British Geriatrics Society
Improving healthcare for older people

Optimising the impact of geriatricians

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Foreword

Geriatric medicine is a hugely rewarding specialty – one that we as geriatricians chose because of the challenges and complexities involved with supporting older people living with multiple long-term conditions. It has however become increasingly clear over the last few years that consultant geriatricians are a scarce resource. This scarcity is set to increase as the population ages.

With this paper, we suggest ways in which the planning and delivery of older people's healthcare might need to evolve to ensure that we are making the most of the geriatricians that we have. There is no right or wrong way to do this – every service is different and will have its own challenges. We know that everyone is working at their maximum capacity and we certainly do not intend to tell anyone that they're doing it wrong. We are however suggesting some things that might help geriatricians to have a greater impact.. We hope that this document will support BGS members to advocate for their profession and for their core purpose and unique strength in providing care to older people with complex needs. We hope that BGS members will feel empowered to have conversations with senior leaders about the value that geriatricians provide to systems and that ultimately this will result in a more efficient service, better care for older people and a more fulfilled workforce.

I want to express my thanks to Dr Ruth Law who started this project in her role as Honorary Secretary and continued after she demitted, and to Dr Claire Copeland, Vice President for Workforce who has also contributed her expertise to this report.

Professor Jugdeep Dhesi
BGS President

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Chapter one: Introduction

Health and care systems across the UK are facing sustained workforce constraints at the same time as demand from an ageing population continues to rise. Geriatric medicine is now the largest adult internal medical specialty in the UK, with strong representation in senior clinical and medical leadership roles, yet the increasing pulls on geriatricians' time are no longer deliverable within the current workforce envelope.

The British Geriatrics Society (BGS) has a mission of improving healthcare for older people. We do this through education for healthcare professionals caring for older people and providing resources that help clinicians and leaders to plan and provide age-attuned services. Our resources set out what good quality care looks like across older people's healthcare including in the prevention and management of frailty,[1] in out-of-hospital care,[2] in care homes,[3] in rehabilitation services,[4] in proactive care,[5] in urgent acute care[6] and in end of life care.[7] We have also been calling for expansion in the older people's healthcare workforce for many years, in recognition of the fact that there are not enough trained healthcare professionals to care for the ageing population. We have called for more geriatricians[8] and more nurses and allied health professionals with expertise in older people's healthcare.[9] All of this fits with national priorities from across the UK where frailty and older people's healthcare are increasingly being seen as national priorities. Geriatricians are key to delivering the change that is needed to ensure that older people remain healthy and independent for as long as possible.

This paper aims to show that the value added by geriatricians is increasingly measurable, recognised and needed. We hope that this empowers geriatricians to advocate for the specialty locally and to set boundaries around their work, ensuring that they continue to focus their efforts where they can add the most value. The document also sets out practical guidance for healthcare systems on how best to deploy geriatrician expertise when capacity is constrained. It aims to support systems to make informed decisions about where geriatrician time adds the greatest value, where alternative models of care or wider multidisciplinary team (MDT) capability should be the default, and what trade-offs may be required to enable this. While we appreciate that there will be local variation in how services and teams are organised, we have, where possible, given examples based on real service models of how services may be organised to ensure the best use of a geriatrician's time and expertise.

We know that even with an expanded geriatrician workforce, which the BGS will continue to campaign for, the changing population demographic and shift of services towards community-based delivery across the four nations mean that the way older people's healthcare is delivered will have to evolve. Currently services for the population group who most need care from geriatricians – those with severe frailty, multimorbidity and complex medical needs – are patchy and poor, and are not delivering what is needed. We have an opportunity now to consider where the skills of a geriatrician as a senior decision-maker are best used to rectify this and how we can re-evaluate service provision to ensure best value for the constrained geriatric medicine resource available. There is room within the system for a range of geriatrician roles. The demand for consultant geriatricians will always mean that consultant geriatricians will have a choice in the type of role that they take on. However, roles will evolve over time in order to meet the changing needs of the population they serve.

Over the last 35 years, geriatric medicine has evolved from a marginal specialty to a central pillar of modern healthcare, grounded in a strong and growing academic evidence base. In parallel, population health demographics have shifted as older people with multimorbidity increasingly constitute the largest user group of health and care services. Models of care are also changing across all four nations, with an explicit shift towards care delivered outside traditional acute hospital settings. Geriatric medicine's move to the medical mainstream is partly attributable to the dual accreditation with general internal medicine (GIM). This means that geriatricians are central to the delivery of internal medicine, both on the acute medical take and across hospital wards, making themselves valuable to services and credible with other clinicians.

