

# BGS NEWSLETTER

**British Geriatrics Society**  
Improving healthcare for older people

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## Speaker's Corner

Ward rounds - a stressor too far?

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**Payment by Results**  
goodbye HRG4; an introduction to the new HRG4+ grouper

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## Editorial



**It's January and it's actually snowing as I write this. Hospitals are full, flu is spreading, and health services are under immense pressure. Despite that, healthcare professionals across the UK and beyond are doing trojan work to keep services afloat to help older people stay well or get home as quickly as possible.**

But there's a growing sense of concern that our ability to handle these increasingly frequent bouts of strain on the system is being challenged in a profound way. The demand for our services seems relentless and at some point there's a chance that we ourselves won't be able to cope. I hope that each of you will be able to take some time to recover once things settle down (for a while).

Meanwhile, this BGS Newsletter should provide ample distraction. It's a bumper issue, and Recia, our sub-editor has been pushed to the limit herself to try and bring it together for you! One of our roles is to tell you some of the stories people come across in their practice and consider how humanities can enhance our enjoyment of work. I'm delighted that Samuel Willis, a fourth year medical student in Cardiff University Medical School, has written about storytelling in geriatric medicine. He shares one particular story that affected him and notes that, "it reminds us we are treating people". Especially when times are busy, we should take a moment to hear our patients' stories. Both parties can benefit greatly.

Our Speaker's Corner column continues to generate good debate and shows that we are not afraid to consider controversial topics! This time, Tarun Solanki asks the

question that (currently) has no answer: how much time should we spend seeing each patient on ward rounds?

He challenges us to consider whether the traditional ward round is broken and needs to be changed. He points out that our patients are increasingly complex, and we are required to make decisions on resuscitation, DOLS, end of life planning and spend more time communicating with families too.

The RCP guidance of 1 PA for a 20-30 patient ward round is no longer fit for purpose in our population. You can leave a comment on the blog site, where the debate is ongoing.

The BGS Conference returned to London in 2017 and there were record numbers in attendance. I was pleased to chair a session where the room was full to the brim, and the buzz around the conference venue was palpable. All the highlights are recorded in Liz Gill's conference report. For many people, the highlight of the conference was the newest aspect: the BGS Fringe. This was an auspicious debut for the daring parallel strand that offered, "Pimp My Zimmer", crocheting a snowflake and a silent disco (I feel obliged to warn you not to watch the videos on twitter)... We have the full report on page 12, without any embarrassing dance moves.

The meetings also offer us a chance to meet up with BGS officers, who are active in many areas and not only in the UK. Cliff Kilgore, Consultant Nurse Intermediate Care for Older People and Chair of the BGS Nurses' Council, was invited to be the key speaker at an international conference in Israel recently. He shared details of his day to day work with the BGS and explained the role of the Consultant Nurse, which was enthusiastically welcomed. Cliff and others work tirelessly to help enhance the international standing of the society. If you have what it takes, come and get involved in our work!

With NHS resources increasingly constrained, the new Health Care Grouper<sup>4</sup>, in the context of Payment by Results, is designed to take greater account of the additional resource required for greater complexity. Amit Arora does a sterling job of trying to explain this rather bureaucratic system. Hopefully, it will continue to evolve in a way that recognises the pressures being brought to bear by increasing complexity.

Finally, in academic geriatrics there are two articles in this issue that are well worth flagging. One of the most interesting papers I've seen recently was from Daniel Davis (previous winner of the BGS Rising Star award) and Thomas Jackson (current BGS Rising Star!) along with other colleagues including Ken Rockwood. They found that fitter individuals are at the highest risk of death associated with delirium. Intuitively this makes sense, as the magnitude of the insult needed to push a fitter brain into delirium would be much greater. It's nice that we now have evidence to prove it. Speaking of proof, the old "Delirium, ?UTI" phantom still haunts many of us and Henry Woodford does a fabulous job of debunking commonly held beliefs surrounding urinalysis. He gives a fine review of the literature in this area and notes that the best place to dip urinalysis test strips is in the bin!

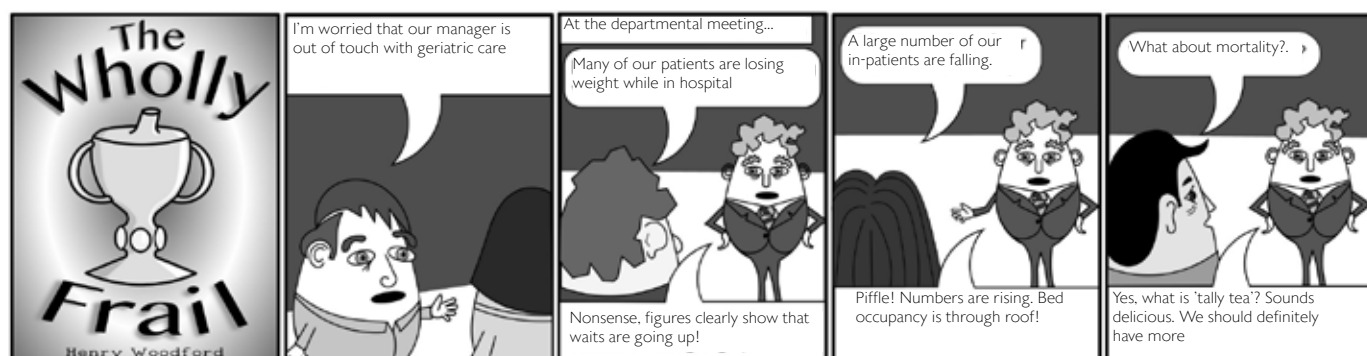
Henry now joins Muna (aka, the Older Person Whisperer and her associates) in producing cartoons which add a touch of lightness and irony to this publication (see below). We welcome other artistically talented individuals to send in their lighter perspective on working at the coalface of the NHS.

It has also been our pleasure to interview a number of notable individuals who the BGS has recognised for their contribution to our specialty, namely Dawn Skelton and the winner of the BGS Special Medal, Jill Normington (pages 42 - 46).

There are two other winners of note, namely Thomas Jackson and Ruth Law, the 2018 winners of the BGS Rising Star Award (page 47.) Congratulations to you both

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Shane O'Hanlon





# From the President



**It has been another busy time as president of BGS since the last Newsletter. The society continues to contribute to development of services for older people in many different arenas - more of this below.**

However, like all geriatricians, clinical work has also been exceptionally busy. At the time of writing 'flu is just beginning to really take hold, and I fear for the care of our patients over the next months. The media tend to forget about a story as soon the headlines are written, but we know that an increase in admission rate has an impact for several weeks as frail people recover and require rehabilitation and discharge planning, and we know that the strain on acute, intermediate, community health and social care services will continue for months to come.

I hope that those of you who were able to get away from clinical work for some CPD at our Autumn meeting enjoyed it as much as I did. Those who weren't able to be there can get a flavour from the report in this newsletter, but the innovation of the BGS Fringe deserves a special mention - hugely enjoyed by everyone I spoke to, and an opportunity to reflect on some of the key skills of our specialty, and to remind ourselves of the importance of seeing our patients as people - not always as older people, or patients, but people.

In December Caroline (our Policy manager) and I attended an All Parliamentary Group on Health where we were invited (jointly with RCGP) to give evidence about integrated care. This followed on from the document we published on *Integrated Care for Frail Older People* last year, which gave examples of geriatricians and GPs working together in innovative ways. Prof Helen Stokes Lampard

(Chair of RCGP) and I spoke about work we've been involved in and gave the attendees information about the wider context and the need for different approaches, based on the wishes and needs of older people themselves. We received considerable interest from peers and MPs.

As you will know, the government has announced that they plan to bring forward a Green Paper on the funding of social care. I have been invited to join a group of experts to advise on this. The group includes Sir Andrew Dilnot who previously produced a report on this topic, and Kate Barker who led the Barker Commission on the funding of health and care for the King's Fund, as well as Paul Burstow (ex care minister under the coalition government), the recent past president of the Association of Directors of Adult Social Services and leading figures from the insurance and finance services. So far it has proved to be a fascinating group of people, with a wide range of views. I'm delighted that the expertise of the society in the care of older people has been recognised by our inclusion.

**The case that for older people, health and social care needs are inextricably linked together has been clearly made. The group are very aware that whilst we meet to advise on a medium and long term solution to the current funding crisis, urgent action is needed to ensure the NHS and social care can get through the next few months.**

Obviously, the minister can choose whether to heed advice offered, but it's at least potentially helpful to be able to be absolutely clear about the gravity of the current crisis (yes, it is a crisis!).

Our society was well represented at a King's Fund meeting entitled, *Enhanced Health for Care Home Residents* in December, with some excellent examples of integrated care. Some of our key academic nurses demonstrated their world class expertise in their presentations. Other conferences at which I was invited to speak or chair included the International Longevity Centre's conference on the *Future of Ageing* in December and a Nuffield Trust event on the *Social Determinants of health* in January. Both gave fascinating insights into aspects of ageing which we may not always consider when fighting the good fight in the acute hospital!

Other key issue which I've been continuing to work on are workforce issues (BGS will respond to HEE's workforce strategy, currently out to consultation), and ongoing work with RCGP and with our society's GP members to continue to explore how we can most effectively support the development of models of CGA in the community.

It was fabulous to see Dr Jackie Taylor voted as President Elect of the Royal College of Physicians and Surgeons of Glasgow- the first geriatrician in that role!

On a related theme, please don't forget that more than one of our members is a candidate for the presidency of RCP London - so if you are eligible to vote, please do so.

The current pressure on the NHS has shone a spotlight on the way we work together for the benefit of our patients across our multidisciplinary teams. In general, the press has recognised this, I know chief executives up and down the country have done so, and I'm sure that you will also have

received thanks from many patients and their families for "going the extra mile" when services are so stretched. It's what we geriatricians do, and will continue to do, whilst at the same time continuing to fight for the improved services our patients need to which they are entitled.

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**Eileen Burns**



## Specialist Care Frailty Network – we need your help!

**Some BGS members may have heard about the Acute Frailty Network, which has been in existence for some years now. The focus of the Acute Frailty Network has been acute medical care and, to some extent, emergency care.**

The Specialist Care Frailty Network will focus upon the care of older people with frailty in six specialist services:

- Renal Dialysis
- Chemotherapy
- Emergency Cranial Neurosurgery
- Interventional Cardiology
- Complex Spinal Surgery
- Adult Critical Care

The first test will be focusing on renal care; we plan to design and deliver a small 'improvement collaborative' to test changes and improve local care models. We are really keen

that the work is supported by geriatricians, so this call is to ask you to get in touch if you might be interested in helping out. Ideally, we would like to convene an expert panel of geriatricians, nurses and allied health professionals who have experience working in these areas or a related field, who can advise the improvement team about interventions that might work and *how* they might work. As there is relatively little evidence in these fields about frailty care, we are going to rely heavily upon expert opinion. No one will have all the answers and so there will be an iterative nature to the programme.

A more hands-on option is possible. For example, if there are folk who have significant experience of working in renal (for example), they might come along to some of the national events as a speaker.

You will be able to influence the national approach to the care of older people with frailty in these areas, and generally have some fun!

If you are interested or would like to know more, please contact Simon Conroy ([spc3@le.ac.uk](mailto:spc3@le.ac.uk)).

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**Simon Conroy**  
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# Life, Death and the Stories in Between: Storytelling in Geriatric Medicine

One of the most sincere forms of respect is actually listening to what another has to say.

Bryan H. McGill

**Storytelling has many roles within society, including geriatric medicine. It unites us, imparting wisdom from one generation to the next and gives us a glimpse into the lives of those dearest to us.<sup>1</sup>**

'Back in my day...' is an opening phrase that we are all familiar with. It is a neighbour talking about how the street has changed, an older friend criticising change or an older relative sharing a story from their younger days.

As a medical student, I am frequently told stories. A familiar face shadowing the doctor on the daily ward round, without the time pressures they face, provides unique opportunities to engage with patients who are always happy to tell their stories. Stories of the fall that led to their admission, of the last time they were in hospital, of what they did when they were my age.

One particular story has stuck with me. It is of an older gentleman on the vascular ward who kindly agreed to allow a peer and I to practise our peripheral vascular examination technique. The introduction could have gone better. We explained that the examination would involve having a look

and feel of both his legs.

"Leg!" he exclaimed.

We forgot to use our eyes. But now we noticed a photograph hanging on the wall of his room.

"Who's that in the photo, is it you and your wife?"

"We used to go on cruises, dancing. We loved dancing!"

"Will you try dancing once you've got your new leg?"

"Oh no, my dancing days are behind me now. I stopped dancing long ago when this leg started going bad. But I am going to get my new leg. My consultant said I'd normally be a bit old to have one, but I am determined to get up and about."

We learned a lot about him that day, so much more than the fact that he only had one leg and no popliteal pulse. We heard of the role that dancing had had in his life, saw the joy it brought him as he reminisced and we understood how important to him was the prospect of getting his independence back.

Looking back, I realise that he had hope. He might have been biologically old and unable to do something he loved, but he was still looking to the future with determination and happiness. He was not ready to die. There was no formal conversation about ideas, concerns and expectations, but we learned what these were, simply by listening to him tell his story.

You get old and you realise there are no answers, just stories.

Garrison Keillor

All patients, especially those who make it onto a Care of the Elderly ward, have stories to tell. Unfortunately for patients in hospital, they have entered an environment that is unfamiliar, incredibly busy and full of noises that can stop these stories from being heard.





Developing strong relationships with patients, by engaging in their stories, is fundamental to patient centred care.<sup>1</sup> This model of medicine is known as narrative based medicine, and it allows doctors to see beyond the clinical facts and explore the personal journey and experiences of patients, communicating using a language that both patient and doctor can understand.<sup>1,2</sup>

Patients can use their story to explore meaning and purpose, to share their emotion and burdens, which narrative gerontologists believe to be the biggest challenge for older patients.

Failure to address these existential issues often results in loneliness and distress. Currently only 49 per cent of patients believe their spiritual needs are met.<sup>3</sup>

Building relationships with patients and listening to their stories in depth takes time, meaning that its importance can often be marginalised in a busy ward environment. However, with average acute admissions lasting around twelve days for older patients, there is likely to be many opportunities to listen to their stories.<sup>4</sup> Two minutes is all that is needed for 80 per cent of patients to express their concerns.<sup>5</sup>

There are many proven benefits from this time investment. Studies report patients having better mental health, receiving earlier access to palliative care and being more likely to die in their preferred setting.<sup>6</sup> The benefits are not only potential. Clinical studies have shown that measurable physiological parameters, such as spirometry, improve when patients record their experiences.<sup>2</sup>

Stories imitate life; each with a beginning, a middle and an end. Talking about the end, or even planning for it, is never easy. Thinking about death can seem like an alien concept in a society constantly striving to live longer. Whilst the advances that prolong life are to be celebrated, it can result in patients experiencing a more gradual decline in health that can be difficult to manage.<sup>6</sup>

There has been an increased awareness of the importance of planning for end of life care, both among health care professionals and the general public. The End of Life Care Strategy expanded the role of palliative care and highlighted the link between advanced planning and the quality of end of life care.<sup>7</sup> Charity campaigns such as *Talk CPR* have encouraged open discussions between GPs and patients, who might not have thought previously about a 'Do Not Attempt Cardiopulmonary Resuscitation' decision.<sup>8</sup>

Discussing end of life decisions and Advance Care Plans can fill both doctors and patients with apprehension. However, when approached through the patient's story it can reduce anxiety and explore dying in the context of patient's accomplishments, which are not diminished by death.<sup>3, 9, 10</sup>

Patients who have advance care plans worry less about the future.<sup>6</sup> Whether or not a patient wants to complete a legally binding advanced care directive, which only two per cent of the Welsh population currently have, recording any patient wishes in medical notes provides reassurance to families that a relative has 'died well.'<sup>12, 13</sup>

Patients and their families often find it difficult to initiate conversations about end of life care, though both would like address it.<sup>13</sup> A role of the doctor can be to encourage patients to include family members in discussions, provide a safe space to explore worries and dispel myths. Combined, this provides much needed psychological support.<sup>14</sup>

There was an ending—there always is—but the story went on past the ending—it always does.

Jeannette Winterson

It is important to remember that a person's story does not end when they are unable to tell it. But as individuals within our society become more isolated, this is felt most strongly among the older people and it becomes increasingly more difficult for them to pass on their story.<sup>15</sup> Encouraging patients to record their story helps them to create a legacy for their family and generations to come.

This idea was explored in a talk given at the Hay Festival of Literature and Arts, entitled, *Before the End – Telling Your Story in Time*. Author George Brinley Evans strongly advocated the importance of the written story as “when you write, it’s just you and the page; there are no conflicts of characters.”<sup>16</sup>

A written version of a story can be used to shape how the writer is remembered. It improves patients’ sense of dignity and helps families with the bereavement process.<sup>3</sup> It allows the continuation of bonds once the patient is gone and helps prepare families for the grieving process, through the development of a shared resilience.<sup>9</sup>

A powerful example of a patient's written story is the autobiography, *When Breath Becomes Air*, by Paul Kalanithi. It explores his transition from neurosurgeon to patient and details his experience with a terminal illness. Unfortunately, Paul died before completing his story. His dying wish was that his story be published. His wife, Lucy, completed the manuscript and described the book as a way of ‘grieving and honouring him.’<sup>16</sup> The vulnerability and honesty displayed throughout the book is very touching and encourages self-reflection. The doctor as a patient narrative also grants insight into how his understanding of the doctor role as a caregiver changed through his personal experience.<sup>2</sup>

The most important role of a story exchange is that it reminds us that we are treating people. As geriatric medicine continues to manage the health of the ageing population, with services and resources under pressure, it must not forget that each patient’s experience of health is individual. Engaging in patient stories, and highlighting their importance within medicine, improves the quality of care and eases end of life decision making. Encouraging patients to share and record their story, before death makes this impossible, prepares both them and their family for the process and helps relieve some of the difficulty we all face when talking about dying.

