



NEWSLETTER

British Geriatrics Society
Improving healthcare for older people

Issue 65 | May 2018



What's in a name

Is it time to change the Society's name?

www.bgs.org.uk

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BGS 2018 Spring

conference report

The Geriatric 5Ms

Giants for the next generation

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treatment seeks disease

Editorial



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We don't usually go courting controversy here at the BGS, but you wouldn't know it from this issue. If you carry on reading, you will encounter a debate about a possible name change for the Society, an argument that a commonly-diagnosed disease doesn't actually exist, and the demise (sort of) of this Editor by the time you finish this column!

There's no doubting that our main feature this time round is the proposal by President, Eileen Burns that we reflect on our Society's name and whether a change is needed. Like Eileen, I have had some strange looks when introducing myself as the Honorary Secretary of the "British Geriatrics Society". This reaction has come almost entirely from non-medics and mostly from people who have nothing to do with healthcare. Yet I call myself a geriatrician, and in my regular lecture on ageing I ask medical students to consider why they are all comfortable with the term "paediatrics" but not with "geriatrics". It's always good to be self-aware and we do need to make sure we have a strong identity in our policy and advocacy work.

But equally, there is a danger that we chase our tail and change our name every time society devalues the most recent acceptable nomenclature. Duncan Forsyth argues that we should keep the name and points out that "we cannot agree on a suitable single descriptive title for our departments". The debate has already started on twitter but the pages that follow will provide further food for thought.

The other potentially controversial declaration in this issue is the well-argued piece by Henry Woodford that calls out Normal Pressure Hydrocephalus (NPH) as, quite possibly, not a disease! He considers possible cracks in the well-beaten path of work up and diagnosis, including the lack of quality evidence for withdrawing CSF or shunting. It's difficult to fault his logic and it left me with an "Emperor's New Clothes" feeling – after all, this is still a condition that appears in all the textbooks. But Henry argues that NPH "fails to meet the basic criteria of a disease"!

Erratum:

In the February issue of the newsletter, in the President's column, we mentioned that Dr Jackie Taylor had been voted as President Elect of the Royal College of Physicians and Surgeons of Glasgow - the first geriatrician in that role. Thank you to all the readers who pointed out that while Jackie is the first *female* geriatrician to serve in that role, she is one of an elite band of geriatricians to hold that office. Our apologies for this oversight!

I will be watching all the above fireworks from a slightly increased distance as I am stepping down as Honorary Secretary, having moved to Ireland, and handing over to the safe pair of hands attached to Frazer Anderson. Many of you will already know Frazer from his work as *Age and Ageing* Abstracts Editor. As Honorary Deputy Secretary he has already been working closely with BGS staff and will be a superb asset to the Society in his new role. Frazer has also contributed an article to this issue on the dangers of the Three Letter Acronym, which should make us all think

before we replace BGS with another TLA...!

For my part, I have been honoured to serve you all and it has been a particular pleasure to work with the staff at Marjory Warren House. I look forward to having less work and more time to drink coffee and mingle at future meetings!

Shane O'Hanlon
Outgoing Editor

From the President



When I was elected president, I sought the advice of a number of my predecessors including the delightfully understated Professor Graham Mulley. One piece of advice he gave me was: don't get involved in a discussion about our name.

So you may wonder why I've chosen to ignore that advice! Read the rationale for this debate, together with two opposing perspectives presented in the following pages of this newsletter to see differing views on the topic.

The process of decision making is slightly complex - your mailing address carrier, which arrived with this newsletter, canvasses your opinion on two options - the best alternative name suggested, and our current "British Geriatrics Society". The results of our survey will inform a decision as to whether or not we take a motion to the AGM at the autumn meeting in London in November. The only binding way to agree any possible change would be through a membership vote at that meeting; members can identify a proxy to vote on their behalf, but our rules currently don't allow any form of binding postal or electronic vote.

Over the last few weeks, members have been responding to my invitation to share their thoughts about our current name and to suggest an alternative if they wished to do so. A small number of officers and staff have selected what seems

to be the best suggestion, so that members can be presented with a clear choice: either to stay with the existing name or to choose the selected alternative instead. The next step is that during May and June, we will ballot members for their vote on the two options. We are doing this at the same time and through the same voting method as we are using for our President-Elect election (of which, more below). **It should be emphasised that this ballot is 'indicative' only: of itself, it does not bind the Society.**

In the event of the matter going before an Annual General Meeting, the rules stipulate that at least 75 per cent of those members present at the AGM, or who have arranged a proxy vote, would have to vote for a change for it to be approved, so the bar for conservatism is set fairly high! So although the forthcoming ballot in May between two possible names isn't binding, it is very important; if the majority indicate they are in favour of the status quo, then no motion will be taken to the AGM. So please do let us have your vote in the ballot.