The care of older people is delivered daily by highly skilled multiprofessional teams working across organisational boundaries. Older people's healthcare is a team endeavour with professionals from nursing, allied health professions and pharmacy all playing valuable roles as well as SAS and locally

employed doctors. In addition, geriatricians work in close partnership with colleagues in general practice, palliative care, mental health and other specialties, and are trained from the outset to lead and contribute to multidisciplinary, inter-disciplinary care. This document does not seek to diminish the contribution of other professionals; rather, it seeks to articulate clearly what geriatricians do best, the value they add at individual, service and system level, and how that value can be most effectively distributed to meet population need. In order for a geriatrician's time and expertise to be used most efficiently, it is important that clinicians across the multiprofessional team are also making best use of their own expertise and working at the top of their licences.

Chapter two: Context: an ageing population with increasing complexity

With the exception of those working predominantly in paediatrics, neonatology and obstetrics, almost all professionals across health and social care will spend a significant proportion of their working lives caring for older people. Older adults already represent the largest group of users of health and care services, and this will increase further over the coming decades.

The population is ageing. The number of people of pensionable age is projected to rise from 12 million in mid-2022 to 13.7 million in mid-2032. The number of people aged 85 and over is projected to almost double from 1.7 million in 2022 to 3.3 million in 2047.[10] This demographic shift is, in many respects, cause for celebration. It reflects advances in medicine, public health and living standards that have driven sustained improvements in life expectancy over the last 40 years. However, gains in life expectancy have not been matched by equivalent gains in healthy life expectancy. Many people are now spending a greater proportion of later life living with long-term conditions, disability, or frailty.

Multimorbidity is becoming the norm rather than the exception: by 2035, an estimated 67% of people aged over 74 will be living with two or more long-term conditions, and the proportion of people aged 65 and over living with four or more conditions is projected to rise markedly from 9.8% in 2015 to 17% in 2035.[11] Alongside this, the prevalence of age-associated conditions continues to rise. The population living with dementia is projected to increase from 982,000 in 2024 to 1.4 million by 2040.[12] Many will also be living with multiple other long-term conditions, requiring care that is coordinated, holistic and sustained over time. Frailty, which affects up to half of people aged 85 and over,[13] is increasingly recognised as a major driver of healthcare utilisation, adverse outcomes and cost. Older people also account for a disproportionate share of new cancer diagnoses[14] and deaths from cardiovascular disease.[15]

While public health measures such as vaccination programmes and cancer screening have delivered important benefits, investment in the prevention and mitigation of multimorbidity, frailty and functional decline has been more limited. As a result, health and care systems are now caring for larger numbers of older people with complex needs. People aged 65 and over account for around 40% of all admissions to hospital[16] and around 60% of hospital bed days.[17] People aged 74 and over consult with their GP almost four times as often as those aged between 5 and 14 and almost twice as often as those aged between 45 and 64.[18] These patterns of health service usage now and into the future mean that it is essential for systems leaders to review how services are redesigned and the workforce best deployed to cater for their main users. If the health service works for the population group that uses it most – older people – it is more likely to work for the rest of the population.

It is crucial then that all healthcare professionals have the foundational skills needed to care for the ageing population. This need for more generalist specialists was highlighted by the Chief Medical Officer in his 2023 report about the ageing population.[19] Within this context, geriatricians are uniquely placed among physicians: trained to deliver specialist care for older people while also bringing generalist expertise in managing complexity, uncertainty and risk. The challenge for systems is how best to balance the specialist and generalist contributions of geriatric medicine in a way that maximises value for patients, services and populations.

Chapter three: What is the current state of the specialist geriatric workforce?

The rate of expansion of specialist services in geriatric medicine has not kept pace with the ageing population, neither has workforce planning reflected the scale and complexity of need. The British Geriatrics Society recommends a ratio of one full-time equivalent consultant geriatrician for every 500 people aged over 85.[20] This figure was calculated by analysing the ratio of consultant geriatricians to older people across the country and comparing the services available in areas that are relatively well-resourced compared to those where there are fewer consultant geriatricians. We found that in parts of the country where this ratio is achieved, such as London and Scotland, systems are usually able to provide services such as orthogeriatrics, perioperative care, oncogeriatrics or hospital at home, in addition to core clinical services. Where it is not achieved, capacity is more limited and services are often confined to essential reactive provision.

