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Now that the vote on the name of our Society has been concluded – and regardless of the result, this was the most successful exercise in participatory democracy the Society has ever carried out – I would like to suggest another way of looking at the issue.

In John Gladman’s excellent Marjory Warren Lecture at the Spring Meeting in Nottingham, he presented some challenging statistics on what older people actually want and – more importantly – don’t want. In a nutshell, older people don’t want to be old if it involves disability, dependence and suffering.

A poster at the same meeting by Aranda-Martinez et al reported on a survey of older people – mainly patients and their relatives – carried out by a “Care of the Elderly” department considering a change of name. This showed a strong dislike of that name and also of most others currently in use by our specialty elsewhere in the UK. Something involving the word “Senior” seemed to raise the fewest antibodies.

These two strands got me thinking about the relationship between what we call ourselves and what we do. I wonder if we might be missing out a few steps in the logic. Most of
the discussion on this topic boils down to:

Older people don’t like being referred to (as), or cared for by, “the geriatrics”,

so

We should change the name of our specialty and departments

The alternative view I came to consider:

- Older people don’t like getting old and infirm
- We are among a group of professions who care for the old and infirm
- Older people see being cared for by us as a sign that they are old and infirm
- Whatever we call ourselves we’ll still be doing the same job,

so

- In due course older people will come to regard our new name in the same way, therefore
- It doesn’t matter what we call ourselves.

I shall call this “the Hypothesis of Nominal Irrelevance”. However, with my background in research, I know that a hypothesis needs to be tested. Our colleagues in Older People’s Mental Health are currently carrying out uncontrolled studies in this area; for example, the two inpatient OPMH units at a hospital near me have recently had their names changed from those rooted in the proud history of their city to those of pretty flowers. However in the interests of greater scientific rigour I have come up with the following experimental model:

An even number of departments currently called “Department of Geriatric Medicine” or similar, are paired by workload and staffing levels. By random allocation, one of each pair renames itself, “The Department of Cute Cats on Facebook”; the other becomes “The Department of Grim Victorian Austerity”.

Approval ratings are compared before the change, just after the change – and again a year later…

My money would be on a sharp divergence early on which almost disappears by the end of the year.

Right… Any volunteers?

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Frazer Anderson
Consultant Community Geriatrician and Honorary Secretary of the BGS
4

From the President

Summer is well under way with a heat wave and the World Cup was dominating the media as I wrote this column. We swapped winter pressures for summer pressures as the high temperatures have their own unwanted effects for some of our frail older patients.

The NHS’s 70th birthday has been much discussed, and although I suspect we’d all agree there is room for improvement, the footage and archive material of the stories of those who remembered a time before we had this precious service are a stark reminder of its value. Little wonder it’s regularly referred to as our “national religion”.

I was delighted to chair a session at the RCP conference in London recently. There were two high profile guest speakers. The right honourable Jeremy Hunt welcomed my question regarding the funding of social care and then failed to answer it. Don Berwick (who is known to many as the guru of patient safety) gave an inspirational address telling us, “The NHS is a breathtaking, unifying, majestic idea” and exhorting us to fight for it and adequate funding for it. Both speakers emphasised the importance of a culture of learning from adverse events rather than one of blame—encouraging words.

The announcement of more funding for the NHS is welcome but the resounding silence regarding social care is ominous, and the treasury’s regular doom-laden messages that there is no more money reinforces the unease regarding the Green Paper. Evidence given by BGS regarding the future development of NHS and social care services has emphasised the need for integrated care and has highlighted the evidence base for Comprehensive Geriatric Assessment, for early supported discharge and Hospital at Home services which have a direct impact on the risk of care home admission.

We’ve also pointed out the evidence for intermediate care and that currently it is substantially underprovided. We’ve recommended proactive approaches to care homes residents’ healthcare. One would hope that the evidence that timely access to these services not only improves patient care but also is highly likely to reduce health and social care costs, would hold sway with decision makers.

I was delighted that we had four such extremely high quality candidates for the post of president elect. Many many congratulations to the president elect to be, Dr Jennifer Burns (no relation)!

Many of us were saddened to hear of the death of one of the foremost geriatricians of his generation, Professor Grimley Evans in March this year. He continued to work tirelessly for our specialty even into his eighties. One of his academic non-geriatrician colleagues, Jeff Aronson wrote a witty and informative opinion piece in the BMJ (June 2018) entitled, “When I use a word… Grimley Evans, Geriatrics, Gerontology and Geratology” describing Grimley’s dislike of the term “Geriatrics” and the derivation of and justification for the title he gave his department in Oxford ‘Clinical Geratology’. Those who are interested may care to read the piece in full. I promise no more mention of “the name”- the members have spoken!

Eileen Burns

Hospital Wide CGA and the Hospital Frailty Risk Score

In many respects, our ageing population is something to be celebrated, reflecting years of sustained improvements in how our society cares for older people through health and social care.

But while nowadays many older people live full, vibrant lives extending into their 80s and beyond, others do not enjoy such ‘successful’ ageing. Though it is undoubtedly important to focus on resilience and the positive aspects of ageing, it is equally important to support those older people who are less resilient, or frail.

Where do we stand?

We already know quite a lot about how to improve outcomes for older people, primarily through using holistic care models. This is about assessing and managing the whole person, rather than just one aspect, such as a heart condition or ‘urinary difficulties’. It typically involves a team of doctors, nurses and therapists working together to improve outcomes, and in the literature is referred to as a comprehensive geriatric assessment.
There is still work to be done, however, in promoting the concept of comprehensive geriatric assessment (CGA) in hospital. CGA is not unique to geriatricians and geriatric teams (or shouldn’t be). Much of the skill set is generic and the remainder is teachable.

As geriatricians we are all aware of the evidence that CGA can reduce untimely deaths as well as prevent admission to long-term care. However, given that older people are such a mixed group — some relatively fit and well, others more vulnerable — a major difficulty for this type of work is how best to identify those most likely to benefit.

Promoting understanding in hospitals

In our Hospital Wide CGA campaign, we have collaborated with the Nuffield Trust in an NIHR-funded initiative to promote CGA hospital-wide. The overall aim of the project is to inform NHS managers, clinicians, patients and the public about how best to organise hospital services for older people.

The project introduces a hospital wide CGA self assessment tool encouraging hospital management to audit their services and the infrastructure they have in place to assess a patient in terms of frailty and the four domains of CGA. The assessment suggests ways to fill gaps in their services (e.g. tools such as Rockwood, PRISMA 7 etc).

Hospitals are then encouraged to use an interactive tool with a set of indicators. These have been populated with data for each local authority and NHS Acute Trust in England to describe populations, hospital costs and hospital activity.

An important part of the campaign promotes patient and public involvement, including ensuring patient and carer representation on the hospital board, the identification of older people’s champions etc.

Finally, the campaign provides practical guidance on disseminating and propagating good CGA practice throughout the hospital.

**The concept of frailty - The Hospital Frailty Risk Score (HFRS)**

Using the concept of frailty, which captures vulnerability to poor outcomes or harm, researchers from the Nuffield Trust, London School of Economics and the universities of Leicester, Newcastle and Southampton have created a Hospital Frailty Risk Score (HFRS).

The score focuses on older people who are likely to be frail and who are more likely to experience poor outcomes during or after an acute hospital admission.

We focused on the hospital because, at present, there are no routine systems in place to allow hospitals or commissioners to identify frail older people. This contrasts with health care settings such as primary care (where the Electronic Frailty Index is in use) and other conditions such as stroke or heart failure, which are well captured on routine hospital information systems.

**Identifying people at risk**

The HFRS was developed using Hospital Episode Statistics (a database containing details of all admissions, A&E attendances and outpatient appointments at NHS hospitals in England), and validated on over one million older people using hospitals in 2014/15.

We found that the score was able to identify a relatively small proportion of people over 75 years old in hospitals who were at the greatest risk of harms. The group of people with the highest HFRS were 1.7 times more likely to die in hospital, had a six-fold increase in staying more than 10 days in hospital, and were 1.5 times more likely to be readmitted following discharge.

Importantly the HFRS can be calculated automatically, which removes the burden and potential errors associated with manual scoring systems. It performed at least as well, if not better, than many existing risk-scoring systems.

**What are the advantages?**

Routinely identifying older people at risk of adverse clinical and/or service outcomes in hospitals means being able to provide interventions specifically for frailty throughout their hospital episode. This could include broadening the assessment to take account of the whole patient and not just the medical issues — such as assessing cognition, for example. Doing so is critical in the acute setting, as it might prompt clinicians to differentiate delirium (an acute medical emergency) from dementia (a long-term condition) — the management for which is very different.

Alongside better service mapping, commissioning and evaluation that is focused on frail older people, a widely accepted method of identifying those people in acute hospital settings could also help to highlight the magnitude of the issue, enable more tailored services, and improve patient and service outcomes.

That could really change how we think about and organise acute hospital care, and make a real difference for both patients and services.

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**Simon Conroy**

Honorary Professor and Geriatrician at University Hospitals of Leicester
Falls occur in approximately 28 - 35 per cent of adults aged 65, and 32 - 42 per cent of adults aged 70 years and above (World Health Organization, 2007). Falls have the potential to result in mild to severe injuries and affect older people’s functional ability and health related quality of life (Stenhagen, Ekström, Nordell & Elmståhl, 2014). There is robust evidence for exercise-based interventions to prevent falls among older adults (Sherrington et al., 2016), which address modifiable risk factors including muscle strength, flexibility, balance, and reaction time (Ambrose, Paul and Hausdorff, 2013).

Otago is one of most widely-used exercise programmes for falls internationally. It primarily involves exercises to strengthen muscles and improve balance (Campbell et al., 1997). One of the key points about this intervention is to try to incorporate strengthening, walking and balance exercises into the patient’s daily routines. The Otago programme has evidence of a 35 per cent reduction in the rate of falls and improvements in confidence for engagement in everyday activities (Robertson, Campbell, Gardner & Devlin, 2002).

A meta-analysis found the Otago exercise programme (n=747) reduced falls for up to 12 months by 32 per cent. (Thomas, Mackintosh & Halbert, 2010). The meta-analysis found a positive impact in falls prevention at a 12 month follow up although only 37 per cent of participants were adhering to home practice three times a week as recommended. Since the effectiveness of the intervention relies on doing the exercises three times a week, it is essential to find strategies to encourage the participants to adhere to a regime of three times a week. One solution is the integration of behaviour change techniques (BCTs) within the Otago programme.

**Psychology of behaviour change**

BCTs are a broad family of strategies which are aimed at changing behaviour through psychological techniques.

