AGENDA

British Geriatrics Society
Improving healthcare for older people

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Food *for* thought

Optimising **nutrition and hydration** for better health in older age

PLUS

- **Health implications of pensioner poverty**
- **BGS Spring Meeting report**
- **Palliative and end of life care policy**

AGENDA
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On the

AGENDA

President's *Message*

The BGS Spring Meeting in Belfast was a fantastic event with learning, laughter, and lovely weather. A huge thank you to all the organisers and attendees, in person or online. Do mark your calendar for the Autumn Meeting in Nottingham, which I have no doubt, will be equally enriching and engaging. Don't forget you can catch up online for 12 months after all our events or read about the highlights on page 20 of this issue.

After the fun and sunshine, we have to return to reality. As we all know, the NHS is currently undergoing major changes, and as multidisciplinary healthcare professionals with older people's needs at the forefront of our minds, we must seize every opportunity to shape the direction of travel. It can be frustrating when change is slow, opaque, or misguided. Ours is among the largest medical specialties in the UK, and with that size comes influence, but only if we channel it wisely. A single voice, or even a handful, is not enough. Our strength lies in our collective power - so please, speak up.

One small but powerful way to do this is by responding to the many surveys currently in circulation. They are crucial touchpoints for influencing design and development of future workforce and clinical services. One such survey is about the BGS strategy for 2026-2029. What are your priorities? What should we focus on? This is your society; please take this opportunity to make your voice count. Members should have received a link to the survey via email so check your inboxes and respond by 23 June.

Certainly, effective communication, both internally and externally, is key to our work at the BGS. We rely on your experiences and insights to guide us in representing you in our work with policymakers, regulators, professional bodies, and the public. You can help by sharing resources with local networks, encouraging colleagues to join the BGS community, forwarding newsletters, and inviting trainees and colleagues to get involved. Only by amplifying our voice can we ensure the needs of older people remain central to the conversation.

'Over the past month, I've found myself returning again and again to BGS's key statistics and insights.'

‘With older people being the NHS’s largest user group, they deserve care delivered by a numerically sufficient workforce that is trained to meet their specific needs.’

Indeed, we’ve seen the value of strong messaging recently in our work on palliative and end of life care. Over the past month, I’ve found myself returning again and again to BGS’s key statistics and insights at the Palliative and End of Life Care Commission (more about this on page 6), at a Royal College of GPs roundtable, and at the Age Anaesthesia Conference. These figures paint a sobering picture, but they also help shift the conversation from identifying problems to proposing solutions.

Across the UK, age-attuned services are showing what’s possible, from care home outreach to support in community settings, from tailored services in surgical and oncology departments to dementia-friendly initiatives in emergency care. We need to spotlight this work, learn from it, and replicate it. Please continue to share your case studies, blogs, and abstracts. These insights fuel peer learning but also strengthen our lobbying efforts and policy development.

Of course, innovation cannot compensate for inadequate staffing. Our recent report on nurses and allied health professionals (AHPs) in older people’s healthcare is a wake-up call. Examining NHS England data obtained through a Freedom of Information request, we highlight the shortages and regional variation of the nurse and AHP workforce working with older people across the UK. While the data has limitations, it lays bare the workforce issues we face. Read more about this work on page 4 of this edition.

With older people being the NHS’s largest user group, they deserve care delivered by a numerically sufficient workforce that is trained to meet their specific needs. Nurses and AHPs are central to this, and their contribution must be properly recognised and resourced. To plan effectively, we need better data that is regularly collected, publicly shared, and used to guide policy. We are pressing the Department of Health and Social Care to make this a priority, and we won’t stop until we see meaningful progress.

This issue of *AGENDA* is themed on nutrition and hydration, an issue that underpins older people’s health on every level but often overlooked as a meaningful intervention. Articles in this issue look at topics ranging from food enjoyment, to nutrition and sarcopenia, malnutrition and poverty. I hope you find it an interesting and useful read. Until the next time.

Professor Jugdeep Dhesi
BGS President

Looking ahead: Developing a new BGS Strategic Plan for 2026-29

During the course of 2025, we will be consulting on our next Strategic Plan which will define our direction for three years, beginning in April 2026.

We are keen to hear from BGS members, from our stakeholders and from anyone who would like to share their views on how the BGS can go further in its mission to improve healthcare for older people.

BGS members are multidisciplinary professionals working in acute, community, primary and social care settings across the UK to provide care for older people. The NHS workforce faces a challenging time delivering care now for older people with frailty and multiple long-term conditions, with numbers only set to increase as the population ages. But there is a wealth of evidence-based practice in caring holistically and compassionately for older people. The BGS is the community of healthcare professionals committed to ensuring that older people lead healthy, active , independent lives for as long as possible, and to providing high-quality care as their needs increase with age.

Help us to refine our strategic direction so that we can support our members to be highly effective in their roles and together achieve systemic change in older people’s experience of healthcare.

On 23 April, we sent out a survey to all our members, inviting them to say what they valued about their membership of the BGS and what services and support they found most useful. We also asked them how the BGS could have more impact and influence on how care for older people is designed and delivered, inviting feedback on how we best use our voice, advocacy and collective expertise.

Please contact us if you need help in completing the survey. The deadline is 23 June. If you have views you’d like to share with us, please contact policy@bgs.org.uk

In March, the BGS published a new report, *The case for more nurses and allied health professionals working in older people's healthcare*. The report analyses data provided by NHS England in response to a Freedom of Information Act request. It collates figures on the number of nurses and allied health professionals (AHPs) working in older people's healthcare across England, broken down by grade and geographical location.

The report raises concerns about the lack of data on the workforce of nurses and AHPs currently caring for older people and about the quality of the data that is available. However, the BGS views publishing this data as a key first step in encouraging the Department of Health and Social Care to ensure the collection of more comprehensive, accurate and accessible workforce data. Given the UK's ageing population, it will be increasingly important to have reliable information for workforce planning.

Findings from the report show that, on average in England, there is one nurse specialising in older people's healthcare for every 120 people aged 85 and over. In some regions this is better, including the North East and Yorkshire with a ratio of 1:79. However, in other regions, such as the East of England, the ratio is worse at 1:165.

The data shows a shortage of allied health professionals with on average just one AHP working with older people for every 3,012 people aged 85 and over in England. Again, the East of England has particularly alarming numbers with the ratio being 1:19,637. These figures are unlikely to be accurate, but nevertheless they point to a workforce shortage.

'Findings from the report show that, on average in England, there is one nurse specialising in older people's healthcare for every 120 people aged 85 and over.'

The figures show that 66% of nurses working with older people are at band 5 level, which is the entry-level for newly registered nurses; 46% of AHPs are working at band 6 level, and these professionals are most likely to be working in specialist older people's services. AHPs working below this level may be working with the general population and therefore not identified as specialising in older people's healthcare. Given that older people use NHS services more than any other population group, it is important that workforce data is properly captured, and the workforce has the skills required to meet the needs of older people.

The BGS is now calling for accurate and complete data about the numbers of nurses and AHPs working with older people, with breakdowns across all regions and care settings including details about roles and responsibilities. This data should be published annually.

Professor Jugdeep Dhesi, BGS President, said: "These findings paint a stark picture of the workforce shortages in older people's healthcare. As the single largest user group of the NHS, older people should have their healthcare needs met by a well-resourced, skilled, multidisciplinary workforce. Nurses and AHPs play a crucial role in the delivery of care across all settings, and their vital contribution should not be under-valued. "

"Data is essential to understanding of the current workforce and enabling planning for the future. Given how limited and unreliable this dataset currently is, a positive first step for the Department of Health and Social Care would be to commit to improving its accuracy and completeness, and to regular publication of the figures."

"We must act now to build a workforce that can meet the needs of our ageing population."

BGS key achievements: 2024-25

#CHOOSE GERIATRICS

campaign launched, celebrating the variety and rewards of careers in older people's healthcare

6th BGS/Dunhill PhD Fellowship awarded to research project on the effect of ageing and blood thinners

Policy roundtable event attended by 25 senior decision-makers

37k followers on Twitter/X

7,687 delegates attended BGS events and webinars

Position on assisted dying updated.

Input to Palliative and End of Life Commission and Inquiry.

163 #Choose Geriatrics ambassadors recruited

A total of **5,310** BGS members spanning all four UK nations and across the entire multidisciplinary team

67 blogs published

2.6 million *Age and Ageing* article downloads

BGS President Prof Jugdeep Dhesi appeared on BBC Breakfast talking about frailty

Reports published on

- Proactive care
- Nurse & AHP workforce
- Reablement, rehabilitation and recovery
- BGS roundtable event

New website launched

18k members of our Special Interest Groups (SIGs)

222 abstracts submitted for our Autumn Meeting...

...the highest number in **18 years**

Highest ranking clinical geriatrics journal

126 free places awarded to enable members to attend BGS events

20,000 CPD hours awarded through our elearning courses

30% overall membership increase over the last 5 years

55% increase in student, FY and preceptorship year members

14% increase in nurse and AHP members

Figures taken at highest point of 2024-25 year. Some numbers have been rounded up or down.

BGS responds to **Palliative and End of Life Care Commission** report

The BGS welcomed the publication of the first volume of the Palliative and End of Life Care Commission report on 14 May.

The report makes useful recommendations about the need for a strategic approach to care provided at the end of life in England, including the importance of training to ensure the health and social care workforce has the necessary skills.

We were pleased to have had the opportunity to contribute to the work of the Commission, with our President, Professor Jugdeep Dhesi, being appointed as a commissioner and several of our expert members giving evidence.

Throughout our contribution to the Commission, we have been clear that the primary focus must be on improving palliative and end of life care for all.

Given that nearly 70% of the 670,000 deaths in the UK each year are in people aged over 75, it must be recognised that most people die in older age at the end of their natural lifespan.

The vast majority of deaths occur in those living with and dying of frailty, dementia and multiple long-term conditions. They are primarily cared for up to and at the end of life, by generalist health and social care staff and experts in older people's healthcare, working in hospitals, care homes and in the community.

While specialist palliative care services do indeed provide crucial and expert care to people dying of a terminal illness, the reality is that this is for a minority of those dying. We would like to see the report further emphasise the roles of both generalists and specialists across acute, community and social care.

'The primary focus must be on improving palliative and end of life care for all.'

We welcome the proposals to strengthen existing good practice in terms of early identification of need, honest conversations, and tailored support for the person dying and their family. But we know there is great variation in how such care is provided, and sustained investment will be needed to ensure everyone is appropriately supported at the end of life.

We look forward to the next two volumes of the report, which will examine the evidence supporting quality palliative and end of life care, and the funding implications.