National modelling suggests that achieving this ratio would require a significant expansion of the consultant workforce, with an estimated additional 1,846 more geriatricians required by 2030.[20] As well as increased numbers of consultants in geriatric medicine, more specialists in older people's healthcare are needed across the multiprofessional team including GPs, nurses, allied health professionals and pharmacists.

This changing demographic must be reflected in undergraduate and postgraduate curricula, and supported through the development of a skilled multiprofessional workforce including general practice, nursing, allied health professions and pharmacy. Strengthening this wider capability is essential if specialist geriatrician time is to be focused on roles where it adds the greatest value, particularly in complex decision-making, service design and system leadership.

Care for older people and those living with frailty cannot sit solely within specialist services. Geriatricians can and should care for the most complex older patients where they add unique value, as well as supporting and supervising other clinicians within the multiprofessional team. Older people are to be found across all services, receiving care on a pathway determined by their main condition and without the holistic recognition of other health needs which geriatricians are skilled in. However, there are clearly not enough geriatricians for the number of older people receiving acute care. That is why it is vital that other specialists and indeed all healthcare professionals develop core skills in caring for older adults, and frailty-attuned practice should be embedded across care settings. The BGS recognises its role in helping to upskill other specialists in conditions of older age and how long-term conditions like frailty intersect with cardiac, renal and other specialties. An example of such training is our frailty elearning module aimed at healthcare professionals working at Tier 3 level. This elearning module was made available free of charge for all healthcare professionals for three years in 2023.[21]

Chapter four: What value do geriatricians add?

Value is added in healthcare through balancing quality, financial spend and outcomes (ideally, those that are most important to patients and their loved ones). Geriatricians have many valuable and transferable skills that improve patient care and the operation of systems. The evidence shows that geriatricians add the most value through the application of specialist expertise in managing complexity, uncertainty and clinical risk in older people with frailty and multiple long-term conditions. Geriatricians' broad and deep knowledge means they are used to holding risk and understanding the trade-offs in holistic treatment of people with several conditions. At the core of this expertise is Comprehensive Geriatric Assessment (CGA), a multidimensional, multiprofessional approach that supports holistic assessment, prioritisation, coordinated care planning and delivery of individualised interventions. Implementation of CGA requires proper resourcing.

The evidence base for CGA demonstrates improved outcomes for older people, including a greater likelihood of living at home following hospital admission, alongside more appropriate use of healthcare resources. These benefits are most consistently observed when CGA is delivered to older people with frailty, particularly when applied early in the care pathway.[22] CGA must be delivered with fidelity to the core components of targets, objective assessment and multidomain, hands-on follow-through if it is to be effective.

The value of geriatric medicine is not limited to individual patient encounters. When deployed within services and systems, geriatricians contribute to the design and leadership of age-attuned models of care, including front-door frailty services, hospital at home, perioperative care and other liaison services. Geriatricians are also increasingly involved in other specialties including oncology, renal and other specialty interfaces. At system level, this enables specialist input to be delivered at scale, supporting population-level decision-making while ensuring that the needs of older people remain visible within service planning.

The demands of the ageing population mean that geriatricians cannot and will not ever be able to see all older people. There is a need to expand the geriatrician workforce – several iterations of the RCP census have found that the most advertised consultant posts were for geriatrics and acute internal medicine, showing a demand for consultants in these specialties.[23] Recruitment and retention of geriatricians is needed to ensure the workforce is as well-resourced as possible. This must go alongside maximising the value that geriatricians provide which requires deliberate prioritisation of geriatrician time towards settings where specialist input delivers the greatest benefit, alongside strengthening of multiprofessional capability across the wider workforce.

