BGS NEWSLETTER

British Geriatrics Society
Improving healthcare for older people

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What is complexity?

Unpicking an age-old problem

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President's column

I started my presidential duties following November's BGS meeting in London with a great sense of responsibility and a desire to represent our society to the best of my ability.

I am excited at the prospect of working with a great team in Marjory Warren House. In preparation for the role, during the last two years I have had the pleasure of attending several regional BGS meetings and meeting many of our members. I have been struck by the enthusiasm and hard work by the regional officers in organising some splendid meetings.

The Yorkshire meeting in Pinderfields focused on frailty. An informative discussion took place about the practicalities of introducing frailty in different settings, including at the front door, and I could sense that delegates found it useful to learn from each other's experiences. I learnt from the Northern Ireland regional meeting in Belfast about the excellent work being done on de-prescribing, and work there could turn out to be a useful template for the rest of the UK.

In contrast, the South East London region's meeting highlighted research being carried out and included great presentations by young specialty registrar (StR) and core trainee (CT) doctors. I also enjoyed contributing to the well-attended regional meetings in Taunton and East Anglia.

The BGS has been working closely with other organisations to highlight the important issue of loneliness in older people. In June we held a conference on the issue where we invited prominent researchers to give us updates on the latest initiatives being taken. There was plenty of enthusiasm among our members to take this work forward and an application for a special interest group is being considered.

I would like to thank Caroline Cook, our Policy Manager, who has worked tirelessly making contacts with Age UK, British Red Cross and the Campaign to End Loneliness. Caroline will be leaving the BGS soon and her hard work on all policy-related matters has really helped the BGS to become an important player with influence on all matters related to older people, and we wish her well in her new role.

Finally there are some individuals who I must say a special thanks to. Eileen Burns, the outgoing President has been a pillar of support for me over the past two years. She has led us magnificently and she was the only doctor to have been invited onto the expert panel on the Green Paper on social care which is due to come out before the New Year. Hopefully Eileen will continue to be involved on further development of this, as well as on some developments on end-of-life care.

I have been struck by the enthusiasm and hard work by the regional officers in organising some splendid meetings

Our retiring CEO, Colin Nee, has been instrumental over the past few years in steering the ship forward into a brighter future. Important achievements of (out of many) have included improving the society's governance procedures and turning the BGS into a highly effective and professional outfit which is now fit for purpose. Colin will be hard to replace but we have made an outstanding appointment into the new CEO role, Sarah Mistry, and I very much look forward to working with Sarah to carry on the good work. I would also like to thank a couple of outgoing Vice-Presidents. As Vice-President for Workforce, Zoe Wyrko has really grasped the issues concerning manpower which will affect Geriatric Medicine in the future, and as a result we are much more aware of the work that is required by the society to keep abreast of this important issue and who we need to lobby. Steve Parry has also ably led the Academic and Research Committee as the Vice-President for Academic Affairs. The society welcomes Claire Copeland and Adam Gordon who have been appointed as Zoe and Steve's replacements respectively as Vice-Presidents.

A very special thanks must also go to David Stott, the retiring Editor of the society's journal *Age & Ageing*. Under his leadership our journal has gone from strength to strength and the impact factor has risen significantly.

On behalf of the society I would also like to thank another retiring member of the BGS staff, Recia Atkins, for her hard work over many years. Recia has been around ever since I first started coming to BGS meetings and her great sense of humor and smile will be greatly missed.

And finally congratulations to Jennifer Burns in taking up her role as President Elect and I look forward to working with her for the next two years.

Tahir Masud
President, BGS

Editorial

As I write this I'm not long back from the BGS Autumn Meeting at London's ExCel Centre and still buzzing with ideas

For me the strongest – and in the longer term maybe the most important – strand was the interface between geriatric medicine and primary care, most notably with the first public outing of the GeriGPs Group. In what seems like the blink of an eye, the number of GPs who are BGS members has gone from a handful to over a hundred and there was some excellent work from our newest grouping on display.

To make the point even more explicit, I'd like to introduce you to Dr David Attwood, your newly elected Honorary Deputy Secretary and my successor when I step down in a year's time. Dave is a GP in the West Country and will be the Society's first non-geriatrician Honorary Secretary.

By chance, our Honorary Deputy Treasurer is Dr Sarah Goldberg who is a Nurse Consultant in Nottingham. Among the candidates for election as President Elect was Cliff Kilgore, an extremely able Nurse Consultant and long-term friend of the Society.

To cap it all the 'cover star' of this Autumn's conference programme was Mel Chawner, a Consultant Physiotherapist and colleague of mine in East Hants. Mel was one of the speakers in the Frailty and Sarcopenia Special Interest Group (SIG) session at the London meeting a year ago which was so packed out that there was a waiting list to get in.

The BGS has since its foundation been an organisation of geriatricians run by geriatricians for geriatricians. So are 'we' being taken over by 'them'? Purely on the numbers, of course not. Geriatricians still make up over 80% of the Society's membership and, even on the most optimistic projections of growth in non-geriatrician membership, will still be a majority for many years to come.

In a broader sense this cuts straight to the core of what geriatricians are and what we are for. Of all the medical specialties I believe that we are the best integrators, the best at collaboration and the best at real, genuine interprofessional working.

In our daily lives all of us are working across organisational boundaries – front door/inpatient, acute/rehab, rehab/community, clinical/academic and many others. To do this effectively we have to be good at bridge-building and teamwork and I suspect that for many (if not most) of us this is one of the two reasons why we chose geriatric medicine in the first place.

The other of course is the sheer joy to be had from working with our patients and their families – but without good interprofessional working this would be much less effective and so much less fun.

Of all the medical specialties I believe that we are the best integrators, the best at collaboration and the best at real, genuine interprofessional working

The places where our jobs have become less fun recently are often at those boundaries. We are – individually in our workplaces and collectively – capable of breaking down these boundaries if we work together.

For these and many other reasons I believe that it is in all our interests that the BGS continues its growth into a "broad church" home for all professions committed to better health and social care for older people.

This hasn't happened by accident. The Society's policy is set by the Board of Trustees and is put into action by Officers, members and the small but incredibly dedicated team of permanent staff based at Marjory Warren House.

For the past five years that team has been led by Chief Executive Colin Nee, who is retiring in January. Colin has been amazingly effective in his role, especially in professionalising the Society's operations and turning us into a powerful voice in public policy debate. I'd like to take this opportunity to thank Colin on behalf of the Society and all current and previous Officers for his leadership and hard work and to wish him well.

We must be doing something right because his successor Sarah Mistry is another big hitter from the NGO sector

with an outstanding track record in strategy, policy and bridge-building. We are delighted that she has chosen to join us.

Sadly, two more of the BGS core staff are also leaving us soon. Recia Atkins is the longest-serving member of the team and has fulfilled just about every BGS staff role there is. Among her current duties is producing this *Newsletter*, so I'll say more about her after she leaves to stop her editing out the praise she richly deserves!

One of Colin's earliest innovations as CEO was to create a permanent staff post of Policy Manager and Caroline Cooke has held that post for the last two and a half years. Caroline has been a joy to work with and has been so effective in making our voice heard in the corridors of power. She leaves with our thanks and good wishes.

For more information and lots of other good stuff, do make sure you visit the new BGS website at **www.bgs.org.uk**. For best results make sure you log in and update your details.

The Members Directory is now fully online but for data protection reasons you'll only be in it if you choose to opt in. Please do so - the more of you who are in it, the more useful it will be for us all.

Frazer Anderson
BGS President Elect
Editor, BGS Newsletter

Interested in writing for the *BGS Newsletter*?

Do you have a story to share? An example of good practice you want to shout about? An issue to get off your chest?

Perhaps you should consider putting pen to paper and sharing your thoughts with other members via your *BGS Newsletter*.

We consider submissions from members and non-members on a whole range of topics and in a variety of formats and styles, from research updates right through to cartoons.

If you think you might be interested, email **editor@bgs.org.uk** with your idea and our editorial team will help guide and support you in creating something you can be proud to publish.

Movement Disorders Meeting

1 February 2019, Birmingham

Organised by the BGS Movement Disorders Section

British Geriatrics Society
Improving healthcare for older people

MOVEMENT DISORDER SECTION
A Specialist Group of the British Geriatrics Society

The meeting highlights current clinical practice and provides a platform to present research outcomes and showcase successful service delivery. The intended audience is healthcare professionals working in the field of movement disorders. The programme enables a multidisciplinary audience of healthcare professionals to share their experiences of best clinical practice.

Reasons to attend:

- Understand more on movement disorders in older people
- Hear focused presentation on research and clinical effectiveness projects
- Network and socialise with other healthcare professionals working in this area of older people medicine

Registration and programme available at https://tinyurl.com/MDOP2019

With CPD credits accredited by the Royal College of Physicians

BGS Autumn Meeting 2018

The BGS Autumn Meeting was held on 14-16 November 2018 at ExCel in London

Spending on healthy ageing should be seen as an investment rather than simply a cost, according to a world expert in the field. The return on investments such as prevention, monitoring, holistic personalised care, lifelong learning, social protection and age friendly environments meant not just increased individual benefits but the chance for older people to participate in the workforce, to continue to be consumers, even entrepreneurs and innovators, and to contribute financially, socially and culturally.

Investing in society's future

This was the powerful message delivered to the BGS's Autumn meeting by Dr John Beard, director of the Ageing and Life Course Department at the World Health Organisation in Geneva.

"People say we can't afford things but that's seeing them in a negative way. Investment in healthy ageing is an investment in society's future, a future that gives older people the freedom to invent lives that previous generations might never have imagined.

"Of course older people want their basic needs met. But they also want to learn, to grow, to build and maintain relationships and to make the decisions that affect them. One of the future key drivers could be the measuring and monitoring of capacity in order to provide better clinical care by earlier identification of change.

"My four year-old son is monitored and measured so that we know he's healthy. Why shouldn't I be at 63?" asked Dr Beard. "I'm pretty robust and I want to stay that way but if I started moving to a lower point I'd want to know."

Life setbacks and recoveries, he added, were different for each individual as were their interactions with their environments. Intrinsic capacity, however, was all the individual attributes that contributed to functional ability. The lowest level physiological changes included DNA integrity, epigenetic changes, cellular senescence, stem cell exhaustion and intercellular communication. These affected higher level physiological systems such as cardiovascular, respiratory, genito-urinary, neurological and musculoskeletal which in turn affected function: locomotive, cognitive, sensory and psychological. Along with the key element of vitality, measuring such functions could help in a clinical assessment of intrinsic capacity. New ways to measure and manage our bodies using smartphones or wrist-worn devices are developing all the time: "Apps which let us know how we're doing will become routine which will allow us to think differently, to intervene much earlier in the curve. This would be a driver for integrated care rather than coming in at each stage of decline."

There were three stages of ageing: high and stable, declining and significant losses with each stage having different needs and therefore requiring different interventions. The first stage involved prevention, treatment and cure where possible and adjustments to the environment. Decline usually meant multi-morbidity which should be helped by holistic care and prevention of further decline. The third stage meant patients needed the support of others for long term geriatric care.

An example of a pathway might be to start with a chair rise test. Those who had no loss of capacity would simply have health and lifestyle advice; those who had moderate loss would be given exercise programmes, dietary advice including increased protein intake and possibly referral to rehabilitation facilities; while those who had severe loss would be checked for pain, frailty and sarcopenia, have their social needs assessed and be given home adaptations and assistive devices as appropriate.

On a wider basis, data helped with research and better understanding of population trends. The current problem with clinical trials for medications for older people was that they excluded the patients who were going to need them but for whom the drugs might prove useless, even dangerous.

The future role of geriatricians, Dr Beard suggested, could be in emphasising patients' capabilities rather than their diseases: "It's not up to us to tell older people what to do. Our job should be to give them functional ability to have the future they want. I hope you'll be part of the move to take that forward."

Another aim could be helping to rethink radically how services should be designed and delivered: geriatricians were the experts who knew the importance of integrated systems of health care but we only focussed on a very limited population group. "Perhaps we need to think about constructing geriatrics principles across the whole health service."

Connecting emergency services

One of the key shifts in geriatrics in recent years has been the growth of interest in alternatives to hospital admission for older people, and the meeting at ExCel in East London opened with a full day organised by the Community Geriatric Medicine Special Interest Group.

The first session began with an example of new approaches by the emergency services when Rob Cole, head of service for Community Safety and Nigel Cooper, group manager for Hampshire Fire and Rescue described their Safety Through Education and Exercise for Resilience (STEER) initiative.

The STEER programme offered 12 weekly two-hour sessions held in local fire stations for over 65s who had been identified as having elements of frailty.

"People like the novelty of being in a fire station so we have a high 98% retention rate," said Mr Cooper. Of the 155 participants who had taken part so far there had only been three fallers requiring admission to A&E. The service also ran interactive three hour 'falls champions' schemes aimed at those who came into contact with the elderly.

The fact that people trusted firefighters and allowed them into their homes meant they could carry out 'safe and well' visits to highlight hazards and suggest safety equipment as well as fit smoke alarms. Such visits could also spot problems like fuel poverty or deliver messages: reminders for flu jabs or alerts about doorstep crime. The aim was to make every contact count.

"Most fires occur in single occupancy homes of the over 65s. It is the most vulnerable who die, the same people you are working with," Mr Cole told the audience. "And those who are at risk of falling are in even greater danger. Our aim has been long term prevention, to make people safe and confident at home. The fire service is now a health asset."

The popular image of the ambulance service was all blue lights and sirens and racing to road traffic accidents. In fact, said Carol Robertson, a community specialist paramedic with the North West Ambulance Service, "less than 10% of our calls involve going in with all guns blazing and loads of equipment, the reality is more likely to be sitting down and talking to someone as a healthcare professional to try and establish what's really happened."