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**Samuel Willis**

Fourth Year medical student in Cardiff University Medical School

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# We are living longer than before, but are we living healthier?

**There is no doubt that people from countries all over of the world are living longer, but there is little evidence to suggest that older people today are living healthier lives than their parents did.**

This is a major concern for many governments around the world because if the added years are marked by chronic disease and disability, this will have considerable social and financial impact on older people, their families and on care systems.

As with other Western countries, Hong Kong, a special administrative region of China situated on the Southern coast, faces a demographic challenge in the coming years. Latest statistics reveal an accelerated pace of ageing. In 2016, there were 1.2 million people aged over 65 years. By 2064, it will increase more than 2-fold to 2.6 million. Furthermore, Hong Kong people are living longer than ever. Compared to other countries, Hong Kong has topped the world charts for longevity, with men expected to live to 81.3 years, while women were expected to live to 87.3 years in 2016. This longevity is a great achievement but, will population ageing be accompanied by an extended period of good health or will it be associated with more morbidity and disability? Can our care systems cope with this demographic shift?

A better understanding of the trajectories of health is crucial to ensure that our care systems respond to population ageing. In 2017, our research team examined the trajectories of the frailty index among over 90,000 community-dwelling population older than 65 years, using 12 waves (2001-2012) of data on multiple birth cohorts (cohort 1901-1923, cohort 1924-1929, cohort 1930-1935, cohort 1936-1941, and cohort 1942-1947) from the Elderly Health Centres of the Department of Health in Hong Kong. The frailty index is a proxy measure of ageing and vulnerability to poor outcomes.

Our findings suggested that more recent cohorts had higher levels of frailty than did earlier cohorts at the same age. Differences were also observed in both men and women. We also found that the cohort effects are independent of age, period, gender, marital status, educational levels, socioeconomic status, lifestyle and social factors.

This trend raises the question, why are our older people today frailer? Unfortunately this study is not able to answer the question, but we speculated that the increase in chronic diseases and impaired physical and cognitive functioning, the higher proportion of sedentary occupations, the rising number of older people living alone and the associated adverse impacts on their social networks, may have contributed to the increased levels of frailty over time.

Our findings on trajectories of frailty carry a negative implication that the gains in life expectancy are associated with concurrent increases in levels of frailty, with the potential for greater associated costs for medical care, social services and long-term care. Our findings are consistent with those published by Andrew Kingston and colleagues in *The Lancet*. Kingston and colleagues' study compares two large British cohorts of older people, aged 65 years or older, interviewed in 1991 and 2011 and shows that while life expectancy rises, the number of years older people have spent with greater levels of dependency and substantial care needs also increases. Findings from our study, as well as from the Kingston study seem to substantiate the notion of the so-called "failure-of-success", which suggested that increased longevity would result in an absolute decline in health.

Having said that, we can combat the increasing rates of frailty through early detection and early intervention, (given that frailty is reversible). Our findings will help to inform the planning to create better care systems. If we could prepare our care systems well, the added years of people could offer new opportunities for our society.

The full study appears in the December 2017 issue of *Age and Ageing* and may be accessed here: <https://academic.oup.com/ageing/advance-article-abstract/doi/10.1093/ageing/afx170/4637483>

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**Ruby Yu and colleagues**

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# Speaker ward rounds – a

## Ward rounds – are they safe and effective for patients and doctors?

**Geriatricians are, in many hospitals, now responsible for looking after more than 50 per cent of medical in-patients and are frequently required to look after outliers on non-medical wards. A recent article in the BMJ suggests that doctors' ways of working would not be accepted by businesses making decisions with far less impact and it suggests that the old concept of the ward round is broken and needs to be changed.**

Since we as geriatricians are providing a substantial element of acute inpatient care, should we not be at the forefront of improving the ward round so that it is not only effective and safe for patients, but also to ensure geriatricians do not suffer from undue work pressures and risk burn-out? At a time when there are increasing pressures to improve not only patient care but also communication with patients and relatives, is it not necessary to review the time allotted to geriatricians to safely and effectively manage acutely unwell frail older patients under their care?

Acute geriatrics has evolved significantly over the past decade. As a consequence of pathways to enable supported discharge from an acute admissions unit or from the emergency department, the patient who requires inpatient care is generally very unwell, with multiple co-morbidities and often has significant complex social care issues. These

patients require comprehensive geriatric assessment and careful consideration of their treatment options.

Alongside the complexity of patients, there has also been a huge rise in the types of activities geriatricians are required to perform during the ward round, such as resuscitation decisions, end of life planning, DOLS, etc. to name but a few. In many hospitals all of these tasks frequently fall on consultants due to lack of trainees, rota gaps or differing work schedules. These activities require time to perform sensitively and sympathetically.

Prof David Oliver recently stated “one of the biggest stressors in work for me and my colleagues, junior and senior, is the relentless demand for information – not from patients themselves but from their relatives”. A significant majority of clinicians of all specialities and grades will agree with Prof Oliver's statement. However, for those of us who are dealing with a predominantly inpatient workload this will create greater stress.

The past decade has seen a significant decline in the number of hospital beds and a concomitant rise in medical admissions. This creates considerable pressures on clinicians, especially geriatricians, to be involved early in the assessment of many of these patients and in early discharge planning. Early discharge also results in added administrative work for consultants who will need to communicate results of outstanding investigations to GPs, patients and care homes. As a consequence, I frequently feel my ward rounds are akin to being on a treadmill which is constantly being cranked up with no respite in sight.

Geriatricians have little or no control over the number of

# 's Corner: a stressor too far

patients admitted to their base ward and, particularly after a weekend, they may arrive on the ward to find ten or more new admissions and probably a number of outliers.

Increasingly we are working predominantly on the ward, with an outpatient clinic perhaps once a fortnight. It is also clear that outpatient work is reasonably well protected with a pre-determined number of patients seen per session.

Many of our organ speciality physicians tend to rotate between being on the wards and doing speciality outpatient work. The majority state that their stint on the wards is hard work and they look forward to going back to their outpatient work.

Geriatricians, unfortunately, do not have this luxury and are responsible for inpatients all year round, with occasional respite for some in the outpatient setting.

The RCP document, *Consultant Physicians Working with Patients*, published in 2013, recommends 1 PA for a 20-30 patient ward round. This equates to between 12 minutes (for 20 patients) and 8 min (for 30 patients) per patient. There is no distinction between a patient who is new to the consultant and one who is known to the consultant. The same document recommends 45-60 minutes per patient in the out-patient setting for complex elderly care patients, which equates to 4-5 new patients per PA in clinic. While the time for seeing a complex needs older person in clinic appears to be wholly appropriate, the time allocated to ward patients in the current environment of variable/ scant junior doctor support, rota gaps, insufficient nurse staffing to attend ward rounds etc. is so stringent as to render the time spent with each patient, no more than token. In addition, the RCP recommendation does not take into account time spent on a daily board round, which can take between 30 minutes and an hour depending on the number of patients on a given ward.

A poll of geriatricians in the South West of England suggests that they are coming under increasing pressure to review and discharge patients as soon as possible, and that the time required to safely assess and plan patient care is insufficient. They have little or no control over the workload on wards, compared to the planned and agreed output in the clinic setting. Most felt that the RCP guidance for ward rounds is insufficient and that a new patient on the ward requires 30-40 minutes of consultant time and a follow-up of around 10-15 minutes.

Caldwell *et al.* reported in 2011 that when attention is paid to quality and safety at the point of care, it took 10 minutes per patient for routine ward round and 14 minutes for a post take patient. Their study did not take into account any communications with relatives and the other aspects of care we are now routinely required to participate in. In a follow-up report in 2016, Dr Caldwell reported that the time for a routine round had increased to almost 16 minutes per patient and, for a post-take round, to 24.5 minutes per patient. Again, this update appears to account only for the medical component of the ward round without taking account of all the additional tasks we are increasingly required to perform.

As geriatrics is the largest speciality providing acute inpatient care, it is important that we as geriatricians lead on redefining and developing safer working on wards not only to enable better, safer, and informed care for patients and relatives but also ensuring we do not suffer from burnout. Is it not now evident that clinicians responsible for the medical management of frail older acutely ill patients need the time to deliver their services safely and competently? If we do not address this issue we are in danger of failing these patients who require our expertise, and we increasingly risk burnout, which may ultimately result in fewer trainees choosing geriatrics - endangering the future and reputation of the speciality.

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**Tarun Solanki**  
Consultant Physician and Geriatrician  
Taunton and Somerset NHS Foundation Trust





# BGS 2017 Autumn Conference Report

**Geriatricians should start introducing themselves to fifty-somethings to help them age well and to combat the widespread negative image of older people. That was the message from Baroness Sally Greengross who told the BGS's Autumn Meeting, "There's a huge reluctance to be old, instead of relishing it, being proud and active and as involved as possible."**

The 82 year-old president and chief executive of the International Longevity Centre-UK added, "I'm very lucky in that I'm very old and still able to work. I want everyone to be in that position and I want geriatricians to be part of that."

Old age now could be anything from 50 to 100 or more. "We should see 50 as beginning the second half of life – perhaps we should be called second-halfers. At that age we should have a health check, a money check, a planning check with our families about what we can do with and for them and, a work check. Do we want to work full time, for instance, or flexibly?"

Such checks could help make the later years the most enjoyable part of life. "We need your help in achieving this. The BGS can make it happen."

There were also increasing economic and social needs for an active and healthy older population, as Baroness Greengross spelled out in her guest lecture. The 'new normal' of longer lives was leading to longer retirements but governments might not be able to pay pensions for extended periods.

"Working longer is an answer to both personal economic stability in older age and to reducing the state pensions bill."

Many industries already relied on older workers and there was a growing trend for retirees – one in four – to return to work within five years of retiring. But it was not only a case of getting paid employment in our 70s and possibly beyond, older people also needed to be well enough to enjoy the arts, use new technology and be volunteers. "No-one could manage an election in this country, for example, without all those older people pushing envelopes through doors."

Not so long ago, Baroness Greengross recalled, when old people became ill they simply died. Now they survived with long term conditions and many co-morbidities. But these in turn meant huge pressures on the NHS where 70 per cent of the budget was spent on the management of chronic disease and on social care with its £100bn a year cost.

There were other stark statistics. The over 65s represented 23 per cent of all accident and emergency attendances but they accounted for 46 per cent of all admissions from those departments. People aged 75 and over were staying an average 9.1 days per admission, compared to five for all ages. And between 2010/11 and 2014/15 the number of outpatient appointments for people aged 60 plus increased from 28.1m a year to 36.1 million.

Residential care fees today averaged £33,000 a year compared to £27,400 five years ago but pensions had not risen accordingly. "There's a huge impossible gap," she added, hence the need to achieve and sustain good health for as long as possible.

Baroness Greengross cited various examples from around the country, of projects and measures aimed at attaining this. These could range from simple measures – such as Hull's decision to give out relatively cheap devices and adaptations such as higher toilet seats or hand rails immediately, without waiting for bureaucratic clearance so that occupational therapists were freed to attend to those who needed more complex help – to the sophisticated, such as the imminent opening of first A and E unit for older people at Norwich University Hospital.

Another example of good practice was in Southampton



where the creation of a consultant geriatrician's post to support the community rehabilitation team had led to a 14 per cent reduction in delays of transfers of care, a six per cent reduction in injurious falls and a seven per cent reduction in admissions for over 65s.

A similar multi-speciality community provider in Hampshire called *Better Local Care* comprised a partnership of GPs, NHS providers and commissioners, Hampshire County Council and a number of local community, voluntary and charity organisations.

Other important factors in healthy ageing included an increasing focus on education, advice and guidance for the prevention of illness, encouraging older people to take exercise, supporting them to manage their own health, helping them to stay safe at home, effective use of outpatients clinics for managing long term conditions and good communication across the primary and secondary care interface.

Housing and social networks had a big role. She was a big fan of retirement living with care but such places needed more space for staff and treatments and the people who were trying to create them were in competition with commercial builders who wanted to pack in maximum housing density.

"Perhaps the role of the geriatricians is to look at these areas and where necessary be involved in politics. A lot has changed but there's a still a lot to do and we want you to be central in making this work."

## Geriatrics in beyond the United Kingdom

One of the suggestions Baroness Greengross made during her address was that we should look at what other countries were doing, which was appropriate as her fellow guest speaker was Dr Roger Wong, clinical professor in geriatric medicine at the University of British Columbia, whose Trevor Howell Guest Lecture was entitled, *Improving Acute Care for Older People – Lessons from Canada*.

He described several of their systems: the geriatric assessment unit GAU, the geriatric evaluation and

management unit, GEMU, the acute geriatric unit AGU, acute care for elders ACE and the senior friendly hospital. GAU and GEMU offered mid to late acute phase or post acute phase care with a broad spectrum of diagnostic and treatment services except for high acuity options. ACE and AGU gave direct emergency room admission with a full spectrum of diagnostic and treatment services including high acuity options. There was also MACE, a round the clock mobile service for patients already known to geriatrics clinics in a hospital to ensure continuity of speciality care on admission.

The principles for the systems were patient centred care, frequent medical review, prepared senior friendly environments, early exercise for rehabilitation and enhanced discharge planning. These could improve patient outcomes, were efficient, could be cost saving or cost neutral and could identify opportunities for improved care but their success required an adequate workforce capacity. Professionals on the team included social workers, dieticians, pharmacists and spiritual care workers as well as doctors, nurses and therapists.

Acute care environments for older people needed adequate and natural lighting, non-glossy flooring, wide hallways and room entrances, wall clocks and calendars, handrails, space for the storage of things like walking aids, easy way finding, the right position and font size of signage, ambient noise management and mobile and wifi technology.

Hospitals of the future, he believed, would integrate care with education and research and provide space to promote wellness. There would be widespread use of technology with wearable devices such as GPS trackers in footwear for patients with dementia who wandered or airbags inside belts which activated automatically if an old person fell.

The first session of the conference had also featured examples of care from abroad, this time from the Netherlands with the opening speaker Prof. Jos Schols, professor of old age medicine at Maastricht University, describing the role of elderly care physicians.

Nursing home care was carried out by multidisciplinary

teams employed by the nursing homes themselves. Teams consisted of doctors and nurses, physio-, occupational, recreational and speech therapists, dieticians, psychologists, social and pastoral workers who could be supported by such specialists as hospital geriatricians, neurologists and psychiatrists.

**The advantages of a home having its own in-house team included better continuity of care, more frequent and lengthier medical, psychological and paramedical consultations and more proactive and preventive interventions.**

“GPs and others from community health services often have inadequate time, affinity or experience to give residents the continuous attention they need. Also, by using their own personnel, nursing homes can achieve logistical and organisational advantages contrary to the situation where the home is visited by many different consulting professionals.

“Professionals employed by the nursing home itself, or working within a closed staff model, seem to be more committed and knowledgeable about long term care practice and more continuously available.”

Moreover nursing home medicine in the Netherlands was now called elderly care medicine, thus recognising it as a distinguished speciality with specific training and experience and giving such physicians an identity and position between the family physician and the hospital geriatrician.

However, although the country was proud of its nursing home traditions, since 2015 there had been moves to reduce the numbers in residential care and postpone the institutionalisation of the frail and disabled people. *Ageing in place* was EU policy and fitted the preferences of most frail older people. Already, the number of residential or nursing home beds had decreased from 163,000 to 96,000.

The new approach meant elderly care physicians giving more complementary support for community based care. Collaborative models might include advising GPs or working in GP practices one or more days a month, doing home consultations or working with hospital geriatricians or old age psychiatrists. By such means the relevant aspects and benefits of the intramural multidisciplinary team approach could be incorporated into community health care services.

The second speaker, Prof Wilco Achterberg, professor of institutional care and elderly care medicine at Leiden University, said that the Netherlands now had 1,500 nursing home medicine specialists who had undergone a three year training programme.

When the speciality began in the late Eighties, it often attracted ‘burnt out’ doctors who thought it would be an easy option. “We worked hard to find a new generation with the motivation to make a career in this field. Now we have energetic problem solvers who really want to improve quality

of life for older people.”

As part of the move towards *ageing in place* there were also training programmes for family doctors and a course for all medical specialisms. “It aims to change attitudes among those who always want to cure and prolong life at any cost. Some like the course, some don’t get it at all though, and still think operating and giving medicine is the only thing.”

Another innovation had been for academics to liaise with nursing homes to ensure research was relevant.

## **Tale of two nations**

The third talk in the Tale of Two Nations session, itself part of a full day devoted to care homes, was given by BGS President Dr Eileen Burns, consultant geriatrician at Leeds General Infirmary, who recalled that when she first became a consultant she and her colleagues had to fight to get older people into hospital. Ageism was common: 25 per cent of coronary care units, for example, had restrictions on the over 65s; 40 per cent were denied thrombolysis.

The problem now, however, was that there was a high risk of older people not being able to get out of hospital. “This is often because the services they’d need are not available. The lack of services might have caused the reason for the admission in the first place and then the care needs are increased even more as a result of the stay in hospital,” she said.

**“Staying in hospital is bad. If discharge to intermediate care is delayed by only two days a patient can never regain what has been lost. Patients are at risk of deconditioning with loss of mobility, weight loss, increasing frailty and worsening cognition. Ten days of bed rest can mean 12 per cent loss of muscle strength at hip and knee and 14 per cent loss of aerobic capacity. People with dementia are especially at risk of adverse outcomes in hospital.”**

A body of evidence was now emerging to support the development of models of care for frail older people in the community. These included support systems for care homes, comprehensive geriatric assessments while a patient was in an acute hospital, remote monitoring of people with long term conditions, improved GP access to specialist expertise, hospital at home projects and the introduction of better tools to measure frailty. “GPs’ new contracts require them to identify frail patients and to offer falls assessment and a medication review,” she added. “This is a tremendous step forward.”