<table>
<thead>
<tr>
<th>BCT</th>
<th>Explanation</th>
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<tbody>
<tr>
<td>Feedback on behavior</td>
<td>Informative or evaluative feedback on performance of specific exercises</td>
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<tr>
<td>Self-monitoring of behaviour</td>
<td>Providing a daily record sheet</td>
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<tr>
<td>Instruction on how to perform behaviour</td>
<td>Skills training</td>
</tr>
<tr>
<td>Salience of consequences</td>
<td>Emphasis on how improved mobility and execution of everyday activities will improve quality of life</td>
</tr>
<tr>
<td>Demonstration of behaviour</td>
<td>Modelling of exercises in class</td>
</tr>
<tr>
<td>Generalisation of target behaviour</td>
<td>Integration of exercises into daily routine activities</td>
</tr>
<tr>
<td>Social reinforcement</td>
<td>Praise for carrying out the exercises</td>
</tr>
<tr>
<td>Verbal persuasion about capability</td>
<td>Instructors ask patients to perform the exercise and assert that patients can do them despite their self-doubts</td>
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There is evidence that they enhance behaviour change in a variety of health behaviours including exercise (Michie et al., 2013). For example, problem solving could be used to analyse the barriers to home practice and strategies could be developed to overcome them. We are aware of only one research study that has tried to improve adherence to an exercise-based programme to prevent falls with the use of a BCT (motivational interviewing), which was not successful in increasing exercise behaviour (Arkukangas, Söderlund, Eriksson & Johansson, 2017). The aim of our study was to evaluate the delivery of Otago training at a day hospital and improve its effectiveness in reducing falls through the integration of BCTs in a quality improvement project.

What we did

We conducted a service user consultation and quantitative analysis of existing patient data. We obtained feedback from eleven patients (aged between 70 and 95 years) twice a week over a period of two weeks. We worked to establish good rapport with them and then conducted semi-structured interviews of around 15 to 20 minutes with each of them, usually before the commencement of a class.

Each patient was asked about how the Otago intervention improved their walking and overall engagement in day-to-day activities. They were asked questions relating to the training itself - class environment, quality and dedication of Otago instructors, strategies used by instructors to increase participation, record of home practice and finally practical barriers and facilitators to home exercise practice.

Over the course of two weeks, we observed and documented class routine and strategies used by instructors to increase engagement and implementation of exercises. We documented, for example, enthusiasm of participants and instructors, and increase/decrease in level of performance of participants on any specific day. By speaking to the instructors we gained insights on performance background of participants and strategies used by the instructor to optimise participants’ engagement in the classes. An overview of the medical history and treatment journey of every patient in the twelve-week intervention was documented through interaction with instructors (after getting consent from patients).

With insights from patients’ and instructors’ perspectives, the project turned to integrating the BCTs in a structured way. This involved online training and then the use of a 93 BCT taxonomy (Michie et al., 2013), where the BCTs used by instructors were coded (see Table 1). A psychologist researcher made recommendations regarding further integration of short, simple evidence-based BCTs into the exercise routines.

The existing data on outcome measures were collected before and after Otago training (n=118) (70 – 95 years) with co-morbidities including asthma, Parkinson’s disease and hypertension. The data were analysed using within-subjects’ analyses to evaluate the effectiveness of the programme. The five outcome measures were (1) functional reach (Berg, 1989) measured in centimetres, in which the patient was instructed to stand close to a wall, and asked to push an object along a horizontal tape measure (like a paddle) with a closed fist using their dominant hand and without moving their feet; (2+3) 6-metre timed walk where patients were asked to walk 6 metres and the number of steps traced and time taken were recorded; (4) a 180 degree turn (Berg, 1989) in which the number of steps taken to turn were recorded; and (5) falls efficacy scale which assessed their confidence to engage independently in daily activities, such as walking to the supermarket without falling (Hill, Schwarz, Kalogeropoulos & Gibson, 1996).

What we found

Patients found the 12-week group intervention to be very useful. Each week, ten or fewer patients attended a class at hospital and were advised to carry out two sessions of home practice with the aid of a booklet. There were high levels of enthusiasm in attending classes, evidenced by the average attendance of ten out of twelve weeks. There was no consistency with respect to recording or engaging in home practice. Patients who had a history of exercising, attending the gym and independently maintaining physical fitness seemed to have a better understanding of the importance of Otago training, walking and documenting home practice compared to patients with no history of prior exercise. In addition, the presence of a partner was shown to improve the likelihood of a consistent walking routine when compared to participants living on their own.
Among the eight BCTs used (see Table 1), participants found the technique of applying target behaviour useful, as this helped them to incorporate the functional Otago exercises into their daily routine. For example, they were prompted to do the sit-to-stand exercise when they sat on any chair, or the heel-toe-walk when working in the kitchen or in the garden.

Within subjects analyses revealed statistically significant (p<0.05) improvements in all five outcome measures post training (see Table 2): reduction in mean scores for 6-metre number of steps (-1.87), 6-metre timed walk (-5.39 seconds), and 180 turn (-0.76 steps), and an increase in mean scores for functional reach (+2.66 centimetres) and modified falls efficacy scale (+13.16). Highest clinical significance was observed in the reduction in seconds to perform the 6-metre timed walk.

In addition to coding the current strategies used by instructors, nine new BCTs were recommended by an experienced health psychologist with a view to improving adherence to home practice (see Table 3). For example, the use of coping planning and problem-solving techniques to encourage recognition and analysis of potential / existing barriers and to develop strategies to overcome them were suggested. Other techniques included encouraging habit formation, providing increased social support, and focusing on positive identity. As this was a service improvement project it was important that the recommended BCTs could easily be incorporated within the existing resources and time constraints of the instructors at the hospital and with minimal staff training.

It was also recommended that the method of data collection for outcome measures be improved so that post-intervention measures be collected blind to baseline data to reduce potential bias. It was also suggested that the initial information provided via a leaflet to patients contain more evidence on the effectiveness of programme, and to introduce a social aspect to the end of each class to facilitate interaction between instructors and participants with a view to improving class attendance.

To conclude

The aim of this project was to evaluate the delivery of an Otago training programme at a day hospital and to make recommendations for improvement through the integration of BCTs. This quality improvement project suggests that the programme has a positive impact of increasing postural stability in older adults who are at risk of falling (Campbell et al., 1997). From patient feedback, although it was found that participants exhibited greater levels of enthusiasm in attending and performing better in weekly classes, there was little consistency in filling in the sheet to record home practice. This is likely due to a lack of monitoring. Therefore, it was recommended that time for socialising was included at the end of each class to facilitate increased interaction and rapport building between participants and instructors and for instructors to use this time to check on completion of home practice. Overall, patients found the current strategies used by instructors very helpful and encouraging.

Motivation and Morale

This is one of the first projects to integrate BCTs to increase patient adherence to home exercise to prevent falls. A previous study used motivational interviewing that did not improve adherence (Arkkuukangas, Söderlund, Eriksson & Johansson, 2017). Staff need training to use motivational interviewing, which was not successful perhaps because it increases initial motivation but does not help address barriers to making exercise habitual. One of the strengths of the current study was obtaining patient feedback which was beneficial to the instructors of the team, boosted their morale and gave them a reassurance that their work made a difference to patients’ lives. Another strength of the study was that the feedback was taken by impartial professionals rather than the training team - reducing the chances of social desirability bias. Further research is required to assess whether the BCTs adopted have led to a significant impact on improving patient adherence to home exercise practice and therefore lead to better patient outcomes following the Otago programme.

The Otago programme has a positive impact on short term improvements of older adults’ functional ability. The integration of BCTs through collaborative work of
a multi-disciplinary team (MDT) of professionals can facilitate increased adherence to home practice and potential improvement in the delivery of the Otago training.

Clinical Implications

• Collaborative work of a multi-disciplinary team can greatly facilitate objective evaluation of services offered in hospitals, encourage evidence based practice and result in evolution of approaches that enable best patient care.

• The integration of BCTs in Otago and other falls intervention programmes could increase adherence to ongoing home practice.

References


<table>
<thead>
<tr>
<th>Problem solving</th>
<th>Identify existing barriers and develop strategies to overcome them</th>
</tr>
</thead>
<tbody>
<tr>
<td>Action planning</td>
<td>Prompt patients to plan when, where, how and with whom they will do their home practice</td>
</tr>
<tr>
<td>Coping planning</td>
<td>Anticipate barriers and develop strategies to overcome them</td>
</tr>
<tr>
<td>Review behavior goals(s)</td>
<td>Review patient’s goal (perhaps jointly); insights can be gained and necessary modifications made</td>
</tr>
<tr>
<td>Discrepancy between current behavior and goal</td>
<td>Bring to the patient’s attention that their recorded exercise falls short of their home practice goal</td>
</tr>
<tr>
<td>Social support (unspecified)</td>
<td>Encourage sharing of exercise plans with family and friends to receive encouragement to continue</td>
</tr>
<tr>
<td>Behavioural practice/ rehearsal</td>
<td>Prompt patients to perform any exercise they find challenging regularly to increase efficiency</td>
</tr>
<tr>
<td>Habit formation</td>
<td>Prompt patients to do the exercises at set times to develop a habit of practising at home</td>
</tr>
<tr>
<td>Identity associated with changed behaviour</td>
<td>Focus on continued positive identity achieved by increased mobility</td>
</tr>
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</table>

Table 3. Recommended behaviour change techniques for future use in the delivery by instructors of the Otago exercise programme

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The Prevalence of Frailty and its association with clinical outcomes in General Surgery

Frailty is becoming more and more commonly recognised. General surgery is no exception. Our recently published systematic review looks at the prevalence and impact of frailty for general surgical patients.

The paper found 9 studies that used clinical (not database derived) frailty scores in emergency and elective patients. The American studies tended to use the Fried phenotype model, 2 Dutch studies used the Groningen scale the rest deficit models including the 7 point clinical frailty scale.

There were 2281 participants included, whose mean age ranged from 61 to 77 years old. All the studies were found to be of at least fair quality.

The prevalence of frailty ranged between 31.3% to 45.8% for pre-frailty and 10.4% to 37.0% for frailty. The day 30 mortality was 8% (95% CI 4% to 12%) for frail compared to 1% for non-frail patients (95% CI 0 to 2%).

Additionally, frail patients’ re-admission rates, complications and length of hospital were all higher than people without frailty.

Overall the conclusion is not rocket science, frailty is worse for you, across all of the outcomes that were looked at, if you undergo either an elective or an emergency general surgical operation. The next steps are to make the use of frailty scoring in general surgery routine. All the frailty scores that this study looked at seemed to work, so perhaps for a surgical team, a quick and simple scale, such as the CFS should be recommended.

Jonathan Hewitt
Clinical Senior Lecturer, Cardiff University

Nursing Perspectives on the Confusion Assessment Method

Despite being common in hospitalised patients, even now, delirium is often under-recognised. The Confusion Assessment Method (CAM) is used to detect delirium but its sensitivity is low when used in real-world settings. We explored reasons for this through a series of focus groups with orthopaedic nurses at two academic hospitals in Hamilton, Canada.

Why did we do this study?
The CAM score is commonly used to detect delirium, with high sensitivity and specificity when done by trained researchers. The CAM has four criteria: (1) acute onset or fluctuating course, (2) inattention, (3) disorganised thinking, and (4) altered level of consciousness. The CAM is positive if criteria 1 and 2 are both positive, in addition to positive response in either 3 or 4.

As part of the geriatric medicine service, we saw many patients with hip fractures on the orthopaedic unit. We noticed that patients who were clearly in delirium had negative CAM scores in the nursing documentation. The nurses were required to perform the CAM once per 12-hour shift, and they all received training at orientation. We approached the nursing management teams at both hospitals, and they welcomed the idea of a qualitative focus group study to determine the reasons for incongruent CAM assessments.

What did we do?
We arranged for four focus groups at each hospital. Each group was held at the end of a shift, following a catered meal. Nurses from both day and night shifts were included. The moderator began with a general conversation about the purpose of the study, then obtained consent. We asked participants how they performed each component of the CAM, how useful the tool was, what sort of training and feedback they received, and their overall experience with delirium. The groups were audio recorded, transcribed, and analysed.