The over 65s accounted for 43% of all 999 calls, she said. "In the ambulance service we come in to save lives and that's what excites us but we also need to figure out when someone can stay at home and not take them to hospital because it makes us feel better.

"I went to a patient recently who'd dialled 999 and it turned out he only had a dial phone, which older people often still prefer, so he couldn't access any internet sites for information which required him to press buttons."

Paramedics were now trained to identify frailty and

recognise delirium and to assess a patient's functional ability and psychological states as well as their physical state.

They could also help care home staff decide if a resident who had fallen but was unhurt still needed to go to hospital: "We can also answer their questions in a way that a GP who might be always rushing on a visit can't."

Care and companionship

Having enough time with patients was a key advantage in the employment of professional care workers as Karolina Gerlich, CEO and founding director National Association of Care and Support Workers, illustrated with three case histories. Eighty eight year-old Mary who suffered from moderate dementia, type 2 diabetes and high blood pressure, had been visited five days a week for eight hours a day for three years by her care worker Anna.

"That's a total of 5,760 hours, more time than any of you can spend with a patient," she told the audience. "It means Anna really knows Mary." Such knowledge meant she could anticipate and avoid crises such as Mary's fear about a hospital CT scan.

Another example was 92 year-old Margaret who was frail with poor balance, macular degeneration and severe anxiety. Admitted to hospital after a fall, Margaret refused to eat or get out of bed until her regular care worker Martina was able to advise hospital staff to move her to a quiet corner, bring her own small plate from home and give her bottled water as she was suspicious of tap water.

Similarly care worker Luke, who was trained in mental health in later life, was able to motivate his patient Steven, 84, to exercise after a hip replacement by making plans to go to the Albert Hall which he knew his patient loved.

Care workers, added Ms Kerlich, helped prevent malnutrition, enabled tests and procedures to be carried out, facilitated quick discharge from hospital, managed post-operative recovery and medication adherence. They also helped with psychological wellbeing: "A lot of people have no family or their next of kin are too busy or live too far away so companionship is very important."

She appealed to geriatricians to use care workers' familiarity with their patients. "Include them in your planning, ask them questions, get them to help in improving outcomes."

Her address was part of the multidisciplinary team working session which had opened with Dr Adam Gordon, clinical associate Professor in medicine of older people at the University of Nottingham, talking about the lessons to be learnt from the PEACH study, the Proactive Healthcare of Older People in Care Homes which looked at how comprehensive geriatric assessments could be established in such institutions.

MDT: greater than the sum of its parts

Another speaker, Esther Clift, consultant practitioner in frailty with the Southern Health NHS Foundation Trust, presented a series of statistics highlighting the problem of unnecessary hospitalisation.

"The proportion of people we admit to hospital who could have been better looked after elsewhere is 23%. The proportion of people in elderly care and longer stay wards who are medically fit but delayed in leaving hospital is 51%. The proportion of people who could benefit from a different pathway out of hospital, one better suited to their needs, is 19%."

The picture was one of fragmented services, inconsistent capacity and over-reliance on beds. She quoted one woman as saying 'being a patient is a full time job.'

"You can have five different appointments on five different days with five different teams. That's hard for patients and their families. The health service needs to get much better at treating the whole person rather than just individual illnesses."

An integrated care model should include prevention, early intervention and ongoing personalised support by a multi-disciplinary team, supported by a quick response service and the enablement of recovery at home: "An MDT is better than the sum of its parts."

Palliative care homes

The afternoon session opened with input from three 'GeriGPs', general practitioners with a special interest in older people. One of them, Dr Maggie Keeble, spoke about the importance of achieving quality in end-of-life care in care homes: over one fifth of all deaths now happened there, and a third of all deaths for those aged over 85.

"Traditionally, palliative care has been associated with hospice care, but only 2% of over-85s die in hospices. And death from cancer is very different: the end-of-life there is fairly predictable - a patient suddenly starts to disappear off the cliff edge. But dying from frailty has a very different trajectory."

Hospices had a very good image whereas we tended to only hear about homes when something went wrong. "But I see very, very good care day in and day out and we need to share and celebrate such good practice and support homes where it is not so good to become better."

The building blocks of quality care were recognition that someone was approaching the end of his or her life, the control of symptoms and the importance of conversations and communications with patients and their families. Subjects to be talked about might include advance care planning and the presence or absence of the different types of power of attorney: "We need to talk about what matters to someone, not what is the matter with them. What are their expectations and their fears and wishes?"

We need to talk about what matters to someone, not what is the matter with them

Pre-medical care

The day concluded with examples of special community projects in Tower Hamlets, the London borough which includes ExCel and Canary Wharf but which is also the third most deprived local authority in England. Opening the session, Dr Tony Joy, consultant in emergency medicine at Barts Health NHS Trust and the London Air Ambulance, described the work of the Physicians Response Unit which aims to bring the emergency department to the patient.

Although emergency departments dealt with cardiac arrests and trauma and other life-threatening events, the bulk of their work was 'cubicle work' which could be done just as effectively in a patient's own home, given that much modern equipment was portable and that records and data could be accessed electronically.

"This puts the patient at the centre," he explained. "It means the clinician is not time-bound and is un-distracted. We see patients in a pre-medicalised state which is an empowering opportunity and in their own habitat so we can see what network they have and how they function and how safe they are."

The scheme has typically seen 5.3 patients a day, nearly 80% of them aged over 65, relieving pressure on ambulance services and leading to far fewer acute hospital admissions – doctors could make decisions ambulance staff could not – giving an estimated net saving of more than £800,000.

Dr Joy was followed by Caroline Ogunsola, head of quality compliance and transformation at Tower Hamlets Community Health Service, who described a project undertaken by her nursing team based on their visit to the Netherlands to look at the Buurtzorg model. This emphasised patient self-managing supported by both formal and informal networks.

The afternoon concluded with Fiona Davies, clinical lead for the authority's Admission Avoidance and Discharge Service, describing how the team worked to implement an integrated

discharge to assess model so that patients could be released as soon as medically optimised rather than staying on in the ward waiting for further social and functional assessment to take place.

Intrinsic ageing

The Trevor Howell Guest Lecture was given by Prof David Stott, professor of geriatric medicine at the Institute of Cardiovascular and Medical Science at the University of Glasgow, who spoke about intrinsic ageing which, he argued, was clinically important but often ignored.

Biological ageing - senescence - was the process of change in an organism which over time lowered the probability of survival and reduced the physiological capacity for self regulation, repair and adaptation to environmental demands.

Modern gerontology distinguished between primary ageing which reflected an intrinsic genetic limit on cellular longevity and secondary which was due to accumulated effects of environmental insult, disease and trauma. "Primary seems to account for the relatively constant maximum life span of all animals and secondary explains the variations among individuals."

The relationship between them was complex but research techniques such as Mendelian Randomisation were shedding new light on the underlying mechanisms and offering targeted opportunities for intervention to prevent or slow age-related decline including intrinsic ageing.

Other fields where there have been significant advances are in the treatments of rheumatoid arthritis and multiple sclerosis. For the latter, said Dr Jeremy Chataway, consultant neurologist at the National Hospital for Neurology and Neurosurgery in London, there were now a dozen possibilities. "Twenty years ago there were none." MRIs had helped revolutionise approaches to one of the commonest neurological condition affecting up to 3 million people worldwide but there was still, he added, a long way to go to protect nerve cells and repair damaged myelin.

Randomised clinical trials were vital in testing all new drugs but the process could take up to 15 years and ways of shortening that without jeopardising effectiveness were now being explored. Although the disease usually manifested itself between the ages of 20 and 50, geriatricians might encounter it in later life through relapse, complications and worsening disability.

The big breakthrough in rheumatology had been the development of biologics, medicinal products manufactured in or extracted from biological sources as distinct from chemically synthesised pharmaceuticals. "They have revolutionised the treatment of many rheumatic diseases," said Dr Christopher Holroyd, consultant rheumatologist at University Hospital Southampton. "The traditional treatment was to start conservatively and gradually ascend the pyramid in terms of potency and toxicity of therapy. Now we can do aggressive therapy from the start." More biologics were already in development and the future was likely to bring ever more personalised medicine.

Good grief

Although BGS meetings always engage with what geriatricians can do, one interesting aspect of the session on bereavement was the suggestion that professionals take a back seat until it was clear they were needed. "Almost everyone experiences bereavement and most individuals and communities have a reservoir of relevant strategies," said Dame Barbara Monroe, a trustee with Marie Curie and Compassion in Dying and a special commissioner at the Royal Hospital Chelsea.

Interrupting too soon could prevent people finding their own solutions and the professionalisation of services once performed by citizens for each other risked making them doubt their ability to help. "Counselling as the normative response discounts or ignores resources in existing local networks."

There were three groups: the low risk majority - the 60% who dealt with grief with the support of family and friends; the 30% at moderate risk who could benefit from peer or

Bereavement could lead to personal growth and new skills, even for older people

volunteer led support groups, and the high risk 7% who suffered complex grief issues and might need referral to mental health professionals.

Immediately after a death, doctors could be proactive in terms of listening, answering questions, pointing to sources of help, giving written information, sharing personal memories of the deceased and recognising the achievements in caring by the bereaved. Otherwise it was advisable generally to wait six months to a year before instituting therapeutic interventions.

Warning signs would be grief so disabling it significantly interfered with the ability to function. The bereaved might have persistent disbelief about a death or be unable to accept it. They might be preoccupied to distraction by thoughts of the deceased, feel life was meaningless without them and have an urge to die to join them.

With older people there was always the risk of a 'cascade of events' – the loss of a life partner could bring financial and practical problems and intense loneliness as well as increased health problems. There might be a change of role, the loss of caring, the loss of a carer. Older people often divided tasks so the one left behind might have no domestic skills or have never paid a bill or operated a computer. Good quality end-of-life care helped a great deal, added Dame Barbara. People who knew that the wishes of their loved one had been followed had fewer regrets or guilt. "Getting it as right as we can before a death really matters."

Bereavement could also lead to personal growth and new skills, even for older people: her own mother had learned to drive in her 70s after being widowed.

The next speaker Letizia Perna-Forrest, head of patient and family support at the Royal Trinity Hospice, listed some of the physical manifestations of grief including headaches dizziness, exhaustion, muscular aches, sexual impotency, loss of appetite, tremors and insomnia. Cognitively there could be an inability to concentrate, a sense of depersonalisation, disbelief, confusion and visual, tactile, olfactory and auditory hallucination. Emotions such as anger, guilt, anxiety and sadness could combine with behavioural problems like impaired work performance, over-activity and withdrawal.

"Any of the above may be enough to interfere with daily life for up to 30% of the population for up to 18 months - and for a significant minority, much longer," she told the audience. It was important to match needs with interventions which could include information, counselling, social support, spiritual support, befriending, financial and housing advice, complementary therapies and specialist bereavement services.

It was also important to distinguish between grief where there was an identifiable loss, a fluctuating ability to feel pleasure and where self esteem was generally preserved and depression where a specific loss may not be identified, there was an inability ever to feel pleasure and the sufferer was stuck with feelings of worthlessness and self loathing.

The third speaker, Janet Morrison, chief executive at Independent Age, looked at bereavement in older men who tended to have smaller friendship circles than women and therefore less practical and emotional support. The wife may also have been the connector with family and friends so loneliness was a particular risk, the equivalent, some experts believed, of being obese or smoking 15 cigarettes a day. Men also tended to have different types of friendships, to do side by side activities rather than talk. "If you ask men to lunch groups as they often see those as 'chatty things'. You're more like to reach them by asking them to do something purposeful like driving or teaching a skill.

"We do notice that when someone is bereaved in their 40s it's seen as a tragedy, but we don't see the same tragedy for someone who has lost a life partner of maybe 50 or 60 years and is now eating a meal on their own beside an empty chair

or sleeping in an empty bed. We underestimate that and rely on an older person's resilience. We need to think harder about how to support older men practically but we also often need to address their spiritual needs, which can be incredibly important for older people."

BGS conferences often offer opportunities to gain insights into patients' actual experiences and the last afternoon provided a brief but powerful example with a video of an elderly woman with dementia with Lewy Bodies describing her hallucinations - "there are about half a dozen people who come to live with me most of the time from around midday until ten at night."

In an update on the condition Dr Rimona Wei, consultant neurologist at the National Hospital for Neurology and Neurosurgery, said there was growing understanding about such hallucinations and improvements in treatments for them though these were only used if the patient was distressed.

The Autumn programme also featured sessions on sarcopenia and frailty, movement disorders, clinical effectiveness, peri-operative medicine, driving and mobility, comprehensive geriatric assessment and the ethical and legal implications of the new BMA guidelines on clinically assisted nutrition and hydration.. There were workshops on vascular disease and urodynamics, a trainees gathering, an Association of Academic Geriatric Medicine symposium and two half day SIGs on anaemia and heart failure.

It also saw a return of The Fringe which was born out of the question – 'could the humanities help us resist the inhumanity of life in hospitals?' There was a wide range of fascinating features: a tai chi class, a workshop on the life organisation system bullet journaling for geriatrics, a book club looking at Kathryn Mannix's With the End in Mind, a display of centenarians' thoughts on being 100, a selection of games like Jenga and Connect 4 and a half hour of hand drumming. Participants were also challenged to lip read a woman on a video screen and guess the number of hearing aids in a jar.

There were four sponsored symposia three of which were on Parkinson's Disease. The subjects were: non invasive options for 'wearing off' in PD with Bial, managing patient outcomes in advanced PD with AbbVie and managing PD across the spectrum with Profile Pharma. A symposium on managing nocturia sponsored by Ferring Pharmaceuticals saw a urologist, a uro-gynaecologist, a geriatrician and a GP each promote themselves as the best candidate for the job. There was then a vote from the audience who picked the GP.