Consultant geriatricians also play a significant role in training the next generation of geriatricians with many taking on supervisory roles or mentoring resident doctors. Geriatricians also have a key role in educating and training doctors and other healthcare professionals who do not specialise in older people's healthcare and providing guidance, audits and care

models across the health system. Most clinicians will care for older people more than any other age group and it is important that they have the skills to care for patients living with frailty, dementia and other long-term conditions. As the population continues to age and more doctors need skills in caring for older people with complex needs, this advisory/education role for geriatricians will become even more important. The need for more specialist doctors to have generalist skills to care for the ageing population has been highlighted by the Chief Medical Officer for England in his 2023 report.[19]

Geriatricians are also crucial in a research setting. Despite older adults being the largest group using healthcare services, they remain underrepresented in clinical research. Geriatricians bring unique expertise in frailty, multimorbidity, cognitive impairment, polypharmacy and functional decline, ensuring that research reflects the complexity of real-world patient populations rather than single diseases in isolation. The best clinical research is informed by both patients and frontline clinicians. Involving geriatricians in research makes studies more relevant, applicable, and focused on outcomes that matter most to older people. Meanwhile involvement in research also strengthens clinical practice by accelerating the translation of evidence into better care, service design, and patient outcomes.

Chapter five: Where geriatricians add the greatest value

Geriatricians are trained to assess and manage complexity, uncertainty and clinical risk in people with multiple interacting medical, functional and social needs.

Adding value across healthcare settings

The evidence base for geriatric medicine suggests that geriatricians add value in a multitude of settings. The strongest and most consistent benefits are seen where specialist expertise is deployed early to support high-risk decision-making, manage complexity, and influence the trajectory of care. Apart from traditional ways of ward-based care, orthogeriatrics and trauma, this is further demonstrated in more recent service models, such as front-door frailty services, acute assessment settings, and emerging models such as hospital at home, urgent community response and in specialist services such as oncology, surgery and renal, which align closely with national strategies to shift care closer to home and reduce avoidable hospitalisation. These service models are highlighted within plans for the implementation of neighbourhood health as models that will support the shift from hospital to community.[24]

Adding value as senior decision-makers

Geriatricians add value by enabling timely senior decision-making, balancing clinical risk, avoiding unnecessary intervention, and supporting safe alternatives to admission. To ensure that this added value is maximised, it is essential that geriatricians embrace their role as senior decision-maker. This means that they should be effectively delegating responsibility for tasks such as clerking, taking histories and ward rounds of stable patients to more junior doctors or other members of the multiprofessional team with appropriate training and skills. These tasks are of course important but they may not be considered to add value at a system level and they should be conducted by team members at an appropriate level. Senior decision-making at this point in the patient's journey often has downstream benefits for patient experience, length of stay, flow, and use of wider system capacity.

Case study 1: Remote support for home visits

The Jean Bishop Integrated Care Centre in Hull covers an area of around 1000 square miles and provides a home visiting service. To ensure best use of clinician time, care assistants have been trained to use digital stethoscopes and secure video-calling facilities which geriatricians can listen to in real time and provide advice about next steps. This allows the geriatrician to use their clinical expertise to remotely support colleagues to provide care without them having to visit the patient in person, a return trip which could take several hours. This enables them to see more patients while also ensuring that the patient at home is able to receive the care they need without a trip to an emergency department or a hospital admission.[26]

Adding value in community care

As focus across the country shifts to provision of care in the community, geriatricians play an increasingly important role in community healthcare and at the interface between hospital and community care. Geriatricians have worked in community services for many years, focusing on supporting older people to remain healthy at home and minimising unplanned hospital care. This has clear benefits to patients who are often keen to avoid hospital-based care, as well as having system benefits such as enabling more cost-effective care for patients in the community. To provide a high-quality service in the community, it is important that all members of the multiprofessional team are supported to make the best use of their expertise and that geriatricians are not tied up engaging in activities that could be conducted by other colleagues. In addition, for the shift from hospital to community to be achieved, changes will need to be made to the geriatrics training curriculum. Currently many geriatric medicine resident doctors report spending little or no time in the community during their training. There is a concern that geriatricians are being trained to deliver care in an outdated setting which focuses primarily on hospital-based care. The 2022 RCP census found that 32% of consultant geriatricians work in the community, compared with 15% of consultants overall.[25] The 2023 RCP census found that 19% of consultant geriatricians undertake work on a virtual ward, compared with 9% of consultants overall and that 41% of consultant geriatricians provide care through Same Day Emergency Care (SDEC) compared with 28% of consultants overall. It is important also to note that community-based geriatricians have a range of roles including working in care homes, supporting domiciliary care, providing hospital at home and virtual ward services and supporting community hospitals and community-based clinics.