What did we find?
The most surprising finding was that most nurses were unaware of how to perform the individual components of the CAM. For example, disorientation to person, place and time was used to determine criteria 2–4, which is inappropriate. Disorientation is a memory issue, which indicates disorganised thinking (criterion 3). The concept of inattention was not well understood. Furthermore, most participants were unable to recall the 4 CAM criteria, despite being required to use it on a daily basis.

We found that nurses used the CAM tool as a method of charting mental status retrospectively. So, at the end of a shift, the nurses would recall whether patients exhibited the four criteria earlier in the day, without actually performing the assessment. As a result, the CAM was not used as a prospective bedside tool, which is a departure from its intended use. This explains both the poor recall of the CAM components and the use of disorientation for multiple criteria.

Participants shared stories of patients in delirium and the challenges associated with their care. Groups at both hospitals brought up concerns about pain management in delirium, in particular sensing pressure to discontinue opioids in postoperative patients. Some participants noticed that pain can lead to delirium, so the pressure to withdraw opioid medications produced a dilemma regarding adequacy of pain control.

What are the implications of our findings?
We gave feedback to nursing management at both hospitals. Education campaigns were implemented to address shortfalls in knowledge and assessment skills. Issues with inadequate pain treatment were also communicated. In the bigger picture, this study raises questions about which tool is best for delirium detection by nurses. Should a tool be used at all if nurses already have too many assessments to perform? If delirium is a fluctuating disease, then does a tool used once each 12-hour shift make sense? Some of the nurses from our group preferred a narrative description of delirium rather than classification by feature. Future work should identify efficient ways to incorporate delirium detection and care into the nursing workflow.

Eric KC Wong, MD FRCPC
Christopher J Patterson, MD FRCPC

Read the Age and Ageing paper at https://academic.oup.com/ageing/search-results?page=1&q=nursing%20perspectives%20on%20the%20confusion%20assessment%20method&fl_SiteID=5255&SearchSourceType=1&allJournals=1

References
Does pain increase delirium risk in people with dementia during a hospital admission?

In the United Kingdom around 3.2 million hospital bed days a year are occupied by people with dementia, who are also six times more likely to be admitted with a delirium which often goes undetected. Delirium is distressing for the person with dementia and their family, and independently predicts worse outcomes such as higher mortality, increased length of stay, and increased institutionalisation.

One way to prevent delirium is to identify and manage risk factors; pain may precipitate delirium. The associations between pain and delirium are likely complex and multi-directional, for example, pain may cause a stress response, lowering the threshold for developing delirium, particularly in frail older people. We wanted to know if experiencing pain makes it more likely that you will become delirious. Is this risk increased during a lengthened hospital admission? What proportion of people with dementia and delirium can report they are in pain?

In our study, published in *Age and Ageing*, we used data from the Behaviour and Pain in Dementia (BePaID) study which was funded by Alzheimer’s Society. We recruited 230 participants aged ≥ 70 years from two UK acute hospitals. They were assessed for dementia severity, delirium (Confusion Assessment Method (CAM)), pain at movement and rest (Pain Assessment in Advanced Dementia (PAINAD)), and analgesic prescriptions within three days of admission. We followed each participant until discharge or death. Median length admission was 12 days (IQR 7-23).

On the first assessment, 10 per cent of participants experienced pain at rest increasing to 42 per cent on movement and 57 per cent were able to self-report pain. Delirium was present in 11 per cent during the first assessment. A third of patients who had delirium on admission were unable to report if they had pain at rest, increasing to half for pain on movement.

We made repeat assessments for delirium at one of the research sites; out of the 113 participants, 14 had a delirium (12 per cent). Four participants remained delirious after the first assessment. This delirium would have gone unnoticed if the CAM was not routinely completed. Pain was associated with a slightly longer length of admission. Although the majority of participants were assessed as having pain on their first assessment (74 per cent during activity, 51 per cent at rest), new episodes of pain also occurred during admission. People with dementia with pain at rest at any point during their admission were over three times more likely to be delirious. We found no association between pain severity and delirium severity or between analgesic prescribing and delirium.

This study highlights how people with dementia experienced pain for a substantial part of their admission without being able to communicate this pain. It has allowed us to begin to explore the complex relationship between pain and delirium, suggesting that people with dementia experiencing pain at rest are more likely to be delirious.
We recommend routine structured pain and delirium assessments to help staff identify, and support inpatients with dementia who are at risk of developing delirium. This type of research is complex to conduct. It can be challenging to recruit people with dementia when they are physically unwell and issues of capacity and consent need to be carefully considered. Using an existing data set to explore these issues is a first step to understanding a complex clinical picture.

Future research should collect longitudinal data with larger sample size to understand this association using more sophisticated analyses. For example, to identify the potential mediating roles of depression, agitation and the impairment of cholinergic signalling, all of which have been implicated in the association between pain and delirium. We also know little about the sensitivity and specificity of pain tools in people with delirium. This will help us to understand the bigger picture, unpick underlying causal mechanisms and develop better ways of detecting and managing delirium in a highly vulnerable group.

Alexandra Feast
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UCL Division of Psychiatry

References
Hip fracture management - plenty of guidelines, not enough evidence

Hip fracture and stroke - these are two common conditions which strike down frail people and require a combination of early intervention, comprehensive geriatric assessment and rehabilitation to achieve success.

A coordinated treatment plan for hip fracture comprises acute assessment of the fracture and co-morbidities, pain relief, early surgery, prevention of complications, rehabilitation, discharge planning and also secondary prevention to reduce the risk of further falls and manage osteoporosis. The difficulty is making all of this happen in a timely and seamless way.

That’s where guidelines, pathways and standards come in. In England, much has been achieved by the ‘Blue Book’ on fragility fracture care published jointly by the BGS and the British Orthopaedic Association in 2007, and by the National Hip Fracture Database and the associated tariff, which denies full funding for hip fracture care unless certain standards are achieved.

Alongside all of this, NICE updated both its 2011 Clinical Guideline (CG124) and the associated 2012 Quality Standard (QS16), in 2017. The most difficult and controversial new recommendation relates to surgery - instead of using the time-honoured cemented hemiarthroplasty for intracapsular fractures, it is now required that patients "who were able to walk independently out of doors with no more than the use of a stick and are not cognitively impaired and are medically fit for anaesthesia and the procedure" should have a total hip replacement. There is evidence that this gives better long-term outcomes, but at the expense of a bigger and longer operation which is not in the repertoire of every trauma surgeon. So getting the surgery done by a specialist hip surgeon without delay (the tariff requires surgery within 36 hours) presents a major challenge for a fairly small and distant advantage.

QS16 states that it should be read in conjunction with CG124 and five other Quality Standards. CG124 refers the reader to no fewer than ten other guidelines on related topics including osteoporosis, pressure sores, surgical wound infections, delirium and venous thromboembolism.

So there is a lot of detail here that is drawn on generic care, not from evidence in the hip fracture population specifically.

Contrast this with stroke management. For the orthogeriatrician, Graeme Hankey’s review in the Lancet last year made for sobering reading. Statement after statement was evidenced by studies performed in stroke patients: research covering not just the stroke itself, but related aspects of management such as thromboprophylaxis and nutrition. Where similar studies have been attempted in hip fracture patients, the results have seldom been robust and consistent, and we are left extrapolating from evidence in other patient groups.

NICE recognises this, and includes five recommendations for research in CG124: comparison of CT and MRI for occult fractures, regional versus general anaesthesia, management of undisplaced intracapsular fractures, intensity and frequency of physiotherapy, and early supported discharge with rehabilitation for patients already in care homes.

To this we might add more generic aspects of care that may still be particular to the hip fracture population:

- Thrombo-embolic prevention stockings do more harm than good in stroke patients, yet we still half-heartedly persevere with their use in hip fracture.
- Anaemia, both pre-and post-operatively, is a common problem: what are the optimum transfusion threshold and target? Might iron infusions reduce post-operative anaemia?
- Malnutrition is common - might early tube feeding or the oral carbohydrate pre-loading used in ‘enhanced recovery’ programmes for other types of surgery be of benefit?
- Secondary prevention - how best to prevent falls and to manage osteoporosis after a hip fracture.

Most importantly, we need to know whether our interventions affect outcomes that matter to patients themselves such as mortality, ambulatory function and pain, length of time spent in care, readmission or destination of discharge. The stroke world has led the way - we now need to get the same level of evidence for all aspects of management of the hip fracture patient.

Roger Jay
Consultant Geriatrician, Newcastle upon Tyne Hospitals NHS Foundation Trust
Daniel Hipps
Research Fellow and Orthopaedic Registrar

The article reviewing the 2017 updates to the NICE quality standard and guideline for hip fracture was published in the Age and Ageing journal at https://academic.oup.com/ageing/advance-article-abstract/doi/10.1093/ageing/afy099/5049047?redirectedFrom=fulltext
The Older Person Whisperer says:

I did this comic as part of a project for Brighton and Sussex Medical School looking at Parkinson’s disease through comics. I interviewed geriatricians who look after people with Parkinson’s. I turned the stories they told me into comics, around the theme that doctors might need support groups as much as patients. If you want to read a great graphic novel by a man with Parkinson’s disease I highly recommend, *My Degeneration: a journey through Parkinson’s*, by Peter Dunlap-Shohl.
Mirabegron – useful for frail older people?

Urinary incontinence (UI) in frail older people is both a prevalent and complex problem. While ‘overactive bladder’ (OAB) may play some role, there are significant effects from brain degenerative and cerebrovascular pathologies (‘underactive brain’ if you like), and also an impact from functional decline due to a whole host of co-morbidities.

Medications have been developed to try to reduce the effects of OAB by acting on the nerves that supply the detrusor muscle. They have mainly been tested in non-frail younger populations.

It seems reasonable to believe that they would have a lesser impact on the more complex reasons for UI seen in frail older people. For example, if you have lost the awareness to go or the ability to physically get to the toilet, then such medications cannot be expected to solve the problem.

We cannot simply assume that trial data regarding efficacy and safety in a non-frail population can be extrapolated to justify drug use in the frail.

Bladder anticholinergic drugs

Bladder anticholinergic drugs (BAD) have been recommended for use in the treatment of OAB. They have been found to have a statistically significant effect in reducing the number of UI episodes compared to placebo, but the effect size is only small. Systematic reviews have found an average reduction of around 0.6 episodes per day. In addition their use is associated with a number of common side effects, including dry mouth and constipation. The net effect of the low efficacy and side effects leads to many people discontinuing the medication in real world situations: only around 50 per cent remain on them after three months, 25 per cent at 12 months and just 10 per cent beyond two years. Regarding the commonest reasons for stopping BAD: 31–52 per cent report lack of efficacy and 21–43 per cent cite side effects. An additional problem regarding their use in frail older people is the limited data in this group. Oxybutynin is the only one that has been tested in truly frail older people and it has been shown to be ineffective. There is also a growing body of evidence to suggest that the long-term use of anticholinergic drugs, including BAD, increases the risk of cognitive decline.

So, through a combination of lack of efficacy and safety concerns, we should surely be avoiding these medications in frail older people. This is perhaps where mirabegron could come in.

Mirabegron

Mirabegron is a beta-3 adrenoceptor agonist that has been recommended for the management of OAB. It is believed to cause relaxation of the detrusor muscle. As it is not an anticholinergic drug we would not expect it to have cognitive adverse effects. However, its adrenergic stimulation could lead to hypertension and a greater risk of cardiac arrhythmias.