In other news we are currently in the process of seeking a successor to Tahir Masud as president elect. The position succeeds automatically to president so it's a hugely important role for the Society. We are fortunate to have four excellent candidates standing - may the best man or woman win! I can hardly believe that my four years (two as president elect and two as president) are coming to a close. It's going all too quickly!

In clinical work the "winter pressure" continues unabated although we're into May (as I write). I know that many of you are being asked to do more, see more "outliers" and that our consultant and middle grade staff (in particular) are being put under huge pressure.

Many of us have been personally affected by the struggle to provide the standard of care our patients deserve and that we wish to offer under current circumstances. The recent National Audit Office report confirming continuing rises in hospital admissions is objective evidence of the continued expectation that we do more and more without adequate resources. Recent political statements that the NHS needs more money (not just from opposition benches but from government too) is encouraging. So too is the survey data indicating that people would be prepared to pay more tax to fund the NHS. Action can't come too soon!

Eileen Burns

The British Geriatrics Society's ballot on its organisational name

From mid-May to early June the BGS is balloting its members on a whether to keep its existing name (The British Geriatrics Society) or to change it to The British Society for the Healthcare of Older People. This ballot is happening simultaneously with the election for the President-Elect, and through the same voting method.

It is an 'indicative ballot' only, which means it does not bind the Society. However, if there is a high voting turnout and a substantial majority in favour, then the Trustee Board will propose a special resolution at this year's Annual General Meeting (AGM) to change the name during 2019. Only the AGM has the authority to change the name. This year's AGM takes place on the last day of the autumn meeting in London, on 16 November 2018.

When you vote for the President-Elect, you will be asked if you also wish to vote on the question of keeping or changing the name. The preferred voting method is online, but postal votes will also be accepted. **The mailing address carrier in this edition of the BGS Newsletter**, which explains how to vote in the President-Elect election and how to vote to keep or change the organisational name, **serves as the ballot paper for those wishing to vote on paper**. Votes will be counted by Electoral Reform Services.

By the time you read this, the ballot will be open and it will close at midnight on Sunday, 10 June.

On the ballot form, you will be given two options: either to keep the existing name or change to The British Society for the Healthcare of Older People. The latter name was selected by a subgroup of elected officers and staff from over forty suggested by BGS members.

Some issues to consider when casting your vote:

Below you will see two opinion pieces, one from Dr Duncan Forsyth in favour of keeping the existing name, and one from the BGS President, Dr Eileen Burns in favour of changing the name to *The British Society for the Healthcare of Older People*. The piece you are reading now is intended to be neither for nor against, but rather to flag up some of the issues you may wish to consider as you cast your vote.

It is our job as a multi-disciplinary membership body to do all we can to further our charitable mission to promote better health in older age, and to deliver against our organisational aims. For this reason we have set out below some key considerations associated with either a change of name or the retention of our current name.

► **This ballot relates only to the name of our Society, the professional body of specialists in the healthcare of older people in the UK.** It is not about the name of the medical specialty or the myriad of names used by the NHS to describe departments catering for the medical needs of older people. Whether we keep or change the Society's name, the specialty will still be called 'geriatrics', both in the UK and abroad, and consultant geriatricians will still be called such.

► **'Geriatrics' is the internationally adopted name for the medical speciality relating to older people;** but BGS is now an avowedly multidisciplinary society, so the weight given to this fact by members may vary according to whether the member is a physician, a nurse, or an AHP.

► **Language and names can be emotive and mean different things to different people.** For example, what limited research there is suggests that older people do not like the term 'geriatric', and nor do they like the word 'frail' if applied to them.