There were more than 100 posters on such subjects as head injuries, virtual wards, vitamin deficiencies, anorexia, fractures and the first emergency department for older people in Norwich and a dozen platform presentations covering a range of topics including hip fracture, depression and anxiety, medication safety, blood pressure and delirium.

BGS members keen to learn more about and possibly become involved in the ways in which the Society was working to influence health and social care at a national level were invited to join a policy breakfast.

The meeting, which was attended by nearly 600 doctors and other health professionals, offered plenty of opportunities for socialising, with a drinks reception on the first evening or a guided walk through Docklands down to the Thames Barrier, a five kilometre run on the last morning and a reception on Thursday evening at The Crystal, a permanent exhibition on sustainability, with food and drink, music, a silent disco and a treasure hunt.

The meeting was dedicated to the eminent geriatrician and past BGS president Professor Peter Millard who died earlier this year.

Liz Gill
Freelance Journalist

BGS Autumn Meeting 2018: prize winners

Congratulations to this year's winning presenters

Best scientific poster

Norman Exton-Smith Prize
This prize was established in 1989 to honour Professor Norman Exton-Smith, past President of the Society, and is awarded each year for the best poster presented at the Autumn Meeting by a member of the Society who is not a consultant.

Winner
D Thayabaran, E Hindley, R Schiff
Trial without Catheter: The role of bladder filling prior to removal of urethral catheters. A systematic review of randomised controlled trials

Best clinical quality poster

John Brocklehurst Clinical Quality Prize
This prize was established in 2004 to honour Professor John Brocklehurst, past President of the Society, and is awarded at each BGS Scientific Meeting for the best poster presented in the Clinical Quality Section, by a delegate who is not a consultant.

Winner
L J Abbott
Proactive frailty management within an integrated care system

Best platform presentation

Elizabeth Brown Prize
This award was established by the late Professor E Woodford Williams in memory of Elizabeth Brown, and is presented each year for the best paper read at the Spring Meeting by a member of the Society who is not a consultant.

Winner
A Wahab, J Michaels, K Ellenger, S Ninan
Did you mean to make me bleed? Treating frail older people with NSTEMI carries a high risk of bleeding

Best nurse and AHP prize

Eva Huggins Prize
This prize, inaugurated in 2007, celebrates Miss Eva Huggins, Matron of the West Middlesex County Hospital in 1936, at the time Dr Marjory Warren took charge of the workhouse and began to re-organise the care of older people, and to formulate her early ideas on the special needs of this group in society. The prize is presented for the best poster presented in the nurses' category at the BGS Scientific meetings.

Winner
C Nelson, L Abbott
The effectiveness of delivering comprehensive geriatric assessments in the emergency department

Gary Fitzgerald receives the BGS Special Medal from Dr Eileen Burns

Interview with BGS Special Medal Winner 2018: Gary Fitzgerald

The BGS Special Medal recognises non-BGS members who contribute to improving the quality of life of older people throughout society

Gary Fitzgerald is Chief Executive of Action on Elder Abuse (AEA) and is due to retire in April next year after 18 years of leading the charity in the fight against the abuse of older people. AEA is a campaigning charity that provides information and guidance on the prevention and amelioration of the abuse of older people which affects more than a million people a year.

There are a lot important causes to campaign for, why focus on elder abuse?

There are a couple of reasons - one of them personal and one of them inspired by the charity itself. It is probably not well known that Action on Elder Abuse was formed by a geriatrician, Professor Gerry Bennett. He had a passion for justice, dignity and the rights of older people which attracted me to the charity.

I used to work in the delivery of care services for older people and was appalled at the way the quality of service was falling down, not by error or lack of knowledge but because of tactic and strategy. People were choosing to expect poorer quality of care to save money, and some of this was abusive in nature. When I saw social workers asking for a service provision that was degrading, I felt I didn't want to be a part of that. This realisation happened around the time I saw the Deputy Chief Executive role advertised at AEA.

Your aim is to ensure that Action on Elder Abuse has the same power to protect older people as the NSPCC does for children. What progress have your organisation made and where is their still work to be done?

There is a tremendous amount of work still to be done. We have seen quality and expectation relating to service provision terms actually go down in the last 10 years. This didn't happen by accident, people made those decisions based on the fact that older people are not the high priority that they should be.

Ageism sits at the heart of what our charity does. The perception that older people are somehow so different that they lose their civil and legal rights and their humanity is simply unacceptable. What we see is a situation where the approach and the attitude to someone in their 80s is sometimes degrading, and at times neglectful and even abusive. We have made progress regarding awareness of elder abuse but it is not where it needs to be.

Your helpline responds to 15,000 calls per year. Can you explain how it works and what happens after someone calls?

Since the helpline was established in 1997 we have taken over 100,000 calls. We get a number of people who ring up just to validate what they already suspect because there is not a widespread understanding of what elder abuse actually is. We also help people get on to the adult protection ladder because they may not understand how the system works. We provide guidance on how to manage a situation - not all elder abuse can be easily dealt with by intervening and saying 'stop it'. You often get complex family relationships, as well as psychological abuse in relation to dependency. We do some work where we will take cases on behalf of people and guide them through the system. The helpline gives us a tremendous amount of information about the nature of elder abuse which can help us challenge the preconceptions out there. For example, most elder abuse happens in people's homes, not in care homes, and by family not by paid workers.

If you could introduce or change one piece of legislation, what would it be and how would you change it?

In England I would start from scratch with the Care Act. The safeguarding provisions in the Care Act provide an illusion of protection, not a reality of protection. I would like the Care Act to be much more robust in the powers it gives to intervene and protect. A social worker has no legal right to gain access to interview an older person in England. They do in Wales and Scotland, but in England they can be turned away. If you called and said an animal was being abused on the property, the relevant authority can gain access, but this is not the case for older people. This Christmas we are issuing a card with a picture of Santa Claus and Rudolf with the message that 'Rudolf remains better protected than Santa Claus'.

In your opinion what is the greatest challenge relating to the protection of vulnerable older adults?

This Christmas we are issuing a card with a picture of Santa Claus and Rudolf with the message that 'Rudolf remains better protected than Santa Claus'

In one word, ageism. None of us want to die young, but how many of us want to be old? We have made old age something to be feared. The public perception is of vulnerability, frailty and loss of faculties. This fear means we turn away from the issues and ignore what is taking place. Less than 0.5% of elder abuse ever reaches the courts and yet there are over a million people older people abused in the UK each year.

What specific signs should doctors, nurses and AHPs be looking for when treating older patients who may be victims of financial, emotional or physical abuse?

I would start by saying healthcare professionals need to take a step back and see the issue, not the patient. I would recommend this because I have seen too many incidents where assumptions are made that an injury is the result of age rather than of abuse. Also if there is an allegation made by an older patient, healthcare professionals should react to it the same way as they would if it was being made by a 30 or 40 year old.

You are due to retire in April after 18 years of leading the charity. What do you consider your greatest achievement?

I think we have got elder abuse recognised as an issue. When I first started there was a Health Secretary who said this isn't a problem in the UK. You would never hear a minister saying that now, and in fact we now have a Prime Minister who says the exact opposite. The fact we have raised recognition among professionals and politicians is a huge achievement, but a lot of work remains to raise awareness among the general public. At the beginning of next year we have a consultation on making age a part of hate crime legislation and that would never have happened 10 or 15 years ago.

If you had one message for BGS members what would it be?

Never forget "I hurt as much at 78 years old as I do at 8 years old" - abuse is abuse.

What does winning the BGS Special Medal mean to you?

The fact that my charity was founded by a geriatrician makes receiving this medal something very special. We took what Professor Gerry Bennett believed in and never let it go. We have come full circle with this acknowledgement of our work. It means a lot, thank you.

Interviewed by Marina Mello
BGS Communications, PR & Media Manager

Interview with 2018 Marjory Warren Lifetime Achievement Award Winner: Dr John Hindle

The Marjory Warren Lifetime Achievement Award is given to BGS members who have made exceptional contributions to the welfare of older people over the course of their careers

Dr John Hindle has been a pillar of geriatric medicine in Wales for over three decades and has made a huge contribution to patient care, education and training in this specialty. His work on cognitive impairment and dementia frailty has inspired geriatricians and other physicians to understand and embrace this as part of older people's care. His research and publications on Parkinson's disease and dementia are recognised internationally.

What first attracted you to geriatric medicine and movement disorders?

I originally trained in psychiatry at St Mary's Hospital in London and had an interest in neuropsychiatry. It was suggested that I go to the Maudsley Hospital, which was a top training centre. In those days, people used to do additional medical rotations and then return to psychiatry. This meant you ended up dually qualified.

Hull was the second teaching centre I went to and I did virtually every medical speciality apart from geriatric medicine. I spent a lot of time doing renal medicine, endocrinology and diabetes. I also did neurology, chest medicine and gastroenterology. I then went to the Maudsley Hospital in London and did old age psychiatry and neuropsychiatry but I missed the medicine. I was trying to work out what I wanted to do, so I looked at different specialities and geriatric medicine seemed to be the one that fitted. I went to St George's Hospital and did a rotation there, and that is how it happened basically. It was by accident really but it was a way of combining specialities.

Over my career I have transcended specialities. I have an interest in neurology, psychiatry and medicine. Geriatric medicine is a very cool place to do that. Also geriatric medicine is a fun specialty, people are very friendly and welcoming.

With regards to movement disorders when I moved to Wales I found there were many people with Parkinson's disease and they were a bit of a lost tribe. I set up the first

Dr John Hindle with Dr Eileen Burns following the presentation of his award

Parkinson's clinic with multidisciplinary research base in Wales and went from there. My interest in lost tribes has become a theme in my career. It has included working with people with dementia and Parkinson's, Parkinsonisms, Dementia with Lewy bodies, neuro-rehabilitation. I basically couldn't say no to anyone who wasn't being looked after.

What areas of your research are you most proud of and why?

My research relating to improving the recognition of cognitive impairment and dementia, and generating interest in whether you can do something about it. In recent years I have done research on cognitive reserve in dementia. I was asked to speak at the 1st International Conference on Cognitive Reserve in the Dementias in Munich last year.

What do you feel the greatest challenge is when treating older patients with movement disorders?

The biggest challenge is cognitive impairment. When people start developing cognitive impairment in Parkinson's quality of life goes down, use of services goes up and mood problems start to develop. They also need more social care.

Life gets more complicated for these patients. The challenge is recognising and managing the cognitive impairment, and trying to address it early.

What are the specific benefits and challenges faced when doing research in Wales?

Wales has a great track record in neurodegenerative disease research. There is a huge amount of work in this area going on in South Wales. Wales is a great place to do research generally - patients were research naïve when I started, so loads of people were happy to take part.

We also receive a lot of help from research support networks. It can be a bit isolated in Wales though. There is a big gap between North and South Wales and this can be one of the challenges. Like anywhere in the UK, the NHS in Wales in under pressure, both financially and from a workforce perspective.

I would also say there is also a great lifestyle in Wales. I have been able to do all my work from a house in the middle of the countryside. I cannot understand why more people don't want to come and work in Wales. Also, we have a great family of geriatricians here.

What is the biggest change you have seen in relation to the public perception of geriatric medicine?

We are a much more recognised as a speciality. When I joined it was a 'Cinderella' speciality. I think the BGS and geriatric medicine has really been put on the map, and that is one of the biggest changes. There is so much more interest in what happens to older people, recognition of frailty and dementia. On the other hand there is not enough community geriatrics. There was a vision that there would be more geriatricians out in the community but that has not happened.

Where would you like to see the BGS in 10 years' time?

Every time there is something on the TV or Radio about older people I would like to see someone from BGS being interviewed. A positive public perception of geriatric medicine is important and there is still work to do in this area. We are the biggest specialty, with some of the greatest doctors, and I would like to see this better reflected. One of the really positive things about the BGS currently is that it is a very personal organisation where everyone works very closely together.

What does winning the Marjory Warren Lifetime Achievement Award mean to you?

I'm absolutely amazed, overwhelmed and grateful to my colleagues in Wales for putting me forward for this award. I think winning is also great for my team. I cannot do anything without my team and this award reflects well on them and they are delighted.

Interviewed by Marina Mello
BGS Communications, PR & Media Manager

Evidence-based nutrition and healthy ageing: time for a paradigm shift

Do you ever consider how much poor dietary choices contribute to the patient caseload we see every day in hospitals or community?

Hyperlipidaemia, hypertension, cardiovascular disease, type 2 diabetes, cerebrovascular disease, Alzheimer's disease, gastrointestinal disorders, cancer, certain autoimmune and inflammatory conditions, fatty liver disease, kidney stones, chronic kidney disease, osteoporosis, prostatism – all of these conditions could potentially be prevented and/or alleviated by dietary changes.[1] Meanwhile, modern healthcare continues to focus on pharmaceutics and procedures, despite their obvious limitations and incapacity to reverse chronic diseases. Complex, non-communicable diseases with multifaceted pathology warrant a different approach in which lifestyle changes are a crucial foundation of the treatment, not an optional bonus.

In our practice, we feel comfortable in the context of malnutrition and gladly recommend supplements, meat or eggs for protein and iron, milk and cheese for calcium, or added butter/oil and cake to increase caloric intake, in the hope of halting the progressive weight loss and ensuing frailty. But do we ever take the time to explore the bigger picture of nutrition science and how it relates to multimorbidity and frailty?