Similar to BAD, a meta-analysis of the available data has shown mirabegron to have a small but statistically significant effect in reducing UI episodes when compared to placebo. The size of the effect was 0.44 (95 per cent CI 0.29 to 0.59) fewer episodes of UI per 24 hours, which is smaller than that seen on average with BAD. On the plus side, adverse event rates were low but most of the studies were just 12 weeks in duration. However, the drug has not been tested in frail older people. The mean age of participants in all of the studies was less than 60 years and only around 10 per cent of people recruited were over the age of 75. A sub-group analysis suggested that the older people in these studies might benefit similarly to the younger ones but the numbers are small, making such conclusions risky.

Does the absence of a major report of side effects in the clinical trials show that mirabegron is safe? Well, the studies were of short durations and didn’t recruit those most at risk of adverse events, i.e. frail older people. Even small rises in blood pressure over long time periods could result in a significant increase in stroke and heart failure, which may not become apparent until sufficient post-marketing surveillance data has been collected. Cardiac arrhythmias may only develop in people with multiple co-morbidities and on many medications that could interact. We are still a long way from having demonstrated safety in our patient population.

So, do the people prescribed mirabegron feel that the small reduction in UI episodes justifies the burden of taking the drug? Just as we have seen with BAD, persistence rates in the real world are very low. After six months around 25 to 48 per cent continue and this falls to just 12 to 32 per cent at a year. Compared to BAD, a greater proportion of people report lack of efficacy as the reason to discontinue (62–79 per cent) and a smaller proportion blame side effects (21 per cent).

Conclusion

BAD have surely had their day in frail older people. Their combination of lack of efficacy and prevalent side effects results in most people discontinuing them. In addition there is mounting evidence that anticholinergic drug use in general is associated with cognitive decline. Unfortunately mirabegron is not the answer. It appears to have fewer short-term side effects but is less effective than BAD, which results...
in about as many people concluding that they don't want to take it. On top of this, it has not been tested in frail older people and may have its own longer-term adverse effects related to adrenergic stimulation. Regarding the journey toward better continence care mirabegron is just distraction by the roadside. When it comes to frail older people we simply need to move along, there's nothing to see here.

Henry Woodford
Northumbria Healthcare NHS Foundation Trust

References


The BGS and the BAD - some good cross-pollination

The British Association of Dermatologists (the BAD) invites other specialist societies to provide a ‘guest parallel session’ at the BAD annual scientific meeting and the BGS was invited to do this at the July 2018 BAD meeting in Edinburgh. Our President Eileen Burns suggested that, since the event was being held in Scotland, it would be good for the Scots provided the speakers so I became the organiser.

It was a fascinating experience. The dermatologists were keen to hear about capacity (since a huge part of their work now is in skin cancer management, and assessing whether an older patient has capacity to make decisions about treatment is a frequent challenge). They were also interested in frailty and multimorbidity in their older patients whose skin problems may be just part of a wide range of issues to be addressed.

So, to an audience of around 200, Dr Cesar Rodriguez, a Tayside consultant in old age psychiatry and national clinical lead for Healthcare Improvement Scotland Focus on Dementia, provided a very useful summary of ‘(In) capacity and consent to treatment’ and Dr Graeme Hoyle, a consultant geriatrician in Aberdeen known to many of you as Aberdeen Geriatrics on Twitter (@AbdnGeriatrics), spoke on ‘Adapting to a frail and multimorbid world’.

The dermatologists provided the third speaker, Dr Tabi Leslie from London, talking on the subject of, ‘Pruritus in the elderly’. She asked me, ‘do you ask all your older patients if they itch?’ and when I confessed that I didn’t, she was most unimpressed, given the vast majority of them would answer ‘yes’!

The dermatologists enjoyed hearing from experts in another field and we enjoyed the interface with another specialty. The ‘guest society’ idea might be one worth copying from time to time, for a national or regional BGS meeting!

Christine McAlpine
Outgoing Chair of BGS Scotland
Low vitamin intake is associated with risk of frailty in older adults

There is evidence that poor nutrition is related to frailty. Frailty is a clinical syndrome characterised by three or more of the following criteria: unintentional weight loss, exhaustion, weakness, slowness, and reduced physical activity.

Frailty is produced by two pathways: First, resulting from age-related musculoskeletal changes, loss of muscle mass, and anorexia of ageing; and second, as a result of the effect of diseases.

Anorexia of ageing, is a decrease in appetite and food intake. Frequently older people fail to ingest adequate amounts of good quality foods to meet their essential energy and nutrient requirements. In addition, physiological changes that occur with ageing in the gastrointestinal system, like alterations in taste and smell, gastric motility, and changes in gastrointestinal hormone, could modify dietary preferences, and impair absorption of vitamins, leading to vitamin deficiencies and malnutrition.

Frailty is characterised by the lack of functional reserve, it undermines the physiological response to new demands. In a previous study of our group (by Sandoval-Insausti H et al., 2017) we found that a diet rich in proteins could prevent frailty. Also, fruits and vegetables intake, and following a Mediterranean diet are believed to minimise frailty. So, it was of interest to know how specific nutrients from diet could influence frailty, and the association of vitamin intake with frailty has hardly being studied.

At the beginning of the study we obtained information about diet in participants without frailty, and three years later we obtained information about unintentional weight loss, exhaustion, weakness, slowness, and physical activity, that are the main elements to determinate frailty. Unsurprisingly, we found that poor vitamin intake, and the lack of adherence to the recommended daily allowances for vitamins, were strongly associated with frailty in older people. Conversely, a well-balanced diet, had lower risk of frailty than those with lower vitamin intake.

For the study analysis, we excluded individuals without baseline information on diet and participants who were taking vitamin supplements. We looked at vitamins obtained through ordinary food only. A balanced diet that contains plenty of vegetables, fruits, whole grains, and some sources of protein, offers nutrients that meet the body’s requirements whereas there is little or no evidence of frailty prevention in those taking multi-supplements. We have to bear in mind that dietary and pharmacological vitamin doses could have different impact in health. On the other hand, a well-balanced diet is safe and can prevent other physical impairments.

Frailty syndrome is potentially preventable with specific strategies. When it appears, it could be reversed through physical activity and a healthy diet. The results of the study are important because the message for those aged 60 and older, is that having a healthy diet, in this case, with appropriate amounts of vitamins, can prevent frailty from manifesting. The recommendation is (1) to have a balanced diet with variety of foods like lean meat, fruits and vegetables, whole grains and low fat dairy, (2) eat less processed foods because they are low in nutritional value and vitamin density, and (3) engaging in regular physical activity.

Optimal nutrition is important to prevent diseases, improving quality of life, promoting healthy aging, and also avoiding dependence throughout the life cycle. Thus, being attentive to the diet of older adults who are close to us, could delay their deterioration associated with age.

Teresa Balboa Castillo
Department of Public Health
Universidad de La Frontera
Temuco, Chile

BGS Policy work on social care

A lot of our policy and influencing work in the last year has focused on social care and the health impacts for older people, and the associated implications for our members’ work, when there are difficulties in accessing good quality social care.

This update provides information on the current position and BGS’s work in this area. It covers:

• why and how BGS is engaging in policy and influencing work on social care
• the legal and funding framework for social care and how it plays out in practice
• the charging framework for social care

It also includes some historical context and wider reflections, and the references used provide sources of further reading.

BGS’s engagement in policy and influencing work on social care

The health implications for older people when they are in need of, but not receiving, support with everyday tasks such as washing, dressing, and eating are only too familiar; the increased risks of a health crisis and an unplanned admission to an acute hospital; repeated readmissions, difficulties with discharge from hospital … the interdependencies between social care and health are clear. This is why one of BGS’s strategic objectives in our 2017-20 strategic plan is to, “Continue to increase our influence with policy makers and policy influencers with respect to health and social care policy for older people across the UK”.

There are few signs of any quick wins which makes it all the more critical that we promote our position on social care as effectively as possible. In summary, our position is that financial investment is urgently needed, and that long term reform of the system is essential – and we explain the health impacts on older people and the work of BGS members that inform our position. We engage with the social care agenda in a range of ways, for example by:

submitting and presenting written and oral evidence to consultations and Inquiries, and participating in high level meetings and debates, attending events and engaging with senior opinion-formers and decision-makers such as All Party Parliamentary Groups. We also collaborate with other charities; earlier this year we provided the clinical voice to support media work by the British Red Cross when they published their report, In and Out of Hospital, which looked at repeated admissions and the difference a volunteer can make by accompanying an older person when they are admitted to, and discharged, from hospital.

We were very pleased when, at the end of last year, our President, Dr Eileen Burns, was invited to join the Expert Advisory Group on the Green Paper on Social Care. It is to Eileen and BGS’s credit that Eileen was the only clinician invited to join the group. At the outset expectations of what a Green Paper might deliver were high. Disappointingly the indications now are that even if a Green Paper is published in the autumn (the publication date was put back from ‘before summer recess’), it is likely to be modest in its scope.

In order to shed light on why any reforms of the current system are so challenging I have provided some information on the funding, legal and charging frameworks for social care.

The funding framework

While overall responsibility for delivery of healthcare is national, responsibility for social care is local. This means it is down to individual local authorities to ensure delivery of the care they are legally obliged to provide to disabled and older people.

Unlike health, social care is not universally free of charge and there is no national budget allocation for social care. Funding from central to local government is not ring-fenced for social care. Local authorities’ main sources of funding are from council tax, business rates and their annual spending settlement from central government. From that they have to find the funds for social care for everyone who is entitled to it.

In 2015 the concept of a social care ‘precept’ was introduced which gave local authorities the power to increase council tax by an additional amount if the funds generated by the increase are ‘earmarked’ for social care (note the word ‘earmarked’ which is a much weaker requirement than ring-fencing income).

In practice, this means that local authorities struggle to fund basic social care. The struggle has been exacerbated by an increase in demand and years of cuts in real terms in the funding settlement from central government to local authorities. The consequence for older people is a tightening of the eligibility criteria for accessing social care. If the current model of funding and care remains unchanged, the funding shortfall is predicted to increase to a minimum of £1.5bn by 2020/21 and £6billion by £2030/31.

The legal framework

The law that underpins the statutory responsibilities for social care is the Care Act 2014. It was introduced in order to simplify and make fairer the legal entitlements to care and support, which were covered under a number of different pieces of legislation. Its focus is on preventing and delaying needs for care and support. Nine pieces of legislation were simplified and made fairer.

The Care Act 2014 also placed some new duties on local authorities. These are briefly summarised in Government guidance which states that:

The Care Act introduced some new functions, with the intention of ensuring that people
• receive services that prevent their care needs from becoming more serious, or delay the impact of their needs
• can get the information and advice they need to make good decisions about care and support
• have a range of provision of high quality, appropriate service to choose from

It goes on to say that local authorities must provide or arrange services that help prevent people developing needs for care and support or delay people deteriorating such that they would need ongoing care and support.

Charging and paying for social care

Unlike healthcare, social care is not universally free. However there are low levels of awareness and understanding of this among the general public, and this is one of the challenges for any government in introducing changes to the current system. The difference between health and social care, and the charging system for social care provided at home or in a residential home, are poorly understood. Recent polling by Ipsos MORI provides clear evidence of the public’s lack of knowledge of the social care system. In particular they found very low awareness of how social care is funded, and just 12 per cent of the public thought that the individual pays.