► **BGS and its members work with a wide range of stakeholders. Their views and perceptions of our name will vary.** The outcome of this ballot, and any subsequent vote on the name at this year's AGM, will impact on the effectiveness of our engagement. To help you consider and assess the likely impact on the work and mission of BGS, we are providing a reminder of whom BGS works with. When casting your vote, you may wish to consider which of the two options would most help us to engage with:

- Our current and potential members
- The international community of geriatricians
- Older people
- Younger people (as healthcare professionals, and as target audience for promoting healthy ageing, and as the family members of older patients)
- The general public, who are also the family and friends of older people
- Key opinion formers and decision makers, such as parliamentarians and civil servants
- Royal colleges and other medical societies
- Universities, medical colleges, other research institutions and funders of research
- Charities we work closely with, such as Alzheimer's Society, Parkinson's Society, Age UK, British Red Cross
- Private companies, especially those who sponsor our events
- The media.

► **Changing a charity's name brings with it costs** (such as changing the logo; publicising the change of name; meeting regulatory requirements; stationery etc.).

As a charity it is also our duty to consider the likely impact on our finances, and our reputation and public profile. We hope that you will give serious consideration to these issues when you respond to our ballot. We are grateful to you for taking the time to do so.

Colin Nee
BGS CEO

What's in a name... the case *against* change

“Oh, not again!” was my immediate reaction to our current president’s call to consider renaming our Society (the third time the BGS has navel gazed since I was appointed as Consultant Geriatrician in 1990).

As a geriatrician (proud to so be called), I accept that some will mis-perceive the political correctness of my title but whenever challenged, most are won over when I ask: “So, are you saying that you don’t wish to be seen by a doctor whose job title means that they are interested in the medical problems encountered in older age?” Why do I not wish to be called ‘Physician with an interest in older people’ or ‘Specialist in care of the elderly’ or any other job title that in more than one word basically means the same as ‘Geriatrician’ – well, do I really need to justify clarity and brevity?!

As a specialty it seems we cannot agree on a suitable single descriptive title for our departments, although all can be found on the internet using the search term ‘geriatric medicine’! There are departments of ‘geriatrics’; ‘geriatric medicine’; ‘care of the elderly’; ‘health care of older people’; ‘geratology’; ‘elderly medicine’; ‘older people’s medicine’; ‘medicine for older people’; and more. There are almost as many different names used for the same specialty services as there are hospitals. So how on earth are we going to come up with a single title for our Society on which we can all agree and that does better than our current title. British Geriatrics Society states in plain English what our Society is about.

Europeans have articulated a preference for “older” or “senior” as the defining adjectives for their demographic group; with the terms they deemed unacceptable being: “elderly,” “aged,” and “old”. The Human Rights Commission of the United Nations has outlined clearly in the International Covenant on Economic, Social and Cultural

Rights why the descriptor “older” should be used. Despite the current appeal of frailty to clinicians and academics, our patient group also do not like being labelled as frail. So, would it be OK to call ourselves ‘The British Society for Health Related Issues in Older People’? Would that become confusing when we speak out on non-health related issues?

Our president is correct that we are no longer a purely medical society – hurrah! Indeed, I was one of those who argued against the resistance in our Society to open up membership to nurses and other allied health professionals, arguing that it was hypocritical for those who could not function alone, outside a multidisciplinary team, to then retreat to a ‘doctor’s only society’, excluding the very colleagues they lauded as excellent to work with by branding them not worthy of sharing scientific evidence and debate. Thank God we won that debate and as a Society are reaping the benefits of our shared interests, clinical and academic, from the expansion of our numbers to include other clinical professionals who share a common interest in the health and wellbeing of older people. But this in itself does not warrant a change in the name of our Society, to what?: ‘The British Society for all Health Care Professionals Interested in Anyway Whatsoever in Older or Mature People who may or may not accept the term Frail when applied to themselves?!’

The American Geriatrics Society, Canadian Geriatrics Society, Australian and New Zealand Society of Geriatric Medicine, South African Geriatrics Society, Malaysian Society of Geriatric Medicine, Sri Lankan Association of Geriatric Medicine, and the European Geriatric Medicine Society all respect the UK as the cradle of Geriatric Medicine and show no signs of losing their origins in their titles. Let us remain proud of who we are, what we stand for and continue to hold dear the name of our Society – The British Geriatrics Society.

Duncan Forsyth

Consultant Geriatrician

Cambridge University Hospitals NHS Foundation Trust
Addenbrooke’s Hospital
and

Adjunct Professor

School of Healthcare and Medical Sciences

Sunway University

Malaysia



What's in a name... the case for change

As a 70 year old Society we have a long tradition of proudly bearing the name of “British Geriatrics Society”. So you may wonder why I have chosen to raise the issue again (it raises its head every so often) of changing our name.