Workforce challenges though, remained significant with not



enough geriatricians, community nurses or GPs, as did the financial pressures. “The vast majority of NHS spend is still on hospitals. There’s a need for some pump priming.”

## No more policies, thank you

In the following section on commissioning high quality health care, Dr William Roberts, care model lead for NHS England, spelled out the dilemma facing today’s providers. “People are living with conditions of complexity which we have never seen before in history.” We did not need more policies though – there were already 45 active policies – nor necessarily massive new investment at a time of financial pressures. “We need a way of working better with what’s already there,” he said.

Enhanced care in six ‘vanguard’ homes had already shown the importance of a person centred approach, good leadership and collaborative working between all interested parties.

“Everyone wants the silver bullet solution but often the best approach is lots of small things in a coordinated way. You can get very quick benefits, almost overnight results sometimes, which helps with staff satisfaction and staff retention. There are people now who are desperate to do good work and there are often pockets of brilliance but we need to spread and share this learning.”

Sharon Blackburn, policy and communications director for the National Care Forum, then asked members of the audience to put up their hands if they had taken any medication that morning, were living with a long term condition or caring for someone. When lots of hands went up she told them – “and we’re still living in the community.” It was the same for older people. “Our language often betrays our attitudes: we talk about people ‘ending up’ in a home. But in fact a person has just changed their address, they have same rights to access health and care as you and I.” The client base was changing. “These are tech savvy baby boomers and they expect professionals to work in their best interests. They have a sense of entitlement and are more aware of their consumer rights. Nowadays we don’t have people who just accept what the doctor or the nurses say: they are often as informed as they can possibly be and they will be challenging you and me.”

## Exercise, the best medicine

Another speaker who asked for audience participation was Prof Dawn Skelton, professor of ageing and health at Glasgow Caledonian University, who asked members to fold their arms and stand up. She then asked them to stand up using only one leg which, of course, proved much more difficult. “But that’s how an older person who’s put on a bit of weight or who’s maybe lost half their strength, might feel.” She also asked them to balance on one leg. Anyone who could not do it for a minimum of 30 seconds needed balance training; Prof Skelton herself can now do it for ten minutes.

The tasks were an attention grabbing way into her talk on the opportunities and challenges for physical activity interventions for older people living with frailty, defined as a loss of physiological reserve as a result of time, disease and

dis-use.

It was important firstly, she said, to distinguish between physical activity which was any bodily movement that expended energy and exercise which was characterised by planned and purposeful training of the components of physical fitness, was planned, structured and repetitive. It aimed to achieve skills and outcomes.

**“Exercise is one of the most frequently prescribed therapies for both health and disease so you should treat it as a drug. As with any medicine the important factors are dosage, of both volume and intensity, frequency of administration, i.e. the number of sessions per week, type, contra-indications and side effects. You should start with a minimum effective dose and titrate upwards.”**

The good news was that it was never too late to exercise. A 12 week strength training programme in nursing home residents aged 90 and above had doubled their leg strength. A group of over 75 year-olds had rejuvenated 20 years of lost strength in 12 weeks of seated strength exercise. A high intensity functional exercise project for care home residents with dementia, also for 12 weeks, improved strength, balance and activities of daily living. Other studies had shown exercise had increased muscle mass and strength for sarcopenia patients and a reduction in falls after a highly challenging balance training project of more than three hours a week for another cohort.

The minimum requirement for any exercise to be effective was 50 hours or more but support and encouragement were also essential. Successful strategies included goal setting, self monitoring, overcoming lapses and relapses, educating participants and highlighting achievements. “Often we don’t push older people hard enough but they don’t have many years ahead so you need to get results quickly.”

It was important too, to encourage an active lifestyle beyond rehabilitation and condition specific programmes and to discourage sedentary behaviour: the over 65s typically sat for ten and a half hours a day while care home residents spent 80 per cent of their day sitting. Being sedentary could lead to musculo-skeletal pain, higher plasma glucose, higher BMI and waist-hip ratio, higher cholesterol, reduced muscle strength and reduced bone density, all of which could affect quality of life and social engagement.

“All contacts with older people need to reinforce the sit less, move more message,” added Prof. Skelton. “I tell patients if you avoid activities that make you feel wobbly you will get more wobbly. It’s use it or lose it. We need to stop wrapping older people in cotton wool but we need to

explain to them why we're doing something. So emphasise the benefits. You can maintain your independence, play with your grandchildren, live life to the full. Strong muscles fight infection, protect your joints and bones, protect your brains and your memory and help you stay warm – so you might even save on your electricity bill.”

Prof Skelton, who had been presented with the Majoro Warren lifetime achievement award at the start of the conference was the keynote speaker following a workshop addressing common problems in movement and posture.

## Seventy and going strong

The meeting at ExCel in London which marked the 70th anniversary of the BGS was the biggest ever with nearly a thousand attendees including visitors from 24 countries and many sessions were fully booked.

It featured a number of firsts, the most eye-catching of which was *The Fringe* (see box opposite).

The initiatives demonstrated during *The Fringe* could be a way of counteracting the widespread depression and loneliness experienced by older people, as highlighted in a session devoted to the problem. There were ten million people over 65 in England and in every thousand, 250 would have a mental illness of which 135 would have depression, said Prof Sube Banerjee, professor of dementia at Brighton and Sussex Medical School.

## The problem of loneliness and depression

Such mental disorders in older people reduced quality of life, increased the use of health and social care facilities and were associated with a range of adverse outcomes especially if occurring with physical disorders. Depression in dementia was particularly problematic: the former may have been there for five or ten years before the diagnosis of the latter. “In some individuals, depression may be a subtle sign of neuro-degeneration,” he added. “But being sad and depressed is also a reasonable reaction to the damage to the brain from Alzheimer’s or other forms of dementia.”

Not everything which looked like depression necessarily was, and there were also several causes of the disorder so it was important to distinguish them to know which might benefit from anti-depressants and which from therapies.

Eighty five per cent of older people with depression received no help from the NHS, the next speaker Prof Alistair Burns, National Clinical Director for dementia at the University of Manchester, told the meeting. And when they did they were six times as likely as younger people to be on medication. They should instead, he urged, have more access to psychological therapies because in fact older people often recovered more quickly than the younger generation.

Loneliness – a good definition of which, he said, was the difference between the contacts you had and the contacts you wanted – was a major problem for older people. Eight and a half per cent of older people said they felt lonely often or always, 1.76 per cent had not had a conversation with friends or family for a month and nearly a third said

television was their main form of company.

“Loneliness can increase the risk of premature death by a quarter; it can be as harmful as smoking 15 cigarettes a day.”

Sometimes, however, there is a simple and charming solution as demonstrated by the Henpower scheme which provides chickens as anti-depressants. The scheme was launched after carers discovered that a man with dementia who was constantly shouting women’s names was in fact shouting the names of his chickens. Provided with six and the support to care for them, he was transformed.

## Chronic pain

Chronic pain in older people was the subject of the meeting’s last afternoon. The problem affects 62 per cent of those over 75. Many of the diseases which cause it, such as diabetes and arthritis, increase with age and many of its risk factors such as reduced physical activity, co-morbidities and reduced social networks are associated with ageing.

An example was presented, of how innovative technological solutions might help. The Chatbot project was an ‘interactive clinical expert’, available via PC, tablet or mobile, which enabled people over 65 to self manage their condition by engaging in a conversation with the device, which then led to suggestions based on algorithms for medication or exercise based treatment. The data could also be fed back in real time to healthcare professionals.

Other sessions included ones on frailty and sarcopenia, movement disorders, gastro-intestinal disorders, cardiac disease, teaching and training including e-learning, drugs and prescribing, respiratory problems and foot disorders. The latter delivered by Mark Davies, consultant orthopaedic surgeon at the London Foot and Ankle Centre, featured the most dramatic visuals of the meeting, some of which were shocking enough to make the audience gasp.

The photos illustrated the many problems older feet are prone to, including corns and calluses, fractures, osteoarthritis, metatarsalgia, problems with ligaments, joints and tendons and the diseases and conditions affecting toenails. “These can be extremely painful – never underestimate the misery they can cause”.

Although foot disorders were widespread among older people, much could be done by chiropody, physiotherapy, orthotics and ultimately surgery. “Making the right decisions is essential to help maintain mobility and independence as their reserve tanks are on low,” he said. “My personal approach is that whatever the affliction there is an optimum treatment. Good podiatry is essential for most older people. Modern surgery has a lot to offer older people and they should not be denied the opportunity to discuss this option. The *elderly* are human beings with more wisdom and life experience than anyone else. As doctors it is a privilege to look after and help these people”.

There were 142 posters and four sponsored symposia: one on nocturia and three on Parkinson's disease – one on the use of Safinamide sponsored by Profile Pharma, another on improving care and referral for patients with advanced PD sponsored by Abbvie and a third on COMT inhibition sponsored by Bial.

Social activities including early morning runs, a guided walking tour of the area, a drinks reception on the first

evening and on the Thursday evening, in a break with tradition, not a gala dinner but a more informal get-together with a finger buffet of locally sourced food and an evening of talks, music and dancing including live jazz, another performance by the flash choir and a silent disco.

**Liz Gill**  
Freelance Journalist

## Come see my etchings! Welcome to the BGS Fringe



Dr Muna Al-Jawad, consultant geriatrician at the Royal Sussex County Hospital in Brighton, also known as the Older Person Whisperer (see the cartoons which have appeared in each issue of the newsletter), has an eye for the hidden talents and peculiar (in the nicest possible sense) disposition of health professionals who have made older people's wellbeing their vocation.

In addition to authoring Older Person Whisperer cartoons (and strenuously encouraging her students to wield their pencils too), Muna, together with Dr Jo Preston, consultant geriatrician at St. George's Hospital, London and Dr Iain Wilkinson, consultant geriatrician with the Surrey and Sussex Healthcare Trust, introduced 'The Fringe' at the 2017 Autumn meeting. As its name implies, The Fringe is a forum for the 'Alternative', for quirkiness and for creativity.

The Thursday Fringe Event began with a film session showing the award-winning Egyptian short *Dry Hot Summers* about an old man with cancer on his way to hospital who becomes entangled with a girl on her wedding. This was followed by a workshop called *Pimp My Zimmer* with a practical demonstration of how personalising and



decorating the walking aids in an Essex care home had led to an increase in their use and a subsequent reduction in falls.

Other workshops featured crocheting a snowflake, Twitter for geriatricians, using Lego to promote inclusion and self expression and a book club discussing Atul Gawande's *Being Mortal*. A flash choir sang *When I'm 64* but changed the age to 94 and inter active media featured a geriatric playlist and displays where members could share their experiences – both their mistakes and what they liked about their job.

Examples of the latter included the satisfaction of finding simple solutions to help with complex problems, working with multi-disciplinary teams, older people having the best stories, there never being a dull moment and being part of a speciality that never lost touch with the fact that sometimes holding someone's hand was the best medicine. There were also age themed exhibitions of sculpture, painting and needlecraft.





# British Society for Heart Failure Conference Report

**The British Society for Heart Failure held its 20th annual meeting in London, attracting a record 850 delegates for the two-day conference.**

It was a reflective meeting, entitled, *Three decades of heart failure*, recognising the 30 year anniversary of the CONSENSUS trial. Now that ACE inhibitors form the backbone of heart failure therapy, it seems hard to imagine a time when bedrest and perhaps a touch of digoxin were all that could be offered to the heart failure patient.

## Keynote speaker

Prof Karl Swedberg (Sweden) delivered the keynote Philip Poole Wilson Memorial lecture, taking us on a whistlestop tour of key trials on heart failure pharmacotherapy covering ACE inhibitors, beta blockers, mineralocorticoid receptor antagonists and the newer angiotensin/neprilysin inhibitor. Concluding on a note of hope, he highlighted that there has been a 60 per cent reduction in mortality in heart failure patients with these treatments over the last 25 years. The take home message was that control of deleterious neurohormonal activation of the renin-angiotensin system with a combination of at least three agents was essential in heart failure patients.

## Research highlights

Prof John McMurray (Glasgow) provided an excellent overview of key heart failure research in 2017. Whilst the prominent international cardiology conferences were notable for a dearth of major heart failure trials, a few studies were worthy of attention, such as CASTLE-AF presented at the European Society of Cardiology meeting. This small study of 363 patients with left ventricular systolic dysfunction and atrial fibrillation, demonstrated an advantage of catheter ablation restoration of sinus rhythm compared to standard treatment. We await the results of larger trials, currently underway.

Another area Prof McMurray highlighted was the contentious role of ICD therapy in older patients with LV dysfunction. Subgroup analyses of both the DANISH and STITCHES trials (DCM and ischaemic patients respectively) have shown that younger patients have a mortality benefit from an ICD and that older patients have less benefit, likely due to co-morbidities and death from non-cardiac causes.

Perhaps the most positive news came from the possibility of heart failure prevention one day. EMPA-REG, a trial of SGLT2 inhibitors in diabetes mellitus, showed unexpected heart failure benefit, with a one third reduction in heart failure hospitalisation. Specific studies are now underway in patients with chronic heart failure (EMPEROR programme) to explore this further.

## Devices, rehabilitation and depression in heart failure patients

Prof John Cleland (London) and Prof Martin Cowie (London) gave updates on devices in heart failure (cardiac resynchronisation therapy and ambulatory pulmonary artery pressure monitoring respectively) which prompted spirited debates at question time – should we be spending more money on heart failure nurses and less money on expensive therapies?

Nationally only five per cent of patients getting cardiac rehabilitation are heart failure patients. Dr Joe Mills (BACPR) stressed that we should be referring stable heart failure patients to cardiac rehab on discharge, particularly older patients, as they have much to gain from quality of life improvements. The national HF audit has shown that cardiac rehabilitation is associated with reduction in readmissions and improves quality of life. It was acknowledged that lots of our patients are very old and frail and cannot come to hospital for group based therapy. Pilot studies are underway trialling home based exercise interventions in heart failure (REACH-HFpEF).

Looking more holistically, John Sharp (Glasgow), showed that anti-depressants are not associated with improved heart failure outcomes. Cognitive behavioural therapy may be an effective alternative treatment.

## Service development

Moving onto service development, Jayne Masters



(Southampton) and Dr Lisa Anderson (London), both gave excellent personal and informative presentations on their development of novel heart failure services. Both discussed how geriatricians could be very closely involved in service developments.

## Conclusion

The BSH annual meeting was educational, entertaining, and collaborative, providing clinically relevant updates and expert commentary. The meeting is an ideal educational opportunity for consultant geriatricians and geriatric trainees

to update their knowledge on heart failure management.

Further information, including membership information and future meeting programmes can be found at [bsh.org.uk](http://bsh.org.uk).

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## Future meetings

- **BSH New Consultants' Meeting, 25 January 2018**, One Wimpole Street, London
- **10th BSH Heart Failure Day for Revalidation and Training**, 1 March 2018, The Institution of Engineering and Technology (IET) Birmingham Austin Court
- **8th BSH Heart Failure Nurse & Healthcare Professional Study Day**, 2 March 2018, The Institution of Engineering and Technology (IET) Birmingham Austin Court
- **21st BSH Annual Autumn Meeting**, 29-30 November 2018, QE II Centre, London

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# Introducing Nurse Consultancy Abroad

**I was recently invited to be the key speaker at an international conference in the city of Beer Sheva, Israel on the subject of 'the care of older people' It was a privilege to attend and participate with like minded colleagues from Israel, Canada and Russia and to share the work I do day to day and nationally with the British Geriatrics Society.**

My topic was 'the role of a Consultant Nurse in the care of older people in the community' and from the organiser's feedback, this was well received with genuine excitement from the delegates on the developments in advanced practice and the quality of our work in the BGS. Although there are nurse practitioners in Israel the role of Consultant Nurse or practitioner is a new concept and one that was met with great enthusiasm by the audience, particularly in the care of older people.

**"I want to thank you for your amazing presentation, as it was one of the special moments of the event.**

**I am very thankful, that you could join the event and share your unique experience and knowledge. I am getting a lot of enthusiastic feedbacks from the participants, who were thrilled with your presentation."**

**Claudia Konson**

The conference was held in a conference facility which was part of a complex that also provided assisted living accommodation and nursing home care for older people and highlighted the way Israeli Healthcare professionals

are pushing the boundaries of long term care. Holding the conference at this venue made complete sense as we considered how we could improve the care of older people around the world.

It was good to be reminded that the needs of older people in health and social care are similar wherever one lives in the world, and to recognise that we can learn from each other internationally. Although there are similarities in recognising that more is needed in the education of healthcare professionals in older people's care, the total integration of health and social care in Israel appears to result in a less fragmented system for older people than we sometimes see in the UK. However, there is a greater reliance on family in the care of parents in Israel, including financial responsibility for long term care if a parent runs out of money. This is quite a contrast to the UK where financial responsibility, for long term care at least, stops at the receiver of care and places no obligation on sons and daughters.

The conference was the idea of Claudia Konson, the lead nurse for the southern region of Israeli Ministry of Health and I was made to feel very welcome by Claudia and her wonderful team. She is an inspirational professional who has been instrumental in the development of older people's services for Israel in hospital, community and care homes. In addition to this, she has now taken on a lead role supporting the Russian government to develop training programmes for the care of older people.

I am forever in awe of people who can achieve so much professionally, but who remain passionate and driven in their vocation to older people's wellbeing. I hope that I inspired the delegates through sharing the work I do locally and nationally but I can honestly say that I gained as much and more, from people like Claudia and the many others who shared innovation in developing healthcare that provides excellent services for older people.