Looking closer at the concept of frailty, I cannot help pondering on the associations with poor dietary choices. Recent cohort studies show correlations of unhealthy dietary patterns with increased risk of frailty and dementia.[2,3]

The list of deficits from which the frailty index is derived contains diet-related conditions: cerebrovascular disease, stroke, cognitive impairment, myocardial infarction, diabetes, hypertension, peptic ulcer, osteoporosis and chronic kidney disease. The suggested pathophysiological processes underlying frailty include cellular and molecular damage from chronic inflammation, oxidative stress, hormonal changes, dyslipidaemia, insulin resistance, gut dysbiosis - all of which are powerfully influenced by diet. Epidemiological studies clearly demonstrate that populations which traditionally follow plant-based diets have very low or non-existent rates of chronic diseases which are rampant in Western countries.[4]

You may have heard about Blue Zones[5] – five places on Earth where people live very long and healthy lives with a high number of centenarians (Okinawa in Japan, Loma Linda in California, Nicoya in Costa Rica, Ikaria in Greece, Ogliastra in Sardinia). These groups of people share a similar lifestyle with a diet based around fruits, vegetables, wholegrains and legumes which resembles the traditional famous 'Mediterranean diet'.

A plant-based whole food diet has been used successfully to reverse chronic diseases such as hypertension, coronary artery disease,[6,7] type 2 diabetes,[8] and surprisingly, mild cognitive impairment and early Alzheimer's, too.[9] This wealth of evidence favouring plant-based diet is supported by heart-warming stories of patients whose lives have been completely transformed by the power of their plate.

A healthy balanced diet has been promoted by the government and various organisations for years. If you ask a patient 'How is your diet?', you are most likely to hear the learned response: 'healthy and balanced,' with little objective evidence that it truly is (source: own experience). Despite these efforts, our eating habits are nowhere near healthy, with ever younger children being raised on high fat, high salt and high sugar, ultra-processed foods. Unfortunately, as doctors we do not tend to be great role models to either our colleagues or patients. We indulge in highly-processed junk food the same way as everybody else - chocolates, cakes and crisps being ubiquitous on the wards. But geriatricians should know better - high sugar diets have been linked with dementia,[10,11] and Alzheimer's disease has long been nicknamed 'type 3 diabetes' for the highly damaging effects of insulin resistance and hyperglycaemia on brain neurons.[9]

We do not notice overweight and do not deal with obesity as much as other medical specialties... yet! Nonetheless, it is not hard to imagine what medicine will look like when the current generation of young people raised on junk food enter a phase of accelerated ageing.

So at what point is it appropriate to educate patients about their diet? Hospital doctors mostly omit this issue and prefer to focus on the acute problem, assuming that the GP will be better placed to handle this ever-present 'elephant in the room'. Mentioning diet has become almost politically incorrect, an area that few hospital doctors venture to explore with patients in fear of stepping on the holy ground of personal choice and opinion, offending the patient, or not being able to offer any meaningful advice due to lack of sound, practical nutritional knowledge or motivational skills. This is the time for a major change in how we think, talk and advise about food as well as in what we put on our own table - the revolution has already started and all healthcare professionals need to join in. Although due to limited resources, geriatricians mainly focus on the frailest patients, who else will drive the change by promoting healthy ageing and warning about the catastrophic effects of unhealthy diet?[12] It is evident that many of the patients we look after will not be able to make major dietary changes on their own, however, we should not make assumptions based on our own preconceptions instead

of using best available evidence (as we do in other areas of patient care).

As doctors, nurses, allied professionals we constantly encounter patients and their relatives, colleagues and friends - there are many ways in which we *can* and *should* endorse healthy food choices in our hospitals and communities. A similar profound paradigm shift was required 70 years ago with regards to smoking; worldwide, the healthcare community took on the challenge of educating patients, while the governmental policy evolved accordingly over the years. Thus, even in an acute environment, we never forget to tell patients off for smoking - likewise, dietary advice should become a top priority in the 21st century.

Hospital staff will play a key role in taking this task on, alongside primary healthcare staff, by influencing our ward environments and hospital menus as well as local and national policies towards a generally more plant-based diet. By making conscious, deliberate choices each day about what we put on our plates and by empowering patients and their relatives as well as colleagues and loved ones to do the same, we will contribute immensely towards the much-needed and long overdue cultural change.

If you are interested in this topic but do not have time to read through all these references, I highly recommend the open access special plant-based issue of the *Journal of Geriatric Cardiology* 2017;14(5):315 with several articles summarising current knowledge and recommendations, specifically directed at the geriatric population.

Dr Alicja Baczynska
SpR and Co-Chair, Gastroenterology and Nutrition SIG

Plant-based smoothie recipe

Why not start your journey by trying and recommending this delicious plant-based, high-energy, high-protein smoothie which can be easily prepared using a high-speed blender?

Containing beneficial plant protein, fibre, multitude of vitamins and minerals, various phytonutrients with anti-inflammatory, antioxidant and anti-cancer properties, this smoothie is of course super tasty too.

Substituting kale and mango for half an avocado and a handful of berries will also give you a great brain-healthy option.

- 1 cup (250ml) fortified soya milk
- 1 ripe banana
- A handful of frozen mango
- 2 large handfuls of spinach or kale
- 30g pumpkin seeds
- 30g flaxseeds
- Plant protein powder (optional) for malnourished patients - will add about 20g protein per 30g serving.

Makes one large smoothie (500mls = 580kcal). Protein content approx 24g (without supplemented protein)

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What is complexity?

The dictionary describes it as "Complex (*noun*): a group or system of different things that are linked in a close or complicated way; a network," but how does our understanding of complexity affect the way we choose to address it?

I stood back and admired the finished article, a 10 metre semicircular stone wall about two foot high. After four days of work I had wheel-barrowed a couple of tonnes of ballast, sand, cement, and stone from the front of my house to the back garden.

There in the midsummer sun and with the monotonous sound of the cement mixer churning in the background, I carefully sculpted and corralled these raw ingredients into a mortared stone wall.

I made that first wall back in 2014. I often stare at this first foray into the realms of DIY, reflecting that if I were a teacher, writing a school report and under pressure to say something nice, I might have said "an excellent case study in task-based learning."

The truth is it is pretty laughable. The colour of the mortar at the beginning was rather heterogenous in pigmentation, reflective of the different strengths of sand-cement mix that had been used. As time went by this became more uniform in colour and the rocks in the wall also appeared more aesthetically pleasing. After building another half a dozen walls, a two tiered waterfall, and a well, I would now consider myself relatively proficient in the complexities of stone masonry. Experience is a good tutor.

Complexity in healthcare is an interesting concept; older people with diagnoses such as frailty, multi-morbidity, and dementia are frequently referred to as "complex." It is true that there is often a lot going on; disease may present atypically, the management of certain conditions is not as clear cut as it might be for a younger population cohort, various professionals are involved in their management, and there is always the future to think about. These are just a few areas to contemplate in the multi-faceted specialty that is Health of Older People.

However, complexity decreases with experience, which itself comes in many guises. For example, it can be knowledge or skills-based, for example how to site a central line, or can be more attitudinal in nature.

In recent years, the concept of patient-centred care has triggered an important paradigm shift in our attitudinal experience and actually made our job easier; many of the other complexities – the known-knowns, known-unknowns, and unknown-unknowns of diagnosis and treatment options – often melt away when viewing the world from the patient's standpoint of "what matters to me?" This, and a generous helping of shared decision-making.

It is true that some cases are more complex than others. However, experience normally leads a healthcare professional to develop a sensible plan that is based on what the patient wants and if uncertain, they may seek the advice of someone with the appropriate expertise. This approach to risk management is not a particularly complex concept.

Are older people "complex?" Perhaps sometimes, to experts. To people that have little experience then, yes. Ask a politician what the biggest challenge in the NHS is and they will probably say "complex older people with…" And out will trot a few buzzwords in the ensuing paragraph,

Experience normally leads a healthcare professional to develop a sensible plan that is based on what the patient wants

such as "lack of integration," "poorly funded social care," etc. Yawn.

In this situation, one might argue that the complexity does not lie in the older person but rather in the system. For example, older people require the skills of multiple different professionals in health, social, private, and voluntary sectors. In turn these professionals rely on each other's skills. It therefore follows that the best way to articulate and co-ordinate this healthcare orchestra is through a shared IT solution. So why has it been such as challenge to address such a pivotal and self-evidently obvious issue? The answer is complex.

In recent years, the concept of patient-centred care has triggered an important paradigm shift in our attitudinal experience and actually made our job easier

As time goes by, I find questions such as "should I hospitalise this patient in a care home who may have had an intracranial bleed?" less complex. I have become much more interested in the 'system questions' - for example, why does the lion's share of the medical take arrive in the late afternoon just when the MDT are going home? Why are we not actively engaging in low cost, high value interventions that prevent, reverse or delay the progression of disease in patients with mild frailty/not frail? Could primary care be incentivised and supported to wrap up the yearly review of medications/long-term conditions/frailty/dementia into one 'super review'? How could this information be shared?

To my mind, this is where the real complexity, and some great solutions, lie.

Dr David Attwood
BGS Deputy Honorary Secretary

BGS Retired Members Group

Are you retiring from active practice, or have you retired? There is no need to end your relationship with the BGS. There are favourable membership rates for retired members and annual activities for retired members and their partners.

The main purpose of the Retired Members Group is to:

- Ensure that retired members can stay in touch with and contribute to the work of the Society
- Provide a number of volunteering opportunities for retired members
- Provide opportunities for social networking on both a regional and national basis.

All retired members are automatically included in the Retired Members Group, which is seeking two or three volunteers to help run the group alongside its two co-chairs, Dr Anne Freeman and Dr Alistair Ritch.

Potential volunteering opportunities include:

- Writing a regular column for the *BGS Newsletter*
- Mentoring junior colleagues through the Association for Elderly Medicine Education
- Monitoring, updating and editing the Retired Members Group page on the BGS website
- Volunteering at Marjory Warren House, e.g. in the BGS library and archive
- Contributing to the Society's policy-influencing work (attending meetings with the BGS Policy Manager, or attending meetings where a member of BGS staff is unavailable)
- Assisting with social media blogs and updates
- Acting as a peer reviewer for *Age & Ageing*
- Participating in the Society's committee structure.

To discuss any of these opportunities, please contact Mark Stewart in the secretariat team, who can be reached at **committees@bgs.org.uk.**

Social group and meetings
A retired members social group has existed for many years and run many successful annual events. Meetings have included visits to places of interest and informal presentations from both members and partners, most of which are of general interest and not health-related. Topics have often been related to post-retirement activities and those of historical interest are always appreciated. Past events have been held all over the country: from Windermere to Windsor, and Norwich to Newquay. We will also be aiming to organise further meetings in different parts of the UK if there are retired members willing to help with organisation.

Please email committees@bgs.org.uk or visit www.bgs.org.uk/retired-members-group for further information.

The journey towards genuine integration: a formula for change

In his previous article, Dr David Attwood, a GP with a Special Interest in Older People, discussed tribalism between professions and how it might be overcome through shared understanding and trust. There is no shortcut to this process - it takes time - but the outcome can be truly transformational. In this third chapter, he outlines the formula that unlocks change in healthcare.

13 September 2008

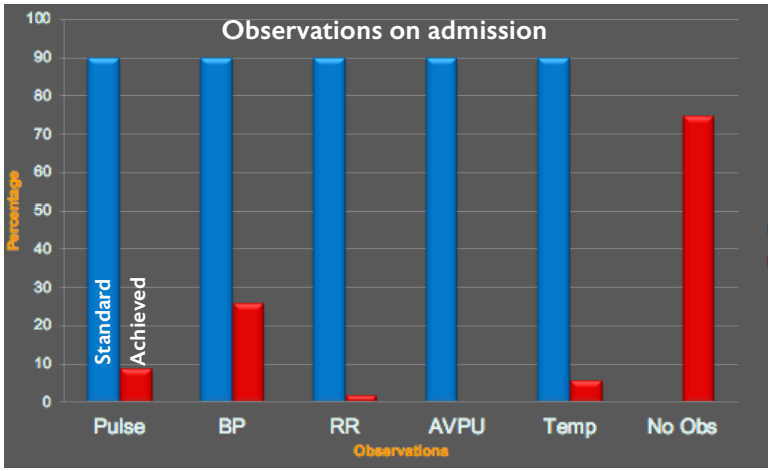
Dr Dario Kuron Lado was Chief Executive of Juba Teaching Hospital (JTH) and Head Surgeon in the Department of Surgery. He was a true general surgeon, turning his highly competent hands to acute abdomens and every permutation of trauma, gun shot wounds and road traffic accidents being high on the hit list. He was a kind, charismatic, and hard-working man, highly thought of by his colleagues and his face nearly always wore a smile. He was proud of the hospital and cared deeply for the people working within it.

Today that smile was gone and James and I were partly responsible.

We were three weeks into our stay and had just presented him an audit of vital signs, identification of shock across all departments and the administration of boluses of IV fluid. The results were grim; hardly any patients had vital signs recorded on arrival, very few were identified as shocked and not one patient received a fluid bolus.

Dario fully understood the ramifications of this for his patients. His eyes lingered at the last slide of the powerpoint, reflecting a mixture of sadness and frustration. "This," He pointed his finger at the presentation "is not good news."

Cleaning day on the Emergency Medical Ward. Every Wednesday the ward was emptied of patients, beds and all other furniture. A hose pipe was passed inside and the place was deep cleaned.



"No it's not," James replied softly. "However the point of audit is not to cast the finger of blame. It is an opportunity for development. This could be a good thing- it can guide change."

"We do audits all the time in the UK, Dario." I added

"They always start out looking like this but then you make some changes, do some training, and you re-audit. If you have done a good job the numbers look much better. In this instance, the audit shows a need for training, more equipment, and more staff."

A single deep 'cluck' sound came from the back of Dario's throat, a cultural expression of agreement in South Sudan. It's a sound I have never been able to imitate but the implication was clear.

"So what shall we do now?" I asked.

Dario's gaze remained a short while on the laptop as he considered the question. As an idea dawned his eyes changed, frustration and sadness being washed away with a renewed steely resolve. He outlined the plan, which to him was simple. He wanted us to train the nurses and junior doctors in recognition and management of the sick patient.