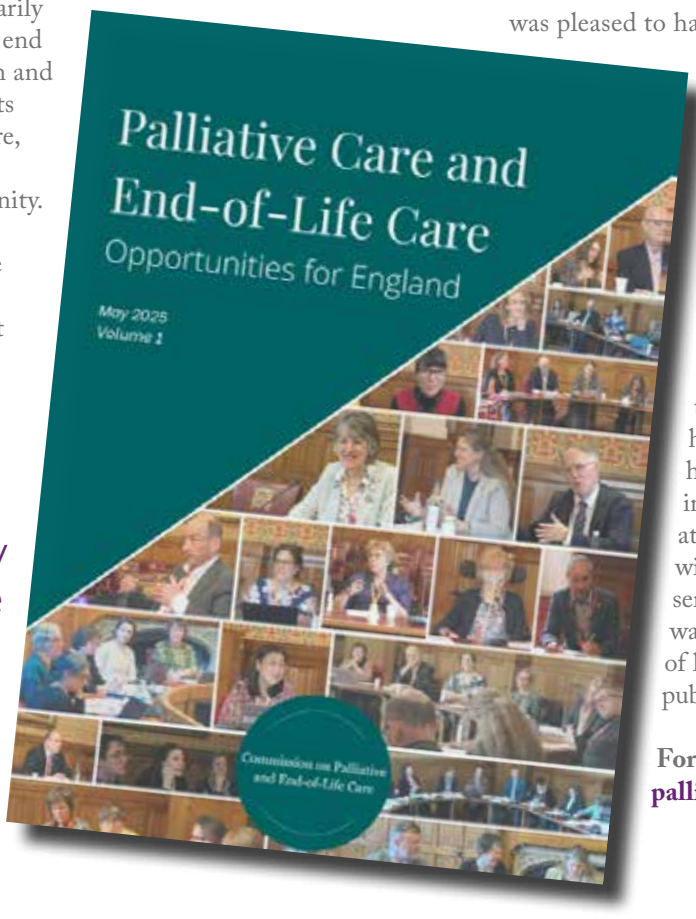
We urge the Commission to provide clarity on the differing approaches needed for older people living and dying with multiple long-term conditions, frailty and dementia; adults with single neurological or cancer diagnoses; and children, so that we ensure everyone receives the care that they need as they approach the end of life.

Professor Jugdeep Dhesi, BGS, President, said:

"It was an honour to be appointed as a commissioner on the Palliative and End of Life Care Commission. I was pleased to have the opportunity to emphasise the needs of the majority of those reaching the end of life, namely older people living and dying with frailty and multiple long-term conditions. The Commission has a real opportunity to advocate for improved quality of care at the end of life for everyone."

"We must do more to ensure that the generalist and specialist health and social care workforce has the skills needed to provide individualised compassionate care at the end of life. We must also work with policy makers to implement services aligned to the needs and wants of people in the last stages of life, and support education of the public about living and dying well."

For more information, visit palliativecarecommission.uk



BGS microlearning

LEARN ANYTIME, ANYWHERE

NEW BITESIZED COURSES FREE TO BGS MEMBERS

We are pleased to announce the first in a new series of short CPD courses from the BGS, *Advance Care Planning: A Patient Journey*, is now available.

With so many pressures at work, we know it can be difficult to make time for learning and professional development. We are developing short courses, worth one CDP credit each, on a broad range of topics to keep you on track to meet your development needs.

Each microlearning course will take you no longer than an hour to complete.

What's even better is that these courses will be free for full BGS members as a fantastic new benefit. Non-members can take Microlearning courses at a cost of £12 each.

Don't worry if this first course is not right for you. We will be rolling out new courses every couple of months, so check back regularly and there will be a course to suit you soon.

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PENSIONER POVERTY

and the wider determinants of health in older age

The news that the government is reviewing the eligibility for winter fuel allowance is welcome, but the cost of living is still a huge issue exacerbating health inequalities at all stages of life. This month I was fortunate enough to represent BGS at the Work and Pensions Committee enquiry into pensioner poverty, *Pensioner Poverty: challenges and mitigations*. The changes to The winter fuel allowance and debate over its impact have brought this topic to the forefront of the political agenda.

As I prepared my briefing, I was reminded of a patient I visited at home last winter who could no longer afford to go out to their local café for lunch. They now ate a sandwich alone at home as using the microwave was too costly. Of course this change had much more far-reaching consequences than just their diet. They were feeling low, disconnected from the social network at the café, and no longer took the walk along the street each day which had been their main exercise. Poverty was making everything harder – and poverty was stopping them ageing well.

Ageing Well: Low income challenges

Although it is generally understood that around 25% of how we age is genetically predetermined, there are several factors throughout the life course that continue to impact on the ageing process. Much of this is determined in childhood and impacted greatly by health inequalities highlighted by the tireless work of researchers such as Professor Sir Michael Marmot (*Marmot Review report – 'Fair Society, Healthy Lives'* and *Marmot Review 10 Years On*). However there is also growing evidence around ageing well physically and cognitively – and that it is never too late to start. Moving more, prioritising social contact and eating well were all compromised for my patient - and these are the exact things we need to focus on as a society to enjoy healthier older age. Physical activity however small is critical for reducing sarcopenia risk and maintaining strength and balance to reduce the risk of falls. Infact the greatest benefit is to be found for people transitioning from no activity to small amounts. We know that about half of people over 75 in the UK aren't physically active, which means they're not moving for longer than 30 minutes a week.

'I was reminded of a patient who could no longer afford to go out to their local café for lunch. They now ate a sandwich alone at home as using the microwave was too costly.'

Social contact is also crucial. Over 4 million people aged over 65 live in single occupancy households, the majority being women. Loneliness is increasingly understood to be a factor in poor health outcomes. One meta-analysis suggested it can increase the risk of early mortality by 26%.[1]

And finally, following a healthy lifestyle in terms of choices around nicotine, alcohol and food also impacts how we age, but this is financially out of reach for many older people. Surveys by Age UK have revealed concerning data around the consequences of the rising cost of living. Older people experiencing poverty are less likely to eat adequately, with polling from Age UK finding that one in five older people were having to cut back on food and groceries.[2] Previous Age UK research from 2022 found that 15% of older people were skipping meals or expected to have to do so in the foreseeable future. In the UK, 1.3 million people aged 65 and over are malnourished with the vast majority living in the community.[3] One third of people aged 65 and over who are admitted to hospital are at risk of malnutrition upon admission.[4] Financial assessment of the government's 'Eatwell' guide has shown that households in the lowest income deciles would need to spend close to 30% of their household income to meet the recommendations.[5] Most households simply cannot afford to 'eat well' at any age - and on average the current food budgets of more than half of households in the UK are insufficient to be able to meet the governments suggested dietary plan. It is no surprise that the need for foodbanks is growing across the country.

Managing illness with the rising cost of living

For those already managing long term conditions, poverty also has a huge impact. We have all heard anecdotes of patients reluctant to receive care at home due to the associated energy costs of hospital beds and equipment. People living in poverty have poorer access to healthcare services for many reasons; there are fewer GPs in more

deprived areas, waits for services are longer. It is harder to travel to appointments when you have a tight budget, and you may not be able to pay for services with associated charges like dentistry. The CMO's report in 2023 highlighted poverty as a major driver of multimorbidity - and evidence suggests that it worsens frailty in the same way. One longitudinal study of the impact of austerity found mean frailty score increased faster during the period of austerity (2012–2018) than in the pre–austerity period (2002–2010).[6]

Heating or eating?

So is there evidence linking fuel poverty to health? According to data from 2024, around 10% of households in which the oldest inhabitant is aged over 60 are living in fuel poverty.[7] As noted by the Chief Medical Officer in his 2023 report, fuel poverty and the resulting cold homes are directly linked to excess winter deaths.[8] Older people who live in poverty are three times more likely to live in cold homes and are twice as likely to have a damp home than those who are not living in poverty.[9] Polling from Age UK earlier this year showed that nearly a quarter (23%) of older people said that their home was colder than they wanted it to be all or most of the time.[10] Older people who are struggling with the cost of energy bills are more likely to make decisions that impact on their health. This may include choosing not to put heating on, only heating one room of the house or staying in bed to keep warm during the winter months with resultant deconditioning. Living in cold, damp homes puts them at risk of respiratory illnesses. Older people conscious of energy bills may also choose not to turn lights on, increasing their risk of falling in their home.

The excess winter deaths index is consistently higher in areas of increased deprivation. Though it is not possible to link this to 'cold' specifically, we have all seen presentations where cold has contributed to worsening a clinical situation; I am reminded of the patient who was caused to trip by the multiple blankets they wrapped themselves in and then lay on the floor in a cold house and arrived at ED in extremis.

What can be done?

It is easy to feel dispirited in the face of such bleak statistics, but there is much that can be done. The Health Foundation state that only around 10% of health is actually generated by our health care services. The vast majority of staying well comes from the wider determinants of health - we need to lobby as healthcare professionals for a society that focuses on creating health not just managing disease. Marmot Places are one approach to this which are springing up across the country. The excellent book *Health is made at Home, hospitals are for repairs* by Nigel Crisp (former CEO of the NHS) describes a similarly hope-filled and practical vision for an NHS that is a health building service as much as a disease management one. This will involve investment in local infrastructure and communities which I hope will form the core of the proposed neighbourhood teams in the upcoming ten year plan, allowing people to age well through the simple measures that we already know work. As part of this we must prioritise equality of access to comprehensive geriatric assessment for those already living with frailty through proactive identification regardless of postcode or income decile.

Finally, it is increasingly clear that there is also a philosophical shift that needs to happen to move this work forward for older people. There is still endemic and structural ageism across our health and social care system.

As a society we need to make decisions from the perspective that we are all the ageing population and lobby government to do the same. Older people are the biggest users of healthcare services - and yet society as a whole, and the health and social care system in particular seems unable to organise itself around these truths. At the British Geriatrics Society we will continue to take every opportunity we can to influence positive change on behalf of our patients so that everyone has the opportunity to age better.