Care provided at home is means-tested but the value of a person’s home is not taken into account. If they have more than £23,250 savings they have to pay for social care in full for however long they need it. If someone’s savings are below £23,250 and they are assessed as needing social care, generally, their local authority will pay for some of it and the individual will pay a top up fee. Once a person’s savings have gone down to £14,250 they will not be charged for care.

When it comes to paying for care provided in a care home the means test takes into account the value of an individual’s home as well as their savings (if their partner or spouse is not still living in the home). At present there is no upper cap on the amount someone can pay for social care. So the current system means that if you are a home-owner with savings of £23,250 and above, you face a potential loss of all your savings, and the value of your home too, if you are in need of care for a significant period of time.

Are there any exceptions?

Well, not really, unless you live in Scotland, where personal care is not charged for (in Northern Ireland responsibility for health and social care are integrated but the charging regime for social care is the same as for England and Wales).

Some history and some reflections

The lack of integration between health and social care and the concept of charging for social care has a long history. In the 19th century basic health care was provided for under the Poor Laws but other care had to be paid for by local authorities (think workhouses). The National Assistance Act 1946 which was implemented in 1948 required local authorities to provide accommodation for older people in need, delivered primarily through charitable and private organisations which they could inspect. It finally did away with the Poor laws and at the same time made clear that care which wasn’t health care, was the responsibility of local authorities. So the roots of the current system of social care are deep. Securing greater investment and reform by central government is likely to take time, and requires public support. But change that takes time and is hard won can be the most effective and lasting change. Our hope is that the case for reforming social care, which has been made for several decades, is now reaching a point where lasting change and real investment will be delivered in the near future, and the health and quality of life of older people will improve as a result. Until then we will keep working to ensure that all older people in the UK receive the care they need at the right time and in the right place.

Caroline Cooke
BGS Policy Manager
In order to make progress against our policy aims and objectives BGS engages in a mix of proactive and reactive activity. All of it is evidence-based and focused on the unique contribution that the Society is able to bring to inform policy development decisions. Some of it involves keeping a watching brief on external developments that have an impact on our members’ work and on the healthcare of older people. In this update I have provided a summary of recent developments and some of the engagement we have had.

Recent policy developments

Announcement of NHS Funding Plan, and delay of Green Paper on Social Care
On 18 June the Prime Minister announced a Five Year NHS Funding Plan which will deliver an average increase of 3.4 per cent per year overall. Since then there has been a wealth of commentaries from senior opinion-formers and commentators, all saying that the increased funding will not be enough to keep pace with demand on services. At the same time it was announced that the publication of the Green Paper on the reform of social care has been delayed until the Autumn, to tie in with the development of Government’s Ten Year Plan for the NHS.

New Minister for Health and Social Care
The reshuffle arising from the resignation of Boris Johnson as Foreign Secretary means that we have a new Minister, Matt Hancock MP. The key question for BGS is, what difference will this make to our members, and to the quality of health and social care for older people? In his first major speech, Mr Hancock stated that increased funding for health and a Green Paper for social care are only the first steps for a long term plan, which must be “nationally agreed, clinically led and locally supported”. The full text of the speech is available here: https://www.gov.uk/government/speeches/matt-hancock-my-priorities-for-the-health-and-social-care-system

Dementia 2020
A review of progress against the Prime Minister’s Challenge on Dementia 2020 is being carried out by the Department of Health and Social Care. BGS submitted written evidence in which we made clear that we believe the 2020 objectives are only achievable if some of the other obstacles to achieving them are addressed urgently. We highlighted the need for: adequate staffing levels; earlier action and investment to address the cardiovascular risks of dementia, for example through expansion of management programmes for diabetes, hypertension, and smoking cessation; and increased education and training for all staff who work with people with dementia on a regular basis as well as increased training in frailty as a specific medical condition. The full submission can be viewed here: http://www.bgs.org.uk/cga-managing/resources/policy-digest/bgs-response-to-the-review-of-the-prime-minister-s-challenge-on-dementia-2020-by-department-of-health-and-social-care

The Mental Capacity Amendment Bill
This Bill was introduced into the House of Lords on 3 July. Its purpose is to reform the current system known as Deprivation of Liberty Safeguards (DOLS). BGS responded to the Law Commission’s consultation on the reform of the current system in 2015, and to the Inquiry on reform of DOLS by the House of Commons Select Committee on Human Rights earlier this year. Government accepted the majority of the recommendations made by the Law Commission, and the introduction of draft legislation is a positive step towards change that will make the system less bureaucratic and more streamlined if the Bill is passed.

Government funding and strategy for tackling loneliness and social isolation
Also on 18 June, Government announced an investment of £20 million to help tackle loneliness and isolation. In response, BGS published a media statement in which we welcomed the investment, while at the same time making clear that tackling loneliness is only one way of helping to improve quality of life for older people, and that ensuring older people can access the right care at the right time is an important means of tackling loneliness. The timing was helpful as it enabled us to promote the work on the health impacts of loneliness among older people which had been the focus of a BGS conference held on 13 June, chaired by our President-Elect, Professor Tash Masud.

Government is currently developing a cross-cutting strategy for tackling loneliness and social isolation which is due to be published later this summer. We submitted a response to Government’s short consultation on the development of its strategy for tackling loneliness and isolation. In our
submission we made clear the importance of addressing the causes of loneliness, and highlighted evidence of what works in practice in terms of health interventions: for example, access to timely and appropriate treatment for health conditions that can sometimes be quite easily addressed but limit independence, and increase the risks of loneliness and social isolation. We promoted the benefits of CGA and a regular medical review by GPs. We also highlighted our own conference on the mental and physical health impacts of loneliness on older people and the evidence and expertise that exists.

Parliamentary engagement

As part of the Inquiry by the All-Party Parliamentary Group on Hospice and Palliative Care into widening access, the APPG is holding a series of evidence sessions. BGS submitted written evidence to the Inquiry in May, and in June, BGS member Dr Anna Steel attended the first oral evidence session. We will be keeping a watching brief on this, and supporting the development, over time, of stronger links between BGS members, and palliative care specialists.

On 11 July I attended the parliamentary launch of a research report by Arthritis Research which highlighted the challenges many people experience in trying to access aids and adaptations which local authorities have a statutory duty to provide. It was encouraging to see that the Minister for Social Care, Caroline Dineage MP, attended and spent a significant amount of time engaging with attendees, and to find that she remembered her meeting with Dr Eileen Burns earlier this year.

On 6 June I attended the parliamentary launch of a report by the NHS Confederation, Securing the future: funding health and social care to the 2030s. This was well attended by parliamentarians, and there was a real sense of consensus among those present about the need for greater investment to support the future development, backed up by strong economic analysis in the report which is available here: https://www.nhsconfed.org/resources/2018/05/securing-the-future

Further Reading

While the publication of the Green Paper on Social Care has been postponed until the autumn, the range of evidence showing the need for reform continues to expand. This includes a report by the Housing, Communities and Local Government and Health and Social Care Select Committees, calling for sustainable funding for adult social care. The report includes input from engagement with the public via a ‘Citizens’ Assembly’ which, when they were brought up to speed with the current system, concluded that it is “complex, dysfunctional and underfunded”. A summary report is available here: https://www.parliament.uk/business/committees/committees-a-z/commons-select/communities-and-local-government-committee/inquiries/parliament-2017/long-term-funding-of-adult-social-care-17-19/

On 4 July the National Audit Office published a report on the health and social care interface which assesses the challenges preventing health and social care working together more effectively. The Head of the NAO, Amyas Morse, is calling for further and faster progress towards integration: https://www.nao.org.uk/report/the-health-and-social-care-interface

The public’s views of the NHS. The King’s Fund in partnership with Ipsos MORI has published the results of engagement with the public on their views on the NHS. They show that most people see the NHS as a key part of society that they are proud of, and they support the founding principles of the NHS as a comprehensive service, free at the point of delivery and primarily funded through taxation. They recognise the current challenges faced and would be willing to pay more tax if it was a dedicated NHS tax. An overview of the findings is available here: https://www.kingsfund.org.uk/sites/default/files/2018-06/The_public_and_the_NHS_summary_0.pdf

Your involvement

If you would like to get more involved in BGS’s policy work or have any questions about this update please don’t hesitate to get in touch as there are a range of ways in which you can engage in the delivery of our policy and influencing strategy.

Caroline Cooke
BGS Policy Manager
Frailty in older people and the stay safe initiative

I was fortunate to attend a fascinating meeting at the Royal Society of Medicine on the impact of frailty in the treatment of older people. The meeting was presented by the British Geriatrics Society; chaired by Dr Mashkur Khan, President of the Geriatric and Gerontology section of the Royal Society of Medicine and presentations were given by Professor Finbarr Martin from Guy's and St Thomas' NHS Foundation Trust, Professor Simon Conroy of Leicester NHS Trust and Dr Anna White from Dartford and Gravesham NHS Trust. Nick Triggle, from the BBC, rounded off the evening with an incredibly insightful update into NHS funding, the state of the NHS and the need for more funding for social care.

Frailty is defined as a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built biological and functional reserves. Frailty is a condition where people lose their ability to compensate when they are medically challenged, and frailty makes an older person more prone to falls and more susceptible to being floored by a minor infection or injury, thereby increasing the likelihood of admission to hospital. Something such as a minor urinary tract infection can cause confusion and rapid deterioration, quickly knocking a frail individual off their perch!

Around 10 per cent of people aged over 65 years are thought to be frail, rising to between a quarter and a half of those aged over 85 years.

Many people with multiple long-term conditions (multi-morbidity or co-morbidity) will also have frailty which may be masked or missed when the focus is on other disease-based, long term conditions. Likewise, some people who have frailty alone, may not have been diagnosed as such and can be lost in the system until they experience a minor injury or infection which causes a swift and dramatic deterioration in their physical or mental well-being.

How many times have we heard people say, “my mother was coping just fine on her own until that fall, or until that urinary tract infection.”

On a personal level, my mother-in-law is now 83 and living what appears to be a full and active life. However, she never fully recovered from her hip replacement three years ago and over the last few months has been struggling to walk, with increasing breathlessness, loss of balance and loss of confidence.

She has definitely lost her physical reserve and we are still struggling to find someone to take a holistic approach to her care and stop referring her to different system specific specialists.

The danger is that she becomes increasingly frail, loses her independence, loses her ability to socialise and a minor injury or infection precipitates a lengthy admission to hospital.

My experience is that the system remains clunky for patients and sadly it is not as easy as it should be to obtain a thorough, comprehensive geriatric assessment and appropriate intervention to treat the older patient as a whole and identify potential frailty.

Key indicators of frailty are factors such as gait, speed, grip strength and these along with several other physical and mental markers are evaluated using various assessment tools. Nutritional advice and exercise are two fundamental approaches to treating frailty. Interestingly, although frail individuals were traditionally thought of as having experienced recent weight loss and being of slimmer stature, obesity induces a pro-inflammatory state and so a weight loss diet may form part of the treatment too. Specific muscle strengthening exercises are important in preventing falls, however there is also increasing research showing that the individual’s self-motivation to undertake the exercise is even more important in the treatment of frailty.