We would have some help and he introduced me to Sister Anna. A week later we were training the nurses of Juba Teaching Hospital.

Mid-October 2008: a few weeks into teaching the nurses

"Dr David, please come quickly!"

Kadija, a nurse whom I had recently taught - and had been a star pupil for that matter - beckoned me to her ward earnestly.

Lying on the floor inside, swaddled in a few tattered robes and no shoes was a malnourished, unconscious, old lady. She had recently been admitted with a fever and vomiting. Kadija had done a set of vital signs; she had a weak thready pulse of 130, laboured breathing, an unrecordable blood pressure and had a GCS of 6.

"Does she have any family?" I asked.

"She has no family."

Juba Teaching Hospital currently had no drugs, cannulas, giving sets and fluids. Patients who were sick depended on their family to cook food and buy them life-saving medicines from elsewhere.

"So, what do we do if they have no family?" I asked.

The realisation dawned at the same time as Kadija answered.

"We watch them die. We see it all the time."

I numbly walked away from the sight of that poor lady, dying on the floor. Poverty killed with a cruel indifference.

At the entrance of the ward, Kadija finally plucked up the courage to ask the question on her mind. "Dr David, what is the point in us recording vital signs and identifying sick patients when there is nothing we can do to make them better?"

She was right. All the training in the world would be utterly meaningless if we didn't have the tools to do our jobs. I walked away from the scene, lost in my own thoughts until I heard a familiar voice.

"Salam alaikum, David!" I looked up and stared into the warm smile of Dario. "You okay?"

"Not really."

He ushered me into his office and I explained what had happened.

"I know this happens all the time, Dario, but poverty is so bitterly unfair. In my country everyone gets access to treatment. It is free and I know we are lucky. In South Sudan if you have no money, the price of life is 35 South Sudanese Pounds [£5]- the cost to buy two litres of saline, a cannula, a giving set, a course of artemether, and some antibiotics."

He knew I did not blame the hospital. It was not the hospital's fault that there were no drugs, and South Sudan was one of the poorest countries on earth. There were wider forces at work.

"You know, David, people should never die because they can't afford life." Dario said sadly. It was my turn to throat cluck. His face soon lightened, the old steely resolve and hopefulness back again.

"I want you and James to expand your role. You shall advise us of how we might undertake a full infrastructure change. We will have a new Emergency Medical Ward (EMW), with life-saving equipment, drugs, and highly trained staff!"

"I need a month to finish training and source the things we need. Do I have your blessing?"

"You have it."

As I was about to leave, he remembered something. "David, I have something for you that may help."

He ushered me into a room at the back of the accident and emergency department. There were four hospital beds and in between them, were some tables, each with a cardboard box on top. He gestured to me to open one of the boxes. I pulled open one of the boxes and gazed at a cardiac monitor with a SATs probe and non-invasive blood pressure monitoring.

"You might find this useful too." He pointed at an oxygen concentrator in the corner.

"You're not wrong!" I grinned happily.

The next few weeks were busy. The hardest part was sourcing drugs. JTH existed in a state of feast or famine. A consignment of medications would come in and they would be used within days. It could be weeks before a resupply. Fortunately the hospital received a resupply in late October and Sister Anna (who incidentally had agreed to be the emergency medical ward's new sister) and I went to speak with the pharmacy team.

The pharmacists had grave concerns about allowing medications to be stored on the ward; in the past, nurses had sold the drugs for money. This was not a surprise; they were paid very little and many of them struggled to support their families.

However, the solution was simple. We agreed to make every drug a controlled drug. They would be locked away in a cupboard with only the most senior nurse having the keys. All medications would be signed and accounted for. The drugs cupboard. It looks pretty bare but we slowly added to it as medications and equipment came in. The pharmacists and stores team were extremely supportive.

In the week leading up to the opening of the EMW, Sister Anna spent her time organising nursing cover and co-ordinating the bed state, while myself, James and Dr Magdy (Consultant Physician on the EMW) taught the future nurses of the EMW how to use the cardiac monitors, give nebulisers and oxygen, and treat shock.

Prior to that teaching day I paid someone a visit. I found her nursing her patients in her ward.

"Salam alaikum Kadija."

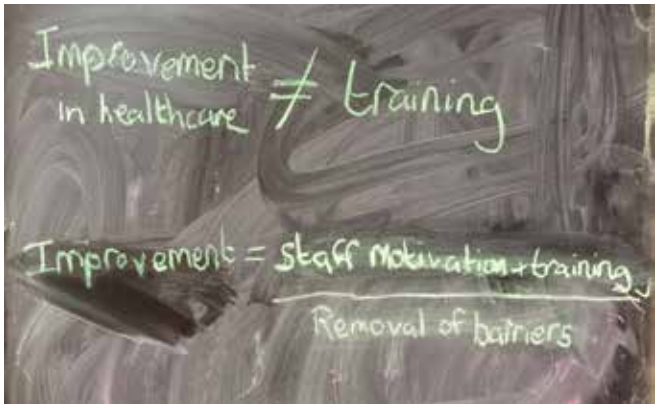
"Alaikum salam, Dr David."

She immediately volunteered to work on the EMW. On 13 November 2008, the new EMW re-opened.

18 November 2008: five days into new EMW

An older lady was brought in on a stretcher. She was feverish, severely malnourished, and unresponsive. She was obviously very poor.

"Kadija, can I have some help? Grab the monitor."



The formula for change

She set up the cardiac monitor, whilst I sited a line. The alarm on the monitor sounded: SATs 83%, respiratory rate 35, pulse 140, BP 50/23.

Without asking, she wheeled over the oxygen concentrator. It could only generate four litres of oxygen a minute but that was enough to bring the lady's SATs up to 92%.
"Where are the family?" I asked.

"They are outside but they can't afford any medicine, Dr David."

"Sister Anna," I called "It's time to open the cupboard!"

I watched Kadija administering the artemether, followed by ceftriaxone, hartmanns, and a dextrose bolus to combat malaria-induced hypoglycaemia.

"Kadija? This lady is going to need high dependency nursing care, will you keep an eye on her? Vitals every 20 minutes? Hourly urine output? I will ask Dr Magdy to post take."

She looked up at me. Her eyes were awash with a kaleidoscope of raw emotions but burning brightest of all were the flames of hope and renewed purpose.

"Mafi mushkila, Dr David!"

She had every right to feel this way. Life's pricelessness had been restored, and she was the first high-dependency unit (HDU) nurse in the history of JTH.

Shortly after Kadija administered the drugs we got some bloods back. She had a haemoglobin of 29 and the family was cross matched. She was transfused two units (it was all they could give).

2 December 2008: closing the loop

The re-audit was encouraging and was presented to Dario, delegates from the Ministry of Health, and a Public Health Consultant from the Netherlands who happened to be visiting that day.

The vast majority of the patients had vital signs recorded on arrival. Of the patients that were identified as shocked, 88% of them received a fluid bolus. The delegates from the Ministry were delighted and after many handshakes they left the room to attend to other duties. The Public Health Consultant lingered a while with me and Dario. "Dario, do you know what I found most interesting?" I asked.

"What's that?"

"We trained 120 nurses to record vital signs. About 20 of them were on the EMW. The rest were scattered around the hospital. Yet on re-audit only the EMW had demonstrated an improvement."

"There is a reason for this." said the Public Health Professor.

"Many people believe that training alone can create change in healthcare." He paused to grab some chalk before drawing on the blackboard.

"The truth is it doesn't. Healthcare change is much more complex but can be summarised using this 'Formula for Change'." He stood back.

14 December 2008

The plane left Juba International airport and circled over Juba City. As the wing tip lowered, I was able to make out Juba Teaching Hospital, a series of white-washed buildings in a rectangular complex. In the middle, on the right-hand side lay the yellow rectangle that was the EMW. I imagined all the staff inside tending to the patients, the smell of the cooking outside, the beep of the cardiac monitor, the hum of the oxygen concentrator, all the noises, sounds, sights, and smells that had made the EMW feel like a living, breathing entity in it's own right. It was more than just a ward.
It was vision of how things might be.

As we climbed further into the sky, JTH grew smaller until it was lost. My little world had been swallowed into vast expanse of Africa.

Reflection

We all have our own little worlds that we work in, whether that be a GP surgery in a poor inner city, a medical on call team at 5pm, or a joint strategy meeting in a Royal College or clinical commissioning group (CCG).

Just like the EMW and the cases above show, our worlds exist in a turbulent state, awash with different, divergent, and competing initiatives from the individual/team, the organisation, and the system level. At each of these levels


Dr Magdy and Sister Anna post-taking the patient

there are issues with training, staff motivation, and barriers. Furthermore, there is still a widely held perception in the NHS that effecting change in our worlds is as simple as training. While training will help at an individual and team level, it will not address all components of the 'Formula for Change' - i.e. training, motivation of staff, and removal of barriers.

In my 'primary care world' the NHS General Medical Services (GMS) contract for frailty is an excellent example of the 'Formula for Change' in action:

- The level of the **individual** or **team**: some professionals are struggling with the concept of the Electronic Frailty Index (EFI) and the wording of the contract, meaning that patients who have 'severe frailty' on their EFI score are being incorrectly diagnosed as severe frailty. This is a training issue.
- The level of the **organisation**: it is a real challenge for practices to prioritise the GMS contract, when there are so many other competing priorities, a key one being primary care's over-arching need to manage 95% of all urgent care contacts. This reduces our ability to take on extra proactive work such as advanced care planning for older people. As a result, staff motivation is lower.
- The level of the **systems**: the method of screening using EFI has limitations; because it is based on cumulative deficits, it will capture patients with frailty who have multi-morbidity but will miss patients with frailty and only a few long-term conditions. Furthermore, our contract makes no mention of identifying patients with mild frailty who benefit from high value, low cost interventions which reverse frailty, or delay/prevent progression.

While there are problems with training, motivation of staff, and barriers at all three levels, I feel it is important to offer a balancing statement; the situation is better than it was before the GMS Frailty Contract came out and these issues will hopefully be addressed as we move into the Quality and Outcomes Framework (QOF) overhaul and new GMS contract due in 2019.

When I consider the challenges of frailty in 'my primary care world,' I find it useful to recall that plane journey home form South Sudan in 2008. It reminds me that my world is just one tiny piece of flotsam in a vast ocean of other little worlds, all with their own frailty challenges at different levels.

Perhaps a better way to think about improving the health of older people is to imagine being in that plane, looking down on the healthcare landscape below and wondering what good health looks like.

Focusing on older people and frailty, it is obvious that we should be preventing it from occurring in the first place and there are high value, low cost interventions that could be trialled. An example might be GP surgeries sending a birthday card when a person reaches retirement age, expounding the benefits of healthy living and the resources available to support this. Even if only 1-2% of the population changed their behaviour, it would be still be simpler, cheaper, and more effective than any drug therapy.

The drugs cabinet. It looks pretty bare but we slowly added to it as medications and equipment came in

When thinking of managing older people with frailty, we need to identify mild, moderate and severe frailty as these tiers will require different interventions, which in turn will inform service design.

As frailty severity increases, complexity increases. The patient will require the expertise of a medley of different professionals, each with a unique role to play. Two key ingredients are needed to conduct and articulate this NHS orchestra. Firstly, structured 'clinical checkpoints' are required in the patient journey, where key events such as de-prescribing take place. This will ensure that nothing is missed; and secondly, a shared IT solution. These services require effective leadership, good governance, training, and robust outcome measures.

Whatever happens, one thing is clear, frailty is a whole systems problem. We need to start viewing our little worlds or organisations as a macrocosm of the MDT, all working in a well-orchestrated manner to deliver excellent joined-up care to the patient and their families.

It is heartening to note that there are case studies up and down the country where individuals and teams from different 'little worlds' have come together, and using the Formula for Change, have broken down organisational barriers, trained, and motivated staff to achieve a common goal. This level of interdependence is ushering in a new era for the health of older people.

Final thought

I give the final thought of this article to Dario Kuron Lado, the hard working and devoted Consultant and CEO of JTH in 2008. His inspirational and altruistic leadership was instrumental in unlocking change on the EMW. At the heart of all change, lies a few gifted, visionary, individuals.

In the next blog, I will be talking a little more about leadership and the central importance of role modelling. To do that I need to tell you another story about a 90 year old missionary who had been in South Sudan since it was still of the British Empire and the plight of the junior doctors and medical students of South Sudan.

However, that is another story.

Dr David Attwood
GP with Special Interest in Older People

Join the new BGS Members Directory

As part of our new services for members, we have introduced an online, searchable directory to encourage networking and to make it easy for members to contact each other or to find people who may have similar special interests in specific regions

What is the Members Directory?

The BGS currently has over 3,500 members - as our membership continues to grow and diversify, and with healthcare of older people moving closer to home, delivered by multidisciplinary teams, networking and establishing contacts is increasingly important. The directory will help members find and connect with each other more easily.

Why appear in the Members Directory?

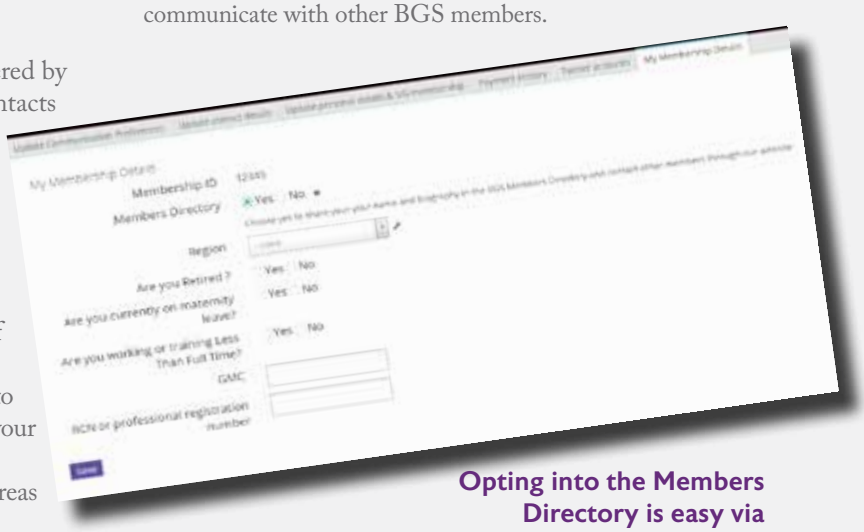
The Members Directory helps members to promote their interests and meet like-minded colleagues working with older people across the UK. It is is open to all members of the BGS but requires you to opt in to the service. Your member profile, part of your online account, will be used to display brief biographical details, your place of work and your interests and expertise. This may include your research interests, your willingness to mentor others in particular areas or to speak at educational meetings.

