent acute deconditioning in hospital.

Thank you to the BGS for this prestigious award and to all those who have contributed to success of the Eat, Drink, Dress, Move Project.'

Research award for Nurses and Allied Health Professionals: Dr Abi Hall

Dr Abi Hall qualified as a physiotherapist in 2004 and has since dedicated her career to advancing the rehabilitation of older adults through clinical practice and research.

In 2016, Abi took a significant step in her career by transitioning into research, earning an NIHR Infrastructure Doctoral Fellowship, and completing a PhD in Medical Studies in 2019.

Her work and research into frailty, dementia, and workforce transformation demonstrate her commitment to improving healthcare for older people and influencing policy and practice at both local and national levels.

Speaking of her award, Dr Abi Hall, said:

'I am truly honoured to receive the British Geriatrics Society Rising Star in Research Award. Like many Allied Health Professionals, I've often struggled to accept recognition, and imposter syndrome has been a constant companion throughout my career. I never imagined I could succeed in research, but this award is proof that with persistence, passion, and the right support, it's possible.

'My journey, from clinical practice as a physiotherapist to research, has been driven by a deep commitment to improving the rehabilitation and care of older people, particularly those living with frailty and dementia. I hope this recognition can inspire other AHPs, especially those who doubt themselves, to take that first step into research.

'I am incredibly grateful to my colleagues, mentors, and the older adults who have shaped my work. This award highlights the vital role of research in transforming care for older people, and I look forward to continuing to make a difference while encouraging others to believe in their potential.'

'This award highlights the vital role of research in transforming care for older people, and I look forward to continuing to make a difference while encouraging others to believe in their potential.'

Professor Jugdeep Dhesi, BGS President, said: "We know we need to find new and improved ways to deliver high-quality healthcare for older people now and into the future. We have established the BGS Rising Star Awards to celebrate innovation in care through research and quality improvement. This year's winners have already made a significant impact on improving care and shown their leadership potential. I'm excited to see their future plans and progress.'

To find out more about our Rising Star Awards, including information about the nomination process and details of previous winners, visit www.bgs.org.uk/bgs-rising-star-awards

Professor Avan Sayer delivers prestigious Harveian Oration at Royal College of Physicians

Professor Avan Sayer became the first geriatrician to deliver the Harveian Oration at the Royal College of Physicians in London in October 2024.

The Harveian Oration is a prestigious yearly lecture followed by a dinner and one of the oldest traditions of the Royal College of Physicians (RCP). Established in 1656 by William Harvey, who discovered the principle of the circulation of the blood through the body, the tradition continues each year with a leading doctor or scientist invited to speak on issues relating to their field of work.

Avan, who is William Leech Professor of Geriatric Medicine at Newcastle University, and director of the NIHR Newcastle Biomedical Research Centre, chose to speak on the topic "From bench to bedside and beyond: new horizons for translational ageing research". Her talk provided a fantastic showcase for ageing research and for all who contribute to research and care for older people. Her talk was typically generous, celebrating the efforts of many colleagues and highlighted work on sarcopenia, ageing and multiple long-term conditions across the whole spectrum of translational research, from epidemiology and the biology of ageing, through experimental medicine and clinical trials, to impacts on policy and clinical care.

Avan reflected after the event that: "It was an honour to give this year's Harveian Oration. Ageing happens to everyone fortunate to live long enough but historically it has proved challenging to understand and influence. This is now changing with breakthroughs emerging across scientific disciplines including the biology of ageing, clinical trials for older people and life course epidemiology."

"We are poised for an exciting era of translational ageing research with opportunities to build an interdisciplinary clinical and academic community, develop national initiatives, involve patients and the public, and link closely to the needs of the NHS.'

The Harveian oration is one of the highest profile lectures in UK Medicine, and recent orators have included Professor Sir Chris Whitty (now chief medical officer for England) and Lord (Patrick) Vallance (now minister of state for science). The oration was followed by a dinner at the Royal College, hosted by acting President of the RCP Dr Mumtaz Patel and attended by Avan's family, friends, colleagues, fellows of the College and other senior colleagues including Professor Chris Whitty (CMO England) and Professor Lucy Chappell (CEO of NIHR). Geriatricians were present in strength to support the event, including Professor Adam Gordon resplendent in his BGS chain of office, as well as Dr Ruth Law (Hon Secretary and also Censor of the Royal College of Physicians), Professor Rowan Harwood, ex-president Dr Eileen Burns and many others.

All of us in the British Geriatrics Society can be very proud of Avan's achievement; she is the first geriatrician to deliver the Harveian Oration in the four hundred years of its existence. Her nomination reflects the high regard that the medical community has for her research, advocacy and leadership, but also reflects the increasing recognition and importance attached to ageing research more generally. The event showcased the very best of academic geriatric medicine, with rigour, passion, advocacy, inclusiveness and collaborative spirit – all qualities that Avan embodies as a clinician, scholar and leader.

Professor Miles Witham
BGS Vice President for Research and Academic Affairs

The 2024 Harveian Oration is now available to watch on demand on RCP Player.

With thanks to RCP for supplying photo and some text.

BGS and Dunhill Medical Trust announce Doctoral Training Fellowship for 2025

BGS has again partnered with Dunhill Medical Trust (DMT) to co-fund a Doctoral Training Fellowship for healthcare professionals with an interest in developing a career in ageing-related research. This is the first award in a new agreement between Dunhill and the BGS to jointly fund doctoral research, the third such funding agreement.

Applications are now open until mid-March 2025 for all healthcare professionals working with older people, including doctors, nurses, and allied health professionals.

Research proposals must focus on understanding and treating age-related diseases and frailty, as well as improving the health and social care of older people, with a particular focus on the following areas:

- Improving the understanding of the underlying mechanisms of ageing and age-related disease
- Targeting the social determinants of healthy life expectancy
- Improving the quality of life for older people through developing and delivering suitable living environments or addressing issues of age-related vision, hearing and oral health
- Preventing, delaying or reducing future health and social care requirements and improving the ability to maintain functional independence for older adults.

The Fellowship offers flexibility, allowing recipients to pursue their research on a full-time basis for up to three years or part-time for up to six years. Successful applicants will receive funding of up to £300,000 to cover salary, PhD tuition fees and costs for training and travel. Host institutions may also contribute financially or in-kind through resources, services, or tuition fee waivers.

Key dates:
- Deadline for submission of applications: Mid-March 2025
- Review and shortlisting: April–September 2025
- Interviews: September 2025 (exact date to be confirmed)
- Funding decisions: Mid-October 2025
- Outcome Notifications: Mid-November 2025

For full details and to apply, visit **https://dunhillmedical.org.uk/apply-for-funding/#open-calls-and-deadlines**

BGS AGM 2024: Appointments

The 50th BGS AGM was held on 15 November and welcomed the following new appointees to various posts within the BGS:

- Professor Jugdeep Dhesi as President
- Dr Amit Arora as President-Elect
- Lyndsey Dunn as Chair of the Nurse and AHP Council
- Dr Claire Copeland as Vice President for Workforce
- Dr Iain Wilkinson as Vice President for Education and Training

We'd like to thank those who participated in the AGM, during which the following items were approved:

- The minutes of the 49th AGM held on 17 November 2023
- The Trustees' Annual Report and Audited Accounts for the year ending 31 March 2024
- The membership subscription rates for the year 1 January 2025 to 31 December 2025

BGS

Spring Meeting 2025

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*Ends 11 February 2025 **Ends 10 January 2025