Adding value in liaison services

Geriatricians also contribute important specialist input to a range of liaison and supporting services, including orthogeriatrics, peri-operative care for older people undergoing

Case study 2: Silver Triage with paramedics

The Silver Triage service in North London was established in recognition that a large number of older people with frailty were being conveyed to hospital unnecessarily. The service brings together London Ambulance Service and NHS trusts. Silver Triage enables specialist doctors (geriatricians) to advise and guide ambulance paramedics in assessing older people living in care homes. The doctors can also help access and coordinate community services to provide care at home if the person does not need to go to the hospital. As a result of the Silver Triage service, there has been a significant reduction in patients in this group being taken to hospital by ambulance – it is now around 20% compared to 75% in 2018.[29]

surgery (POPS), oncology and renal services. These models have demonstrated benefits in defined patient groups and settings, particularly where CGA is embedded within service design. The role of the geriatrician in these services is crucial, as demonstrated by orthogeriatrics services following the introduction of the National Hip Fracture Database (NHFD). This has transformed the care of older people with hip fracture and ensures consistency across the country. Research comparing hip fracture mortality before and after the introduction of the NHFD shows a reduction in 30-day mortality between 2007 and 2011.[27] While not yet as widespread, POPS models have also shown that the involvement of geriatricians in surgical services results in better outcomes, with cost savings, as illustrated through national audits, and are being increasingly deployed across the NHS and emulated internationally.[28]

Workforce constraints may mean that it is difficult to dedicate consultant time to the development of these services. However, patient outcomes when a geriatrician is involved in liaison services are overwhelmingly positive. Consultant geriatricians should be supported to be involved in the establishment and operation of these types of services with other colleagues such as advanced and consultant practitioners and SAS doctors taking on other responsibilities as appropriate.

Adding value in General Internal Medicine

Geriatricians are best deployed providing pragmatic, holistic care at the intersection of geriatric medicine, General Internal Medicine (GIM) and frailty. Frailty in this context refers to the definition published by NHS England of a clinical state that is more common with increasing age. It is characterised by decreased physiological reserve, an increased vulnerability to stressors, and an increased risk of adverse outcomes such as falls, delirium, loss of function or independence, hospitalisation, long-term care needs and premature mortality.[30] Geriatricians can do pure GIM but they are not the only ones who can – other specialists can take on this responsibility as well. Everyone providing GIM should also be able to manage long-term conditions in older age, including end of life care, and should be able to manage complexity in younger patients. Care of these patients should not fall to geriatricians by default, although they will continue to contribute to the management of these patients in a proportionate way.

There is increasing recognition that frailty interacts with other conditions and, as such, decision-makers in other specialties will need to modify how they treat their patients who are living with frailty, dementia and other conditions

Case study 3: Collaborative history-taking

A geriatrician working in an acute hospital is working on the general acute take. They see patients who have not been triaged and are required to take a history from the patient and undertake clerking. A better distribution of skills might be for an appropriately trained resident doctor or senior nurse to clerk the patient, taking a history and bloods, and for a geriatrician to see the patient after this has been completed and when a treatment decision needs to be made. This would enable geriatricians to see more patients and reduce the number of patients waiting for a decision to be made about their care.

associated with ageing. There is a definite role for geriatricians in the acute medical take, especially given older people with frailty account for around half of the acute medical take. The specialty of acute internal medicine (AIM) is relatively new, having been established in the early 2000s.[31] As such, there are relatively few AIM consultants and this role often falls to geriatricians. It is also worth noting that a large proportion of doctors specialising in stroke medicine and Parkinson's disease and other movement disorders are geriatricians by background. Geriatricians have an important role in ensuring that care is holistic and personalised to the individual – something that other specialists in other areas may be less accustomed to. While caring for younger patients with complexity is clearly valuable, if geriatricians spend too much time doing this, the core purpose and unique strength of geriatricians in caring for older people with frailty is neglected.

This has implications for service design and workforce planning. Maximising the value of geriatric medicine requires not only sufficient numbers of specialists, but also deliberate decisions about where their expertise is best deployed, and where wider multidisciplinary capability should be developed to support older people with less complex needs. In addition, a high percentage of geriatricians still contribute to GIM within their job plans through a combination of inpatient ward work and leading the acute unselected 'medical take.' Patients in this cohort are aged 18 and over and are admitted with a range of medical presentations from decompensated single organ illnesses to complex multimorbidity; increasingly the latter. Depending on local service configuration, acute admissions may be subdivided by age; however, in many organisations this is not the case, and geriatricians continue to function as pure generalists during on-call shifts.