How will the information be used?

As with all member data, we take the privacy and security of your personal information very seriously. Your profile will not be included in the directory unless you opt in and your email and address information will never be displayed in the directory. Members will contact each other using the website without their email details becoming exposed.

How do I appear in the Members Directory?

To opt into the directory, log in to your **MyBGS** account and make sure your profile is up to date, including a picture if you wish. Then navigate to the '**My Membership Details**' tab. Select '**Yes**' under '**Members Directory**' to join and communicate with other BGS members.



Opting into the Members Directory is easy via www.bgs.org.uk

2019 Trainees Weekend

2 - 3 February 2019, Birmingham

British Geriatrics Society
Improving healthcare for older people

Organised by geriatric medicine trainees *for* geriatric medicine trainees

Registration and programme available at
https://tinyurl.com/BGSTW2019

Who should attend?

This annual two-day weekend meeting addresses key training and learning points within the specialty. The meeting will be of benefit to all registrars training in geriatric medicine but it may also benefit other specialist trainees who will come into regular contact with older people and are interested in the specialty. In particular, those doctors undergoing training in generalist specialties, including GP trainees and Core Medical Trainees, are welcome.

Sessions on: continence, ageing ear, falls and syncope, movement disorders, dementia, pallative care, nutrition, intermediate and community care. There will also be SCE exam preparation and mock consultant interviews.

Realising the relevance of research

Adam Gordon is Clinical Associate Professor in Medicine of Older People at the University of Nottingham. Here he talks about what he hopes to achieve during his tenure as BGS Vice President for Academic Affairs

Three times a year in the East Midlands we run the Enabling Research in Care Homes (EnRiCH) forum. It is attended by care home staff, academics and clinicians. We use the forums to share news about care home research in our region and we do so in as fun and interactive a way as we can. Over three years we've had opera singers, dysphagia chef of the year, television celebrities in the shape of our own Zoe Wyrko, hearing aid clinics and many other fun and interactive sessions. The aim is to let care home staff see that academics don't live in ivory towers, to help academics understand the body of expertise that care home staff hold, and to bring NHS clinical staff into the heart of planning and running research in care homes. One of the most common pieces of feedback from first time attendees is that they "didn't realise research would be so relevant."

Given that I'm now encountering care home staff who proselytise for research into ageing, it's a source of frustration to me that a significant number of geriatricians I meet see research as irrelevant to their work. We have some of the best academic geriatricians in the world working here in the UK, it's important that the BGS membership feels that they, and their patients, benefit from the efforts of our research leaders.

Steve Parry and Gordon Wilcock, the last two vice presidents for academic affairs, have done a lot of work to develop and raise the profile of academic geriatrics within, and outside, the specialty. We need to build on this by driving home to members the impact associated with the research being led and conducted by BGS members. That word – *impact* – is important. Researchers' performance is increasingly measured using impact statements, which universities have to return as part of the Research Excellence Framework. It is no longer enough to publish your research in a journal and be damned. Researchers now have to summarise how research work has made a demonstrable contribution to society and the economy, individuals and organisations. Academics are no longer speaking only to themselves. They have a bigger audience. These impact stories are what BGS members need to hear, and we will be making this a priority. One way that we're going to get researchers to describe the impact of their work to you is through a regular column in the BGS newsletter. With each edition of the newsletter we will invite a researcher to tell the story of how their research is making a difference to patients and healthcare professionals – and we'll be encouraging you to contact the researchers in question if you want to find out more.

Another area where impact narratives will be helpful is at BGS meetings. A perennial problem for the society has been getting the balance of research and continuing professional development at these meetings right. The tension is between research colleagues who want a meeting crammed with cutting-edge science and time-poor clinicians who want to maximise their opportunities for CPD. My hope is that structuring academic sessions around the difference that research makes in the real world, without dumbing down the science, is a way to square this circle.

A fantastic recent example was Thomas Jackson's 'Rising Star' talk at the Nottingham meeting in Spring – we were given a scientific *tour de force* summarising Thomas' work around delirium undertaken through his PhD, but with some very clear lines to impact – concrete changes we could make to our practice based upon his work. I'll be working with the Association of Academic Geriatric Medicine (AAGM) to work out how we bring more of these talks to our meetings. I hope that you, the members, will show your support by turning up in numbers – and giving us constructive feedback that enable us to iterate how these talks are formatted, so that they become more relevant with each meeting.

Researchers now have to summarise how research work has made a demonstrable contribution to society, the economy, individuals and organisations

Aside from specialist registrar start up grants and a small number of the research fellowships that we aim to increase, the BGS has not, for some time, funded research on the scale we would like. The advent of the NHS National Institute of Health Research (NIHR) was a game-changer for research into the type of applied academic work that the BGS used to fund through the Dhole and Warren Fellowships. From a period where ageing researchers were competing with each other to get any funding at all, suddenly there were more opportunities to get funding to support ageing research than academics had time to apply for. This was a time for the BGS to take stock and work out where it fitted in the funding landscape. The NIHR turned 10 last year and it is now clear that there are gaps that the BGS could work with partner charitable funders to address.

One area where funding opportunities are limited are fellowships which enable healthcare professionals to make the transition into academia, whether as trainees or as fully-fledged healthcare professionals. A reinvigoration of the Dhole and Warren fellowships could aim to support these colleagues and we're going to consider how we can revitalise these. I'll be reaching out to charitable research funders with this in mind.

A rekindling of the fellowships would be one step towards getting more BGS members doing research but there are other plans as well. Being a local principal investigator (PI) on a multicentre trial is an excellent pathway into research for lots of healthcare professionals. The NIHR Clinical Research Network (CRN) wants to encourage and train more doctors to be PIs. Working with the NIHR CRNs, we'll try to get more sessions on how to be a PI into regional BGS meetings. The registrar-led Geriatric Medicine Research Collaborative (GeMRC) is a promising model to bring more doctors in training into research, the BGS will be working with this group to support their continued expansion and success.

Many healthcare professionals get their first taste of research success by presenting a poster at BGS meetings. There is a growing sense that the recent experiment to remove poster judging from the meetings has left many feeling short-changed. I'll be working with the meetings committee to work out how we can develop a formative approach to assessing posters, so that colleagues who bring work feel valued, and learn through the process of presenting their work. We'll be considering making this an opt-in process, so that senior academics don't receive an unnecessary grilling and we make the most of the time available to educate and reward effort. So that's where I'd like to see the BGS going with academic affairs over the next few years. My hope is that, a bit like our East Midlands EnRiCH forums, we'll convince you that academics don't live in ivory towers, remind our academic colleagues of the expertise of the BGS membership as a 'core constuency,' and we'll get more people involved in the design and delivery of research.

And maybe, just maybe, once we've been at it for a bit some of you will come up to me at a meeting and tell me how surprised you are that research is so relevant.

Adam Gordon
BGS Vice President of Academic Affairs

EuGMS Congress 2018: report

The 14th International Congress was held 10-12 October 2018 in the Berlin Congress Centre in Alexanderstrasse, in the heart of Berlin City

My reason for attending the EuGMS Congress was to attend the EuGMS Task and Finish (T&F) Group meetings on fall-risk increasing drugs (FRIDs). The group founded in 2016 with Dr Nathalie Van der Welde as Chair and Dr Lotta Seppala Secretary to develop Europe-wide educational material for patients and doctors about FRIDS. One of the main objectives of the group is to update and disseminate knowledge related to FRIDs to health care workers, students and the older population, lessen the unnecessary use of FRIDs in older persons and reduce the risk of falls. By developing educational materials about the risks of individual drugs patients' and doctors' shared decision-making about withdrawing medications will be facilitated. Three systematic reviews on FRIDs have recently been published on cardiovascular, psychotropic and 'other' drugs.

Within the Conference programme there was a symposium of the FRIDs Special Interest Group (SIG) entitled 'How to prevent medication-related falls.' I would like to mention two particularly interesting talks in this section. The first, entitled 'Falls risk increasing drugs: the French Occitanie Macvia experience' was presented by Professor Hubert Blain, University of Montpelier. The second, entitled 'Medication review in Nursing Homes' was presented by Professor K Szczerbińska, Head of the Unit for Research on Ageing in Society at the Jagiellonian University in Krakow.

Falls prevention

Professor Blain highlighted the extent of the problem, giving details of the huge number of falls in the older population and consequent falls-related injuries and deaths, the risk of loss of independence and reduced quality of life. As European demography is ageing, falls are rising as are the costs involved. Professor Blain explained international recommendations for patients who have experienced a fall include a multifactorial assessment which entails asking about the falls and the circumstances around them, assessing gait and balance, prescribing interventions such as strength and balance exercises, treating vitamin D deficiency and reviewing medications. This type of approach has been estimated to be capable of reducing falls buy 24%. Professor Blain drew attention to recent metanalyses by members of the EuGMS T&F group on FRIDs highlighting the risk of falls associated with antipsychotics, antidepressants, benzodiazepines, loop diuretics, opioids, antiepileptics and polypharmacy. Professor Blain explained that providing information on the risk factors for falls and how to reduce them helps maintain older persons quality of life and independence. He described the 'Living Lab Falls-Macvia-LR' falls prevention programme in Langeudoc Roussillon, in Southern France, an initiative of the European Innovation

British Geriatrics Society
Improving healthcare for older people

The Royal College of Emergency Medicine

Frailty & Urgent Care Meeting

15 February 2019, London

Organised by the **British Geriatrics Society**, **Royal College of Emergency Medicine** and the **Society of Acute Medicine**, this event is intended for clinicians and healthcare professionals working with older people in urgent care settings. The day will include keynote presentations from experts in their field, time for questions, and sessions demonstrating best practice approaches available. We hope you will make contacts and start collaborations which will continue on from this meeting.

Conference aims:

- Improve attendee's skills in the urgent care of frail older people
- Inspire attendees to achieve personal excellence in the urgent healthcare of older people
- Share focused best practice presentations and the latest research
- Provide activities and ideas to advance attendees' workplace services.

Registration and programme at https://tinyurl.com/UCFOP2019

Partnership on Active and Health Ageing (EIP on AHA). It is a community project which engages older people through social meetings and educational activities which include information on FRIDs. Professor Blain concluded that a reduction of FRIDs is essential to reduce falls and that information on FRIDs should be made available to older people, GPs, medical trainees and care professionals. Furthermore, on a practical basis, he suggested that physical activity is a good means to reduce psychotropic drugs most often given for isolation, sleep disorders due to physical deconditionin and anxiety. In his practice he has found that progressive withdrawal of psychotropic drugs is well accepted by patients visiting the falls prevention clinic. Professor Blain hopes to involve pharmacists in the future.

Medication review

Professor K Szczerbińska also stated at the outset of her lecture on 'Medication review in nursing homes' that the recommended approach to reducing falls in older people is a multifactorial falls risk assessment which includes review of medication. Professor Szczerbińska highlighted again that the riskiest medications on recent metanalyses were antidepressants, antipsychotics, opioids and benzodiazepines, and that there is a high prevalence of potentially inappropriate medication (PIM) use in European nursing home (NH) residents. She recommended regular medication review in NH residents to reduce the number of drugs and advised to 'limit them to those absolutely necessary.' A number of trials of systems for reducing in appropriate medication underway internationally were reviewed. These include involving pharmacists in medication reviews, and educational interventions such as workshops, eLearning sessions, clinical and electronic decision support systems. Professor Szczerbińska concluded the prevalence of psychotropics in nursing homes is a high and advocated that quality standards for nursing homes should include obligatory medication review. From the question and discussion sessions it was evident that polypharmacy, together with the compounding effects of multiple morbidities in older people, are issues grappled with by clinicians in many different European countries. This engendered a feeling among participants of a common sense of purpose and a resolve and determination to find a way forward. There was an emphasis that, where feasible, patients as consumers should have information on medication risks and benefits to enable them to discuss their own priorities and wishes with their clinical team.

The congress showed that geriatricians of many different countries are experiencing the same dilemmas as we face in the UK. Attending EuGMS allowed me to glimpse the many enterprises of international geriatricians endeavouring to solve problems faced by us all. It was good to hear of European colleagues' journeys and projects to improve patient care, to share practical solutions as well as innovations. An overall message on falls prevention is the need for educational material relating to FRIDs, which is the goal of the EuGMS T&F group on FRIDs. I would like to convey my grateful appreciation to the British Geriatrics Society Falls and Bone Health Section for the award of a Travel Grant to enable my attendance.

Yvonne Morrissey

Community service use of frail older patients: opportunities for better care planning

Frailty is an increasing priority in society, with many attempts to design tools to improve detection of frailty, implement early intervention strategies and understand care needs for future provision planning

Frailty is characterised as a state of increased vulnerability after a minor event, such as an infection, which means the person does not return to their previous health level, which in turn causes further decline as more minor stresses occur.[1] This results in an increased risk of falls, confusion and disability, leading to increased care needs, more hospital attendances with longer length of stays and subsequent long-term care.[1,2] Unsurprisingly, this can lead to a high healthcare burden and an increasing drive to keep frail patients out of acute hospitals, however there is little information on how frail older people use wider healthcare services. Community health services provide care closer to home, and a better understanding of which services frail people are using will facilitate improved care planning to reduce unnecessary hospital admissions and improve quality of life.