Introducing the Stay Safe Initiative

Carolyn Cripps OBE of Fit for Safety and I have worked together to develop the Stay Safe Week for Older People. This initiative has been created to signpost people to the wealth
Our website www.staysafe.support has just been launched and we would love contributions from more interested and relevant parties who are able to support our endeavours.

There will be considerably more information nearer the time, along with blogs, articles and infographics covering all the key elements.

We hope the Stay Safe Week will make a huge difference to older people and their carers, providing them with a host of extremely beneficial information to help keep them live life to the full.

We would be most grateful for the support of all medical and health professionals and other organisations responsible for the well-being of older people. Please let people know what we are doing and signpost older people, their family and carers to this as a helpful resource.

For more information about participating in the Stay Safe initiative, please email emma@firstaidforlife.org.uk

Emma Hammett www.firstaidforlife.org.uk

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of resources and advice available to help them as they get older – including support on nutrition, exercise and accident prevention. There is nothing like this currently available and so we are funding this ourselves, utilising the wealth of our connections, to raise the profile of injury prevention and safe living for older people. This free initiative is particularly important in light of the impact that falls and other accidents affecting older people have on the long-term well-being of the older person, on the NHS and on those caring for them.

October 1st (our launch date) is the United Nations International Day of the Older Person and we are being supported by many other high-profile organisations and celebrities (hopefully Dame Esther Rantzen among others) to raise awareness about keeping older people safe. This will be a new, annual, national initiative aimed at older people, their carers and professionals, offering them a wealth of resources to help them remain fit and active, stay safe and understand what to do should something untoward happen.

Most of the activity during the week will occur online, but the initiative will also be widely supported by the media on TV, radio and in newspapers. We have already gained interest from The One Show, BBC, The Mail and other media. We will also have a live educational event that week on the 3rd October in conjunction with AGE UK London.

We will have different topics each day and if you would like to contribute to a particular area and use the #staysafe that would be wonderful.
John’s Campaign: three (and a half) years’ old - Changing the culture of care?

In 2016, the BGS Newsletter carried an article on John’s Campaign. In the last issue, we reported on the progress of the campaign in Wales and Northern Ireland. In this issue, we look at its expansion in England and Scotland.

Scotland

Chief Nursing Officer Fiona McQueen has been a long standing advocate for John’s Campaign as she sees it as “entirely in keeping” with the Scottish Government’s policy on supporting people in hospital. She actively endorses this approach “to ensure person-centred care is in place.”

Implementation of welcome to carers takes place under a variety of titles in Scotland: NHS Grampian has removed all visiting restrictions under its Welcome Ward policy which it is happy to link with John’s Campaign. NHS Fife is also allied through its well-established Partners in Care scheme. NHS Tayside has similar good practice. NHS Lanarkshire, NHS Forth Valley, NHS Shetland, NHS Western Isles, NHS Dumfries and Galloway are explicitly committed to the campaign, NHS Ayrshire and Arran, NHS Highland, NHS Lothian, NHS Greater Glasgow & Clyde, NHS Borders have varying degrees of involvement. We have not yet reached NHS Orkney or the Scottish Ambulance Service.

This is an inequitable situation which the Scottish Nurse Directors intend to resolve. They have recently agreed that open visiting is not an optional piece of policy but something that must be implemented by all Boards. Some will need time to make this change but it will happen everywhere during 2018. This is a huge advance that will be welcomed by so many patients and families across Scotland. Another promising development is the recent motion passed by the Edinburgh Joint Integration Board to implement the principles of John’s Campaign in community health and social care. There have been some pledges from residential homes in Scotland but it’s not an area where the campaign has made any significant progress – lack of capacity again.

Wishaw General Hospital in Lanarkshire was the first hospital to sign up to John’s Campaign, on the initiative of senior charge nurse Karen Wilson and then emergency nurse Andy Pender. It has remained at the forefront of innovation, eg developing the Theatre Buddy system which enables the carers of dementia patients to continue support as far as the operating theatre. Gillian McAuley, Chief of Nursing Services and John’s Campaign Ambassador writes: “Introducing John’s Campaign has improved the care and experience for patients with dementia in our acute and community hospitals. Clearly family engagement keeps our patients connected to their world, it assists us with person centred care planning, supporting us to get all the elements that matter and make our patients the unique individuals they are. In particular we have noticed that patients eat better when their families are with them, they are less stressed and therefore at lower risk of falls and families are less concerned as they see the care being delivered or get involved themselves. JC has given us the platform to reconsider what we are doing in relation to visiting for all and as a result have open visiting in all wards and departments.”

Analysis undertaken by Carol Andrews, senior charge nurse in Ward 10 in NHS Lanarkshire’s Monklands Hospital has provided evidence of reduction in incidents of violence and aggression when wards are “open all hours”. In mental health settings the Welcome Ward approach adopted throughout NHS Grampian – including the Royal Cornhill hospital in Aberdeen, their main centre for the treatment of people with mental health problems – may be the most useful in showing how a general principle of openness and welcome can be adapted to every individual’s therapeutic needs.

England

CNO Jane Cummings and the NHS England Patient Experience team were supportive from the first. MP Valerie Vaz organised a Commons Early Day Motion and then lobbied the (then) shadow Health Secretary Andy Burnham for support and the (then) Care Minister Norman Lamb. Jane Cummings wrote to all directors of nursing in acute hospitals urging support for carers welcome, Norman Lamb and National Clinical Director Alistair Burns wrote to all CEOs of acute trusts with the same request. A local CQUIN offered encouragement to both acute and mental health trusts.

Despite this impressive early support, the uptake of John’s Campaign in England has been very much dependent on individual initiative, taken very often (though not exclusively) by lead dementia nurses and their colleagues. The award-winning dementia team at Imperial Healthcare Trust has provided a shining example; adopting the campaign label to give visibility to their own welcome strategy, meticulously disseminating it through all areas of their large and complex hospitals, eliciting management support at the highest levels (including the Hospital Board) and finally reaching a point where they no longer need John’s Campaign at all because welcoming the carers of people with dementia is simply the way they work.

Lead dementia nurse Jo James describes the change: “‘Carers are welcome’; this simple statement now stands outside all of our wards at Imperial and it has changed the way in which staff see carers and how they treat them. Before John’s Campaign, there was a rigid adherence to visiting times alongside various other rules, designed to
protect patients, but unwittingly sending a signal to carers which said ‘you are not welcome here’. Since we started working with John’s Campaign and changed the message, the wards have become more humane, more accessible and less frightening for patients. Staff have realised the value of having a carer present to support the patient and to provide that link between what happens at home and what happens in hospital.”

Professionals from other trusts agree. “I see the benefits daily on wards, patients comforted and looked after by their carers.” (Teresa Jude, Carers Liaison NW Anglia) “I have thought about it and I think the most important aspect has been building relationships between patient carer and staff recognising the value of working in partnership.” (Angela Moore, Admiral Nurse)”I would never return to restricted visiting hours” (Professor David Oliver, geriatrician). Sam Foster, the former chief nurse of Heart of England Trust -- which removed restricted visiting entirely -- has produced robust data to evidence the reduction in falls, for instance. Raj Sookhy of West London Mental Health Trust is among many who has noted a significant drop in complaints and Natasha Lord and Paul Stokes of Worcestershire Health and Care (Older People’s Inpatient Mental Health Unit) describe their adoption of the principles of John’s Campaign as “the best thing we ever did.”

This testimony from professionals is supported by positive comments from family carers, especially where the welcome has been extended through the last period of someone’s life. People living with dementia have been unequivocally glad. There have been numerous examples of innovation, good practice and great care (see our publication Voices). A tweet posted while I am writing this reads “Very much appreciated when my father was in Derriford a couple of times last year! Hugely reassuring for him. Great for family.”

So where is the problem? It’s in the sheer size and fragmented nature of the English hospital system. The issues of capacity and inequality are urgent. Although all but 15 of the acute hospital trusts have some involvement in the campaign the quality and consistency of this is unknowable and too often depends on the enthusiasm and commitment of a single individual. Conversely only 15 mental health trusts are involved (though good practice elsewhere via the Triangle of Care system is likely to be relevant) and community hospitals, community trust, community services are only beginning to sign up. No ambulance service has pledged yet. In this highly complex system carers accompanying patients through transitions are a vital source of stability and knowledge.

Sources of optimism?

Residential Care: England is the UK country where a significant number of residential care providers have begun to take an interest in proactively welcoming families through pledging to John’s Campaign. This unanticipated extension of the campaign’s scope was partly inspired by a carer’s experience in trying to make the transition between a John’s Campaign hospital where her involvement was welcome and a nursing home where it was not. At the end of her partner’s life she was glad that he returned to a (different) John’s Campaign hospital where she was once again welcome. The principles are the same even when the issues are different. Nothing should be put in the way of a loving person wishing to care for someone special to them in their time of need.

Professor Martin Edwards at Care England has taken a lead role in promoting involvement in the campaign and has sponsored Honoured Guests, a guide for care home managers and an accompanying leaflet for families. There is explicit support from Andrea Sutcliffe, Chief Inspector for Adult Social Care, and underlying support made manifest in the CQC new Key Lines of Enquiry for Adult Social Care.

NHS England & Age UK: In the NHS Jane Cummings and colleagues are ready to renew their efforts to ask all English acute trusts to review the situation welcoming and supporting carers in their own organisations. Patient Experience England are working with Age UK to discover how best to assist mental health trusts making the change. The work of Yorkshire and Humber Clinical Network shows how useful regional networks can be in bringing equality to an area and encouraging mutual assistance for people making quality improvements.

Involvement by CCGs: Perhaps the most encouraging pledges received recently by John’s Campaign have come from two neighbouring CCGs in Surrey. Since the 2012 Health and Social Care Act CCGs have become the single unit in each locality with links to all types of hospital, to primary care, to community care, to private providers, social care, hospices, ambulances, residential care. But there are 211 of them, their numbers and finances fluctuate, they feel pressure. The example of the Surrey CCGs who have chosen to include John’s Campaign under the Commissioning for Carers principle has immediately shown an increase in the number and variety of organisations pledging their support – and therefore an increase in equality and consistency across that locality. Could this be replicated country-wide?

John’s Campaign will try to reach the CCGs. NHS England will try to promote a wider and deeper welcome to the carers of people with dementia (and perhaps to all those who offer emotional and practical support to its patients). But is it not time for the politicians, the councillors, the government to take a hand? Three years of individual initiative and voluntary support have provided overwhelming evidence that this is popular, effective – and the right thing to do.

Nicci Gerrard
Julia Jones
Founders of John’s Campaign
Discussing palliative care for people with dementia living at home and in care homes

On a warm, sunny afternoon in an English pub at the Brighton Pier, I struck up a conversation with a lovely couple in their mid-70’s. After discussing many subjects including the weather, the beach, food and wine, theatre shows, Brexit, and their working life, they asked me what I do. With great pleasure, I shared my work and passion for research on end of life care for people with dementia. Both of them were baffled but curious and wanted to know why studying end of life care would be relevant for people with dementia.