Ruth Law
BGS Honorary Secretary and Vice President Policy

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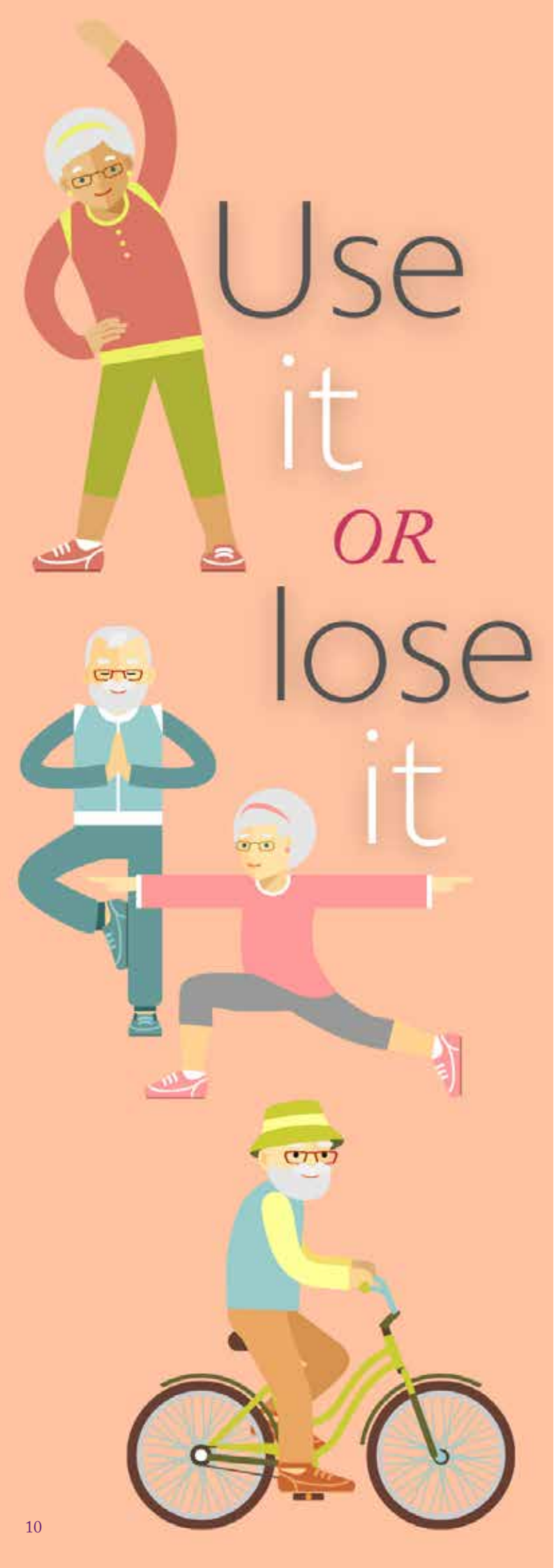

Dr Harnish Patel, Chair of the BGS Nutrition Special Interest Group (SIG), reviews some of the current evidence for the role of diet and exercise in preventing and reducing sarcopenia in older adults.

Two billion people are projected to be aged over 60 years globally by 2050.[1] Sarcopenia, a muscle disease characterised by a progressive decline in muscle strength, function and mass is highly prevalent in older adults and is associated with adverse physical and metabolic outcomes. Origins are complex, multifactorial and include cell and molecular changes, chronic diseases, lower physical activity as well as undernutrition. Given these demographic shifts, there is an urgent need to prevent or reverse the decline in 'muscle health' in older adults. As there are no pharmacologic therapies, it is reasonable to consider the roles of exercise and nutrition in the maintenance of muscle function.

The role of exercise

Exercise interventions have been shown to improve muscle strength and function. For instance, a systematic review of 23 studies involving 1,252 older people with sarcopenia found that resistance and multicomponent exercise interventions improved grip strength, knee extension strength, walking speed, mobility, and lower extremity muscle mass.[2] Safely executing resistance training may be challenging for older people, but guidelines or pragmatic solutions for implementing resistance training programs for older people are emerging. Hurst *et al*. recommend a two-session weekly program combining upper and lower limb resistance exercise with high effort.[3] In an improvement study, physical activity markers of wellbeing, and likelihood of being discharged home by virtue of the maintenance of physical capability, were seen in hospitalised older people subject to group or one-to-one exercise interventions by a non-clinical exercise practitioner employed by a local football club working within the MDT.[4] Low repetition, light load power training improved knee extensor strength in 6 weeks in a small study of postmenopausal women with sarcopenia,[5] while multiple studies have explored multimodal interventions.[6-9]

A recent network meta-analysis of 116 trials involving 4,711 adults found that milk, mixed protein (animal and plant-based) blends, ingested after exercise are more beneficial than placebo in improving muscle strength and mass.[10] This supports the additive effects of nutritional supplementation to enhance the effects of resistance training on muscle function in older adults. However, given the heterogeneity of the results from randomised controlled trials (RCTs), interventions should be tailored to the intended population to maximise benefits.

'A combination of protein supplementation and exercise has been shown to be beneficial for muscle mass, muscle strength, balance and functional capacity.'

Looking at diet

Attention should be given to an individual's diet in the first instance. Recent focus has been on varied dietary patterns, such as those rich in fruits, legumes, whole grains, nuts, fish, lean meat, and unsaturated vegetable oils. These dietary patterns are associated with lower all-cause mortality in older people.[11] However, trial evidence of role of 'healthier diets' on muscle health is inconsistent.[12] A Mediterranean diet involves higher daily intake of vegetables, fruits, cereals, olive oil, fish, and moderate red wine consumption, with lower intakes of red meat, processed meat, sweets, and dairy. The benefits of the Mediterranean diet in cardiovascular disease, cancer, and neurodegenerative disorders are well-documented, but few studies have specifically examined its association with sarcopenia. A cross-sectional study of women aged 45 and older found that the Mediterranean dietary pattern was associated with lower odds of sarcopenia compared to a Western diet.[13]

As sarcopenia is a key component of physical frailty, what evidence is there on the effect of the Mediterranean diet on frailty? Bollwein *et al.*[14] found that greater compliance with the Mediterranean diet was associated with a significantly reduced prevalence of frailty in adults aged >75 years. Similar findings were observed in community-dwelling adults aged >65 years after a six-year follow-up, where adherence to the Mediterranean diet was associated with a lower risk of developing frailty.[15] These findings were also seen in a meta-analysis of four observational studies that found that greater adherence to the Mediterranean diet was significantly associated with a reduced incidence risk of frailty.

Supplementation

Protein

Protein is central to muscle anabolism and adequate intake should be prioritised based on the recognition that in older people, protein intake is low, especially in situations of stress or intercurrent illness. Higher protein intake has been shown to be protective against the decline in physical function in older individuals - including those with a previously sufficient protein intake - independent of physical activity.[16] Protein supplementation above the recommended daily amount for adults, in combination with resistance exercise or endurance type exercises, has been advised for older people. High-quality protein intake of 1-1.2g per kg of bodyweight is suggested per day through a variety of foods and/or supplementation.[17,18] As mentioned already, a combination of protein supplementation and exercise has been shown to be beneficial for muscle mass, muscle strength, balance and functional capacity.[19]

Leucine

Leucine, an essential amino acid has been studied for its effects on skeletal muscle mass and strength. A plethora of studies have shown mixed results. A systematic review of 16 studies found that leucine increased lean body mass in older adults at risk of sarcopenia but not muscle strength.[20] Another review considered leucine supplementation in older adults.[21] It found that leucine and protein supplementation especially with exercise, was a promising combination for better muscle health. A systematic review of 17 RCTs found

'Maintenance of adequate circulating vitamin D levels, through dietary intake as well as exposure to sunlight, is important.'

that leucine-isolated supplementation had no effect on total lean mass, grip strength, or leg press, but leucine-combined supplementation with vitamin D significantly improved grip strength. Participants included in these studies were older adults with or without sarcopenia.[22] This synergistic effect with vitamin D was also seen in another meta-analysis of 17 RCTs by Guo et al.[23] Leucine supplementation alone didn't improve muscle mass and strength in older adults but combining it with vitamin D improved hand grip strength and gait speed. An umbrella review of 15 systematic reviews and meta-analyses suggested leucine consumption enhanced overall muscle mass in older people with sarcopenia, and the benefits of resistance training are further amplified by protein supplementation.[24] However, heterogeneity in populations, methodology, type and frequency of intervention evident in all the studies mentioned above makes it difficult to provide definitive guidance on leucine supplementation.

As a derivate of leucine (β-hydroxy-β-methyl butyrate - HMB) has been suggested to increase or mitigate the loss of skeletal muscle and improve muscle function. An umbrella review of 15 systematic reviews of HMB supplementation considered muscle outcomes.[25] Five of 15 studies found some evidence that HMB increased lean soft tissue mass (measured using DXA); the remaining 10 studies reported some evidence favouring no difference (6/10 studies) or insufficient evidence to determine an effect (4/10 studies). Of the 12 studies that considered muscle strength, the findings were very mixed. No study reported a positive effect of HMB on physical function. Taken together, literature around leucine and HMB suggests that while benefits of supplementation on skeletal muscle 'health' may be present, these are modest in the absence of resistance exercise.

Whey protein

A study investigated the benefits of whey protein on muscle health with or without resistance exercise in women aged 55 years and above.[26] 14 studies were identified for review and meta-analysis in the group that also included exercise, whey protein supplementation was associated with significant improvements in lower limb lean mass. The benefits of combining whey protein supplementation and resistance training were confirmed in a recent systematic review and meta-analysis of 30 studies, comprising 2,105 participants aged 60 and over where the combination improved lower body strength but no effect on hand grip strength or physical performance.[27]

Vitamin D

Perhaps one of the most considered nutrient for musculoskeletal health is vitamin D, as low levels of vitamin D are commonly found in sarcopenic individuals.[28-30] Low vitamin D levels (where deficiency is defined as a serum 25-OH-D level <25 nmol/l) are likely to contribute to muscle weakness and increased risk of falls and hence maintenance of adequate circulating vitamin D levels, through dietary intake

as well as exposure to sunlight is important. An adequate vitamin D status is associated with better muscle mass and function,[31] and reduced number of falls in postmenopausal women,[32] so attention to vitamin D status is important in this context.

Probiotics

A relatively recent focus of research is on the composition of gut microbiota and the impact on skeletal muscle function. Signals generated by the gut microbiome (microbial metabolites, gut peptides, lipopolysaccharides, and interleukins) regulate muscle functionality through modulation of systemic/tissue inflammation and insulin sensitivity. Considering published evidence, a recent systematic review and meta-analysis of 24 RCTs explored the impact of probiotic supplementation on muscle mass, total lean mass and muscle strength.[33] The study's main analysis reported that muscle mass, but not total lean mass was improved following probiotic supplementation compared with placebo. A significant increase in global muscle strength was also observed among six randomised controlled trials analysed. It appears that there may be some benefits to skeletal muscle health through probiotic supplementation, but further high-quality studies and trials are needed this area.

A combination of nutrients i.e., whey protein, leucine and vitamin D-enriched was considered in a systematic review exploring supplementation with or without accompanying resistance exercise in different clinical settings.[34] Results suggested that this combination may provide an optimal recipe for treating sarcopenia. This was confirmed in a recent scoping review of 11 studies experimenting with whey protein and leucine enriched multi-nutrient formulas high in vitamin D3 with or without combining exercise rehabilitation on measures of sarcopenia in older adults aged 66-86 years. These nutritional interventions appeared to improve body composition, lean mass and physical function with or without exercise in older adults recovering from sarcopenia.[35] Analyses on studies that have explored nutritional supplementation such as protein, creatinine, essential amino acids, β-hydroxy-β-methylbutyrate and vitamin D in combination with exercise and have shown a modest but positive impact on muscle mass and function with greater benefits on physical performance in adults over the age of 60[36] as well as demonstrating the efficacy of progressive resistance exercise to stimulate muscle protein synthesis.[37,38]

Conclusions

Sarcopenia is a growing public health problem. A lifecourse approach focusing on interventions in adolescence and adulthood to maximise peak gain in muscle function, and in later life to slow the decline in muscle function, is important. This can be achieved through multimodal approaches combining resistance exercise and nutritional supplementation. Evidence slants towards higher protein consumption in association with healthier dietary patterns. Although these approaches appear to represent a cornerstone of therapy for sarcopenia, more well conducted research studies required.