Chapter six: Conclusion

Geriatricians occupy a unique position within the medical workforce, combining specialist expertise in the care of older people with strong generalist capability. In the context of an ageing population, rising multimorbidity and sustained workforce constraints, the challenge is no longer whether geriatricians add value, but how their time and expertise are most effectively deployed.

This paper argues that the greatest value from geriatric medicine is realised when specialist skills are applied deliberately and early to support complex decision-making, manage clinical risk and shape age-attuned models of care. Default deployment of geriatricians to undifferentiated activity risks diluting this impact and limits capacity to develop and lead services that better meet the needs of older people and the wider system.

Geriatric medicine is, and will remain, a team endeavour. Older people's care cannot sit solely within specialist services, and all healthcare professionals require core skills in caring for older adults and people living with frailty. Strengthening multidisciplinary capability across the workforce is therefore essential if specialist geriatrician time is to be focused where it adds the greatest value.

Making the most of this scarce resource requires systems to move away from implicit or historic patterns of deployment, and towards explicit, evidence-informed choices about where geriatrician expertise is prioritised. When supported to do so, geriatricians are able not only to improve outcomes for individual patients, but to influence service design, workforce sustainability and system performance in ways that benefit the whole population.

Taken together, these considerations point to a clear set of priorities for how geriatrician expertise should be deployed when capacity is constrained. We hope that those working within geriatric medicine will feel empowered to open up the conversation about how they are spending their time so the core purpose and unique strength of geriatricians is not lost. We know those working in older people's healthcare face system and resources barriers that can inhibit change and that, as a result of this, they are unable to provide care in the way that they would like. We hope that this paper has made the case for how the scarce resource of consultant geriatricians should be used for the benefit of patients, systems and geriatricians themselves.

Chapter seven: Recommendations

1. Rebalance geriatrician job plans to reflect population need

Organisations should actively protect time for leadership, service development, education and research, recognising these as essential components of delivering sustainable, high-quality care for an ageing population.

2. Prioritise geriatrician deployment to overseeing complex patients in high-value settings

Services used by older people must be designed to maximise the impact of geriatrician expertise: enabling early senior decision-making for people with frailty or complex needs, particularly at the front door, in hospital at home, and across key interfaces of care.

3. Embed geriatric expertise in system planning and redesign

Geriatricians should be actively involved in healthcare planning and strategy at organisational and system level, ensuring that pathways and models of care are explicitly designed to meet the needs of older people as care shifts from hospital to community settings.

4. Ensure that system leadership structures include geriatricians

Older people are the biggest group using healthcare services and have the most complex needs. Involving geriatricians in systems leadership will ensure that systems are designed for the needs of the people who use them the most and will unlock other system problems such as waiting times and delayed discharge.

5. Ensure that geriatrician shortages are addressed in future training and development of the workforce

Given the current national shortage of geriatricians and the changing demographics, training and development of geriatricians of the future should be prioritised in order to meet the BGS's suggested ratio of one full time equivalent geriatrician per 500 people aged 85 and over.

6. Reform medical training to ensure that the next generation of doctors is prepared to care for the ageing population

Training in all specialties should be widened to embed GIM in the curriculum for all specialties. The role of geriatricians in training the next generation of physicians should be recognised and expanded.

7. Ensure that geriatricians are supported to add value beyond their clinical roles

Geriatricians have much to add outside of clinical roles including in research and training. Job plans must be flexible enough to allow for these additional responsibilities.

8. Embed geriatric medicine at all stages of the curriculum

Older people use health services more than any other population group and therefore geriatric medicine must be embedded at all stages of medical training from undergraduate study through to resident doctor training.

9. Ensure geriatric medicine trainees have exposure to community-based working during their training

As we shift to providing more care outside of the hospital environment, it is crucial that the geriatricians of the future have the skills needed to provide care in community-based settings. Placements in community teams should be a core part of their training.

10. Adopt a proportionate approach to GIM delivery across specialties

Geriatricians should continue to contribute to General Internal Medicine, including the care of younger adults where appropriate, but the time allocated to undifferentiated GIM activity should be proportionate to that of other physician specialties, both during training and after CCT.

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Published August 2026
Images: iStockphoto; BGS image library

Registered Charity No. 268762. A company registered in England and Wales No. 1189776