I elaborated with reference to our recently published article in *Age and Ageing* on the “Quality of primary palliative care for older people with mild and severe dementia”. They listened attentively as I explained how we had assessed the quality of end of life care for people with dementia living at home and in care homes in Belgium, Italy and Spain. We found that although the countries differ considerably in quality, overall, there is an urgent need to reduce avoidable hospital admissions and to put more attention to regular pain assessments of people with dementia. For a moment, there was silence as they contemplated the implications of these findings. The man seemed unsure about the first conclusion but strongly agreed with the second, while the woman agreed with both. The man laughed, “I am glad I still don’t have it [dementia]!” and then more seriously continued, “But if I do, I hope that my pain is assessed and managed properly. If possible, I would prefer to live and die at home. However, I would want to go to hospital for necessary treatment.” I nodded, but then explained that many concerns are raised about people with dementia being admitted to hospital even if symptoms and problems, such as pain or high fever, can be managed at home or in their care home. The woman shared her own, stressful experience of being in hospital and agreed that it should be avoided if it is unnecessary.

We need to ensure that not only researchers, doctors, nurses and other health professionals are aware of these issues, but also the public and the people with dementia themselves, and their families. Considered discussion of the evidence may lead to improved health policies and pave the way for more realistic and practical solutions that may enhance the quality of palliative care for people with dementia in primary care. Now is the time to act and start discussing ways in which we can further reduce unnecessary hospital admissions and improve pain assessment of people with dementia living at home and in care homes!

Rose Miranda is an Early Stage Researcher working on the INDUCT project: an EU-funded multidisciplinary and intersectoral research training network focusing on (complex) health technologies and dementia. Rose is affiliated with the End of Life Care Research Group at the Vrije Universiteit Brussels and Ghent University in Belgium. Twitter handle @INDUCT_MSc and @EOLC_research
’Geriatrics’ - an old problem

On seeing the debate around the word 'geriatrics' in the last issue of the BGS Newsletter, Dr Tak-Kwan Kong, Editor-in-Chief of the Journal of the Hong Kong Geriatrics Society sent us this editorial on 'packing geriatrics'. It was published in the HK Society's Journal in 1996 - twenty-two years ago - which only goes to show, some controversies die hard!

Jean Martin Charcot (1825-1893) of France, Ignatz Leo Nascher (1863-1944) of America and Marjory Winsome Warren (1897-1960) of Britain, have often been credited with being the pioneers of modern geriatric medicine in the West. The term "geriatrics" was coined by Nascher, an American born in Vienna. When he was a medical student, he observed an incident in which an old woman, limping up to his clinical tutor with complaints of aches and pains, was sent away dissatisfied. The tutor said, "She is suffering from old age. There is nothing to be done to her."

In a visit to an old people’s home in Vienna, he was impressed by their good health and longevity and was told, "It is because we treat our old patients in the same way as paediatricians treat children."

This statement inspired Nascher, in 1909, to create a special branch of medicine that he called geriatrics, a name recommended by his friend, Dr. Jacobi, who had managed to get paediatrics accepted as a specialty after a long struggle.

"Geriatrics, from genus, old age, and iatri.kos, relating to the physician, is a term I would suggest... to emphasise the necessity of considering senility and its diseases apart from maturity, and to assign it a separate place in medicine."

Recently, there has been much debate concerning the name "geriatrics", in relation to the future direction of geriatrics as well as the perceived negative connotations this name has acquired. In the United Kingdom, attempts have been made to "rehabilitate" the term "geriatrics" by changing its name. Thus a plethora of bewildering names have been coined as alternatives to "geriatrics" or "geriatric medicine", e.g. geratology (Greek for the study of ageing); gerocomy (Greek for old, tending); elderology and its variants (Care of the Elderly, Health Care of the Elderly, Medicine for the Elderly, Elderly Care Medicine), e/o health (archaic / poetic old, health) and lastly frailtology (to emphasise that the targets of care are frail older people). It seems that heterogeneity is the hallmark of geriatrics, whether in terms of the patients served, the styles of practice, or even the names of the profession. Our American colleagues have packaged their "geriatric evaluation and management" programs as GEM, though whether they can convince their policy-makers that their programs are as valuable as a "gem" is another matter.

Ever since the establishment of geriatric service in Hong Kong 21 years ago, the term "geriatrics" has been in use locally up to now. This year, our society name has just been rejuvenated from "Hong Kong Geriatric Society" to "Hong Kong Geriatrics Society". Sixteen years from its birth, our Society is certainly not "geriatric", and in fact has just passed the growth spurt.

In a culture in which the marketing orientation prevails, modern men’s happiness consists in the thrill of looking at the shop windows. "Attractive" usually means a nice package of qualities which are popular and sought after on the market.

There is a Chinese saying, "Fear not a bad birth, but fear a bad name". To Nascher, "geriatrics" must be a good name.

Has the spirit of Nascher been changed since the birth of the name "geriatrics" 87 years ago? Can the fate and fame of "geriatrics" be changed by simply packaging it with another name? Whatever title we would like to call ourselves, be it geriatricians, elderologists, or physicians for the care of older people, the substance of our profession will remain the same. Thanks to the dedication and efforts of our predecessors, a special knowledge base in geriatric medicine has been built up to meet the needs of our older people. Instead of changing the name of our profession, it is much better to change the fame of geriatrics by educating our medical fraternity, the general public and policy makers about the content and substance of geriatrics.

We all know the Hans Christian Andersen fairy tale of the Emperor who fell for the con that the material from which his new clothes were made was of such a quality that it was invisible to all but the wise. So, what is geriatrics without clothes? To quote Professor Peter Millard, past president of...
the British Geriatrics Society, "Geriatrics spearheaded the attack on bed rest and transformed wards full of bed-bound patients into active treatment units. Geriatrics developed treatment services where there were none...Think of the health care state you would not want in your old age. Old, alone, unwanted, sick, confused, incontinent and catheterised in a cot sided bed in a general medical ward or lying on a trolley in an accident and emergency department. Or continually falling at home, faecally incontinent and a strain on your family and friends. This is our stock in trade, this is the very reason for our being."

A similar echo has been provided by Professor William R. Hazzard’s response to the question "What is the typical geriatric patient?:" "Think of your oldest, sickest, most complicated and frail patient." The number of disease processes and interactions which can result in these geriatric presentations are enormous and their detection and management intellectually challenging. The complexity of the deficits, however, inspires anxiety rather than interest in those not trained in the trade so that these frail older patients are too easily rejected as "incurable", mislabelled as "social problems" or "bed-blockers", and finally dumped in nursing homes or infirmaries. The commitment of a geriatric service to its patients actually begins where that of traditional medicine seems to end. Only geriatricians, equipped with the special knowledge, skills and attitudes, can provide an answer to meet the needs of these frail older patients. I believe that "geriatrics" will survive as long as our culture has not degraded to one in which "gerontophobia" and "geriatricide" prevail; but rather life is respected and valued from beginning to end.

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**BGS Wales Update**

The following report was delivered at the July meeting of the BGS Board of Trustees:

**Formal links with Welsh Assembly Government**

A National Speciality Advisory Group (NSAG) was set up around five years ago for each speciality to report to government. How useful and productive this has been is hard to determine but we will persist with this group. The current chairperson rotates into this role.

**Regional Meetings**

BGS Wales has held two regional meetings each year, alternating between north and south. The last meeting in North Wales was well attended. The next meeting is in Cardiff. Meetings last for one and a half days and provide a forum for good educational, professional and social networking.

The national BGS meeting in Cardiff (again) in Spring 2019 is high on our agenda and likely to be well attended by Welsh colleagues.

**Workforce Issues**

There are 88 Consultant geriatrician (stroke) posts in Wales. Most HBs have unfilled posts.

There are 45 whole time trainees (registrars) in geriatric medicine in Wales. Seven mature every year and the majority remain in Wales. Absolute number of vacant posts is small but due to a fairly low denominator, there can appear to be large percentage of absence in posts (especially North Wales).

Wales needs to fill 10 -15 posts per year

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**Key problems facing older people in Wales**

A service reconfiguration is occurring in Stroke nationally and at HB level for several HBs - predominantly to a hub and spoke based model. The stroke reconfiguration has not moved on substantially since the last report. Like all UK stroke services, thrombectomy will be challenging but there is central government acknowledgment of its importance.

There is central government interest in PROMS and PREMs, this is beginning roll out, especially in Welsh stroke care.

There is a lack of capacity for frail older people including people with dementia. There are various reasons for this (delays in providing community services, myth that older people do not need assessments in hospitals, reduction in care home beds etc.) The continued divide between health and social care also remains an issue.

There is a growing interest in frailty across speciality and with some higher level engagement. There are some national moves to implement a comprehensive and Wales wide frailty scale, most likely the seven point CFS.

**Demographic facts**

Wales has a population of around 3.15 million (as opposed to 53 million in England, 5.3 million in Scotland and 2 million in Northern Ireland). 8.6 per cent are above the age of 75, 2.5 per cent are aged over 85.

There are seven health boards in Wales (replacing the 22 LHBs).

There are two medical schools located in Cardiff and Swansea.

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Jonathan Hewitt
Chair, BGS Wales

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Tak-Kwan Kong
Editor-in-chief, Journal of the Hong Kong Geriatrics Society
BGS Vacancy
Editor-in-Chief of Age and Ageing Journal

Professor David Stott will be retiring as Editor (in Chief) of Age and Ageing, journal of the British Geriatrics Society, at the end of 2018 and expressions of interest are invited from qualified candidates to succeed him in January 2019 after a period of handover. The Editor shall serve for five years, which period may be extended for one further year by mutual agreement.

The Editor has responsibility for the overall editorial process. He/she needs to become fully conversant with the editorial software, ScholarOne Manuscripts (Manuscript Central), used to manage the submission and peer review process. Applicants should hold current membership of the British Geriatrics Society. The Editor should expect to commit one day per week, on a flexible basis, to the editing of the journal.

The Editor is responsible for ensuring a close and efficient working relationship between him/herself and the Editorial Manager. The Editor is responsible for appointing and maintaining an effective working relationship with a number of Associate Editors.

The Editor and Associate Editors are also members of the Editorial Board, which is responsible for the governance, editorial and operational strategy for the journal and meets twice a year. The Editor is a member of the Editorial Executive Committee which convenes via conference call four times a year. The Editor will also receive support from an International Advisory Panel and colleagues at Oxford Journals, who are the journal publishers. Per annum remuneration (currently 1 session per week) may be paid to the releasing institution of the Editor, subject to the terms of engagement.

Expressions of interest to reach Katy Ladbrook aa@bgs.org.uk by Monday 17th September 2018.

For a full description of the role, see the BGS website (About Us/BGS vacancies)

BGS Vacancy: Deputy Honorary Secretary 2018 - 2019

Expressions of interest are invited for the post of Deputy Honorary Secretary of the British Geriatrics Society.

The Deputy Honorary Secretary will serve until the Honorary Secretary demits (scheduled to be November 2019), on which date s/he will automatically take over as Honorary Secretary, and serve in that role for two years.

The duties of the Honorary Secretary are: Act as one of the most senior officers of, and ambassadors for, the society; Serve as a member of the BGS Trustee Board and as a director of BGS (Trading) Ltd., our wholly owned trading arm; Commission articles and edit the BGS Newsletter (6 issues a year); Act as one of the commissioners of BGS blogs; Act as one of the Society’s tweeters in chief; Approve press releases, blogs and policy submissions to government etc.; Liaison with external organisations; NHS, Royal Colleges, other specialist medical societies, voluntary organisations and allied professional groups.

With the other senior officers, the Honorary Secretary will have a key role in strategic planning. Both the Honorary Secretary and Deputy Honorary Secretary can expect to be involved in key projects during their term of office.

Expressions of interest to reach Mark Stewart committees@bgs.org.uk by midnight on 30th September 2018.