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Appetite & food enjoyment in later life

Eating food isn't a purely functional act - the enjoyment, social connection and cultural significance that comes from food and eating becomes arguably even more important in older age. Maintaining appetite can contribute to a better quality of life in ageing adults.

Appetite, or our 'desire to eat,' is essential to maintain good nutrition in later life. Poor appetite is common among older people, affecting around 1 in 5 of community dwellers.

Many older people consider a decline in their appetite as a normal aspect of ageing and their body requiring less. But this is not completely true, as appetite decline can lead to consuming inadequate amounts of food to maintain a healthy weight and a tendency towards poorer diet quality with less protein, fibre and vegetables. This can lead to malnutrition and poor overall health.

Appetite decline in ageing can be secondary to recognised clinical causes, such as medication side effects, malignancy, or chronic conditions such as heart failure. However, there are wider factors linking ageing to appetite decline, which can be encompassed by the term anorexia of ageing.

These factors include:

- Alterations in the nervous and hormonal signals that control energy homeostasis. Predominantly affecting signals from the gut, these alterations promote feelings of satiety.
- Diminished senses, such as sight, taste and smell, and the ability to chew and swallow, can make food and eating less desirable. This acts to reduce the pleasure-seeking drive to eat.
- Wider life events, such as bereavement or moving to a care home, which can alter the manner and type of food eaten. This can negatively impact on social and cultural relationships with food, which are often unique, learned over a lifetime, and play an important role in a person's eating behaviour.

'Food enjoyment is of key importance, not only for the principles of person-centred care but also in promoting the pleasure-seeking drive to eat.'

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Encouraging appetite and food enjoyment

Different approaches to improve appetite have been trialled amongst older people, but in very small numbers and with mixed effects. This is an area of increasing interest in research, with likely more evidence to come. Meanwhile, observational studies highlight suggestions that might encourage appetite. These include being more physically active, improving social connectedness and mealtime companionship, and paying attention to the person’s social and cultural norms around food.

There are no specific recommended amounts of physical activity to promote appetite, and it doesn’t mean undertaking a rigorous exercise regimen, as this has been linked to transient suppression of appetite. Instead walking, gardening, or other lighter activities may be helpful to encourage appetite. Attention to the person’s social networks, such as attending social mornings or lunch clubs to aid companionship, could improve appetite. It is important to note however, that mealtime companionship is seen to encourage eating when the person knows their companion, hence eating alone in the company of strangers is unlikely to have the same impact.

Food enjoyment is of key importance, not only for the principles of person-centred care but also in promoting the pleasure-seeking drive to eat. The five tastes of sweet, sour, bitter, salt and umami diminish with ageing, so enhancement of food flavour with seasoning or sauces can be helpful to improve food enjoyment and encourage appetite, particularly when the texture or consistency of food may need to be altered. In addition, oral health and appetite are intrinsically linked through food and eating enjoyment, so attention to dental needs and hygiene are imperative.

Mitigating a declining appetite

There are approaches that can be helpful in mitigating a declining appetite, after exclusion or treatment of a clinical cause. Firstly, suggesting smaller but more frequent meals (four to six times a day), which are nutrient dense i.e. contain more protein-energy and nutrients in a smaller volume. Examples of nutrient dense foods include nuts, cheese, and eggs. Meals can also be fortified to make them nutrient dense by adding in or swapping ingredients, for example changing to full fat milk or adding double cream or nut butter.

An alternative to smaller more frequent meals is to suggest the addition of nutrient dense snacks between meals. This may need to be well communicated to overcome often-held views of snacking being linked to overweight and obesity. There can also be concern that adding in snacks may reduce intake in subsequent meals, hence leading to substitution rather than addition of energy and nutrients. However, this has not proven to be the case in research studies.

An important hurdle in mitigating a declining appetite is the recognition and education that it can be problematic. This hurdle sits within the nexus of appetite and weight, and our understanding that in early, mid and early-later life, being of a healthy weight or body mass index (BMI) is desirable for health. So, when older adults unintentionally lose weight due to appetite decline, they may see this as a positive outcome, particularly if they have previously been overweight. However, there is no clear ‘ideal weight’ or BMI in later life and BMI is an inaccurate predictor of outcomes in older people. It is also well recognised that once unintentional weight loss occurs in older people it is difficult to regain weight in a meaningful way. In addition, observational studies highlight a link between appetite decline and poor health outcomes, such as sarcopenia and mortality, which are independent of weight. Therefore, it is important to recognise and mitigate appetite regardless of the presence of weight loss, as there is increasing evidence it is likely to aid in maintaining health and independence.

Useful further information for older people, their family and friends

- **The British Dietetic Association’s website contains lots of useful information from their Older Person’s Specialist Group. Amongst others, resources to search include ‘Eating, Drinking and Ageing Well’, ‘Guide to good nutrition in older age’ and ‘Losing weight is not a normal part of ageing’ advice, which includes tips for fortification of food, as well as ‘Hydration in Older Adults’: www.bda.uk.com**

- **The Malnutrition Task Force website contains guidance for everyone to help combat becoming under-nourished and dehydrated in later life. Their ‘Eating Well in Later Life’ booklet contains lots of useful information: www.malnutritiontaskforce.org.uk**

- **Eat Well Age Well was developed for older people living at home in Scotland. The resources are freely available to everyone, including ‘Staying well and nourished in later life’ and ‘Eat Well: A guide for Older People in Scotland': www.eatwellagewell.org.uk**

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Fighting Vitamin B12 DEFICIENCY IN OLDER ADULTS

My journey with vitamin B12 began when my mother received a diagnosis of Alzheimer's dementia, and was told she needed admission to a nursing home. It broke my heart to watch her rapidly descend into dementia, apathy, paranoia, and physical frailty.

All lab results were in the reference range, so there did not seem to be any treatable cause. However, inspired by the VITACOG study,[1] I decided to supplement her with 3000mcg methylcobalamin and 1200mcg folic acid daily, hoping it might just slow progression of the dementia.

To my utter astonishment, paranoia disappeared within two weeks, Mini-Mental State Examination (MMSE) normalised from 14 to 29/30 in eight weeks, and the majority of frailty symptoms disappeared.[2] It was an incredible journey to observe her transformation. She lived nine more years in her own home, without dementia.

Professor David Smith, the principal investigator of the VITACOG study, introduced me to the breadth of clinical manifestations of vitamin B12 deficiency and the beauty of the science. I have been studying B12 ever since.

In 2020 we started CluB-12, an international association of scientists and clinicians with a strong interest in B12. That same year I joined the National Institute for Health and Care Excellence (NICE) committee for a guideline on B12 deficiency, which was published last year.

Having seen the devastation of B12 deficiency and the power of supplementation first hand, I am passionate to see older people benefit from optimal diagnosis and treatment. Below some highlights about vitamin B12 relevant to the care of older people.

Prevalance

B12 deficiency is prevalent in older people. Estimates range from 10-30% in community dwelling older people, increasing with age, and as high as 40% in nursing home residents.

Prevalence is increasing due to increasing use of metformin and antacids, higher rates of atrophic gastritis in older people (helicobacter-related and auto-immune), iatrogenic causes (e.g. gastrectomy, bariatric surgery, ileostomy, radiotherapy to the pelvis), diets low in animal source foods (e.g. limited appetite, food insecurity, 'tea and toast' diets, more plant-based diets), and use of nitrous oxide (gas and air) for pain relief, which disables B12 and can tip patients into deficiency.

Symptoms

Symptoms of B12 deficiency overlap with the geriatric giants. Dementia, delirium, mental illness, behavioural problems, insomnia, peripheral neuropathy, neuropathic pain, poor mobility and balance, postural hypotension, resulting falls, incontinence, fatigue, can all be manifestations of B12 deficiency. B12 deficiency can be the sole or a contributing cause in any of these syndromes. However, it is easily overlooked or misdiagnosed as one of the geriatric syndromes. Only optimal diagnosis and vigorous treatment can reveal the contribution of B12 deficiency in each patient.

The threefold function of B12 in the cell explains the symptoms of deficiency. B12 deficiency affects the nervous system more than any other organ, because of its high energy and metabolic demands.

- B12 supports mitochondrial function. In B12 deficiency, methylmalonic acid increases, which impairs mitochondrial function and slows energy generation.
- B12 and folate together enable methylation, by converting homocysteine to methionine, which is further converted to SAM, the nearly universal methyl donor in the cell. Methylation is essential for myelin synthesis and repair, hormone and neurotransmitter metabolism, cell membranes, amino acid and protein synthesis, cell division and tissue repair.
- B12 converts folate into the form needed for purine synthesis, which enables DNA and RNA synthesis and repair. This pathway causes anaemia, but sufficient folate intake prevents it. Only around 20% of deficient patients have anaemia.

Diagnosis

Older people have increased need for B12. Optimal levels are in the upper half of the normal range in older people.[3] This may be due to decreased transport across the blood-brain barrier, or increased requirements of the nervous system in older age.

In the VITACOG study, vitamin B12 and folic acid supplementation slowed progression of mild cognitive impairment,[1] reduced brain atrophy by 40% in those with highest plasma omega-3.[4,5] So for cognitive impairment, and probably for other neurological syndromes, we need to co-supplement with omega-3.

Deficiency is underdiagnosed. There is no gold standard test. The 2024 NICE guideline for B12 deficiency introduced an indeterminate range of B12 levels (180-350ng/L for serum B12) in which there is 24% risk of deficiency. Even above 350ng/L there is 15% risk of deficiency. A secondary test (homocysteine or methylmalonic acid) may confirm the diagnosis. However, there is no test or combination of tests that definitively rules out the diagnosis. If clinical suspicion remains despite negative tests, high dose pragmatic treatment can be given. Improvement in the patient's condition on treatment confirms a diagnosis of deficiency.

In high-stakes conditions such as dementia and frailty, it is safest to assume B12 deficiency is at least a partial cause until proven otherwise, and to treat accordingly.

Deficiency is too often undertreated. The majority of people treated parenterally say their symptoms improve after injections, but return or worsen well before the next one. Families, when asked, may say their loved one gets more confused towards the end of the injection interval. The interval should be optimised to eliminate return or worsening of symptoms, which can prevent complications such as falls and neurological damage in the long term.

Some patients may need injections every other day for a long time to achieve optimal neurological function, before slowly reducing injection frequency, as long as symptoms do not return. This requires careful questioning and observation of symptoms. Patients treated with oral replacement should receive at least 1,000mcg B12 daily. They should be regularly monitored for insufficient response, return or worsening of symptoms, and adherence.

In older people, it is safest to continue B12 treatment lifelong. The danger of stopping treatment is that gradual return of symptoms is either not noticed, or attributed to age or comorbidities. The balance between the risks of stopping and the safety and benefit of continuing is entirely on the side of continuing.

'In high-stakes conditions such as dementia and frailty, it is safest to assume B12 deficiency is at least a partial cause until proven otherwise.'