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**Cliff Kilgore**

**Consultant Nurse Intermediate Care for Older People  
and Chair of the BGS Nurses' Council**



# An interview with the Past President of the British Association of Stroke Physicians



**Stroke has long been an important sub-specialty of general medicine. The British Association of Stroke Physicians (BASP) was founded in 1999 with the overarching goal of promoting stroke medicine within Great Britain. Many of its members, including Professor Helen Rodgers, immediate past president of BASP, are members of the British Geriatrics Society. In December, Colin Nee, BGS CEO, asked Helen for her views on developments in stroke medicine as many of the issues affecting the specialty are relevant to geriatric medicine too.**

**We asked: What first attracted you to specialise in stroke medicine, and what has motivated you to remain within the specialty?**

**Helen:** As a registrar in geriatric medicine and neurology I was struck by how much could and should be done to improve the care of stroke and TIA patients. At that time stroke patients could spend weeks or months on a general

medical ward, usually occupying six beds at the end of a nightingale ward. Undertaking a CT head scan for a stroke patient was seen as a waste of a valuable resource. TIA patients often waited months for an outpatient appointment. As a trainee I became involved in a small randomised controlled trial to evaluate stroke unit care and I've been involved with developing and evaluating stroke services ever since. For me, stroke medicine combines the need for quick decision making in the acute setting (the shortest door to needle time in our hospital is nine minutes), and working with patients, their families and a skilled multidisciplinary team to optimise outcomes for those who have residual disability.

**Seeing someone make a full recovery post thrombolysis and return home the following day is a great experience.**

Similarly, planning a complex discharge from hospital which goes well is very rewarding. Throughout my career I've had close links with colleagues in stroke care throughout the UK. We are a very supportive community who work well together in terms of education, research and service development. There are still opportunities to make a difference and I would still choose the same career path and recommend it to junior doctors.

**Colin: Looking back over your time as BASP President, what would you say have been the most key developments in the organisation of acute stroke care nationally?**

**Helen:** The cornerstones of stroke care are TIA clinics, stroke units and early supported discharge services. These services are underpinned by high quality research evidence and are now widely available. The quality of stroke care in England, Wales and Northern Ireland is audited SSNAP (Sentinel Stroke National Audit) and it was great to see that the care that stroke patients receive in hospital continues to improve year on year. Local service improvements and reorganisation of services in some areas of the UK have resulted in overall improvements in care as well as increased thrombolysis rates.

**A number of trials have now demonstrated that mechanical thrombectomy is an effective treatment for stroke due to a large artery occlusion with a NNT (number needed to treat) of 3-7 for regaining independence. When the results were first presented they received standing ovations (which I've never seen at an academic meeting before or since).**

This spectacularly effective treatment will be commissioned centrally in England and although there are challenges

in terms of the number of available interventional neuroradiologists and potential further service reorganisations, we must push this forwards as quickly and safely as possible.

The NHS England National Stroke Strategy 2007-2017 was an important driver for service improvement and BASP has worked closely with the Stroke Association to press for a further national stroke initiative. Following several high level meetings we're delighted that the NHS England National Clinical Director, Professor Sir Bruce Keogh, indicated at the recent UK Stroke Forum meeting that there is likely to be a new National Stroke Plan and that rehabilitation and longer term care will be a priority <https://www.youtube.com/watch?v=AqOA67aXnUc>. Developing the neglected area of community and longer term services will involve close collaboration with colleagues from geriatric medicine.

**Colin: What are you looking for from *Shape of Training*?**

**Helen:** We need to ensure that all junior doctors learn how to diagnose and care for stroke patients. I hope that current and future training in stroke medicine will be attractive to trainees, be high quality and provide rewarding experiences.

Currently stroke medicine is a sub-speciality of internal medicine and trainees come from a range of parent specialities – geriatric medicine, neurology and acute medicine.

The majority of stroke medicine trainee posts are currently filled by doctors with a background in geriatric medicine. Training in stroke medicine is undertaken within the parent speciality programme plus an extra year dedicated to stroke medicine. BASP is keen to maintain the broad base of training in stroke medicine and would prefer to remain a sub-speciality rather than become a full speciality.

We feel that stroke medicine benefits from involvement of doctors from a range of backgrounds. We value and emphasise the importance of the core values of geriatric medicine in assessing and caring for stroke patients and the diagnostic skills of neurologists. The Stroke Medicine SSC is working with our parent speciality SSCs to develop a core curriculum for stroke medicine across all specialities and it is likely that once *Shape of Training* is implemented that there will no longer be an additional year for training in stroke medicine. There may be some areas of stroke medicine where post CCST credentialing is required e.g. if a stroke physician wishes to learn to undertake thrombectomy but these discussions are at a very early stage.

**Colin: The BASP leadership has been investing developing plans to reorganise the society. What changes might we see at BASP over the next 3 - 5 years?**

**Helen:** BASP will be celebrating our 20th anniversary next year and we are keen to continue to develop as a medical membership organisation.

We have five strategy areas: developing and influencing local and national policy on stroke; providing expert advice on all aspects of stroke care; leading on clinical standards for stroke; promoting and disseminating research in stroke; and improving and assuring the education and training of doctors in stroke medicine.

We have recently commissioned a consultancy to look at how we deliver our strategy and how to better engage and support our members. The findings were discussed at our recent AGM and we will be seeking to increase our organisational capacity by appointing a policy and communications co-ordinator as well as increasing our administrative support. This will involve an increase in our membership fees (currently £40 per annum) and we will shortly be asking our membership to vote on these proposals including an increase in our membership fees.

**Colin: How can the BGS and its members help BASP achieve its vision for the future?**

**Helen:** We are very keen to maintain and strengthen links with the BGS and all of parent specialities. It has been a pleasure to work with Eileen and you (Colin) over the last two years, I'm really grateful for their advice and support.

I'm delighted that BASP will be contributing to the BGS Spring Meeting in 2018 and look forward for the opportunity for future collaborations.

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**Colin Nee, BGS CEO talking to  
Helen Rodgers, past president of BASP**

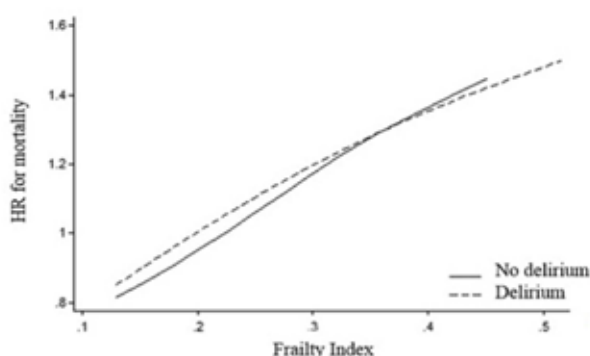


# Fitter individuals are at the highest risk of death associated with delirium

It is well-recognised that delirium is associated with increased mortality. It is less clear, though, whether this is the case across the spectrum of frailty. There is an idea that delirium might have bimodal outcomes – worse in frailer people, but may be protective in fitter individuals by highlighting an underlying problem early and (potentially) prompting earlier treatment.

While past studies have accounted for chronic diseases and acute illness severity, few have accounted for both. We wanted to see whether the associations of delirium with mortality remained so, even after accounting for acute and chronic health factors, so we modelled both these together in a frailty index. This included 31 variables encompassing chronic disease, acute illness parameters, and functional status and was applied in a large cohort of acute medical older inpatients.

We found that delirium and frailty were both associated with increased rate of death. Indeed, the association between delirium and mortality was evident at all levels of frailty. This can be seen in Figure 2 below where the relationship with death is linear. Surprisingly, though, a higher risk of death associated with delirium was seen in the fitter end – where the two lines cross on the left part of the figure.



We predicted that delirium could be protective in fitter individuals, but we actually found the opposite – that the impact of delirium was particularly bad in fitter individuals.

One reason for this could be that for fitter individuals to develop delirium, a larger insult is required. Alternatively, a distinct neurological insult in fitter individuals may cause a delirium and drive a worse progression at the same time.

This study also raises some questions about the relevance of acute illness severity when determining frailty status, and how frailty should be operationalised in this context. Either way, we are again reminded that regardless of underlying reserve, delirium is a sign of global systemic decompensation, and should be treated as a medical emergency.

Read the full article Delirium, frailty and mortality: interactions in a prospective study of hospitalised older people at <https://academic.oup.com/biomedgerontology/advance-article/doi/10.1093/gerona/glx214/4584142>

This article was first posted as a blog on the BGS blog on 21 November 2017. One reader commented as follows:

**That is why daily delirium monitoring in hospitals is so important. Delirium is the next vital sign. At the university medical center Utrecht the Netherlands years of research resulted in a technology to objectively detect delirium, based on EEG. In 2018 nurses can use the device to scan for delirium, nearly as simple as taking a blood pressure.**

A Willems

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## Melanie Dani

Trainee in geriatric medicine in the North West Thames deanery. She is also completing a PhD at Imperial College London studying biomarkers in Alzheimer's Disease, and has an interest in cognition and dementia



# A passing perspective on geriatrics down under - Elective project

**In 2016, the British Geriatrics Society granted me partial support to undertake my elective in Queensland, Australia in geriatrics at Townsville Hospital.**

During the placement I worked in three areas of geriatrics, namely, general geriatrics, orthogeriatrics and subacute geriatrics. As part of my placement I attended ward rounds with the consultants, reviewed patients, attended clinics and participated in departmental teaching.

## Mixed sex

On the general geriatrics placement, this was a ward comparable to a care of the elderly ward in the UK. The front part of the ward housed general patients while the back part of the ward constituted a secure unit for those with dementia. The routine of the ward was similar to that of the UK, consultant or registrar led ward rounds, with the addition of junior doctors, interns and physician associate students. The ward layout was also similar with the exception of mixed sex bays. This included some two-bed side rooms. Again, these could be mixed sex. I questioned the practice of mixed-sex accommodation, particularly given the risk to vulnerable older patients, some of whom had some level of dementia. I was told however, that any “incidents” resulting from mixed sex rooms and bays were minimal.

## Inadequate funding

When I attended clinic on this placement, I had a discussion about healthcare costs and patient care. This was instigated by a patient we saw in clinic, who had memory problems. The doctor told her she needed CPAP at home to help with her breathing, which could have been contributing to her memory problems, but the patient said she couldn't afford it at \$2000. There was no subsidy from the hospital for this apparatus.

## Poor continuity

On the orthogeriatrics placement, the majority of patients were fractured neck of femur. I was struck by the apparent lack of co-ordination in patient care between specialities. For example, the anaesthetist would review a patient, but would fail to bring the geriatrician up to speed. Consequently, I often saw patients having information repeated to them. This lack of communication was mirrored among other members

of the healthcare team.

In particular, I observed a certain ‘separation’ of the nursing fraternity, not only within the medical team, but also between healthcare teams. I often wondered if this was fuelled by division of finances amongst the medical teams, by systemic inadequacies or whether the teams were, in fact, trained into this ‘silo’ mentality.

Other UK doctors there had commented on this. There was no concept of nurse-led clinics or nurses being able to prescribe. I had a conversation with the orthogeriatrics registrar who noted that the UK doctors of the same grade as her, who went to Australia, performed better. She ascribed this to UK doctors having more training and working longer hours. Whilst I was on placement, the registrar would come in at 8am and leave at 4pm most days.

## Delayed Discharge – it happens down under too

While on the subacute unit, I encountered many patients who had been there for weeks, if not months – one patient had been there for over a year – all waiting on social care arrangements. In Townsville there was a huge shortage of nursing home places. This meant many older patients were medically fit in hospital. There never seemed to be a shortage of beds in Townsville, unlike back home in the UK hospitals, despite many patients not needing to actually be in hospital.

## Family-led DNAR policy

I discovered that resuscitation guidelines were different in Queensland. It is not a doctor who makes a decision about a DNAR form, it is the family. So even if a doctor feels that a patient should have a DNAR form, if the family want resuscitation to go ahead, the medical team will have to comply with this request. I don't agree with this as I feel that most families do not understand the procedure of CPR and the experience it puts the patient through.

## Cultural differences in Australia

There were not many indigenous Australian patients in geriatrics, given that their life expectancy was around mid 60's. However those that were there were treated differently in some ways. For example, it was culturally inappropriate for a female doctor to see an indigenous male patient for intimate medical problems. I was also told that one should not stare directly into the patient's eyes as this would be interpreted as a threatening gesture in their culture. I found this strange, because we are taught as medical students to engage in eye contact with patients, especially when performing examinations.

On reflection, I used my elective to see what it is like to work in Australia. In review, I feel that my experience in Queensland was not a reflection of what it is like to work everywhere in the country - this, from speaking to staff working in Sydney. On the upside, it was my impression that the staff in Australia were happier than the medical and healthcare fraternity in the U.K. This is a general observation on all teams I engaged with. The doctors seem to be more content with their jobs. Teaching time appears to be heavily protected, as is annual leave. The staff also seemed to take a sufficient lunch break, compared to the UK where I often see F1s eating sandwiches in the ward office around 3pm.

On the downside, however, I feel that the training in the UK has considerable merit over that of Australia. As a

UK trainee I may be more qualified than my Australian counterpart. The consultant even pointed this out and said the fifth year UK medical students had more knowledge than their Australian counterparts.

Looking forward to the future, if I were to go and work in Australia I realise that I would probably end up in an under-subscribed area like Queensland, as I would get last priority placing as an international doctor. I think though, that this might be worth doing, for the benefit of ultimately working somewhere like Sydney.

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**Melanie Lowe**

Fifth year medical student, Manchester University

## Research off the beaten track - Profiling Dr Louise Tomkow

**After completing ST4 in Geriatric Medicine, I decided to take a year out of clinical training to study for a MA in Humanitarianism and Conflict Response at the University of Manchester.**

The rationale for this decision was multifarious, however the move was primarily motivated by a desire to diversify my career and explore interests outside the world of medicine. The Masters, based at an interdisciplinary institute with its foundations deeply rooted in the social sciences, developed my critical thinking and altered my world-view. Just over two years later, I am still at the HCRI, entering the second year of my PhD.

Like many health care professionals who work in geriatrics, I was drawn to the speciality by its holistic focus on social and psychological, as well as physical issues. I have always had an interest in global health and spent time volunteering in Malawi and India after completing foundation training, however through my clinical experience working with often-vulnerable patients in the hospitals of North West England, this interest evolved into a passion about health inequalities.

Older migrants represent a multiply-marginalised social group. This dynamic is reflected in the academic literature; dominant geriatric concepts such as frailty are unexplored in this population. Looking to address this gap in the research,

I clumsily crafted a research proposal, found a team of supportive supervisors and embarked on the convoluted, and often perplexing, process of applying for PhD funding.

My initial proposal somewhat boldly aimed to establish whether asylum seekers and refugees become frail at a younger age than those born in the UK, however the first year of the PhD saw me critique and deconstruct the assumptions I had taken as given.

I am currently working with more nuanced and critical ideas, collecting qualitative data through semi-structured interviews with older asylum seekers and refugees. There are challenges; the uncertainty and shapelessness that dominates the research process is in stark contrast with the role of a clinician, and maintaining motivation throughout such a solitary and prolonged endeavour can be tough. Nevertheless, I feel hugely privileged to have been afforded this indulgent opportunity for erudition. The acquiescent research timetable allows time for the pursuit of other personally and professionally rewarding ventures; I volunteer with Freedom from Torture as a Medico-Legal Report doctor and am involved with teaching at the university.

After completion of the PhD, I will return to Geriatric clinical training whilst endeavouring to maintain an academic presence. My prevailing aspiration however, perhaps naively, is that the project has real-world impact and goes some way in improving the lives of the often-overlooked individuals I am researching.

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**Louise Tomkow**  
Manchester

# The Older Person Whisperer (and asso

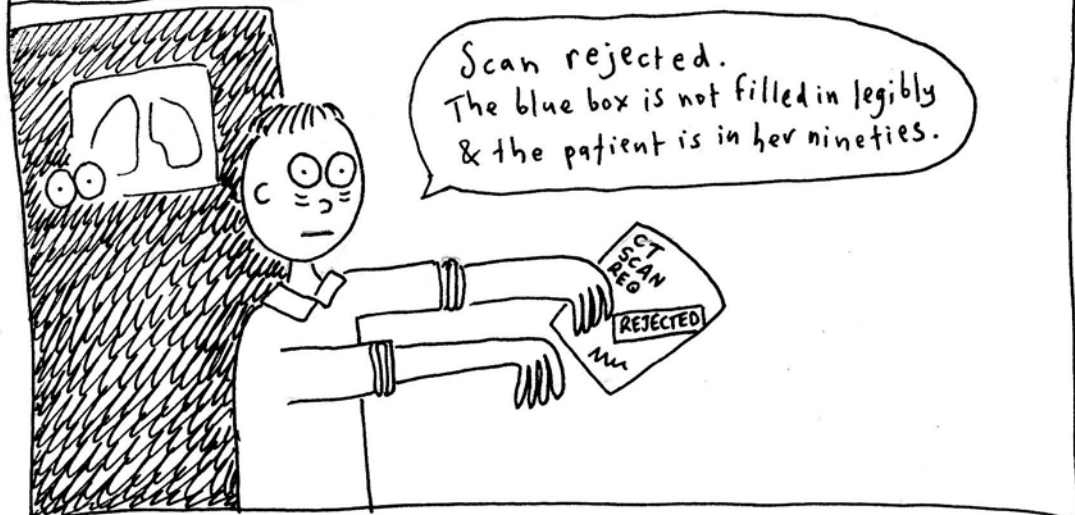
The Older Person Whisperer says: I was asked to do a grand round in my hospital and I wanted to do it in a relaxed, informal settings. I asked my F2 at the time how to get junior doctors to come along and he said "Don't mention the word 'ZOMBIES' to the junior doctors. His suggestion was "ZOMBIES?" The comic flowed from there.

Just to explain the conventions, our matrons and bed managers wear purple, the eye hospital was a

Most of my colleagues are reassuringly human, however stress seems to turn them into...