For a full description of the role, see the BGS website (About Us/BGS vacancies)

Vice President, Workforce

The BGS is now inviting expressions of interest for the post of BGS Vice President: Workforce.

The VP will use his/her best endeavours to ensure that the Society, through its publications and electronic media, provides its members with every opportunity to keep up to date with relevant workforce developments and to provide those considering a career in the healthcare of older people to have the information they need to make informed choices.

The VP will be responsible for ensuring the BGS captures and analyses all relevant UK workforce data and will provide expert input to inform policy initiatives and to guide the Trustee Board on workforce matters. S/he will work with the Vice President: Training and Education and the Education and Training Committee to ensure good coordination across BGS’s work on education/training and workforce matters.

The VP will represent the BGS on the RCP’s Specialist Advisory Committee (SAC) for Geriatric Medicine. S/he will work with the Honorary Secretary and the Policy and Communications Committee to instigate and/or inform any policy initiatives with workforce impact.

The anticipated time commitment is one half day a week, but this may vary according to the demands of the role.

The post holder will work with the Chief Executive to establish an Advisory Panel - meeting only as and when needed – through which to gain intelligence from ground level, share out the necessary work and provide stimulus and accountability. Although not a BGS trustee, the post holder will also be expected to attend and report to meetings of the Trustee Board which take place four times a year.

Expressions of interest to reach Mark Stewart committees@bgs.org.uk by midnight on 30th September 2018.

For a full description of the role, see the BGS website (About Us/BGS vacancies)
See the BGS website for more meetings (both BGS and external events and job vacancies)
Select Conferences and Events, or Resources/Vacancies

BGS EVENTS

BGS Scotland Trainees
29 August 2018, Glasgow

19th Falls and Postural Stability Conference
14 September 2018, Leeds

BGS Improving Continence
1 September 2018, Manchester

BGS Wessex
18 September 2018, Manchester

BGS West Midlands Autumn
20 September 2018, Birmingham

Improving Continence in Older People
21 September 2018, Manchester

BGS Cardiovascular
21 September 2018, London

BGS Trainees Leadership
22–23 September 2018, Manchester

BGS Mersey Autumn
26 September 2018, Warrington

BGS Northern
26 September 2018, North Shields

BGS Yorkshire Autumn
26 September 2018 Pinderfields Hospital, Wakefield

BGS Wales
27–28 September 2018, Cardiff

BGS Northern Ireland/IGS
27–29 September 2018, Cavan

BGS Trent
3 October 2018, Nottingham

First Northern Ireland Frailty Network Conference
9 October 2018, Newtown Abbey

BGS North West
11 October 2018, Rochdale

Living well in older age: preventative and anticipatory care, RCN/BGS
19 October 2018, RCN London

BGS South East/South Western
31 October 2018, Guys/St Thomas’ Hospital, London

BGS Scotland Autumn Meeting
1 November 2018, Inverkeithing

BGS North West Thames
6 November 2018, London

BGS Autumn Meeting
14 – 16 November 2018, London

G4J (Geriatrics for Juniors)
24 November 2018, London

BGS Spring Meeting 2019
10 – 12 April 2019, Cardiff

Online registration and programmes may be found on www.bgs.org.uk

Palliative Medicine

New Directions in Palliative Medicine
27–28 Sept, Edinburgh

Professor Mike Bennett - Evolving Challenges in Cancer Pain Management

Professor David Clark - Palliative Care and Public Health

Dr Richard Simcock - Is Cancer a Chronic Illness yet?

Dr Kevin Boyd - Myeloma: An Update on Management

Dr Claire Higham - Sodium Abnormalities in Malignant Disease

Dr Jean MacLeod - Managing Diabetes at the End of Life

Dr Katherine Hands - Blood Transfusion and the Alternatives

Professor Allan Gaw - Academic Writing – Tips for the Beginner

Professor Richard Huxtable – Surely it must be time to stop now?

www.bgs.org.uk [Events/ External Events]

Osteoporosis and Metabolic Bone Diseases

2 Sept 2018, Birmingham

This one-day training course aims to help GPs and other primary care practitioners to better manage patients with metabolic bone disease. Taking into account the restrictions of primary care and the 10 minute consultation, the course will focus on providing practical and actionable information.

www.bgs.org.uk [Events/ External Events]

BIRAX Conference 2018

4 Sept 2018, Birmingham

The programme aims to bring the British and Israeli academic sectors closer together and build on their complimentary expertise to foster high quality and cutting edge research, that will sustain long lasting and border crossing relationships and collaborations amongst senior researchers and early career researchers from UK and Israel, scientists involved in ageing research.

www.bgs.org.uk [Events/ External Events]

Safety and older people

4 Sept 2018, Birmingham

A one day conference by CESOP in association with a number of partners. We still have huge ongoing challenges around healthcare issues such as falls and frailty, pressure ulcers and VTE, dementia and mental illness, as well as around nutrition and medicines management. There is a huge need for provision of medical, nursing and social care that embodies compassion into all aspects of care and that treats people with dignity and respect.

www.bgs.org.uk [Events/ External Events]
18th Falls and Postural Stability Conference
British Geriatrics Society Falls and Bone Health Section
14 September 2018, Leeds

Meeting Aims:
• Further overall knowledge and understanding of current research and practice in falls prevention and rehabilitation
• Improve skills in the treatment and care of older people
• Achieve personal excellence in the care of older people at risk of falling
• Take away new activities and ideas to progress falls service in the workplace

Registration and programme at https://tinyurl.com/BGSFalls18

Autumn Meeting
14 - 16 November 2018, ExCel, London

Wednesday focused sessions on:
• Intermediate care and community Geriatric Medicine;
• Cardiovascular topics: Anaemia & Heart Failure

Plenary sessions sessions on:
• Bereavement
• Movement Disorders
• Comprehensive Geriatric Assessment
• Rheumatology
• Perioperative Medicine
• Urodynamics

Joint session with AGILE [Chartered Physiotherapists working with older people]

Registration and programme at https://www.bgs.org.uk/events/autumn-meeting-2018
The journey from Gerontologia Clinica to Age and Ageing

In the 1940s, British pioneering geriatricians, wishing to contribute articles about modern management of older people, had to convince sceptical editors of general periodicals such as the British Medical Journal or Lancet of the value of their work at a time when geriatric medicine was not recognised as valid specialty. Thus the advertisement for the appointment of the first ever consultant geriatrician in Cornwall in 1947 was delayed by the BMJ because the word ‘geriatrician’ was new to them. Journals specialising in the diseases of old age were late in appearing. Amongst the first was the American, The Journal of the American Geriatrics Society published in 1953. Dr Trevor Howell, the early pioneer based at St John’s Hospital, Battersea was very keen that the UK should have its own geriatric society and journal. His enthusiasm culminated in the foundation of the British Geriatrics Society in 1947, but his hopes and plans for a periodical only prospered in the 1960s. The Executive asked Dr John Agate, BGS treasurer based at Ipswich Hospital, to negotiate with the BMJ regarding publishing the Society’s journal.

The overtures were smartly rebuffed, because ‘[geriatrics] isn’t of sufficient importance’ and the Society was too small.

Howell understood that publishers were only interested in print runs exceeding 800, which far exceeded BGS’s existing membership. The Society was not discouraged and sent Agate on his travels once more and eventually, the Swiss publishers, Karger, agreed to publish Gerontologia Clinica on a quarterly basis.

The periodical’s first issue appeared in 1959, labelled as an International Journal of Geriatrics. By 1967, it was the official journal of the BGS. The co-editors, Exton-Smith (UCH) and Woodford-Williams (Sunderland), wrote in the first issue that the average life expectancy in the time of the Roman Empire was about 23 years, whereas it had blossomed to 70 in 1959. They emphasised that, although several countries had their own specialist geriatric publications, there was a need for an international journal. Worldwide contributions were encouraged by a six member advisory board, supported by a large number of global contributing editors.

The number of articles published each year ranged from 28 to 45 with the total number of pages per year ranging from 252 to 407. As more contributions were submitted, so the publication rate increased to bi-monthly. The first supplement, on clinical aspects of ageing, appeared in 1961. The majority of papers were in English with many having summaries in French and German. The expectations that the journal would become a major international journal were not entirely fulfilled since foreign language papers only appeared three or four a year and not all had English summaries.

Initially articles were general in nature with subjects ranging from the medical aspects of ageing, functions of a geriatric unit, health in retirement, surgeries for the elderly in local authority health clinics to housing for older people. Later, specific articles appeared considering iron deficiency anaemia, drug trials, osteoporosis, incontinence of urine, eye and dental problems. Occasional case reports, book reviews, papers read at BGS and international IAG meetings were published as well as symposia on day care, drug therapy and an ‘Intensive Course in Geriatrics for General Practitioners’.

It is difficult to assess the influence of Gerontologia Clinica publications, since measures such as the Impact Factor were not introduced until the 1970s. Nevertheless, contributions about functions of a geriatric unit and day care are
some articles are of special interest. the 1960 edition contained a long paper by the controversial professor ana aslan (1897–1988) about procaine (gerovital h3) delaying the onset of old age. allegedly, it was used by nicolae ceausescu, john f kennedy, kirk douglas and others. however, the drug’s efficacy was challenged by arguments about quality control and by bmj reports which found it had no merit for any of the problems of ageing. the american fda went further by banning the drug from interstate sale and in 1982 prohibited its import.

the 1965 and 1967 editions contained papers by non-medical authors. the 1965 issues included two papers by nurses with considerable experience of working with the older people. firstly, miss b j smith, who was with dr irvine at hastings, stressed the need for improved nursing establishments to cope with the heavy demands on acute geriatric wards. she based her paper on a recent survey of nursing staffing levels in the south east metropolitan region that had shown, on average, geriatric wards had staff/patient ratios barely more than half those on general wards. secondly, doreen norton ventilated her firm conviction that ‘no nurse should be launched upon the world as ‘qualified’ without having had geriatric nursing experience welded into the structure of his or her training’. in 1967, alice sheridan, marjory warren’s social worker, discussed the role of the state in the social welfare of older people and described her work in west middlesex unit. she later became chief welfare officer at the ministry of health.

in the late 1960s, the journal’s management changed. in 1967, the editorial board increased to twelve bgs members, while the number of contributing members reduced from 31 to 14. in 1970, exton-smith retired as joint editor, and was replaced by james andrews (west middlesex hospital).

woodford–williams continued as co-editor until 1975. the society became ‘restive’ in early 1970 wanting a british publisher for its journal. john agate went on his travels once again. this time he secured the services of baillière tindall, who agreed to publish a new journal, age and ageing, in 1972 with exton-smith and malcolm. hodkinson as editors. oxford university press succeeded baillière tindall as publisher in 1989.

this proved the death knell of gerontologia clinica. by 1975, it reduced its issue rate to quarterly. the next year it merged with gerontologia, which soon became gerontology. james andrews continued as section clinical editor until 2007.

the name of gerontologia clinica, however, lives on in some form in the journals of several countries, such as spain and brazil and portugal to name just three who have invoked geriatria e gerontologia or geriatria y gerontologia as the name of the societies or journals.

with professor david stott retiring as the editor-in-chief of the now very successful age and ageing journal, and with his replacement being sought, it is gratifying to know that a publication on a topic once thought ‘not sufficiently important’ now has one of the higher impact factors in its category.

michael denham
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