Safety

Vitamin B12 has an excellent safety profile: it has no interactions with other medication, virtually no side effects, it is inexpensive and well tolerated.

High serum B12 levels due to supplementation are safe. Overdosing is not a concern with B12, but undertreatment is. Spontaneously high B12 levels can be a sign of disease: increased production of carrier protein keeping B12 in the circulation (malignancy), or reduced excretion (liver and kidney disease). In patients on oral B12 replacement, low blood B12 levels indicate insufficient adherence or absorption. Otherwise, blood tests for B12 should have no place in treatment decisions. The dose of oral B12 and frequency of injections should be titrated according to symptoms only. High blood B12 levels should never lead to reducing or stopping treatment.

The brain needs all micronutrients. Of particular importance are vitamin D, omega-3 and choline. For folate, the upper tolerable limit is estimated to be 1 mg daily.[6]

My dream is for every older person to have optimal nutritional status, so they can enjoy their best quality of life. Given the cost of dementia care alone (£40 billion annually, and rising fast), not even counting frailty and fractures, optimising B12 diagnosis and treatment could benefit the national economy to the tune of hundreds of millions.

Willemina Rietsema
Oxfordshire GP, co-founder of CluB-12, member of the NICE committee for the guideline on vitamin B12 deficiency

NICE wish to emphasise that the opinions expressed here are entirely my own. The guideline speaks for itself.

The full guideline can be accessed at www.nice.org.uk/guidance/ng239

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Malnutrition Task Force

Eating and drinking well in later life

It is estimated that around one in ten people over the age of 65 are malnourished or at risk of malnutrition. Malnutrition is both a cause and a consequence of ill health and is a silent and, all too often, hidden problem. It will affect health and wellbeing, increasing hospital admissions, and can lead to long-term health problems for otherwise healthy and independent older people.

Of the 11 million older people in England, over a million are estimated to be malnourished or at risk of malnutrition.[1,2]

Unfortunately, despite excellent guidance and awareness raising,[3,4,5] awareness of malnutrition amongst older people, their families and many health and care professionals remains low. The risk factors that can contribute to malnutrition remain. There is also patchy availability of care and support services to prevent malnutrition or identify and treat it when it occurs.

The myth perpetuates that it is 'normal' to get thin as you get older, associated with outdated perceptions that becoming frail is all but inevitable in later life.

This is not helped by health messages and public health policy that are preoccupied by reducing levels of obesity, so that weight loss is seen as desirable. There is little recognition that widely publicised advice about diet and nutrition is often unsuitable for older or more vulnerable members of society.

Yet malnutrition is largely preventable and treatable, other than when it accompanies a serious illness like cancer, in which case highly specialist support is required. Because of its widespread prevalence, reducing incidences of malnutrition are associated with large potential cost savings across the NHS and social care.[6]

There are many examples of good practice with teams up and down the country making real progress on tackling malnutrition, however efforts are patchy and access to help remains a postcode lottery for older people and their families. We urgently need to invest in a proper joined-up strategy, bringing together health, social care and the voluntary sector, to ensure all older people get the support they need.

We also need to look to the future. The UK population is ageing; there are now more people in the UK aged over 60 than under 18.[7] Furthermore, the next 15 years will see a huge increase in the 'oldest' old; indeed the number of people aged 85 and over is projected to increase from 1.6million (2.5% of the total population) to 2.6 million (3.5%).[8]

The fact that so many people are living into late old age is a real cause for celebration, however it also means that, if nothing changes, there will be many more older people at risk of malnutrition. Living longer means little if it's not living well.

The Malnutrition Task Force (MTF) was established in 2012 and is united to address avoidable and preventable malnutrition in older people. The MTF believes that good nutrition and hydration are fundamental to delivering dignified care and enabling older people to live fulfilling and independent lives.

Tackling malnutrition is everybody's business so the MTF works with partners across sectors and settings, working with older people, their relatives, their informal carers and their friends, as well as with health and social care professionals in the community, hospitals, care homes, local authorities and private & voluntary organisations.

The MTF raises awareness of undernutrition in later life and its causes, provides information and guidance, and spreads best practice and innovation to improve the lives of older people in the UK.

The MTF was set-up in 2011 by a partnership of Age UK, apetito, BAPEN, Nutricia and The Royal Voluntary Service. In 2012, Diane Jeffrey CBE DL, was invited to be its first Chair; and later on in 2013 Dianne led the Hospital Foods Standards Panel to investigate standards of food and drink in NHS hospitals.

In 2012, the MTF was awarded £500,000 from the Department of Health and Social Care to develop a Pilot Prevention Programme to tackle malnutrition at a local level. This programme brought together local NHS trusts, hospitals, GP practices, care homes and community groups in five 'pilot sites' across the UK to develop innovative solutions to tackling malnutrition locally. The funded

programme formally ended in March 2015, but these sites continue to lead the way in tackling malnutrition in their local areas.

The MTF continues to work in the community – with care homes, domiciliary care, community groups, and older people and their families – to raise awareness of and tackle the causes of undernutrition in later life. There are a number of resources and guidance that have been developed in collaboration with older people, for those working with older people. There is a video illustrating the screening tools available for older people and/their friends/family to use and for health care professionals; and how to use them.

In 2015 the MTF partnered with NHS England to develop the first NHSE guidance on *Commissioning excellent nutrition and hydration* (**www.england.nhs.uk/wp-content/uploads/2015/10/nut-hyd-guid.pdf**)

In 2018, the MTF co-founded the UK Malnutrition Awareness Week (UKMAW) campaign with BAPEN. The aim of this annual week is to raise awareness of undernutrition and dehydration in the UK. The campaign seeks to increase understanding of the dangers, risk factors and signs of malnutrition and dehydration amongst health and social care workers, community groups, the public, parliamentarians and policy makers. Through using the simple request - for everybody to Ask, Look and Listen and recognise that we are ALL in this together. The awareness week is not in its 8th year and is growing every year, with learning events and more and more people getting involved.

The UKMAW vision is that there will be a future for the UK where preventing and managing malnutrition is everybody's business. This means that we want:

- Members of the public to understand the risks, causes, and signs of malnutrition, and know where to access resources and self-screening tools.
- Health and social care professionals to be able to spot the signs and symptoms of malnutrition and routinely screen for malnutrition.
- Policy makers to be engaged in helping to raise the profile of malnutrition (and dehydration) as a public health issue.

In 2019, the National Hydration Network joined the Malnutrition Task Force, to strengthen the combined work to tackle malnutrition and dehydration.

Tackling malnutrition is everybody's business and it is through working together that we can make a difference, and link in with the making every contact count. If you would like to find out more or get involved please get in contact **enquiries@malnutritiontaskforce.org.uk**.

The MTF has a long list of resources and information to help people and health and care professionals; and encourages the sharing of practice. To keep up to date with the MTF activities people can also sign up to the newsletter on the website (**malnutritiontaskforce.org.uk**).

Below are some of our most popular resources and tools

- **Using Tools to start conversations animation**
  tinyurl.com/toolanim
- **Eating Well in Later Life**
  tinyurl.com/eatwellpdf
- **Lyn's Story**
  tinyurl.com/lynstory
- **Malnutrition in England factsheet**
  tinyurl.com/mn-eng-fs
- **State of the Nation**
  tinyurl.com/mn-state-nation

The Malnutrition Task Force is supported by Age UK, apetito, BAPEN, and Nutricia.

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The British Geriatrics Society Spring Meeting took place from 9-11 April at the ICC in Belfast, bringing together clinicians, researchers, and allied health professionals from across the UK and beyond. The event featured a rich programme of keynote lectures, research presentations, panel discussions, and workshops, with a focus on innovation, inclusivity, and improvement in the care of older people.

Day 1: Movement Disorders, Major Trauma, Falls and Clinical Quality

Day 1 opened with a President's Address by Professor Jugdeep Dhesi, who began by setting the tone for the three days and by thanking the event hosts in Northern Ireland. "What we really want to be doing is addressing things that really matter on the shop floor," she said. "And a really big thank you to our organising committee here in Belfast and nationally who have contributed to a really interesting programme over the next few days."

The first day saw a comprehensive exploration of movement disorders, trauma care, and clinical quality. In the Movement Disorders stream, Dr Karen Doherty addressed the diagnosis of Parkinson's Disease, sharing some diagnosis 'hacks and hints', including how to perform a 'top down' examination, starting with the eyes. This was followed by Dr Seamus Kearney on Parkinson's management. "If you've just diagnosed someone with a life-changing condition," he shared, "I think it's important to offer them treatment at an early stage, so they know there's something that can be done about the condition." Dr Neil Archibald shared practical clinical insights, offering some case study examples and potential interventions.

'I quickly learned that if we don't step up, others will decide how we work and what our services will look like, and ultimately what kind of care older people receive.'

Later, the advanced session included talks from Dr Mihaela Boca on dystonia, Dr Marco Toffoli on GBA1 variants, and Dr Kirstie Anderson on sleep disorders.

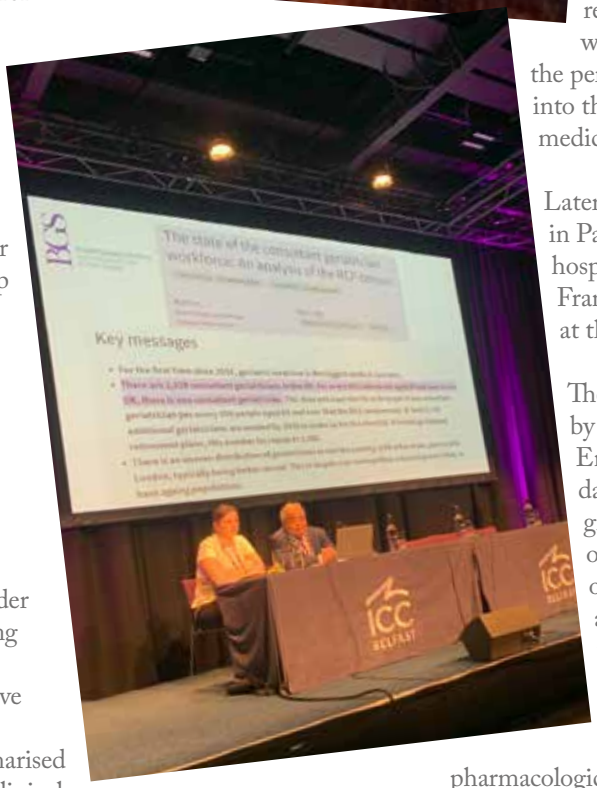
The BGS Rising Star Awards session recognised outstanding early-career contributions from Dr Peter Hanlon, the winner of the Clinical Quality award, and Dr Abi Hall, the Nurse and AHP winner. These prestigious awards are given annually to people who show exceptional promise in their research or clinical quality work, and have the potential to be leaders within the field of healthcare for older people. "I used to think research was for academics, something done in universities, far away from my clinical work," explained Dr Hall, talking about her career journey. "I quickly learned that if we don't step up, others will decide how we work and what our services will look like, and ultimately what kind of care older people receive."