# ZOM

Radiologist turns Zombie when slots are limited...



Purple people turn Zombie in bed crisis...





ciates)

use my comics-research to talk about why compassion is so difficult to sustain in healthcare  
tion compassion in healthcare." So I asked what title of grand round would attract the most

popular outlying destination for the frail elderly last winter.

# ABIES?

\* Thanks to  
Ori for  
title



# BGS Policy winter update



**Concern about the challenges of meeting the health and social care needs of older people has continued to be high on the political agenda. But while there is a long way to go in identifying and implementing long term strategic solutions, there have been some positive developments that are cause for optimism.**

## Government announcements and BGS engagement

### *Green Paper on care and support for older people.*

One of the most significant policy developments is the announcement by Government, made on 16 November, of a timetable for publication of the Green Paper on Social Care. Government has now committed to publishing the Green Paper before summer recess in July 2018. We were extremely pleased to receive a phone call from the Cabinet Office the day before the announcement, inviting Eileen Burns to serve on the expert advisory group, which will be working with Government during the drafting of the Green Paper. This provides BGS with an excellent opportunity to influence the content of the Green Paper. It is also great credit to Eileen and to the BGS that she is the only clinician who has been invited on to the expert group. I am looking forward very much to supporting Eileen with policy briefings and support while she serves on the group.

***The Chancellor's Autumn budget.*** This was announced on 22 November, the first day of the BGS Autumn conference.

In our press statement we described the budget as a 'missed opportunity to help frail older people stranded in hospital'. The announcement of an additional £10 billion for capital investment, and £2.8 billion extra funding in England "to recognise the exceptional challenges and address immediate pressures this winter" is welcome (although the King's Fund had estimated that an additional £4 billion is needed in the short term). However the lack of any additional funding for social care was disappointing, and is likely to undermine some of the benefits of the additional funds for the NHS.

## Participation in parliamentary events

- **A parliamentary roundtable organised by the British Psychological Society was held on 29 November.** It brought together an expert group of parliamentarians, clinicians and policy influencers to discuss the BPS report, *Psychological dimensions of dementia: Putting the person at the centre of care*. We were very pleased that BGS member, Dr Rowan Harwood, accompanied by our Communications Manager, Marina Mello, was able to attend and bring his clinical expertise to the discussion, which was chaired by Dr Lisa Cameron MP. Dr Cameron is a member of the SNP and shadow spokesperson on mental health.

- **House of Lords event on health and social care 2018-25.** I attended this event on 6 December which was organised by the Adam Smith Institute and chaired by Baroness Masham, who co-chairs the All Party Parliamentary Group on Health. Speakers included Norman Lamb MP, and Dr Peter Carter. Some of the themes emerging in the discussions were familiar: the need to reach political consensus and move away from treating health and social care as a political issue; the lack of capacity within Government to developing a lasting solution to the challenges faced because of the time being devoted to Brexit; and the need to engage the public in a mature conversation about the future of health and social care.

- **House of Lord event on healthy independent ageing,** chaired by Baroness Sally Greengross, was organised by Care and Repair who launched their new publication *Homes fit for ageing*, which makes the case for why ageing well at home is key to health, housing and care policies. BGS member, Dr Amit Arora and I attended this event held on 14 December which offered a good opportunity for networking and helping to raise the profile of BGS.

### **Collaboration with the Alzheimer's Society on impact of delayed transfers of care on people with Alzheimer's.**

We were delighted that Eileen Burns was filmed in St James's hospital, Leeds and featured at on *Channel 4's evening news* at the prime time of 7.30pm on 12 December. Following a meeting with a Senior Policy Officer from the Alzheimer's Society earlier this autumn, BGS was offered the opportunity to support the media work that the Alzheimer's Society are engaging in as part of a programme of work on delayed transfers of care, experienced by people with Alzheimer's. This provided an excellent chance to highlight the effects on patients and their families and the lack of capacity in social care.

I recently participated in a policy roundtable on patient

flow organised by the British Red Cross. They are currently exploring the difference that low key support can make to patient flow, for example when a Red Cross Volunteer is waiting at a patient's home when they are discharged from hospital, or escorts them home and makes follow up phone calls. I will be keeping in touch with the Policy Director who is leading this programme of work as there will be some potentially useful costings on the economic benefits emerging from their findings.

## Publications

- **Independent Age's report**, *Doing Care Differently* was published on 14 December showcasing views from a series of blogs published in the summer. BGS was one of the contributors and features in the report which presents a range of views and explores long-term options and reforms needed to transform social care.
- **Jo Cox Commission** on loneliness final report was published on 18 December. It contains a vision for the future and some specific calls for action by Government. *Combating loneliness one conversation at a time - A call to action* can be found here: [https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/active-communities/rb\\_dec17\\_jocox\\_commission\\_finalreport.pdf](https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/active-communities/rb_dec17_jocox_commission_finalreport.pdf)

## Policy consultations

The regulation of medical associate professions in the UK: the Department of Health have held a public consultation, and BGS submitted a response (published on the website

under Policy Digest). Our agreed position is that we support statutory regulation for all four of the medical associate roles, of which physician associates are one. We support this on the grounds that we believe it is the best way of ensuring accountability and managing the risks associated with the roles, and that we view statutory regulation as integral to the development of public understanding of and confidence in the physician associate and other medical associate roles. We believe that a single regulator will help to ensure cohesiveness and would welcome the formal recognition that statutory regulation offers.

## Engaging further with our policy and influencing work

I am keen to make sure that our policy work reflects the UK wide nature of BGS's membership, and have very much enjoyed attending meetings of BGS Wales, Northern Ireland and Scotland this year, and building contacts and understanding, both with our members and with other organisations that have a UK wide presence such as Age UK. Finally, wherever you are based, it would be very useful if you could let me know of any contact you have with parliamentarians, civil servants or other key decision makers at it will help us to be as joined up and proactive as possible in our policy work.

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**Caroline Cooke**  
BGS Policy Manager

# Spring Meeting

11 - 13 April 2018, NCC, Nottingham



with a dedicated day on Stroke,  
co-organised with the  
British Association of Stroke Physicians



British Geriatrics Society  
Improving healthcare for older people

## Other dedicated days on:

- Dementia

## Sessions on:

- Postural instability
- Orthogeriatrics and Osteoporosis
- Education and Training
- Management and NHS structure
- Research: Presentations and workshop on getting it published
- Respiratory
- Sensory impairments – Hearing
- Renal Diseases in Older People
- Tissue viability

Registration and programme at [bit.ly/BGSSPR2018](http://bit.ly/BGSSPR2018)





# Time to dip the urinalysis test strips in the bin

**I wonder how often the following question is asked on hospital wards: “[patient] doesn’t look right today. I’ve dipped her/his urine and it’s got everything in it. Do you want to start antibiotics now or wait for the culture result first?”**

Comprehensive geriatric assessment (GCA) is known to be effective in the evaluation of older people but takes time and skill to do well. Wouldn’t it be great if there was a rapid bedside test that could be performed by people with only minimal training and could be reliably used as a surrogate for this process? This would be especially true for the frail who can be challenging to assess due to multiple co-morbidities, including cognitive impairment, and atypical disease presentations. One possible solution is the urinalysis dipstick test.

The diagnosis of urinary tract infection (UTI) in older people is trickier than many imagine. Most diagnostic schemes rely on the presence of classical urinary tract symptoms (e.g. dysuria, frequency, urgency, haematuria and costovertebral tenderness), but these are present in just half of people aged over 75 with bacteraemic UTI and less than 10 per cent of care home residents with advanced dementia and suspected UTI.<sup>1,2</sup> So, how do all the other people with UTI present? The answer is the geriatric giants (i.e. falls, confusion, incontinence and/or loss of mobility). So how can we distinguish these presentations caused by a UTI from all the other possible causes (i.e. every other illness)? Indeed, UTI is commonly blamed for non-specific illnesses in older people even though this is not supported by sound evidence and is often overtly wrong.<sup>3,4</sup> If we knew there were bacteria in the urine then this might help – a role for urine dipsticks?

Although dipsticks are available in a variety of forms to detect a wide range of substances in the urine, when used for old people in hospitals it is mostly for the diagnostic evaluation of UTI. Leukocyte esterase (LE) is a surrogate marker for the presence of white blood cells and nitrites are present when nitrates in the urine are metabolised by some bacteria (e.g. *E. coli* but not *Pseudomonas*). Typically urinalysis results are considered suggestive of bacteriuria if either nitrites or LE are positive and not suggestive if both nitrites and LE are negative.

Unfortunately in older people it’s seldom so simple. Asymptomatic bacteriuria (ASB) is the presence of bacteria in the bladder urine with no attributable symptoms. It is common in older people (10–20 per cent in the community), especially the most frail (up to 40–50 per cent of care home residents) and universal in those with long-term catheters.<sup>3,5,6</sup> ASB is frequently misinterpreted as symptomatic in the presence of non-specific symptoms, e.g. subtle changes in functional or cognitive status (‘not their usual self’ or ‘foul-smelling urine’).<sup>7</sup>

Urinalysis cannot be used to distinguish ASB from UTI. Additional problems with relying on urine testing are difficulty obtaining a sample (e.g. in the presence of cognitive impairment or incontinence) or unreliable results (e.g. contamination, catheter samples or the prior receipt of antibiotics).

Putting these concerns aside, just how reliable is urinalysis to detect bacteriuria?

## False positive results

Due to both the lack of specificity of the test and the high rate of ASB, a large proportion of older people will have a positive urinalysis result irrespective of whether or not

they have a UTI. In studies of older people in hospitals and nursing homes, 34-97 per cent of people tested had a positive urinalysis result (LE or nitrites) but only 17-57 per cent actually had a positive urine culture.<sup>3,8,9</sup> So, in each study approximately 50 per cent of people with a positive urinalysis had a positive urine culture.

Or to put it another way, a positive urinalysis result is about as accurate as flipping a coin to detect the presence of bacteriuria in frail older people.

### False negative results

Some have suggested that urinalysis is useful to exclude UTI if both LE and nitrites are negative.<sup>8,10</sup> However, given that many pathogenic organisms can't produce nitrites it is an inherently risky approach that depends on LE. The majority of studies have shown false negative rates of 6 to 30%.<sup>3,10-15</sup>

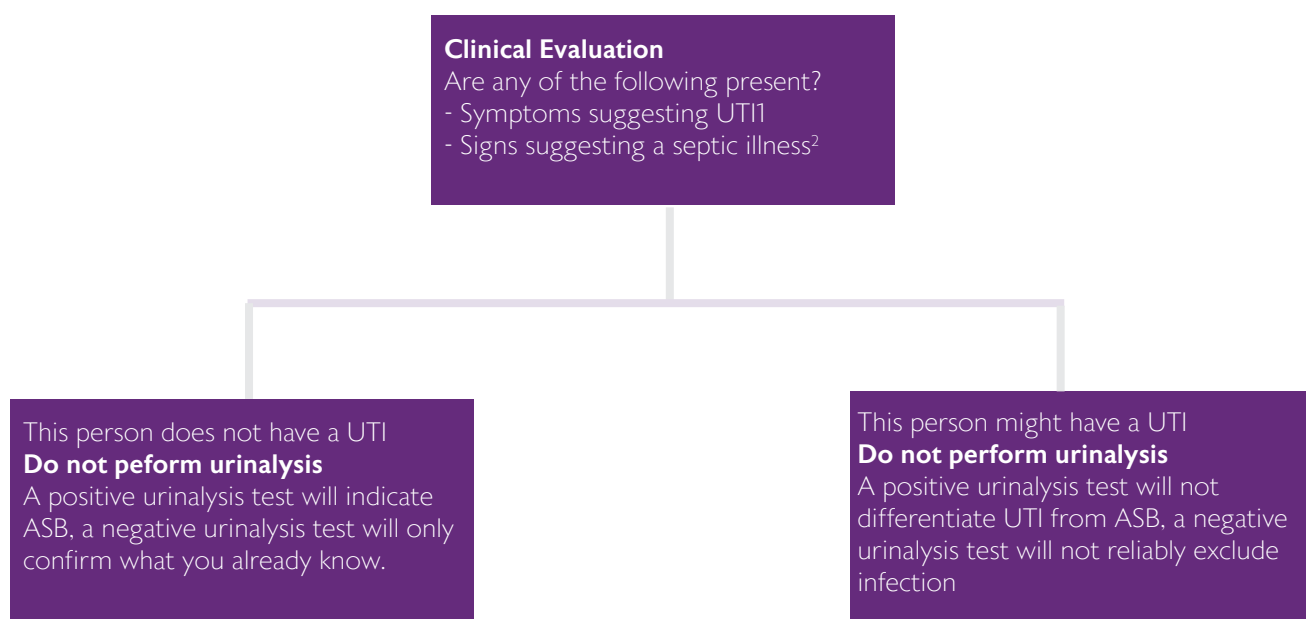
As urinalysis is inaccurate for bacteriuria and can't distinguish between UTI and ASB, it can't be used as a replacement for clinical assessment of the patient. So after your assessment, if you aren't thinking the diagnosis is UTI but the urinalysis is positive then you should ignore the result, and if you are thinking the diagnosis is UTI but the urinalysis is negative then you should ignore the result. Or you could say that the urinalysis result is irrelevant to your clinical assessment and is therefore pointless (see Figure 1).

Of course none of this evidence is new. The Scottish Intercollegiate Guidelines Network stated in 2012 that urinalysis has no value in the diagnosis of UTI in older people.<sup>5</sup> So did the mounting evidence against urinalysis in frail older people lead to the removal of dipsticks from elderly care units?

No, along came the FallSafe project suggesting that all older people at risk of falls in hospital should have their urine dipped to 'consider the possibility of infection'.<sup>16</sup> The basis of this recommendation was that two studies that had shown a reduction in hospital fall rates included urinalysis among many other components of a care bundle.<sup>17,18</sup> Both sides of this debate can't be right, perhaps highlighting a problem with care bundles in research. Are we obliged to replicate everything in the positive studies, even if it lacks face validity? If the investigators had all worn yellow socks would we be mandated to implement them? So we attend hospital governance meetings where fall reduction policies are reviewed and we are asked why everybody hasn't had their urine tested. The answer is that using urinalysis alone to diagnose UTI would be terrible medicine, so if we aren't going to do anything about the result then why do the test?

Of course falls aren't the only geriatric giant. UTI, like every other illness, can also lead to urinary incontinence. Many continence guidelines, including those of the BGS, suggest using urinalysis to 'rule out' UTI for everyone with incontinence.<sup>19</sup> These may be well-intentioned ideas but common sense has to intervene. If there are no signs of an acute septic illness or the duration has been over a week then the cause is not a UTI.

**Figure 1** When to use urinalysis in the diagnosis of UTI in frail older people



1 For example: an acute onset of dysuria, urgency or frequency.

2 For example: tachycardia, pyrexia, hypotension, delirium, raised serum white blood cell count or C-reactive protein.

So, urinalysis for older people is very unlikely to be beneficial, is often performed in the absence of relevant symptoms and abnormal results frequently lead to antibiotic prescription.<sup>20</sup> The financial cost of a urine test strip is just a few pence and a course of trimethoprim just a few pounds (and carries a low risk of *C. difficile* associated diarrhoea).

Is it really causing any harm just to 'be sure' we haven't missed a UTI? The answer is overwhelmingly, yes! Firstly your diagnosis is wrong. The real reason for the person being unwell goes unknown and untreated. Delays in diagnosis lead to longer lengths of stay, longer lengths of stay lead to more muscle loss, more muscle loss leads, ironically, to a greater risk of falls and so on for many other complications.

Secondly, we are told that the era of the 'post-antibiotic apocalypse' is nigh. Surely it's time to take prescribing seriously and heed the available evidence. If we don't, we will find ourselves unable to treat genuine UTIs in the future. The net negative effects of over-diagnosis of UTI far outweigh any small positive effect of providing some reassurance that our clinical suspicion was correct.

In summary, urinalysis is not an alternative to CGA and lacks accuracy to add to this process. It is merely clouding the already turbid waters. Let's not be a bunch of unthinking pee-dippers. Geriatrics is better than this, older people deserve more. It's time to consign the urinalysis test strips to the bin.

---

**Henry Woodford**

Northumbria Healthcare NHS Foundation Trust

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# Keeping older people independent and homeward bound at Norfolk and Norwich University Hospitals

**Norfolk is home to one of the largest and fastest-growing populations of older people in the UK. This presents both challenges and opportunities for health and social care services – including for the Older People's Medicine (OPM) team here at Norfolk and Norwich University Hospital.**

Up and down the country, there are teams looking after older people who are passionate about supporting them to enjoy a long and healthy life, and it's no different for us. However, in Norfolk last year we reached a peak of 350 older inpatients, and knew we had to redesign our services to be more responsive to the needs and volume of patients.

As a Trust, we chose to engage with an external operational consultancy. This gave us a platform to think differently about how we could continue to deliver outstanding care in the face of rising demand. Under the banner of *Excellence Together* (a collaborative improvement programme) we focused on three areas where we knew we could make the biggest difference. These ideas were each generated, developed and led by clinical team members – including therapists, nurses and doctors.

## Reducing Avoidable Admissions

We know that the earlier a frail older patient can access specialist opinion, the faster we can get them back to health and the more likely they are to retain their independence. In 2016, we had already engaged with our Emergency Department (ED) to provide in-reach, specialist elderly care at the front door. We built an established presence of consultants, registrars and our specialist nursing team in the ED to assist, and educate, in the care of frail patients. Alongside a new on-call advice service for ambulance crews and a frailty referral process, we've contributed to a 12 per cent reduction in Emergency Admissions in the last year (against a backdrop of a 10 per cent rise nationally).