Although frailty awareness is increasing in clinical practice, the ability to identify those patients with frailty is limited, due to a lack of clinical consensus or standardised tool for measuring frailty. The electronic frailty index (eFI) which generates an eFI score of fit, mild, moderate or severe is now used in primary care. Since this tool only requires routinely recorded patient data, it can used easily to help identify frail patients in the population.[3]

Using eFI to study comminity service use

We conducted a study using the eFI to identify a cohort of frail individuals and follow their healthcare usage over six months. Patient eFI scores from primary care were anonymously linked to community data in Norfolk to determine community service use of patients with a mild, moderate or severe eFI score compared to fit patients.

An eFI frailty level of mild, moderate or severe was associated with higher rates of community referrals compared with those classified as fit. A higher eFI score was a strong indicator of community referrals, with nearly 60% of severe eFI patients requiring a community referral compared with 37% and 40% of mild and moderate eFI patients respectively. The average number of community referrals per fit patient was 2.49 compared to 6.42 community referrals per patient with a severe eFI score.

What does this mean for care planning?

These data indicate that community services are an important part of frailty healthcare and such services are essential in the planning of future provision for this vulnerable population. Ensuring there is enough community service capacity is vital given the ambition to keep frail patients away from acute hospitals. Interestingly, the community services with the highest number of referrals for patients with any eFI score were the community nurse and therapy services. There is a shortage of district nurses and potentially allied health professions in the NHS, meaning that some frail individuals may not be able to receive the best support and have their care closer to home, which could mean they lose their independence and be more reliant on acute hospital service to manage their condition.[4,5] Additionally, the relationship between the severity of frailty eFI score and community health service use suggests that early detection of those 'at risk' of frailty could be beneficial. It would allow intervention strategies to be executed earlier, which could help to halt or reverse frailty progression stopping unnecessary acute hospital admission and ease the burden on other health services. Targeting frailty earlier may decrease the likelihood of later health crises, through a more holistic community approach.

What's next?

Frailty assessment of the older population is important to understand their relationship with healthcare, which will enable better evidence-based healthcare service planning and potentially create opportunities for specialised frailty community care plans. Further understanding of how frail patients are using mental health and social care services through further data linkage studies would be important future research to gain a more comprehensive road map of frailty healthcare needs.

Although frailty awareness is increasing in clinical practice, the ability to identify patients with frailty is limited

Penelope Boyd
CLAHRC EoE Senior Research Associate

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BGS policy update

In this update I highlight some of the key developments in health and social care policy as well as some of the collaborative work we are involved in with other organisations which is now bearing fruit

Policy developments

Autumn Budget: The Chancellor's 2018 budget statement reiterated the government's promise of £20.5bn of additional funding for NHS England by 2023-24 and included additional grant funding for social care of £240m for 2018-19 and £240m for 2019-20. The social care funding is intended to ensure that people can leave hospital when they are ready and help the NHS to free up beds over winter. New funding for mental health services was included in the budget but the extent to which this will support mental health services for older people is unclear.

NHS long-term plan: At the time of writing we are awaiting publication of the NHS long term plan which Government has committed to publishing before the end of 2018. An indication of the direction the plan will take was given in the announcement by the Prime Minister on 21 November, saying that more patients will be cared for at home and in their community to avoid them going into or staying in hospital unnecessarily.

BGS submitted its views to NHS England through the public consultation. These are summarised in our priorities for the NHS long term plan which you can find on our website. Once the Government has published the plan, NHS trusts will be working out how best to implement it locally; the first six months of 2019 will be a key time to communicate our priorities. We hope that you will find the BGS priorities publication useful and will share them with senior decision makers in your own health trust.

Green Paper on social care: There is little to update on since the last newsletter. We continue to await publication of the Green Paper which is promised before the end of the year, and to press for a long-term sustainable funding solution for social care. However, the work being done by parliamentary committees in parallel with Government's work on developing the Green Paper shows a seriousness of intent about the need for reform.

The Economic Affairs Committee Inquiry into Social Care Funding was launched in September. This follows an inquiry into social care funding conducted jointly by the Health and Social Care Committee, and Communities and Local Government Committee, which BGS submitted evidence to. This further inquiry by the Economic Affairs Committee is aimed at assessing the effectiveness of different funding models.

Mental Capacity (Amendment) Bill is currently being debated in the House of Lords. The purpose of the Bill is to reform the process for authorising arrangements for people who lack capacity, for the purposes of providing care or treatment. The Bill is intended to enable the Law Commission's recommendations for reform (which BGS fed into) to be implemented. These include replacing the current Deprivation of Liberty Safeguards (DoLS) scheme with a new regime termed Liberty Protection Safeguards which would make the process more streamlined and efficient. However, concerns have been raised during the passage of the Bill about the capacity of care home managers to take on the additional responsibilities which would be placed with them, and which could introduce some conflicts of interest. Age UK have been lobbying on this, and have produced helpful briefing material which is available on their website: **www.ageuk.org.uk/our-impact**.

View our priorities for the NHS long-term plan at www.bgs.org.uk

RCGP's consultation **Towards a Future Vision for the Future of General Practice:** BGS submitted a response, drawing on our recently published Position Statement on Primary Care and informed by members of our recently formed 'Geri GPs' group. We highlighted the need for future developments to ensure that GPs are at the heart of community-based healthcare, and general practice is the central hub for that, with sufficient resource, funding and the capacity to offer Comprehensive Geriatric Assessment.

Loneliness: As part of a programme of work our President Tash Masud has initiated, I have been representing BGS at the Loneliness Action Group, which is convened by the British Red Cross. It has a membership of more than 60 organisations which have fed into the development of Government's Strategy for Tackling Loneliness, published in October. At the most recent Action Group meeting the focus was on how the group can best use its collective skills and voice to influence the implementation of the strategy in the coming year. Following on from the successful BGS conference we held on the health impacts of loneliness in June, we have our own programme of work which comprises a mix of meetings, submissions and the development of a position statement on loneliness among older people.

Meetings and events

The BGS and Royal College of Psychiatrists are hosting a roundtable event on depression among older people living in care homes. In September we published our joint report which contains good practice examples of collaborative approaches to treatment. We are using the report as a route to influencing improvements in practice, and in January we will be holding a roundtable meeting with a group of senior opinion-formers and decision-makers to discuss how best to tackle the issues raised by the report. Professor Alistair Burns, Clinical Director for Older People's Mental Health at NHS England, will be chairing the event, which is taking place at the Athenaeum Club in London.

National Voices: In October I attended National Voices' annual meeting and AGM, which included a presentation on care and support planning in general practice; specifically support for self-management through fitness to frailty. National Voices is a coalition of health and social care charities that promotes person-centred care. I am a member of their policy and public affairs network which helps me stay up-to-date with the policy activity that other health-related charities are engaging in, as well as sharing intelligence on policy developments.

BGS Policy Breakfast: I was delighted that at the BGS Autumn Conference more than 20 people came to an 8am meeting. Eileen Burns and I led the event where we explained why and how BGS engages in policy and influencing activity, what some of our key messages are, and how members can become more involved. Our intention is for this to become an annual event.

We highlighted the need for future developments to ensure that GPs are at the heart of community-based healthcare, and general practice is the central hub for that

Further reading

The Health Foundation, King's Fund and Nuffield Trust have together published a full analysis entitled **Budget 2018: What it means for health and social care**. It provides a very useful analysis, as well as a reminder that a disorderly Brexit could force an emergency budget in the Spring which would impact on the budget announced at the end of October. It is available to download at: **www.kingsfund.org.uk/publications/budget-2018-what-it-means-health-and-social-care**.

The CQC annual report on **State of health care and adult social care in England 2017-18.** This report provides an annual assessment of health and social care in England. It looks at trends, shares examples of good and outstanding care and highlights where care needs to improve and is avaialable at: **www.cqc.org.uk/publications/major-report/state-care**.

Getting involved

If you would like to get involved in BGS's policy and influencing work please get in touch with me by emailing **policy@bgs.org.uk**. We are building a policy stakeholder group of members who are willing to contribute on an occasional basis to consultation responses, attend policy and parliamentary meetings, and comment on draft policy publications.

Caroline Cooke
BGS Policy Manager

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.

The Geriatric Medicine Research Collaborative (GeMRC)

News from the national trainee-led collaborative designed to bring together collective experiences into a research and audit network

Performing research and good quality audit or Quality Improvement Projects (QIPs) as a trainee are difficult. This is due to things such as time constraints, rotating jobs, and a lack of consistency of practice. Positively, rotating posts give trainees a unique perspective on how things work elsewhere and importantly what things don't work. GeMRC, the national trainee-led collaborative, has been designed to bring together collective experiences into a research and audit network that can bring about changes that are important in day to day clinical practice. Our aims are:

- To enable trainees without previous research experience to get involved in research.
- To complete meaningful audits/ QIPs that also fulfil ARCP requirements.
- To conduct large scale projects that will make a difference to older adults.

In September 2017, the West Midlands held a research sandpit for trainee-led research collaboratives. We thought the event sounded interesting, but at the time geriatric medicine didn't have a trainee research collaborative, so we decided to start one! We were aware that surgical collaboratives had been very successful and loved the idea of developing this model in geriatric medicine. It started off with five of us meeting up over pizza and generating some project ideas. We made use of web-based networking and social media in promoting our collaborative,[1] as detailed in our first ever article published under our collaborative name.[2] All collaborators listed are acknowledged and PubMed citable.

Gaining national support and projects to date

Previous trainee-led collaboratives had developed regionally, with national collaboration occurring years after inception. We quickly realised we already had a network of friends and former colleagues across the country who might be interested in getting involved, so we decided upon a national collaborative right from the start. We decided on a model that included a trainee representative in each region, who was responsible for liaising with trainees regionally; we mainly communicate via email but also use WhatsApp and hold virtual meetings. We now have trainee representatives in nearly all regions but we're still looking for a representative from Oxford (Thames Valley)! We successfully conducted our first two national audits, and a national survey, before the end of 2017. These were a national audit of anaemia management in patients with fractured necks of femurs, a national flash audit of mouth care assessment, and a survey of knowledge of oral pathology amongst UK physicians and trainees. We presented the results of all three of these as posters, and gave an oral presentation about our collaborative at the BGS Spring Meeting 2018. We were even awarded the Fergus Anderson Prize for best poster! Our most successful feat to date has been our Delirium Day Audit, which involved 45 hospitals and 1,507 patients. We utilised other collaboratives to spread the word, and involved medical students in data collection. We were able to give a presentation at EuGMS in Berlin about this, and even talked about European-wide collaboration. Our results are now being written up for publication.

What next and how to get involved?

We are running breakout sessions at the BGS Trainees Weekend in February. We have planned another two rounds of our delirium audit, as well as a continuing care audit, and more. Feel free to email **gemresearchuk@gmail.com**, Tweet **@gemresearchuk**, or Facebook message us to get involved. Our website is **http://gemresearchuk.com**.

With thanks

We are very grateful to the West Midlands BGS who provided a small start-up fund, to all our data collectors, to Hannah Moorey, Katy Madden, and Natalie McNeela for helping with our initial set-up, to Dr Thomas Jackson for his mentorship, and of course all our regional representatives:

- Roisin Healy (previously Emma Cunningham (Northern Ireland)
- Stephen Makin (Scotland)
- Sarah Richardson (North East)
- Joanne Taylor (North West)
- Oliver Todd (Yorkshire)
- Ruth Willott (East Midlands)
- Lauren McCluskey and Carly Welch (West Midlands)
- Benjamin Jelley, Welsh Geriatric research network (WeGeN) (Wales)
- Victoria Gaunt (Severn)
- Lindsay Ronan and Jane Masoli (NIHR CRN Ageing representative) (Peninsula)
- Natalie Cox (Wessex)
- Kelli Torsney (BGS Research and Academic representative) (East of England)
- Mary Ni Lochlainn (NIHR CRN Ageing representative) (London)
- Kumudhini Giridharan (Kent, Surrey, and Sussex)

Dr Carly Welch
Specialist Trainee in Geriatric Medicine
Health Education West Midlands

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1. Geriatric Medicine Research Collaborative. 2018.Available at: http://gemresearchuk.com.

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A personal perspective from BGS Policy Manager, Caroline Cooke

BGS Policy Manager Caroline Cooke reflects on her own experiences as a family member of an older person with complex health and care needs approaching the end of life

My Mum, Ena Margaret Cooke, passed away on 8 June this year at the age of 91. One of our members suggested to me that when I feel ready I might want to write something about my experience. He said that in medicine you usually hear very little about a family perspective on how we manage end-of-life care and even elderly care, and that it helps health professionals when people share the good and bad of their hospital experiences.

Total immersion

When I came for my interview at BGS in February 2016 I included in my presentation a photograph of Mum with me and my sister, taken when Mum was 88, and used the photo to make the point that I care passionately about the healthcare of older people. When I was asked about how I would get up to speed with the policy issues if I came to work for BGS, I gave a standard reply but summed it up by saying "through total immersion." I didn't know then how true that would be.

After starting at BGS, working in my policy role which I was very much enjoying, it was January 2017. That was when Mum had a serious fall at home one Sunday morning.

My sister and I live in London and Mum lived in Somerset. Until then Mum had lived independently, though with severe visually impairment from advanced macular degeneration, considerable hearing loss, and limited mobility due to arthritis and osteoporosis.

She used the transport services of dial-a-ride to do her weekly shopping, and was supported by her neighbours and her wonderful cleaner who went above and beyond to help Mum in whatever way she could. Mum was engaged in her local community and especially enjoyed a group run by her church called 'Snack and Chat'!