Neuropsychiatric aspects of Lewy body disease were explored by Dr Joe Kane. "If you take nothing else away from today," he advised, "go and learn about your community mental health team, how to refer to them, learn what their inclusion criteria are and learn what they can offer." Later, platform presentations highlighted rural care disparities and dementia research.

A multidisciplinary panel of experts gathered to examine complex movement disorder cases, inviting perspectives from colleagues to holistically review factors that might be affecting the individual patient in the scenarios described. These ranged from issues around impulse control, to safeguarding, and the social environment.

‘The message here is to start small, control what you can, and use success stories to influence others.’

The Major Trauma and Falls stream included sessions on fragility fractures, delirium, rehabilitation, and falls. Speakers such as Professor Alex Trompeter, Mr Owen Diamond, and Professors Louise Allan and Katie Sheehan shared research and practice updates. “When we look a the evidence and the literature, in terms of fracture healing, there is no study out there that has showed improved outcomes with immobility compared to mobility,” shared Prof Trompeter.



Dr Emer Ahern and colleagues discussed trauma from low falls and cervical injuries, while Dr David Shipway addressed subdural haematoma. Oral health in older adults was tackled in a workshop by Professor Gerry McKenna and Michelle Harvey.

The Clinical Quality session showcased innovations in palliative care and hospital-at-home services with a focus on multidisciplinary involvement, bringing in specialists in speech and language therapy to help older people with frailty. “Streamlining referral from a population and neighbourhood health perspective into one hub, from a frailty perspective, makes sense,” summarised Dr James Adams of the BGS Clinical Quality Committee.

The Nurse and Allied Health Professional (AHP) Community of Practice session explored research leadership and daily QI practice, empowering nurses and AHPs to find their voice and use it to help improve processes, services and care. “The message here is to start small, control what you can, and use success stories to influence others,” advised Jacqui Holmes, Operational Lead for Inpatient Physiotherapy at Kingston Hospital NHS Foundation Trust.

The day finished with some group meetups for like-minded professionals interested in research and workforce issues, and members of the BGS Nurse and AHP Council, Trainees Council, and Specialty Grade (SAS) doctors.

Day 2: End of life care, Dementia and Research

The focus of Day 2 shifted to end-of-life care, dementia, and translational research. In the End of Life Care sessions, Dr Sarah Combes talked emotively about advance care planning (ACP) experiences, drawing on her PhD research. "For older women in particular," she reflected, "it was all about their families and protecting their families. I was so privileged [to have these conversations]."

Dr Pippa Collins reflected on planning and conversations around frailty, reinforcing the importance of listening to the person. "Really listening to Colin changed my priorities for advance care planning, " she stated, after sharing a recording of an older person she had worked with. "We need to find a way into the person's story, and then fit our planning into their narrative, rather than going in with medical questions that they can't relate to."

Later, Dr Alex Lindsay–Perez spoke on ACP in Parkinson’s, while Dr Sarah Hoare covered hospital admissions in the final days. Dr Frances Da Cunha shared insights on values at the end of life.

The keynote guest lecture was delivered by Dr Jeremy Isaacs, who discussed NHS England’s dementia strategy. Sharing data and insights on the prevalence and growing challenge of dementia care, he offered an insight into what the future of dementia care might look like from an NHS England perspective. Some of the goals included diagnosis and care plans within 18 weeks of referral, greater consistency in diagnostic practice, and removing barriers to NICE-approved pharmacological and other interventions. Continuing this theme, the Dementia stream included talks from Rachel Thompson, Ruth Sedgewick, and a panel including Professor Emma Reynish and Professor Sarah Pendlebury, focusing on diagnosis and BPSD management. Dr Katherine Patterson and Dr Jagrit Shah covered novel Alzheimer’s treatments.

The Association of Academic Geriatric Medicine symposium tackled the topics of AI and behavioural interventions for prescribing, with talks from Professors Frank Moriarty, Lauren Walker, and Debi Bhattacharya. Implementation science was presented by Professors Annette Boaz and Frazer Underwood. Platform talks addressed SNAP-3 findings and insomnia treatment.

Dr Claire Dow from the BGS Equality, Diversity and Inclusion Group and Dr Adrian Hayter from the Royal College of GPs led a packed session on the development of

BGS Spring Meeting 2025: Prize Winners

Best Clinical Quality Platform Presentation

Quality Improvement: Integrating Speech & Language Therapy into a Hospital at Home service for Older People living with Frailty
M McDowell

Elizabeth Brown Prize for best Research Platform Presentation

Memory function and post-traumatic stress disorder related to civilian conflict: Findings from the NICOLA study
C Potter

Eva Huggins Prize for Best Nurse/AHP Poster

Older adults are now the face of Major Trauma in Ireland
Louise Brent

John Brocklehurst Prize for Best Clinical Quality Poster (joint winners)

Aelirium assessment and management in health care for older people wards at good hope hospital: a quality improvement project
S Maddock

Reduction in the use of nursing enhanced observation within acute care
Louise McKay

Fergus Anderson Award for Best Research Poster

Practitioners' Perspectives on Medicine Optimisation for Older People from Ethnic Minorities with Polypharmacy in Primary Care
Nasrein Hamed

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

a Core20Plus5 framework for older adults. Core20Plus5 is an NHS England initiative aimed at reducing healthcare inequalities, identifying five clinical areas where improvement could make a difference to the most deprived 20% of the population. The session suggested areas that a Core20Plus5 framework for older people could focus on and gathered feedback from participants.

Day two concluded with a conference dinner hosted at the Hilton Hotel, where many delegates (*pictured, right*) enjoyed an evening of food, céilí dancing and general merriment.

Day 3: Ageism, Education and Training, and Community Care

Day 3 addressed ageism, chronic disease, and policy direction. Representatives from all four UK nations - Louise Jackson, Adam Stachura, Rhian Bowen Davies, and Siobhan Casey - spoke on ageism's impact, while Dr Paschal McKeown and Anne Murray shared lived experiences. Dr Glynis Magee addressed diabetes management in older adults.

The Marjory Warren Guest Lecture was delivered by Dr Jennifer Burns, who served as BGS President during the pandemic, reflecting on lessons learned from COVID and their implications for the future of geriatric medicine. Sessions on renal disease featured Dr Ruth Fergie, Dr Andrew Mooney, and Dr Andrew Nixon discussing transplantation, frailty, and CKD care. Platform presentations included trials and qualitative studies on sarcopenia, oral hygiene, and delirium. In community care, Dr Rory Nee and Dr Maria Costello shared integrated models from Ireland.

A rapid poster round featured early career researchers, and the day concluded with sessions on education, including simulation training by Dr Elaine Nelson and Dr James Irvine. The policy session focused on what policy is and how and why BGS gets involved in national policy work. BGS Policy Manager, Sally Greenbrook, spoke about what policy is, before handing over to Policy Co-ordinator Lucy Aldridge (*pictured, left*) to talk about how we influence national policy. During this session, Lucy joined with Dr Andrew Stanners, Vice Chair of the BGS Ethics and Law SIG, to discuss the process of developing the BGS position on assisted dying.

As the meeting drew to a close, the President and President Elect, Professor Jugdeep Dhesi and Dr Amit Arora, took the opportunity to gather thoughts about the next iteration of the BGS strategic plan, and to get feedback from members on their priorities for the next three years, and reflecting on another successful conference.

Amy Brewerton
BGS Publications and Website Editor

Missed the conference? Catch up with sessions on demand at www.bgs.org.uk/25Spring for 12 months following the event *(registration required)*.

British Geriatrics Society
Improving healthcare for older people

Join us

Group membership

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

The key benefits are:

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

Benefits **not** included in group membership:

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

Group membership package	Numbers of members in the group	Annual group membership	Annual individual membership equivalent	Saving for the organisation
Package 1	<10 members	£551	Up to £960	£409 compared to 10 individual members
Package 2	11-20 members	£1,103	Up to £1,920	£817 compared to 20 individual members
Package 3	21-30 members	£1,654	Up to £2,880	£1,226 compared to 30 individual members
Package 4	31-40 members	£2,205	Up to £3,840	£1,635 compared to 40 individual members

How to join:

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

All inclusive: Equality, diversity and the BGS

In 1947 when founding the BGS, Dr Marjory Warren recognised that multi-professional teams with diverse skills are instrumental in the care of older people. In other words, an inclusive working culture has been a fundamental part of the specialty since its inception.

But we all know that ensuring equality, inclusivity and diversity within our membership, and for our patients, is a continual work in progress – a work that is ever-evolving, ever-learning and needing constant attention from each and every one of us.

With that in mind the BGS Equality, Diversity and Inclusivity (EDI) working group was established in April 2023. The aim was, and is, to develop the BGS's EDI strategy - identifying areas of focus for our members and our patients, collaborating meaningfully with our partners, building up resources to help our members with EDI issues, raising the profile of EDI issues faced by our patients and enabling us to learn from each other through the sharing of stories, projects and ideas which drive forward equality, inclusivity and diversity.

Ageism will unsurprisingly be a big focus for this group, in all it's forms – societal, internalised, interpersonal, and particularly institutional and healthcare-related ageism. This needs tackling head on, and the BGS should be a leading voice in this.

The group consists of members from various disciplines, including a staff representative. Our initial task was to embed EDI within our BGS conferences, and we ran a successful Schwartz Rounds at the BGS Spring Meeting in 2024, and a popular session about Core20Plus for the older adult at the Spring Meeting in 2025. We have also started contributing to the **#ChooseGeriatrics** campaign and will continue to do so, to show the diversity of people that choose our specialty as their home and why, and we have built up important links with partners including RCP Health Inequalities Alliance.

As we begin year 3 of the group, we have appointed a new chair, Dr Laura Pugh, and are actively recruiting to the group. We want to introduce our members, and ivite you to get in touch with us and tell us what we can do for you and your patients. If you are interested in joining the group, please email Mark Stewart at **m.stewart@bgs.org.uk**.

Meet the BGS Equality and Diversity (EDI) Group

Laura Pugh (she/her)

Role: Consultant Geriatrician

Location: Sherwood Forest Hospitals

Special interests: Challenging discrimination in the workplace, tackling stereotypes faced by older patients, promoting diversity in our patient group, LGBTQI+ issues

Why I joined the EDI group: To remove barriers and inequities face by our patients, to promote positive change and role modelling, and raise awareness and appreciation of the diversity of our patients.

Huma Naqvi (she/her)

Role: Consultant Geriatrician; Senior Medic Wellbeing Lead; PostGraduate Tutor; TPD for Geriatric Medicine (West Midlands)

Location: Sandwell and West Birmingham NHS Trust

Special interests: Doctor and colleague wellbeing, empowerment of senior colleagues, advocacy for older South Asian patients and those with limited English

Why I joined the EDI group: To improve awareness of the complexities of sexuality in older people and promote diversity in the workplace and patient care

Ghalib Choudhury

Role: Consultant in Stroke and Geriatric Medicine

Location: East of England

Special interests: Medical education, clinical leadership, language around race, healthcare disparities

Why I joined the EDI group: To discuss and address discrimination related to protected characteristics and promote positive change through education and leadership

Emma Vardy (she/her)

Role: Consultant Geriatrician; Clinical Frailty Lead; Honorary Clinical Chair

Location: Northern Care Alliance NHS Foundation Trust; University of Manchester

Special interests: Ageing research, inequality in healthcare, women in medicine, dementia care, advocacy for carers and people with chronic conditions

Why I joined the EDI group: To reduce healthcare inequalities for older people in relation to factors such as ethnicity and social deprivation, and to support women in the workforce.