We also needed to offer primary care an alternative to the front door, so we challenged ourselves to replace traditional clinics with a rapid assessment service. We simplified our range of services, improved demand planning and increased efficiency by (for example) introducing electronic clinic outcome templates. We can now see every new fall and complex medical referral patient within 48 hours and respond to GPs within 24 hours, compared to a total of up to 10

weeks previously. We've also enhanced our service, providing wrap around therapy capacity and Comprehensive Geriatric Assessments (CGA) for all our patients.

## Increasing 'Day-0' Discharges

We've worked hard to get our patients home faster by establishing a dedicated ambulatory care facility for the patients who are older and frail. Alongside existing ambulatory and short stay services, this facility provides specialist care for handpicked patients in the first eight hours of attendance, with the aim to get a CGA completed and the patient home on day 0.

This means we have capacity to move 1,000 patients a year from the ED whilst we complete assessments. Our patients are happier, and our ward staff have found that by moving frail patients from the ED earlier, they can better maintain their dignity and condition. The results speak for themselves; we've tripled the proportion of older patients we're sending home without an overnight stay.

## Reducing Deconditioning

Building on the excellent awareness campaign at University Hospitals of North Midlands, we've been working with our staff, patients and families to raise the profile of deconditioning. Our doctors have also introduced audits to help us identify, measure and treat its root causes. For example, our fantastic volunteers have helped us to almost double the proportion of patients receiving daily cognitive stimulation.

We've a long way to go to embed this data-driven approach to patient care, but early outcomes are excellent: our patients are happier, our wards are better places to stay and to work, and our length of stay has dropped by 10 per cent over the last six months.

## To Close

Over the last year we've seen what can be achieved by better managing frailty throughout the pathway – from the front door to the discharge lounge – and we'll be taking this further over the winter as we open the first dedicated ED for the older and frail patients. Thanks go to the team at NNUH, who've come together from across the hospital to make a real difference for our patients.

The ageing demographic in Norfolk is not unique, and we hope that aspects of our approach can be applied elsewhere. In acute medicine the time is right for us to reposition Elderly Care right at the front door – just as we do for Paediatrics – to deliver specialist care to our older and frail patients as early as we can and right through the pathway. This can only be a win-win: we keep our patients healthier and happier, we free up time for our staff, and we reap the operational benefits in the wider health and social care system.

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### Martyn Patel

Service Director – Older People's Medicine, Norfolk and Norwich University Hospital

### Alastair Butler

Operational Consultant – Newton Europe

# What are GPs views on the management of BPSD?

**Behavioural and psychological symptoms of dementia (BPSD) affect the majority of people with dementia at some point in their illness. General Practitioners (GPs) play a pivotal role in managing BPSD but how do they manage people with BPSD? What aspects of care do they find challenging? How do they overcome these challenges? To date there has been very little research that explores these questions.**

In our recent study from University College Cork, published in *Age and Ageing*, we investigated the challenges GPs experience when managing people with BPSD, we explored how these challenges influenced GPs' management decisions in BPSD and what strategies GPs employ to overcome these challenges. We conducted semi-structured interviews with 16 GPs in the southern region of the Republic of Ireland. The GPs interviewed had a wide range of experience of managing BPSD in the community and in nursing home settings.

Overall we found that GPs view managing BPSD to be complex and challenging. Many GPs struggled at a professional, and sometimes at a personal level, with what they saw as the limited treatment options available. Rather than deciding on the 'best' treatment option, they felt they were merely making a decision on whether or not to sedate

the person with BPSD. In this context three main challenges of managing BPSD in general practice were identified.

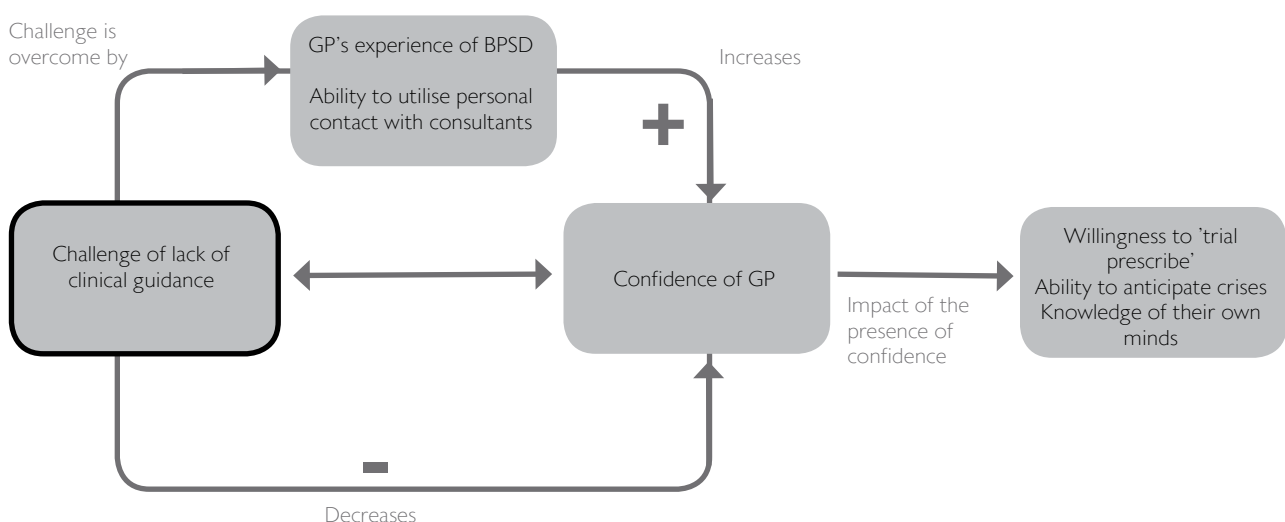
GPs found the lack of clinical guidance on BPSD to be challenging. In the absence of what the GPs considered to be implementable guidelines for the management of BPSD they felt they were often making decisions in a vacuum. The GP's own experience with a drug emerged as the critical factor that influenced their prescribing decisions.

Additionally, GPs found the lack of clear referral pathways to secondary care problematic, describing how they often relied on personal contacts to access advice. GPs who had significant experience of managing dementia and who were supported by access to consultant advice appeared to have more confidence in managing BPSD. This confidence influenced their management (Fig 1 below). However, this confidence did not extend to non-pharmacological management strategies. Even the GPs with extensive professional dementia experience often lacked confidence in recommending non-pharmacological strategies to family carers.

Stretched resources was identified as another challenge of managing BPSD. GPs reported that the paucity of resources in the community and in nursing homes made the implementation of non-pharmacological strategies unfeasible. Insufficient access to home-help in the community and the chronic under-staffing of nursing homes were two significant resource constraints identified. As a result of inadequate resources GPs felt under increased pressure to prescribe sedative medication.

Managing conflicting expectations, both in community and nursing home settings, was another difficult aspect of BPSD for GPs. The GPs described how tensions arose when the family had unreasonable expectations of what they could do to improve these behaviours. However, in the context of inadequate resources, it is possible that a reasonable request for support from a family member was seen by the resource-poor GP as being an unrealistic expectation. Managing the

**Fig. 1**



expectations of nursing home staff was also challenging for GPs. Some GPs described how they struggled to maintain their advocacy role for their patients in a nursing home setting. However, where there was a long-standing relationship of trust between the nursing home staff and the GP, their priorities were more aligned.

In the context of rising dementia prevalence the demand for community-based dementia care will increase. This study helps to explain the apparent discrepancy between

best practice recommendations in BPSD and real-life practice. We are using these findings to inform the design of educational and resource interventions to support GPs in the management of BPSD.

---

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**British Geriatrics Society**  
Improving healthcare  
for older people

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# Payment by Results: Good bye HRG4; an introduction to the new HRG 4+ grouper

**The Healthcare Resource Grouper (HRG) produces the funding for the Trust and is the currency for the NHS. HRG4 is updated annually to enhance the system, reflect changes in clinical practice and to include changes to policy.**

In 2016/17, a NHS Trust's activity was mapped using HRG4 grouper. In HRG4 there were limited HRG's with only a few options for recording complications and co-morbidities which did not fully recognise the complexity of care provided by the Trust.

It was proposed that this be changed to the latest version, known as HRG4+, as the basis for prices in the NHS. From the 1st April 2017 the new system, HRG4+ was introduced for recording patient complexities and co-morbidities. This is described as a 'better currency' because it identifies the level of comorbidity and complexity through a score reflecting the varying costs incurred in treating patients at different levels.

## Summary of HRG4+ grouper

There are 21 chapters consisting of 51 HRG subchapters, each one containing root and branch HRG's. With HRG4+ there are selective co-morbidities and complications which now attract points. These points determine which branch HRG the activity would group to and determine the funding for the Trust. The majority of co-morbidities and complications (CC) generate 1 point; however there are a few which generate 2 points. Each root HRG has different CC for their chapter. In 2017/18 this expanded the number of HRG's from 1,673 to 2,782 with differing levels in how services are grouped. As a result, different prices can be set based on the relative costs in delivering services, as well as where costs differ according to the age of the patient.

Using HRG4+ suggests a 'potential increase of income' of £172,398.60 yearly for this department. This could affect the future range and quality of services that can be provided by the department. These results could be of interest to elderly care departments nationally.



## Examples of difference between HRG4 and HRG4+

In 2016/17 the HRG4 tariffs for chapter D Respiratory System the root HRG DZ had 669 co-morbidities/ complications which had the potential to change the HRG and the income received (See table 1).

Table 1 - 2016/17 Chapters D Root HRG DZ as coded using HRG4

HRG Root	HRG Branch	Description	CC	Non-Elective Tariff
DZ22	A	Unspecified Acute Lower Respiratory Infection	Major CC	£2,579
	B		Intermediate CC	£1,749
	C		No CC	£456

In 2017/18 HRG4+ tariff for chapter D Respiratory System root HRG DZ there are 3980 co-morbidities/conditions that give additional points and have the potential to change the HRG and the income received (See table 2).

Table 2 - 2017/18 Chapters D Root HRG DZ as coded using HRG4+

HRG Root	HRG Branch	Description	CC	Non-Elective Tariff
DZ22	M	Unspecified Acute Lower Respiratory Infection	13+	£4,382
	N		9-12	£2,955
	P		5-8	£2,069
	Q		0-4	£959

There are 268 that have a value of 2 points and 3712 have a value of 1 point.

Examples of some of the conditions which generate points can be found at table 6.

Implementation of HRG4+ means that the depth of coding

is important as certain secondary diagnoses can influence or qualify the HRG produced. The CC lists have been given score value-d with the HRG to denote complexity. The more points the episode of care produces the higher the income could be, see table 4.

We audited 26 spells consisting of 50 finished consultant episodes for Geriatric Medicine. We compared the HRG4 with HRG4+ income using the clinical data recorded on the electronic discharge summary. When using the new HRG4+, this sample of 26 patients represents an average 1.5% of the annual in-patient attendances within the Elderly Care department of the University Hospitals of North Midlands. Of these spells 11 (42.5%) resulted in a decrease to the income and 15 (57.5%) resulting in an increase income - in total a net overall increase of £1,915.54 when using HRG4+ instead of HRG4. Like for like activity comparing 2016/17 with 2017/18 tariffs with the 26 patients audited this has a potential increase of £172,398.60, if calculated with using an average of 200 spells per month. Rationale for this calculation can be found in the additional information at the end of this document.

The electronic discharge summaries need to accurately reflect the patient care, documenting all conditions being treated or investigated. All relevant co-morbidities or complications affecting the episode of care must be documented along with any interventions carried out. These need to be clear and concise so that the clinical coders can understand the terminology used. In the absence of a definitive diagnosis sign and symptoms should be documented or clinical terms such as treated as, presumed or probably.

## General Findings

All examples below were non-elective admission to the emergency portal from their usual place of residence; this includes private dwellings and residential accommodation. Quick references to the examples in this report are shown in table 3. Details of all audited data can be found in table 5 within the additional information.

Table 3

Example	2016/17 HRG	Tariff (HRG4)	2017/18 HRG	Tariff (HRG4+)	Difference
1	DZ11A	£3,090	DZ11R	£5,494	£2,404
2	DZ22A	£3,297	DZ22P	£2,069	£1,228
3	DZ21A	£504	DZ65K	£467	£37
4	LA04D	£3,604	LA04P	£4,313	£709

**Example 1:** A 93 year old male was admitted to hospital from home and was diagnosed with lobar pneumonia. During the patient stay they developed a pressure ulcer and hypokalaemia which were treated. Swabs were also taken and identified that the patient had methicillin resistant *Staphylococci aureus*. The patient had a background history of emphysema, poor mobility, and ischemic heart disease with presence of prosthetic heart valves, taking warfarin, hypertension, arthritis, previous myocardial infarction, oesophagitis, dermatitis, *aspergillosis*. Following a 5 day stay

in hospital the patient was discharged back home.

In 2016/17 the above activity would have grouped to DZ11A £3,090. Using the 2017/18 HRG4+ grouper this same activity maps to the HRG DZ11R £5,494, an increase of £2,404. This is provided the complications and multi-morbidity was mentioned accurately. This does not require doctors to be trained in coding but highlights the importance of working with coders and capturing issues in the discharge letters.

**Example 2:** A 92 year old female was admitted to hospital from home feeling unwell with a raised temperature. She was diagnosed with a lower respiratory tract infection. Whilst in hospital she developed an acute kidney injury which was treated with fluids. She had a background history of dementia, osteoporosis, hypothyroidism, double incontinence and was wheelchair dependent. She remained in hospital for 4 days and was discharged on clinical advice back to the usual place of residence. In 2016/17 the above activity would have grouped to DZ22A £3,297. Using the 2017/18 HRG4+ grouper this same activity maps to the HRG DZ22P £2,069, a decrease of £1,228.

If the above patient had other co-morbidities or complications and these were recorded correctly, (for example, acidosis, hyper or hyponatraemia, anxiety, ischaemic heart disease, old myocardial infarction etc. to name a few; during the hospital stay), the HRG could have attracted one of the other tariffs in table 4.

Table 4

HRG Code	HRG Name	Combined day case/ ordinary elective spell tariff (£)
DZ22M	Unspecified Acute Lower Respiratory Infection without Interventions, with CC Score 13+	4,382
DZ22N	Unspecified Acute Lower Respiratory Infection without Interventions, with CC Score 9-12	2,955
DZ22P	Unspecified Acute Lower Respiratory Infection without Interventions, with CC Score 5-8	2,069
DZ22Q	Unspecified Acute Lower Respiratory Infection without Interventions, with CC Score 0-4	959

**Example 3:** A 77 year old female was admitted to hospital from home with shortness of breath. She was diagnosed as having a lower respiratory chest infection. She has underlying conditions of chronic obstructive pulmonary disease, epilepsy, bronchiectasis, hypertension and high cholesterol. She was treated and stayed in hospital for 1 day. She was discharged on clinical advice back to her usual place of residence.

In 2016/2017 the above activity would have grouped to DZ21A £504. Using the 2017/18 HRG4+ grouper this same activity maps to HRG DZ65K £467, a decrease of £37.

**Example 4:** A patient was diagnosed with UTI. The following example highlights how the tariff could change depending on what's written in the discharge letter:

1. UTI main condition £464 – with unspecified / lobar pneumonia as complication £1316
2. UTI Staph aureus main condition £1316 – with unspecified / lobar pneumonia as complication £2605
3. Unspecified / lobar pneumonia main condition £697 – with UTI £697 – if mention of e-coli UTI £2154
4. Bronchopneumonia main condition £1821 – with e-coli / Staph aureus UTI £1821 – if with multiple co-morbidities complications £2877
5. AKI main condition £774 – AKI with UTI Staph aureus/ Strepmit D or enterococcus agent still £774 – with pneumonia as complication £2169

Table 5

Main condition being treated	HRG4+ tariff with minimal * complication score	* HRG4+ tariff with maximum * complication score
Lobar Pneumonia	£697 (with 0-3 score)	£5,494 (with 14+ score)
Lower Respiratory Tract Infection	£959 (with 0-4 score)	£4,382 (with 13+ score)
Acute Kidney Injury	£774 (with 0-3 score)	£5,161 (with 12+ score)
Chronic Obstructive Pulmonary Disease	£1,919 (with 0-4 score)	£4,693 (with 13+ score)
* complication score includes but is not limited to: Parkinson's, vascular dementia, ischaemic heart disease, angina, arterial fibrillation, empyema, emphysema, essential hypertension, tendency to fall, diabetes, blindness, incontinence, alzheimer, UTI, decubitus ulcers, rheumatoid arthritis, cellulitis, presence of cardiac device, bedbound etc.		

There follows a condensed list which shows the co-morbidities and complications that would affect the HRG and the income for activity which groups to some of the common challenges encountered in older people's wards. More details can be found on the NHS digital link or local clinical coding departments in the references below.

## References

<https://digital.nhs.uk>  
<https://digital.nhs.uk/.../HRG4-201718...>  
 Changes.  
[digital.nhs.uk/media/21742/HRG4-201718-Engagement-Grouper-Code-to-Group](https://digital.nhs.uk/media/21742/HRG4-201718-Engagement-Grouper-Code-to-Group)

Table 6

Code Description	Value	Code Description	Value
Angina pectoris, specify type	2	Sepsis, specify type	1
Cardiomyopathy, specify type	2	Anaemia, unspecified	1
Pneumonitis due to food and vomit	2	Hypothyroidism, unspecified	1
Pneumonitis due to other solids and liquids	2	Diabetes mellitus: specify type	1
Abscess of lung with pneumonia	2	Dementia specify type	1
Decubitus ulcer III & IV specify grade	2	Metabolism disorder specify type	1
Urinary tract infection, site not specified	2	Parkinson disease	1
Injury/fractures etc. specify type & site	2	Alzheimer disease, specify type	1
Medical services not available in home	2	Epilepsy, specify type	1
Tendency to fall	2	Essential (primary) hypertension	1
Person awaiting admission to adequate facility	2	Decubitus ulcer and pressure area I & II specify stage	1
Incontinence specify type	1	Blindness, specify type	1

## Suggestions:

- Rolling training program and collaborative working with clinical coders for clinical staff (about PbR and HRG4+) highlighting the importance of accurate discharge documentation could be useful.
- Encouraging clinical engagement and the possible vetting of some of the discharge documentation on a weekly/random basis and providing feedback. However this may prove challenging due to time constraints.
- A brief list of common complications/co-morbidities which could help improve the discharge summaries.
- Accurate record keeping of clinical work undertaken is vital for appropriate remuneration from commissioners; the clinical coded data is also used for clinical and statistical purposes.
- Discharge documentation also needs to be accurate as it not only informs the primary care colleagues but is also a formal document of hand over of care to other colleagues.
- A brief list of common complications/co-morbidities which could help improve the discharge summaries.
- Re-audit with a bigger sample will be useful.