When Mum fell backwards onto the kitchen floor she broke her arm and pelvis. The fall was caused by one her 'dizzy spells' – she also had chronic heart failure and had previously fallen in the living room. She was waiting for an occupational therapy (OT) assessment at the time of her fall. Thankfully Mum wore a personal alarm and her next-door

Caroline and her late mother Ena

neighbours were with her in minutes. She was then admitted to an acute ward at a busy city centre hospital.

Hospital stay

The next day I took the day off work and caught the train down to visit Mum. Arriving in a state of considerable anxiety, I was relieved to find that she was sitting in a chair, and though in some pain and discomfort, quite upbeat and chatty. Fortunately I arrived just at the end of a ward round and spoke to someone who I think was an orthopaedic registrar. He told me Mum was doing well and was ready to be discharged to a community hospital for rehabilitation to start as soon as possible. Less fortunately, there was no bed space in any of the community hospitals in the area.

For two weeks Mum was moved from bed to chair to commode and no further, apart from when she was moved from the ward she was admitted to because her bed was needed. She was sent to an outlier ward and placed in a dark corner where she couldn't see the food on her plate at mealtimes or the faces of staff speaking to her. There was a lamp near the bed but no-one thought to turn it on.

Unsurprisingly, Mum's initially upbeat mood deteriorated considerably. My sister and I both visited twice a week, and asked as many questions as possible. It was only after my sister completely lost her temper in a phone call with a consultant that anything changed, and at last Mum was given daily physio and started to be able to get as far as the ward toilets, with support.

Further difficult phone calls ensued and after three weeks, to our utter relief, Mum was moved to a community hospital. I cannot describe how pleased we were to see Mum in her new setting. Again, arriving after a long drive, and asking where to find Mum I had been terribly nervous. But seeing

She was sent to an outlier ward and placed in a dark corner where she couldn't see the food on her plate at mealtimes or the faces of staff speaking to her

I'd worked my way through a list from a website called Somerset Choices, which the OT had directed me to. There was no choice at all

her in a two-bedded room next to a large window with light flooding in made a huge difference. The other enormous difference was the attitude of the nursing staff and health care assistants. They genuinely cared about Mum and made that clear to us in a whole range of ways, which this was the opposite of our experience with staff in the city hospital.

Recovery was not straightforward and an issue arose that meant Mum suddenly deteriorated greatly. Unexpectedly we found ourselves talking to a nurse about whether to move Mum back to the hospital she had hated being in, or whether to "order in the meds." We chose the meds!

However, things changed overnight and the next morning, there was Mum sitting up in a chair looking much much better and ready to have a nice chat with us.

Returning home

To fast forward through another two months, Mum eventually got back home to her bungalow. She was adamant that she was never going to a care home. She arrived home eight days before her 90th birthday, and there was much joy when we hosted a tea party that many of her friends and neighbours came to. We were borrowing crockery and chairs to accommodate everyone and it was a very special day.

I can hardly bring myself to write about the challenges faced in getting a small amount of social care in place. Mum had stayed an extra two weeks in the community hospital waiting for a multi-disciplinary team (MDT) meeting to take place, before she was discharged with a four week package of care twice a day. The care agency provided support for just four days before pulling out because Mum was doing 'too well'.

Six weeks later I cried down the phone when one of the many agencies I'd called said they could provide carers. I'd worked my way through a list from a website called Somerset Choices which the OT had directed me to. There was no 'choice' at all. I should have been ready for that after all the work I'd been doing on social care in my job at BGS, but I wasn't.

More happily, once care was in place so that Mum had just a little help with washing and dressing each morning and evening, things went far more smoothly and for 11 months we were able to enjoy visits and quality time with Mum.

At the end of May this year Mum and I spent a lovely weekend together. With an enormous effort by both of us we'd made it to Cheddar Garden Centre. We sat in the outdoor café with Mum enjoying the smell of freshly watered plants. Mum had her last ever taste of cake there. It was a little piece of mine as her appetite hadn't been good – raspberry and white chocolate sponge.

The final days

On the Sunday evening after I left, Mum had bad stomach pains. She didn't call anyone but waited until the morning when she phoned me in London. Her GP did a home visit a short time after my phone call and arranged a direct admission to Taunton hospital where Mum spent 24 hours on a medical assessment unit. Brilliantly, they were able to hand a phone to Mum when I called in the evening and she told me she'd had a cup of tea. She was then admitted to a Care of Older People's ward where she spent the last three days of her life.

Initially she was being treated to find the cause of her stomach pains and so I continued to come to work here at BGS. But on the Thursday morning something made me phone the ward from work. The nurse I spoke to said that Mum had been asking for me. I left the office and caught a train to Taunton. On arrival I found that Mum was dressed and sitting by her bed. She was in some pain and a bit confused but still able to chat a bit and listen. The staff on the ward could not have been more helpful. I spoke to a lovely junior doctor at the end of the afternoon. He told me what treatment Mum was getting and I made it clear that if she deteriorated she didn't want to be over-treated; she had made that clear to us in the previous months.

I returned to London, and at 10am the next morning I had a call at work from a staff nurse asking if my sister who was visiting that day could get there any faster. I explained she was at Paddington station and asked for more information.

Amazingly I was put on the phone to the same doctor I'd met the previous afternoon. He told me that Mum's pain had increased overnight, her heartbeat was weaker and she was now approaching end of life. She had been moved to a side room. Clear communication and information from someone I had already met made it easier to receive this news than it might have been. After a terribly slow drive with my husband, we arrived to join my sister who was sitting beside Mum who was sleeping. We had a brief chat to the same lovely doctor who was as informative as he could be, and were sitting by Mum's side when she very peacefully passed away just a short time after we'd arrived.

The nurses could not have been kinder to us, and the same doctor stayed on to speak to us again and complete the final checks and paperwork for Mum. He had been about to leave the ward but heard that Mum had passed away and returned to see us. The cause of death was thought to be lack of blood supply to the stomach and bowel. For me, the treatment Mum received in the last few days of her life could not have been better and it exemplified the best practice I'd been learning and hearing about in my work here at BGS.

The timing of me writing this coincides with me moving on from BGS to a different part of the charity sector. I will always be an advocate for the work of all members of the Society, and for improvements in health care for older people. It has been a privilege working at BGS.

Caroline Cooke
BGS Policy Manager

Obituary: Professor Peter Millard (1937-2018)

Professor Peter Henry Millard MD, PhD, FRCP was a dedicated geriatrician who devoted himself to improving elderly patient care

Professor Millard was born in 1937 and received his medical training at University College Hospital (UCH), London. After various junior posts, he was appointed senior registrar in geriatric medicine at UCH under the tutelage of Professor Norman Exton-Smith, for whom he had a lifelong regard. He was appointed consultant physician in geriatric medicine at St. George's Hospital, Tooting in 1969 and became the Eleanor Peel Professor of Geriatric Medicine at St George's in 1978. He obtained his MD in 1989 and his PhD in 1993. He was a Visiting Professor, University of Westminster, and a past president of the Section of Geriatrics/Gerontology of the Royal Society of Medicine. He was a Health Advisor to the National Pensioners Convention.

Peter was committed supporter of the BGS and was Secretary from 1974-76 and President from 1994-96. In 1974 the Society had to leave its accommodation at the Institute of Biology and Peter became instrumental in negotiating with David Hobman, the then Director of Age Concern, to allow the BGS use of office space in the Age Concern headquarters in Mitcham at a 'peppercorn' rent. Later he was involved in discussions which led to the Society's move to its present HQ in St John's Square in 2000. In later years, he was a stalwart supporter of the group of retired BGS members.

It was while he was training at UCH that he developed his research interests in the organisation and efficiency of day hospitals and inappropriate referrals for inpatient care. These early studies demonstrated how much time was 'wasted' in transporting patients to and from their homes to the day unit. He concluded that patients might spend between 30 minutes and 2.5 hours travelling to/from the day unit. Consequently, it was not surprising that travel sickness was often given as the reason for non-attendance. These findings exemplified the importance in improving the quality of care provided to elderly people, wherever they might be, but especially those requiring continuing care. His philosophy concerning 'decision making' at the end of life was supported by his firm religious convictions.

Patient flow, particularly elderly patients through hospital wards, continued to claim his attention into retirement. In 1993, he had created a new word to describe the process: 'nosokinetics.' The word was derived from the Greek *noso* meaning disease and *kinetics* meaning movement. He developed methods for measuring and modelling the process of inpatient care. He was editor of *Nosokinetics News*, President of the UK Nosokinetics Group and was co-supervisor of doctoral students modelling health care systems at the Universities of Ulster, Westminster and Adelaide. He published more than 120 articles on aspects of modelling health and social care. Unfortunately, the later years of his life were marred by steadily worsening dementia. Peter died on 2 October 2018.

BGS Membership 2019: act now

Ensure that you continue to enjoy uninterrupted benefits of BGS membership by following three simple steps

Membership is due for renewal and action is required to ensure your membership continues at the correct rate.

You should have by now received a renewal communication email from BGS - if you haven't, please contact **membership@bgs.org.uk.** This communication will include a personalised button for you to click on and confirm your details for 2019.

We request that this action is done even if you are paying by direct debit. Your grade and circumstances do (often positively) impact on your membership fee.

If paying by direct debit, your membership will automatically renew - if you do not confirm your details or update us on your circumstances, you will be debited on your current membership category.

If you are paying by card and do not reconfirm your details, your membership will lapse and your membership benefits will cease as of **31 December 2018**. Student members will also need to reconfirm their eligibility for their membership using the link.

If your membership lapses, this means you will no longer be able to access:

- Reduced registration rates at BGS conferences and events
- *Age & Ageing* journal online or continue to receive hard copies in the post
- The member sections of the BGS site and new members directory.

To ensure your membership is renewed, please follow these three simple steps:

1. **Click** on the personalised button in your recent/due renewal communication email
2. **Confirm** your details are correct and up-to-date
3. **Complete** payment for your membership (if paying by direct debit you won't need to re-enter your details).

The 2019 membership fees are listed in the table at the bottom of this page. As you will see, there is a £20 discount for UK-based members who set up a direct debit and pay their membership fee via this payment method.

We do have two reduced rates for those who are:

- Currently or about to take maternity leave. A 50% discount will be applied to your membership and you will retain all your membership benefits. This rate is applied to the year of membership in which the greatest part of the member's maternity leave falls.
- Working 60% full time equivalent or less.

For both reduced rates, we will ask you to provide supporting documentation. If you are unsure whether you are eligible, please contact **membership@bgs.org.uk**.

Please note, for those paying by card, and complimentary members, if you do not renew your membership, your membership will lapse and your membership benefits will cease as of **31 December 2018**. For direct debit payers, your membership will automatically renew and if you do not confirm your details or update us with your circumstances, you will be debited on your current membership category.

Category		Fee for January to December 2019	Direct debit payments (represents £20 saving on the full rate)
Specialist medical rate **Category A**	Medical student/ Foundation year doctor	£0	£0
	CMT	£105	**£85**
	Registrar/specialty doctor	£125	**£105**
	Consultant/senior doctor	£215	**£195**
Healthcare professional rate (non-specialist medcal rate) **Category B**	Student nurses and AHPs	£0	**£0**
	Nurses, AHPs and GPs (etc) without journal, standard benefits	£50	**£30**
	Nurses, AHPs and GPs (etc) with journal, enhanced benefits	£105	**£85**
International rate	Overseas members	£100	Not available

Notices

Vacancy for BGS Oncology Special Interest Group (SIG) Officer

After three years as chairs of the BGS Oncology SIG, Danielle Harari and Tania Kalsi are completing their term. Expressions of interest and/or nominations to take on this fantastic role to **tania.kalsi@gstt.nhs.uk** and **danielle.harari@gstt.nhs.uk**. The new chair will be announced at the Annual General Meeting.

Upcoming BGS events

www.bgs.org.uk/events

25 January 2019
Cardiovascular Section Meeting: The Ageing Vasculature – Where Can We Intervene?
Royal College of Obstetricians and Gynaecologists, London

1 February 2019
Movement Disorders in Older People MDOP
Etc Venues Maple House, Birmingham

2-3 February 2019
Trainees' Weekend 2019
Etc Venues Maple House, Birmingham

14 February 2019
East Anglia Region Spring Meeting 2019
Norfolk & Norwich University NHS Foundation Trust

15 February 2019
Frailty and Urgent Care Meeting 2019
Etc Venues Prospero House, London

27-28 February 2019
Joint BGS & Macmillan OncoGeriatrics Meeting 2019
Etc Venues Hatton Garden, London

BGS appoints new Chief Executive

BGS has appointed Sarah Mistry as its new Chief Executive effective from February 2019. Sarah Mistry will succeed Colin Nee who announced his retirement from the BGS earlier this year.

Sarah comes from Bond, the UK network of NGOs working in international development, where she has represented the UK NGO network at many global fora and is currently leading co-ordination of the NGO sector's safeguarding response. She is on the board of the Scottish Power Foundation, the Council of the Development Studies Association and the Advisory Board for the Centre of Excellence for Development Impact and Learning, and is a Fellow of the Royal Society for the encouragement of Arts, Manufacturers and Commerce.

BGS victim of cyber attack

The BGS server was subject to a 'ransomware' malware attack on 27 November 2018 which encrypted all the Society's files with a demand for money to decode them. Files encrypted included the personal data of staff, members and other service users. There is no evidence that any of the files were viewed, copied or transferred. The BGS staff team have worked with the network supplier to get the problem resolved, and the Society is now back to business as usual. The attack happened despite the Society having comprehensive, up-to-date security provided by a specialist IT provider. These security measures are now being reviewed to help prevent future attacks. For more information about what happened read the Q&A at: **https://tinyurl.com/bgsattack.**

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