Moe Oo (he/him)

Role: Head of Undergraduate Medicine; Chair of Medical Education and Inclusive Practice; Consultant Geriatrician

Location: University of Leeds; Sandwell General Hospitall

Special interests: Inclusive academia, supporting underrepresented groups in Higher Education

Why I joined the EDI group: To help foster a more inclusive academic and professional culture within the BGS and promote diverse career advancement

Claire Dow (she/her)

Role: Consultant Geriatrician, Divisional Director for Medicine, Board Member Academic Centre for Healthy Ageing

Location: Whipps Cross Hospital, Barts Health NHS Trust

Special interests: Intersectionality in ageing (race, gender, sexuality), health inequality, frailty in deprived populations

Why I joined the EDI group: To advocate for equitable care for older adults and address systemic barriers exposed during the COVID-19 pandemic

Lynn MacDiarmid

Role: Registered Nurse; Lead Advanced Clinical Practitioner

Location: Leicestershire Partnership NHS Trust – Community Hospitals

Special interests: Advanced practice; Mental health in physical health settings; Clinical academic nursing; Equity, and justice; Patient experience

Why I joined the EDI group: Recognising intersectionality in older people and the workforce - To advocate for equality, diversity, and equity - challenging inequalities.

Navigating the final step of the CESR JOURNEY

Insights from the GMC

With the closure of the Certificate of Eligibility for Specialist Registration (CESR) pathway to new applicants on 30 November 2023, doctors outside traditional training routes must now apply for specialist registration via the updated Portfolio Pathway (assessed against 'the knowledge, skills and experience of an eligible specialist in the UK'). However, a number of CESR applicants (being assessed against 'equivalence to CCT') remain in the system, awaiting outcomes. While their numbers are gradually decreasing, their concerns remain a key priority for the BGS.

To address ongoing challenges and explore potential improvements, BGS engaged with the General Medical Council (GMC) in a dedicated meeting with Faye McDonald, the GMC's Specialist Applications Manager at the time (Faye has since moved to a different role in the GMC).

Representing BGS were Dr Amit Arora (BGS President-Elect) and Sarah Mistry (BGS CEO), alongside Dr Nicola Dearnley and Dr Hannah Mottershead - both recently successful CESR applicants. Discussions covered critical issues, including applicant concerns, reasons for delays, and the GMC's ongoing efforts to refine the process.

This article summarises key developments in the CESR pathway and highlights improvements that are also relevant to those applying via the Portfolio Pathway.

Understanding the delays in CESR outcomes

One of the biggest concerns raised by CESR applicants is the prolonged delays in receiving outcomes. Can you shed some light on what's causing these delays?

GMC: Absolutely. We are experiencing significant delays, and we fully acknowledge the frustration this has caused applicants. The primary driver of these delays has been an unprecedented increase in applications over the past two years, particularly ahead of the 31 October 2023 deadline for applications under the previous curriculum. Many applicants aimed to submit before the transition to the Portfolio Pathway, leading to a major spike in submissions.

This isn't just an issue in geriatrics - it's affecting other specialties. The sheer volume of applications has strained our capacity, particularly when it comes to the availability of clinical evaluators. The Royal Colleges, which traditionally assess CESR applications, have struggled to keep up with the demand. As a result, we have supported with our own GMC Specialist Associates in the evaluation process.

'Many applicants aimed to submit before the transition to the Portfolio Pathway, leading to a major spike in submissions.'

Can you explain the process that happens after an application is submitted? Where exactly do these delays occur?

When an application is submitted, it first goes through an internal GMC review before being assigned to an advisor. Right now, that initial review process takes an average of eight weeks before an application is even assigned. From there, it is passed on to clinical evaluators, either through the Royal College or our own GMC Specialist Associates. The bottleneck has primarily been in this clinical evaluation phase, as we simply haven't had enough assessors to keep pace with the volume of applications.

That sounds challenging, but the reality is that such extensive delays are having significant impact on applicants who are left in limbo. What steps is the GMC taking to address this backlog?

We've implemented several key strategies to reduce delays. These include:

- Recruitment of additional clinical evaluators: We are actively expanding our pool of assessors beyond the Royal Colleges by recruiting more GMC Specialist Associates.
- Closer collaboration with the JRCPTB: We now have weekly rolling meetings with the Joint Royal Colleges of Physicians Training Board (JRCPTB) to review progress and troubleshoot bottlenecks.
- A rolling recruitment process for evaluators: From 2025, we will keep an open recruitment cycle for Specialist Associates, allowing more consultants to apply throughout the year.
- Encouraging consultant engagement through BGS and other networks: We welcome support from professional bodies like the BGS in publicising these opportunities to their members.

While these efforts are ongoing, I want to be upfront that we haven't yet seen a significant reduction in waiting times. However, we are committed to improving this process.

Some applicants feel that communication from the GMC during the waiting period has been insufficient. Do you think there's room for improvement in keeping applicants informed?

Yes, I understand why applicants feel this way. Because CESR is an applicant-led process, we've tended to avoid providing detailed status updates until an outcome is reached. However, we are now exploring ways to improve transparency about expected timelines at different stages of the process. While we cannot pre-empt decisions, we do acknowledge that better communication about processing times would help manage expectations.

Transparency in the assessment process

There has been confusion about who assesses CESR applications, especially with the introduction of GMC Specialist Associates. Can you clarify who these assessors are and how they are selected?

'Each application is assessed holistically. If an applicant has provided other strong evidence that demonstrates competency, they may not be asked for DOPS.'

GMC Specialist Associates are fully registered and licensed consultants who are on the specialist register in the relevant specialty. Their training and expectations align with those of Royal College assessors. The main difference is that they are directly employed by the GMC, rather than working through the Royal College.

We recognise that this distinction has caused concern among applicants, particularly because we do not publicly disclose the identities of our assessors for data protection reasons. However, I want to reassure applicants that all assessors - whether from the Royal College or the GMC - undergo the same rigorous training and follow identical evaluation criteria.

Some applicants have asked why the GMC didn't simply work with the Royal Colleges to expand their pool of assessors instead of creating a separate group of GMC assessors. What's the reasoning behind this decision?

That's a great question. Ideally, we would have expanded the Royal College assessor pool. However, due to the surge in applications, the Colleges were unable to recruit enough evaluators quickly enough. The GMC had to step in to ensure applications weren't left indefinitely on hold. The use of GMC Specialist Associates was introduced as a support mechanism, and it was done in full agreement with the relevant Royal Colleges.

I want to be clear that the process remains the same regardless of whether a GMC or Royal College assessor evaluates an application. The standards are identical.

Variability in evidence requirements

One of the biggest frustrations applicants have shared is inconsistency in feedback regarding evidence requirements. As an example, some have been asked for DOPS (Direct Observation of Procedural Skills) for procedures like lumbar puncture, even though this isn't explicitly required in the geriatric medicine curriculum. Others were not required to submit this evidence. Why is there this variation?

I completely understand why this feels inconsistent. The key thing to understand is that while there is no single required method of proving competency, applicants must still demonstrate engagement with core medical competencies. DOPS is one of the easiest ways to provide this evidence, which is why it is often recommended. However, it is not the only way.

Each application is assessed holistically. If an applicant has provided other strong evidence that demonstrates competency, they may not be asked for DOPS. But if the

other evidence is insufficient or unclear, the assessors may request DOPS as a way to definitively confirm the competency.

That makes sense, but many applicants feel that these expectations are not clearly communicated. Could there be more transparency in what constitutes acceptable evidence?

We do have specialty-specific guidance, but I acknowledge that it may not always be explicit enough. Moving forward, we are considering creating additional FAQs or clearer hierarchies of evidence to help applicants understand what is most likely to satisfy competency requirements, and continue to work with all Royal Colleges and Faculties to improve guidance.

Final thoughts

What advice would you give to CESR applicants who are currently navigating this process?

First and foremost, plan ahead. Be meticulous with your evidence and review the specialty-specific guidance thoroughly. If you are unsure, seek clarification early. Engage with peer networks - learning from the experiences of others can be invaluable.

Finally, what is the GMC's long-term vision for improving this process?

Our goal is to make the CESR and Portfolio Pathway as clear, fair, and efficient as possible. We are committed to reducing delays, improving transparency, and ensuring consistency in assessments. While the transition to the Portfolio Pathway will help address many of these challenges, we recognise that continuous improvement is necessary. We will keep working with organizations like the BGS to refine this process and support applicants.

Conclusion

The GMC acknowledges the frustrations applicants have faced in the CESR process and is actively working to address them. While delays and inconsistencies remain a challenge, efforts to recruit more assessors, improve communication, and clarify evidence requirements are underway. Continued collaboration between the GMC and professional bodies like the BGS will be crucial in ensuring a fair and transparent process for future applicants.

Dr Amit Arora
BGS President-Elect

With thanks to **Dr Nicola Dearnley and Dr Hannah Mottershead**

Dr Abi Hall was the 2024 winner of the BGS Rising Star Award for Research (Nurses and Allied Health Professionals category). Here she explains why research isn't just something that 'other people' do...

When you think of a researcher, who do you picture? A scientist in a lab, maybe? Someone in a university, surrounded by books? For a lot of allied health professionals (AHPs), research can feel like it's something other people do - something for the academics, not for those of us working in health and care services.

But here's the thing: research isn't just for academics. And it shouldn't be.

AHPs are in a brilliant position to lead research that makes a difference, especially when it comes to improving care for older people. We're the ones working alongside patients and their families, seeing first-hand the challenges they face and what could make things better. We spot the gaps, the things that aren't quite working, and the opportunities for change. And research gives us a way to turn those insights into evidence that can shape services, improve outcomes, and influence policy.

Still, I get why it doesn't always feel like research is 'for us.' I didn't set out to become a researcher. Like many AHPs, I was focused on providing good care, making sure my patients were supported. Research felt like a world away - something that belonged in journals rather than in day-to-day practice. But over time, I realised that if I wanted to make a bigger impact - beyond individual patients - I needed to get involved in research.

It wasn't an easy step. There are a lot of myths about what research involves. I used to think you had to be 'academic enough' or have endless time and funding to get started. But research doesn't have to mean big clinical trials or complex methodologies. It can start with small questions: Why do we do it this way? Could we do this better? Sometimes, it's those small service evaluations or quality improvement projects that lead to bigger things.

‘AHP-led research matters because it’s grounded in the realities of care. We’re dealing with the complexity of older people’s needs every day.’