## Amit Arora

Consultant Geriatrician, University Hospital of North Midlands and BGS lead for Payment by Results



# A celebration of collaborative working

**The Royal College of Physicians London (RCP) invited service review (ISR) offers consultancy services to healthcare organisations that require expert, independent, objective and external advice. These reviews provide an opportunity to deal with issues and concerns at an early stage, before serious concerns arise.**

In the last three years the team have carried out 24 reviews across the UK, six of which have either exclusively or in part looked at care of the elderly medicine. The ISR team provides solutions around service redesign or reconfiguration, service design, the functioning of departments; clinical governance arrangements and how well teams work together. They can review individuals' practice in a supportive way. Bespoke packages are also available, such as clinical record reviews, which can be used to determine whether clinical management of care provided to patients is in line with peers and national good practice.

The ISR is (by definition) invited by the organisation to undertake a review. The intent is that through a reliable and professionally led review process, standards can continue to be improved and concerns can be addressed. The ISR process seeks to work in collaboration with organisations in a supportive way to address and resolve concerns and promote the continuous improvement of services.

Since last year the ISR team has been taking steps to work more closely with specialty societies to deliver this important work. Memoranda of agreements (MOA) about clear ways of working are being rolled out with all specialties and set out to strengthen the RCP's relationship with specialty societies and associations helping support of clinicians and driving improvements in patient care. We are pleased to report that the BGS has now signed an MOA with the ISR team and this marks a significant milestone for both the BGS and RCP.

Leading work for the RCP London, as medical director for invited reviews, Peter Belfield says, "As a former medical director at Leeds Teaching Hospital, I am all too aware of the challenges in managing difficult situations within medicine and in areas such as concerns about clinical practice, team working, leadership and clinical governance.

"I have previously been in receipt of reports from 'experts' and these have been of varying quality and standard, and some more helpful than others. The impact of these reports often tended to be minimal because their status could be called into question and there was little buy in by the specialists.



**"There is often a need to get external help, sometimes we can't sort out problems internally and there are many occasions where help is needed to check out if change is sensible or in line with best practice.**

Coming into this role, I have been determined to raise the standard of work we offer and in a way that ensures that we have traction with Trust Boards. We strive to present recommendations that are SMART, helpful and accepted by all those involved.

Along with my team, we have been taking steps to make our processes more robust. We need work that can be held up to public scrutiny, for example, with the introduction of lay reviewers and use of rigorous quality assurance of reports. A key part of this work has been to build our relationship with specialty societies and to have them closely involved in the delivery of this work. "

For the BGS (and other specialty societies) there are significant benefits in partnering with the ISR team in this way, as the societies get the expertise in arranging and carrying out reviews, quality assurance by the College and they are indemnified, protecting them from any possible legal implications that arise as the result of a review. This cover also applies to all members of the review team panel. Service and individual review visits usually take place over two days (travelling down the night before), and clinical record reviews are usually done in one day at the RCP in London. Some preparation prior to the reviews is required. Reviewers (or their Trust's) are remunerated at a rate of £450 per day of the visit.

The BGS will play a pivotal role in appointing consultant physicians with the right expertise and experience to carry out the reviews in our specialty, which enables the RCP to carry out high quality work. If you would be interested in joining a panel of reviewers and meet the criteria below, then please contact the BGS office to express an interest.

## Experience, skills and knowledge requirements

- Be a fellow of the RCP and member of the BGS
- Be registered with their relevant regulatory authority.
- Be in active practice within healthcare, or recently retired with licence to practise.
- Must have equality and diversity training up to date.
- Demonstrate knowledge of RCP and BGS service standards and publications and their application.
- Demonstrate their area of specialty expertise and knowledge.
- Excellent communication, analysis and judgement skills in order to gather and evaluate information and evidence from sensitively conducted interviews, and provide clear and logical feedback.
- Good listening and team working skills.

- Ability to remain impartial, non-judgemental and objective.

- Ability to assimilate large amounts of information and weigh evidence from more than one source in order to substantiate or refute criticisms or complaints made.

- Demonstrate empathy, tact, discretion and maintain confidentiality.

- Provide comments on the draft report as required within the agreed timescales.

If you would like to find out more about reviews please visit their website <https://www.rcplondon.ac.uk/invited-reviews>

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**Jasvinder Sidhu**

Head of Invited Service Reviews, RCP

**Peter Belfield**

Medical Director for Invited Reviews, RCP



# Fast-track publication

## **Age and Ageing journal has introduced a fast-track peer review and production service.**

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For more details contact the Editorial Office - [aa@bgs.org.uk](mailto:aa@bgs.org.uk)

# Moving research beyond the printed page

**Vast sums are spent on research into the care of older people, but they are wasted if the findings are not put into practice.**

I had an epiphany a few years ago. I looked at my carefully curated *curriculum vitae*, and noted that I had over 100 peer reviewed papers to my name. But I suddenly felt deflated when I realised that hardly anybody (apart from the journals' editors) had ever read them.

I then went through a cycle of feeling justified and shamed. I realised that I had made no effort to disseminate my findings to those who might find them useful, or to encourage the application of the findings in practice (*shame on me!*) But it wasn't just me (*justified!*). There is a real problem as the amount of research being published is monstrously huge (*double justification!*). But I thought about how little effort I have taken to ensure that I keep up to date with other people's research (*shame on me!*).

The academic and clinical communities have been aware of this problem for some time. In 2001, the Institute of Medicine, in its report *Crossing the Quality Chasm*<sup>1</sup>, stated that it now takes an average of seventeen years for new evidence to be incorporated into practice. Part of the problem (but certainly not all of it) is that research findings are placed in academic journals, often obscure ones, written to placate peer reviewers, and not read by the potential users of the research, such as busy practitioners, managers, commissioners, patients or their carers. So what should we do?

The NHS research arm, the National Institute of Health Research, funds lots of health research and is well aware of this problem. In 2015 it set up the NIHR Dissemination Centre, which provides short and accessible summaries of recently finished studies but also writes themed reviews of its current and recently completed research on given topics.

In early 2017, a review of research conducted in care homes called *Advancing Care* was published, and at the end of 2017 a themed review of research into the acute hospital care of older people with frailty, *Comprehensive Care*, was published. Elaine Maxwell from the dissemination centre who curated the themed review (and also helped with this article), and I

were delighted to be among the many researchers asked to contribute to it. It's a slim volume and is easily accessible, tracing research in older people with frailty before they get into hospital, through the emergency phase, the hospital admission and to aftercare.

To me, it shows that the care of older people is not a boring old backwater anymore (if it ever was), but a field brimming with innovation and invention. Gone are the days of futile debates about age cut-offs for treatments – we now have the notion of frailty to understand the catastrophic responses we see in our vulnerable patients.

Andy Clegg and colleagues' paper on the electronic frailty index is one of many studies in this review, one that is set to become a classic alongside Stuck's Lancet *meta-analysis of comprehensive geriatric process*<sup>2</sup>. In the report, we see CGA being re-affirmed and elaborated, extended into acute care and dementia care. We are given a heads up that Stuart Parker and Simon Conroy's *Hospital Wide CGA study* is near to completion, so we can look out for it. The review also includes the state of current knowledge on managing the five frailty syndromes on busy hospital wards and the importance of good planning for transitions to the next stage of care.

Take a look at the NIHR Dissemination portal (<https://discover.dc.nihr.ac.uk/portal/home>) and Comprehensive Care (<http://www.dc.nihr.ac.uk/themed-reviews/frailty-in-hospital-research.htm>) in particular. What resonates with you? What surprises you? What might you do differently? Let's hope that it does not take seventeen years before we put this research into practice.

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## John Gladman

Professor of Medicine of Older People, Division of Rehabilitation and Ageing, School of Medicine  
Queen's Medical Centre  
Nottingham

## References

- 1) Institute of Medicine (2001) *Crossing the Quality Chasm: A new health System for the 21st Century* Washington DC: National Academies Press
- 2) Stuck, A.E., Siu, A.L., Wieland, G.D., Rubenstein, L.Z. and Adams, J., (1993) Comprehensive geriatric assessment: a meta-analysis of controlled trials. *The Lancet* 342(8878), pp.1032-1036.



# BGS Special Medal Winner - Jill Normington

**Jill Normington who is Local Champion for Parkinson's UK at Parkinson's UK Volunteer has Parkinson's Disease and has been a member of the Peterborough branch of Parkinson's UK since 1997.**

She has worked tirelessly to ensure that this group provides a range of exercise and social activities for those affected by Parkinson's and that these are accessible especially to older members of the group. Jill is at the heart of all local inclusion events and has worked to ensure older people with Parkinson's are connected to the information and support available for them. When people have needed advice about the condition, or needed a friendly ear to listen to their concerns, she has been the one to whom branch members have turned for help.

We met Jill and asked her about her role in Parkinson's UK. She said:

I am on the local committee of the Peterborough Branch of Parkinson's UK, serving as Secretary for a number of years, as well as Vice-Chair. My connection with Parkinson's UK began when I was the local champion responsible for looking into the management of people with Parkinson's Diseases. I was also on the Steering Committee for the *get it on time* campaign - working to ensure that patients could access their medications when they were due, especially if they were in hospital and the requisite timings for taking their medication did not coincide with a ward round.

Medication is usually three times a day. Personally I take my medication six or seven times a day. In 2009 we started a hospital Parkinson's awareness group with the help of a Parkinson's Nurse. This group meets two to three times a year and organises events within the city hospital to raise awareness for the staff. We also organise the local *Parkinson's Awareness Week* and have a stand in the hospital. This year we are celebrating Parkinson's Awareness Day which is taking place on the 11 April.



## Why Parkinson's UK?

Parkinson's UK provides invaluable information for patients. When I was first diagnosed with Parkinson's in 1997 I was given no information whatsoever. I was just told, 'I suppose you know about this disease?', followed by, 'We will see you again in six months'. I had never known anyone with Parkinson's and had no idea how it progressed, what its effects on my life would be, and ultimately, the prognosis. At the time I worked in a health promotion resource library for the NHS and I knew there must be a Society for people living with the condition. I subsequently joined Parkinson's UK and found lots of helpful information. This made me appreciate that while I might know where to go for help, many did not. This applies particularly to older people who may be scared to ask or not want to bother anyone.

Although there have been many positive changes to the diagnosis and management of Parkinson's it is an ongoing battle. Owing to lack of continuity among medical and health professionals, and that some hospital wards aren't exposed a great deal, to patients with Parkinson's, the management of their medications may go awry. Also, some Parkinson's patients are thought to be 'uncooperative' because they cannot respond. Symptoms can change very quickly. Personally, I can go from being unable to walk at all, to being able to manage with my two sticks. Also, Parkinson's patients can become a bit confused and this behaviour may be mistaken for dementia.



## The specific challenges faced by people living with Parkinson's

I find the little things challenging. For instance, I find it difficult to sort through paperwork, it easily becomes jumbled up. Also, it is unpredictable when I will be able to walk.

For the last 18 years I have had unpleasant symptoms but in the last year these have worsened. My walking and sleep are affected and I experience considerable discomfort in my feet. My handwriting is so small it is almost unreadable. Also, I find handling money and shopping bags difficult. At one time I would think nothing of having six carrier bags, now I can barely manage one together with my handbag.

People who know little about Parkinson's have no understanding of how variable the symptoms can be. One of our local members went into respite care for a week. He could walk alright during the day but in the evening and at night, when he needed to use the toilet, he needed assistance. Upon pressing the buzzer for assistance, the answering care assistant replied, 'I saw you walking this afternoon, you can walk tonight', and left him to it. That is just one incident. We have heard stories from families whose relatives were admitted to hospital and did not receive their medication on time. This inspired me to do what I could to raise awareness. It is vital we treat people with dignity and kindness.

## Supporting people with Parkinson's in the local area

We have over 100 members in our local area, who do everything from rattling tins to providing advice and support. An example of their work to support Parkinson's patients is the campaign *Time for Tea*. We put up displays in the hospital about Parkinson's and organised tea and biscuits for staff. Two or three people with Parkinson's attended, who were willing to speak about their experiences. The event was attended by a wide variety of staff from students to doctors. We ran this event on several wards and it was well received.

I cannot stress enough, how diverse the symptoms of Parkinson's can be, and how variable within the person living with it. No two people are the same. Giving a human face to Parkinson's is important. For example, I don't have much of a tremor but this is not the case for everyone.

I am proud of the work I have done organising Parkinson's Awareness Days. These include workshops by physiotherapists, a carers' session and information about complementary therapies including reflexology and aromatherapy. Personally I have a regular massage which helps my condition. We also promote exercise like Tai Chi and Pilates. The Tai Chi session was so popular I sourced some funding and started a separate group, exclusively for people with Parkinson's, not including carers. This gives people living with the condition the opportunity to talk openly and without pressure with others who have the condition and who understand the challenges for daily living, around the condition. I also spoke at the House of Commons during the Parkinson's Awareness campaign, about my diagnosis.

## Major areas of concern for older people with Parkinson's Disease

A major area of concern for older people with Parkinson's is receiving their medication in a consistent and timely fashion, when they are in hospital. In our local area we created a 'Parkinson's Passport'. It lists what medications one takes, when they are to be administered, as well as other important information such as what one might need help with and when. This Passport is essential for patients who are unable to self-manage their medications, which is often the case on a hospital ward.

## A message for BGS members

Listen to your patients. Don't rush them through an appointment. My consultant listens and includes me in the decision making process and this is incredibly important to me.

## The BGS Special Medal

I am coming to the end of my career at Parkinson's UK and this is a nice way to remember my achievements over the years. It came as a complete surprise, thank you!

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### Jill Normington

speaking to Marina Mello, Communications Manager for the BGS



# Marjory Warren Lifetime Achievement Award Winner - Professor Dawn Skelton

**Professor Dawn Skelton is an internationally renowned researcher and knowledge implementer in falls prevention, physical activity interventions and maintenance of independence in older adults. She has transformed UK falls prevention services, working with medical and AHP colleagues in national advisory and education programmes to increase awareness of the benefits of physical activity in the older population.**

We met Dawn and asked her about her views on a wide range of subjects. Given her work in falls prevention and physical activity, we asked what had first attracted her to exercise physiology. She said:

"Do you know what? I have actually always hated exercise! I am not the sort of person that became so passionate about being fit myself that I wanted everyone else to do it. It was purely because, as a youngster, I lived with my grandmother, grandfather and my parents. My other grandparents lived with my aunt and uncle. The grandmother that lived with me didn't sit still. She was always getting up and doing something.

She would even knit standing up. She was always off to see the 'old people' who were often ten years younger than her. She ended up passing away at 98 years old but was still using the stairs and doing her own shopping six months before she died.

I saw that she had a good quality of life. She had health problems but she was still mobile, whereas my other grandmother who avoided activity, because she was fearful, lived nearly as long but had nowhere near the same quality of life. She had to have everything brought to her and she rarely got out of the house.

This was all happening when I was in my early teens and I decided when I went to university I wanted to study Human Sciences and I did my PhD in exercise physiology at the



Royal Free. I know that most people want the minimum effect dose of exercise. It's like green beans or peas. You know you have to eat them but you want as little of the stuff as possible to meet the requirements for good health. I have always been interested in what are the quickest wins relating to exercise, so people can get back function and make exercise part of their everyday life.

## Later Life Training (LLT)

After doing my PhD, I developed the *Falls Management Exercise Programme*. At that time my grandmother was falling a lot. So I came into contact with John Campbell (a geriatrician, now deceased). He had set up the *Otago programme* in New Zealand. His was a home based programme, whereas I was interested in a group based programme. We set up our own programme and saw great results.

It occurred to me that there was all this great research not being used, literally gathering dust. It certainly was not being used on the ground by physiotherapists; they were doing what they had always done. They hadn't put into practice some of the things we now know are vital, like progressive strength training and balance challenge.

With a couple of colleagues, I went to the Department of Health to secure funding to develop a training curriculum for physiotherapists and specialist exercise instructors. To start with, we ran the programme through a small college but within a year it was obvious we couldn't meet the demand. We returned to the Department of Health who suggested that we set up a company. This started with my colleagues and I delivering the training ourselves, and it grew from there. We have kept the enterprise as a not-for-profit,



because we are not business people. Our passion is in our everyday jobs; research and implementation.

Our company has always been a vehicle for getting the research into practice and for linking therapy with self-managed exercise. For example, if someone is very frail when they start therapy, and they have had lots of falls, they are probably not ready to go from therapy straight to the gym or to join a walking group. There was this big gap and we were looking how we could them from A (sedentary frailty) to B (exercising and mobile). It's not just about a series of exercises; it is about providing support, promoting self-efficacy and building confidence. It is important to find out what will motivate people. For some it will be playing with their grandchildren and for others it will be having a soak in the bath. If you find that 'hook', you can make people do that exercise they might otherwise be unwilling to do.