For me, it started with a curiosity about how we could deliver better rehabilitation for older people. That curiosity led to projects looking at proactive rehab in community and intermediate care settings, and more recently, digital solutions like telehealth and remote monitoring - things that could help tackle workforce shortages and meet the growing demand for community physiotherapy. I’m also currently exploring how AHP support workers contribute to care and what development opportunities they need to strengthen their role in community rehabilitation teams. My involvement with NHS England on intermediate care initiatives and, unexpectedly, being awarded the British Geriatrics Society’s Rising Star award are outcomes I would never have predicted when I first started. None of this was planned, but all of it started with a few simple questions.

And that’s the point—AHP-led research matters because it’s grounded in the realities of care. We’re dealing with the complexity of older people’s needs every day. It’s not just about treating conditions; it’s about supporting independence, keeping people moving, and helping them stay where they want to be - at home. Research allows us to test new approaches, develop evidence-based interventions, and make sure services are fit for purpose.

It also lets us address the big workforce questions. How do we make community rehabilitation sustainable when there’s a shortage of physiotherapists? How can digital solutions support what we do? And crucially, how do we develop and support AHP support workers so that their skills are used where they’re most needed? These are the questions I’m tackling in my current projects, and they’re questions that more AHPs should be exploring through research.

If you’re wondering where to start, my advice is: don’t overthink it. Start small. Get curious. Collaborate. There are universities looking for clinical partners, trusts with research support, and plenty of people ready to share their experiences. Research isn’t about having all the answers—it’s about being willing to look for them.

AHPs already make a huge difference in the lives of older people. By stepping into research, we can make a difference to the future of their care too.

Dr Abi Hall
Senior Research Fellow at the University of Exeter and AHP Faculty Lead, NHS Devon

Rising Star Awards 2025: Applications opening soon

The prestigious BGS Rising Star Awards are made annually 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.

There are three Rising Star awards given out each year:

- **Rising Star Award for Research**
- **Rising Star Award for Clinical Quality**
- **Rising Star Award for Nurses & Allied Health Professionals (AHPs)**

The Rising Star Awards are a prestigious acknowledgement of an individual’s leadership potential. Past winners have gone on to take up senior clinical or academic roles and have also become senior officers within the BGS. If you'd like to find out more about nominating or applying for this year's awards, please visit **www.bgs.org.uk/bgs-rising-star-awards** or email **j.gough@bgs.org.uk**

#CHOOSEGERIATRICS WEEK 19-23 MAY

Our #ChooseGeriatrics campaign celebrates the rewards and diversity of careers in older people's healthcare. On the week of 19 May, we held our first #ChooseGeriatrics Week, sharing videos and blogs full of inspiring stories from BGS members across the multidisciplinary workforce caring for older people. Here's a taste of some of those stories, and do visit the blog section of the website (www.bgs.org.uk/blog) for more.

Do you have a story about why you #ChooseGeriatrics? Email us at communications@bgs.org.uk

'Choosing geriatrics has profoundly changed my understanding of medicine. I have learned that healthcare is not merely about treating illness; it's about seeing the whole person. Working with patients who live with conditions like dementia, Alzheimer's, and Parkinson's, alongside their families, has helped me appreciate the importance of compassionate communication, holistic assessment, and the value of time and patience.'

Vanitha Regunathan, Trainee Advanced Clinical Practitioner in Frailty

‘Keeping patients at home to live well is an ethos I feel passionate about. Every day, I see the positive impact that innovative services can have on patients. Providing a wrap-around service of primary, secondary, and third sector care to patients can make them feel supported and empowered to recover safely at home.’

Sam Davies, Urgent Care Clinical Practitioner for Palliative Care and Frailty

Get the latest **BGS news** straight to your inbox

Don't miss out on the latest news, information, policy developments, event dates and abstract submission deadlines - sign up for our regular e-bulletins to stay ahead.

From our regular monthly general e-bulletin FRONT PAGE, to updates tailored to your own specific interests, profession or region, head over to your user profile on our website at **www.bgs.org.uk/user/register** to update your e-bulletin preferences.

Make sure you're the first to hear about our latest elearning offerings, earlybird discounts for events, officer vacancies, position statements and new campaigns and resources - and much more!

Celebrating Nurses' Day 2025

As the Chair of the BGS Nurse and AHP Council, I am thrilled to introduce our own theme for this year's International Nurses' Day, which took place on 12 May - *Each One Teach One*. This theme resonates deeply within our profession, encapsulating the essence of mentorship and the invaluable exchange of knowledge that occurs daily among nurses. It serves as a reminder that we are not just caregivers but also educators and leaders, shaping the future of nursing through our shared experiences and insights.

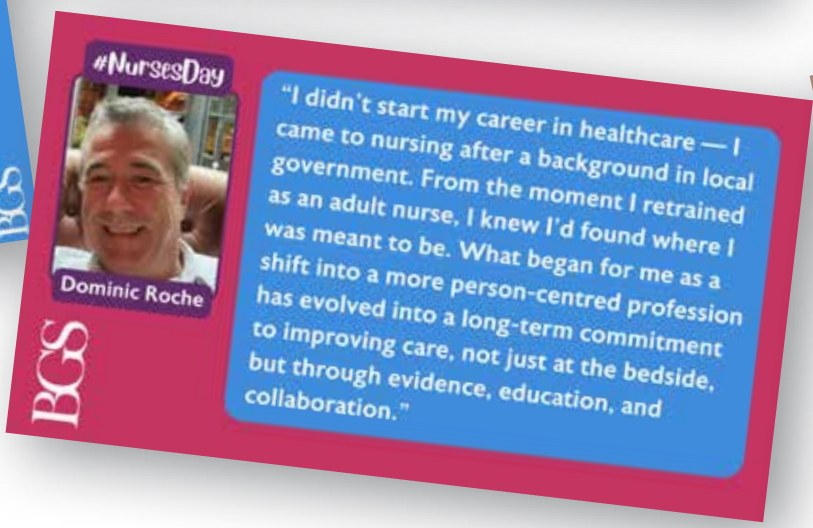
This year, we were eager to hear from a rich tapestry of voices across the nursing spectrum, from student nurses just beginning their journey to seasoned professionals with years of wisdom to share. We reached out to leaders from each nation, inviting them to engage with their colleagues and gather reflections on their roles and personal journeys in nursing. Our goal is to create an inclusive environment that celebrates the diverse contributions of our profession and highlights the vast opportunities available within it.

My own journey into nursing was unconventional; I entered through the Higher National Certificate (HNC) pathway, which opened doors I hadn't initially considered. I am profoundly grateful for the opportunities this route has provided me, allowing me to grow both personally and professionally. My passion for working with older people stems from the deep connections I've formed with my patients, who share their stories, wisdom, and experiences. Each interaction reinforces the importance of compassion and understanding in our field.

On International Nurses' Day 2025, I am incredibly proud to serve as Chair of the British Geriatrics Society (BGS) Nurse and AHP Council and to be part of such a phenomenal profession. This day is not just a celebration of our hard work and dedication; it is also an opportunity to reflect on our shared commitment to improving the health and wellbeing of our communities, especially the older population.

Together, let us embrace the spirit of Each One Teach One, ensuring that knowledge flows freely among us, empowering the next generation of nurses and enhancing the care we provide. I look forward to celebrating with you all and hearing your stories as we honour our profession and the incredible impact we have on the lives of those we serve.

Lyndsey Dunn
Chair, BGS Nurse and AHP Council; Clinical Services Manager, Fife Health and Social Care Partnership



For more #NursesDay stories from our amazing BGS Nurse members, visit www.bgs.org.uk/IND25

Enhance your skills with BGS elearning

All of our elearning courses are FREE to members (£150 for non-members) and include:

10 CPD hours per course

PLUS: Continence elearning - coming soon!

Sign up online at www.bgs.org.uk/bgs-elearning

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

Vacancies: BGS Healthcare in the Community Group - New Committee

The BGS Healthcare in the Community Group (HCG) (formerly the BGS Community & Primary Care Group) has grown to over 2,000 members since its launch in 2022. It brings together a diverse range of healthcare professionals - including GPs, community geriatricians, nurses, allied health professionals, pharmacists, and others - who are dedicated to improving care for older people in community settings.

The group previously operated under a dedicated committee focused on enhancing healthcare for older adults outside of hospital environments. Its recent name change reflects the group's evolution and the increasingly integrated nature of the workforce supporting older people in the community.

As we adopt this new name, we are also forming a new committee. We are currently recruiting two new co-chairs, who will be helping with the committee vacancy application process. This is an exciting opportunity for BGS members to shape the group's direction and ensure that the community perspective is represented across other BGS committees.

With the NHS shifting more care closer to home, this group plays a vital role in shaping policy, education, and workforce development. We are now seeking enthusiastic and committed individuals to join the committee and help drive this important work forward.

Positions available at present are:

- GP subgroup representative (representing GPs at this HCG committee)
- Community geriatrician (representing community geriatricians at this HCG committee).
- Education and Training representative (HCG representative on BGS Education and Training Committee).
- Clinical Quality representative (HCG representative on BGS Clinical Quality Committee)
- Research representative (HCG representative on BGS Research and Academic Development Committee)
- Policy and Communications representative (HCG representative on BGS Policy and Communication Committee)
- Meetings Committee representative (HCG representative on BGS Meetings committee)
- Digital representative (looking at digital health innovations/systems in the community)
- We will also be inviting representatives from other BGS committees, including the BGS Nurses and AHP Committee and the Trainees' Committee, to join. There are a few past committee members who are staying on the committee, including a Pharmacy rep from the BGS Pharmacy Group and a representative for Hospital at Home.

We welcome applications from all multidisciplinary healthcare professionals involved in community and primary care across the four countries of the UK. Please note that you must be a BGS member to apply.

Terms: committee posts are held for 2 years and posts are voluntary and unremunerated. If you would like to learn more about the committee posts, please contact Joanna Gough at j.gough@bgs.org.uk.

How to apply: Please write a short statement for the post you are in interested in (up to 250 words) and send to Joanna Gough at j.gough@bgs.org.uk The deadline for applications is 9am on Monday 16 June 2025.

Joint BGS/Vivensa (formerly Dunhill Medical Trust) Undergraduate Research Placement Scheme

BGS and Vivensa are partnering on a new scheme which aims to increase opportunities for undergraduate students, from any discipline, to undertake ageing-related research.

Up to four centres/departments/institutes will be awarded funding to each provide three undergraduate research placements. The placements will be a maximum duration of six weeks and can be structured flexibly – i.e. in a single block (full-time), or spread out over a longer period of time (part-time). Applications are welcomed from prospective supervisors within centres/departments/institutes at any UK university, or other eligible research organisation, with a strategic commitment to ageing-related research.

Applications open late May 2024. See vivensafoundation.org.uk/apply-for-funding for full details.

BGS

Autumn Meeting 2025

12-14 November

Nottingham & Online

Frailty and Sarcopenia

Dementia

Community and Primary Care

Pain

Tissue Viability

...and more!

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bgs.org.uk/Autumn25