## **Main benefits of physical activity in the older population?**

Most of us know the physical benefits of exercise in an older population but in my opinion, improved mental health is actually the biggest benefit. It helps people avoid loneliness, isolation and to have the energy to get out and meet people. We know people who exercise regularly are less fearful, less anxious and less depressed.

## **Challenges for NHS Trusts in implementing an effective falls prevention service**

The main challenge is the cost. All evidence suggests that a patient needs fifty hours of sessions before one sees an effective reduction of falls. Six to twelve weeks of one class a week is not even scratching the surface of what is needed. The challenge is to think longer term. Yes, it costs more to put an effective programme in place but the revolving door will revolve less often and maybe not at all.

Also, what really worries me about inadequate programmes where the physical competence is not restored to an adequate level, the first thing to return in frail patients is confidence. It improves before muscle strength and balance. If one is not thorough, people will think they are better and put themselves in more risky situations, only to experience another fall. One could actually see an increase in falls. There are studies that show that when people first start exercising, their increase in risk goes up. The NHS may never be able to deliver an effective dose of physical training because it is an expensive service, but the NHS needs to link in properly with other services, such as charities. There needs to be a seamless pathway out of the NHS into something else that will carry on the good work.

A key element to a seamless pathway is ensuring the older person meets the person who will be coordinate the ongoing service, check the exercise venue/service (making sure that the co-exercisers are not Lycra clad young people!). This could be facilitated by showing them a short video, on an iPad for example. It is also important to explain to people from their very first session, 'This is the start of your journey, you will be with us for a bit but you will be moving on to other services'.

Transport is another big problem. When people are very frail we often provide hospital transport to the rehabilitation setting but then we expect them to hop onto their local bus to a community class up the road. There is a big disconnect there. Community services can help, including befriending organisations, but we need to facilitate that connection.

## **Motivation to exercise and adherence to physical activity**

If a person doesn't do the exercise regularly and consistently, it won't work, just the same as if they don't take their pills regularly and consistently, the medicine won't work. We need to remember exercise isn't easy, like a pill. With exercise you don't only need to remember to do it, you also have to have the energy to do it. As soon as the person experiences any depression or anxiety they won't want to exercise. We see this time and time again in research.

## **Sedentary behaviour is a much larger problem in people who are lonely and depressed.**

We cannot just assume that everybody is motivated to exercise because they "want to reduce their risk of a fracture", for example. What might be motivating them, is staying in their home (as opposed to losing their independence), or going to the shops. To explain the importance of exercise to meet these aspirations, you have to have a conversation to firstly, tease out what their motives are likely to be, and then to making the person understand why and how physical activity is essential to achieving their goals (of staying in their own home, going to the shops, or whatever). We need to give our healthcare professional the time to have these conversations, in addition to delivering therapy.

## **Public perception of physical activity in the older population**

There is the growing understanding that frail older people can do exercise without keeling over and dying. When I started my PhD in strength training, securing ethics approval was a nightmare, because of the perceived risks. Then, when I started my falls training programme all the participants had to wear hip protectors.

Nowadays on YouTube, there are hundreds of 90 year old folks doing pole vaulting and marathons. There has been a massive shift in the public perception of what older people can do. What hasn't changed enough, is that when people become a bit frail, all we do is offer them a seat wherever they go. This happens in care homes, hospitals and on buses.

You know what? It would be better for an older people to stand on the bus. Standing on the bus provides balance training and strength work. But of course immediately we say to the older person, 'please, have a seat'.

Interestingly this is not the culture in Scandinavia. There, older people are not treated any differently. In the UK we are so risk adverse that we 'over care' when we perceive a little frailty. The carer should be saying to the slightly frail older

person, 'come with me to the kitchen and we can make a cup of tea together'. We have become really good at dealing with the pre-frail but we have a complete disconnect when the person becomes frail. This encouragement of sedentary behaviour hasn't changed, if anything it has become worse. This may be because people are so adverse to falls. People think it is safer to sit the frail older person down when in fact it is having the opposite effect. Sitting vastly increases their risk because they are losing muscle and strength.

### The BGS and geriatric medicine

I would like to see the Society carry on growing. I would also like the BGS to be even more proactive, rather than reactive, and go to the government and the NHS saying, 'THIS is what we need...'. Let's be really loud! Let's get more geriatricians in the NHS and ensure patients are seeing them first. Older patients with multi-morbidity should be seeing a geriatrician, not just the specialist related

to the issue they were admitted for. Studies show that wards with geriatric input have much better patient outcomes. Personally I would like to see geriatric input on every ward, except paediatrics of course.

### The Marjory Warren Lifetime Achievement Award

It is absolutely amazing to receive this award, especially as I am not a geriatrician. I have worked closely with geriatricians over the years. Many of my mentors have been geriatricians and I value their knowledge and their support. It is a real honour to receive an award from a speciality for which I have so much respect.

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#### Dawn Skelton

speaking to Marina Mello, Communications Manager for the BGS

## BGS Membership Subscription renewals 2018

Members will have been emailed in 2017 from [membership@bgs.org.uk](mailto:membership@bgs.org.uk) about renewing and confirming their membership information.

If you didn't receive this email, please contact us in order to update your details as these are vital to ensure we continue to provide your membership benefits accurately. Please note we will not be sending letters this year so it is important to have a valid email address on file. Membership information may be updated via the BGS office by calling 0207 608 1369 or by emailing Geraint Collingridge on [membership@bgs.org.uk](mailto:membership@bgs.org.uk).

### Age and Ageing

Please also let us know if you have had any difficulties receiving your journal copies, either in hard copy or online. Online access is free to members already receiving the journal in print. To get online access you will need to register for an Oxford Academic account. You will need to have your subscriber number (an 8-12 digit code) which is printed on the address slip that comes with your hard copy of *Age and Ageing*. If you do not have a copy of that code you can still set up your online account by contacting Oxford Journals' customer services on [Jnls.Cust.Serv@oup.com](mailto:Jnls.Cust.Serv@oup.com) or + 44 (0)1865 353907.





# Rising stars in older people's care

**The BGS Annual Rising Star Award recognises young doctors, nurses and AHPs who have made exceptional contributions to the field of older people's health care, early in their career. Two awards are available each year; one for research contributions that have translated into, or are in the process of being translated into, improvements to the care of older people, and the other, for a clinical quality project which improves the care of older people with frailty in the award holder's locality.**

In 2017, the award for quality went to Dr Ruth Law, Consultant in Integrated Geriatric Medicine, Whittington Health, for her work with the Integrated Community Ageing Team (ICAT) in Islington and to Dr Thomas Jackson for the work he has been doing in research.

Ruth trained mainly in and around London. She says that her training included a formative year as part of the stroke team at the National Hospital for Neurology and Neurosciences where she had the privilege of working alongside world-class researchers as they developed a new service.

"This training provided a good springboard into my consultant post as I found myself with a new title of 'integrated geriatrician,' a request to 'do something about care homes' and an absence of any blueprint to follow.

"With the support of my department and our local GPwSI in Geriatrics (Dr Philly O'Riordan) the 'Integrated Community Ageing Team' (ICAT) soon came into being. For the first year we focused on supporting our ten local care homes (all dual registered). We created link geriatricians to deliver CGA in the care homes, spent time working alongside the existing care homes GPs and began monthly MDMs. On the secondary care side, we offered access to geriatrics advice in working hours via a hotline, created rapid access slots in clinic for assessment and made sure any care home admissions received rapid review by a geriatrician.

"With this relatively simple intervention we saw a sustained drop in unplanned admissions from care homes by 26 per cent.

"The success of ICAT opened doors to becoming involved



in raising the national profile of care homes medicine. Within months we had been invited to speak at the launch of the Five Year Forward View at The King's Fund with its particular focus on care home medicine. I contributed to NHS England's winter toolkit for care homes and spoke at the Royal College of Physicians *Future Hospitals* event.

"Thankfully our success also led to cost savings which our commissioners re-invested in community geriatrics and so, in year two, we widened our scope. We recruited a frailty specialist MDT (occupational therapy, physiotherapy, pharmacy and nursing) and started to deliver CGA in the homes of community dwelling frail older people. Now in its third year, this service is widely valued by patients and GPs and we are currently involved in supporting local GPs to identify more of the frail patients on their lists and offer tailored interventions.

Reflecting on the growth of both the care home and general community services I feel there are three key elements to growing a quality service, namely patient and primary care involvement, and interdisciplinary education."

## Patient Involvement

"With the support of Islington CCG we were able to involve Healthwatch in undertaking a resident feedback exercise around integration, early on in our care homes work. The positive results gave us the momentum and local support to



move forward at pace. We continue to collect patient's views every quarter ,as part of our ongoing service development.

The team are particularly passionate about supporting older people to access the services they are entitled to, and prioritising integration of services within a person's care plan."

## Primary care

"From the outset, Islington's GPwSI in Geriatrics (Dr Philly O'Riordan) has been involved in the operational and clinical side of the service. This has enabled us to develop in a way that dovetails appropriately with existing services in primary care and does not generate extra work. We have also chosen to fully integrate our IT with Islington primary care and work on the 'EMIS' system, used by every local GP.

With patient consent we are able to view the GP record in real time, and type our notes so that they can be viewed directly and immediately. This means we have access to all documents, prescriptions and investigations relating to a patient when referred. We have put effort into visiting local surgeries, speaking at practice meetings and attending relevant commissioning meetings to maximise opportunities for improving communication and building relationships with our GP colleagues. The efforts we have made to work together with primary care are highlighted in this RCGP publication: [http://www.bgs.org.uk/pdfs/2016\\_rcgp\\_bgs\\_integration.pdf](http://www.bgs.org.uk/pdfs/2016_rcgp_bgs_integration.pdf)

## Interdisciplinary education

"The power of CGA as an intervention lies in the team, and we are proud of the integrated community ageing team, their commitment to patients and each other. Our focus on interdisciplinary education underpins this. With the support of the interdisciplinary philosophy at Whittington Health we have been able to maximise opportunities for learning together, rather than in professional silos. The team have trained in areas as diverse as advanced care planning, vestibular examination and 'stop smoking' training. Learning together has built deeper professional trust and makes day to day working more efficient and enjoyable.

"The common thread that joins these three elements is of course, time. Time with patients, time with GP colleagues, time to learn together, time to develop ideas. By some standards we have achieved a lot in three years, but we have still felt the pressure to do things more quickly.

**I strongly believe that the key to quality is allowing the time needed. Paradoxically things have happened faster and more effectively, precisely because we have not rushed.**

"Moving forward we will continue to work closely with our colleagues in primary care, neighbouring trusts and the CCG to deliver the patient-centred, integrated service our patients deserve."



## The research award went to Dr Thomas Jackson. Speaking about his work, he says:

"I am currently working as a clinical academic geriatrician in the Institute of Inflammation and Ageing at the University of Birmingham. Clinically I work as a consultant orthogeriatrician at the Queen Elizabeth Hospital, Birmingham.

"My current work hopes to understand the immune-inflammatory basis of delirium, and how this impacts on the development of longer term cognitive outcomes, as well as understanding how our ageing immune system may drive frailty and sarcopenia.

"My PhD was on pragmatic methods to identify dementia in older people with delirium, and the effects of clinical subtypes and inflammatory profiles of delirium on outcomes.

"The BGS has been central to this as I was funded through a joint Research Training Fellowship with the British Geriatrics Society in 2012, and the BGS has helped fund further work through Spr start-up grants to colleagues I work with."

The British Geriatrics Society Rising Star Award was inaugurated in 2014 to recognise young doctors, nurses and AHPs who have made exceptional contributions to the field of older people's health care, early in their career.

Applicants must be within 15 years of graduation or achievement of their first relevant degree, and have already made a significant impact in the healthcare of older people, beyond what would normally be expected at that stage of their career.

## BASP Trainees' Weekend

2 - 3 March 2018, Cambridge

### The British Association of Stroke Physician Trainees' Programme includes the following topics:

- The future of stroke care services: what have we done and where are we going?
- Haemorrhagic stroke
- Update on hyperacute and acute stroke management
- Blood pressure management and secondary prevention in stroke
- Incidental findings on imaging
- Optimising patient selection and management of thrombectomy
- Complexities in vascular neurology
- To close or not to close? Interventional cardiology for the stroke physician
- Posterior circulation stroke
- Stroke chameleons
- Stroke at the ends of the spectrum: stroke in the young and in the oldest old Young stroke
- Trainee/student cases
- Vascular cognitive impairment
- Technological advances in stroke rehab
- Anticoagulation in AF: Which and when?

**For more detail, see the BGS website, select Conferences and Events/  
External Events**

## Managing Complexity and Uncertainty - Medicine for Older People Royal College of Physicians Edinburgh Conference

21 March 2018, Edinburgh

We aim to provide a stimulating, varied and informative day on topics including:

- Realistic medicine for older people in Scotland and beyond
- Providing comprehensive assessment: the Primary Care perspective
- Community management: a geriatrician's perspective
- Infectious diseases
- Heart failure
- Respiratory medicine
- Frailty in the emergency department (ED)
- Frailty in intensive care unit (ICU)
- Frailty in the operating room (OR)

See <http://events.rcpe.ac.uk/>

## Perioperative Nursing

23 April 2018, RCN London

Join us for this workshop as we explore the perioperative patient journey from preoperative assessment to discharge. Whether you are a new staff nurse, returning to practice or an experienced perioperative nurse, this workshop is your invaluable learning opportunity:

### Topics:

- Understanding the requirements of your patient
- Helping to optimise health of patient before an operation
- The phenology of operating theatres
- The importance and interpretation of the WHO checklist
- Surgical site infection and the 'One Together' toolkit
- The patient experience in recovery
- The elderly patient journey

Accrue over 5 hours of CPD at the workshop. At the end of the workshop delegates will be given an interactive case study to write up which will bring together their learning from the day, and can be used as a reflective piece for revalidation.

Price: £50.00 plus VAT (£60.00).  
Workshop open to RCN members and non-members.

To book: Places are limited.  
Book online, call RCN Event Registrations on 029 2054 6460 or complete and return the attached booking form to secure yours.

**Website:** [www.rcn.org.uk/PN18](http://www.rcn.org.uk/PN18)

See the BGS website for more meetings (both BGS and external events and job vacancies)  
Select Conferences and Events, or Resources/Vacancies

# Notices

## BGS EVENTS REGIONS AND SPECIAL INTEREST GROUP MEETINGS

**Living and Dying Well with Frailty  
- Quality End of Life Care for Older People**  
6 March 2018, London

**BGS Spring Meeting**  
11 - 13 April 2018, Nottingham

**Age Anaesthesia Association &  
British Geriatrics Society POPS  
SIG Joint Conference 2018**  
17 -18 May 2018 London



**Frailty and Urgent Care**  
25 May 2018, Horizon, Leeds

**Medical Impact of Loneliness in  
Older People**  
13 June 2018, London

**19th Falls and Postural Stability  
Conference**  
14 Sept 2018, Cardiff

**BGS Trainees Leadership and  
Management Course 2018**  
29-30 September, Venue TBA

**BGS Autumn Meeting**  
14 - 16 November 2018, London

**BGS East Anglia Region Spring  
Meeting**  
22 February 2018 Ipswich Hospital  
Education Centre

**BGS Trent Spring**  
28 February 2018 Leicester

**BGS South East Thames**  
8 March 2018, Orpington

**BGS South West**  
13 March 2018, Bath

**BGS West Midlands Spring**  
15 March 2018

**BGS Wales Spring**  
22 - 23 March, Bangor

**BGS Mersey Spring**  
28 March 2018, Warrington

**BGS Yorkshire Spring**  
28 March 2018, Pinderfields Hospital

**BGS NE Thames Spring**  
26 April 2018, UCH

**BGS Scotland Spring**  
27 April 2018 (TBC) Lanarkshire

**BGS Northern Ireland Spring**  
10 May 2018

**BGS West Midlands Autumn**  
20 September 2018

**BGS Mersey Autumn**  
26 Sept 2018

**BGS Yorkshire Autumn**  
26 Sept 2018 Pinderfields Hospital

Online registration and programmes may be found on [www.bgs.org.uk](http://www.bgs.org.uk)  
(Select Conferences and Events)

## Osteoporosis

26 - 28 March 2018, Merton  
College, Oxford

**Programme Chairs:**  
**Tash Masud (Nottingham, UK)**  
**Jon Tobias (Bristol, UK)**

This three-day residential training course aims to provide clinicians working in medical specialties such as rheumatology, endocrinology, care of the elderly, gastroenterology, orthopaedics, respiratory medicine and clinical chemistry with the knowledge and understanding to manage patients with osteoporosis and other metabolic bone diseases. The course focus is on practical issues relating to patient management and is strongly recommended for anyone who treats patients with these disorders. A stimulating interactive format will be employed combining lectures, panel discussions, debates and workshops. The course is suitable for clinicians of different levels of expertise, including doctors in specialist training, consultants, GPs and specialist nurses.

Both residential and non-residential options are offered. We recommend participants to take the residential option to take advantage of all the networking opportunities the course offers. Previous attendees have found it very useful to share experiences with each other in the evenings and over breakfast (also see below regarding the evening dinners).

<https://boneresearchsociety.org/meeting/brsosteo2018/>



British Geriatrics Society  
Improving healthcare for older people.

## Join the British Geriatrics Society

We welcome all healthcare professionals caring for older people

Passionate about improving healthcare for older people? Join us!

Everyone providing healthcare to older people is welcome to join. Student nurses and therapists, medical students and foundation doctors can join free of charge.

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- Networking opportunities at national, regional and Special Interest Groups meetings
- Access research and educational grants



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## Help our Society grow and diversify!

Are your colleagues passionate about improving healthcare for older people? Are they interested in the latest research, and recent developments in best practice? Are they currently members of the BGS? If not we need your help!

Please take the inserted Join Us Poster to your workplace and find a communal space to display it!

## Publications Information

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