We are all proud to work in healthcare for older people and many of us have long been known as Geriatricians. We are used to other specialists asking us “is it alright” to use the term (sometimes tongue in cheek) or to ask “are you still called geriatricians?” But, since when was our specialty led by a concern about the opinion of those narrow minded enough to care for single organs rather than for whole people?

Many surveys of our patients and the general public indicate how much they *hate* the word “Geriatric”. My daughter’s 20+ year old graduate friends gasped in shock when they heard the word used and asked, “are you still allowed to call people that?” Age UK recently surveyed older people about their views on a number of topics including terminology; their dislike of the term “geriatric” came through loud and clear.

Coincidentally, there was a poster on this subject at our recent Spring meeting (from colleagues at Ashford and St Peters). It reinforced the dislike our patients and their families have for the term.

Only last week, at no less an august gathering of the Royal College of Physicians Council, a councillor used the term

derogatively to apply to older fellows.

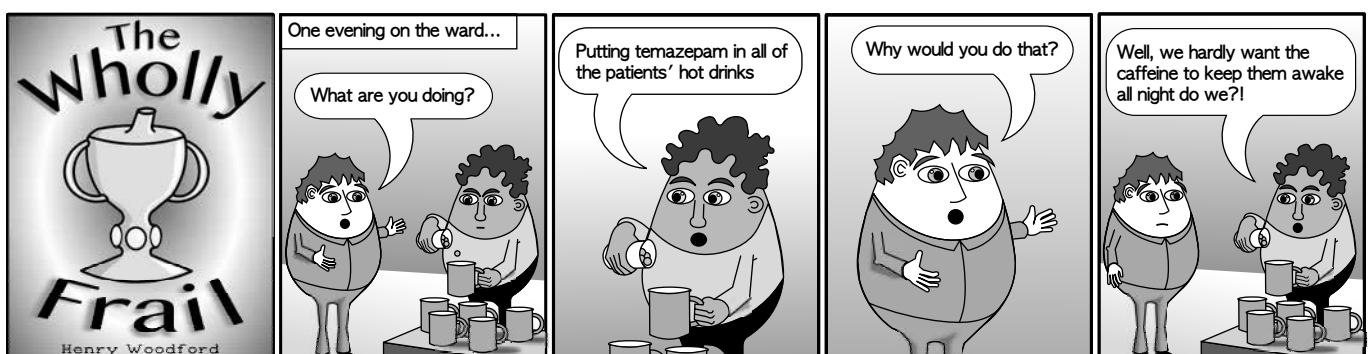
Over the years, several studies have been presented at our scientific meetings, demonstrating the same stigma, and I believe it was a study done by Marion McMurdo’s department which concluded: ‘if our client base, namely older people, dislike the term geriatric, who are we to continue using it?’

When our Society was originally formed it wasn’t called British Geriatrics Society. It was called *The Medical Society for the Care of the Elderly*, so we have precedent for reviewing our title in the light of current prejudices. Some worry about the risk of causing confusion in the science of our subject, but the use of scientific terminology would remain unaffected by our choice of name. When the “Spastics Society” changed its name to “Scope” (for example) the change had no impact on the continued use of the term “spasticity” to refer to the clinical condition.

One of the strategic aims of our Society is to influence policy as it affects older people, and from my interactions with the media, politicians and others who wield power in my years as president, I have no doubt that our name is a handicap to our effectiveness. Journalists can’t resist jokes about “where’s your zimmer frame?” which sets interviews off with the wrong tone, when we have serious points to put across.

Internationally other health economies look to our Society for a lead in the field of healthcare of older people. BGS is the largest medical society by far, for healthcare of older people in Europe, so we should not be reluctant to take the lead in reviewing our title and in saying loud and clear, “if the term geriatric is anathema to our patients then we should no longer use it”

Eileen Burns



British Goat Society

Welcome to this edition of *Goating World*, the official journal of the British Goat Society.

Oh, sorry, was it the Bagot Goat Society you were looking for? British Geological Survey?

All of the above are potential results from a Google search for “BGS”. The fact that our professional lives involve a great deal of hacking through thickets of acronyms will not come as news to any of you, but I would like to take particular aim at the Three Letter Acronym, or TLA. [Of course, “TLA” is itself a TLA which makes it a rebus – a little treat for obscure grammar fans there.]

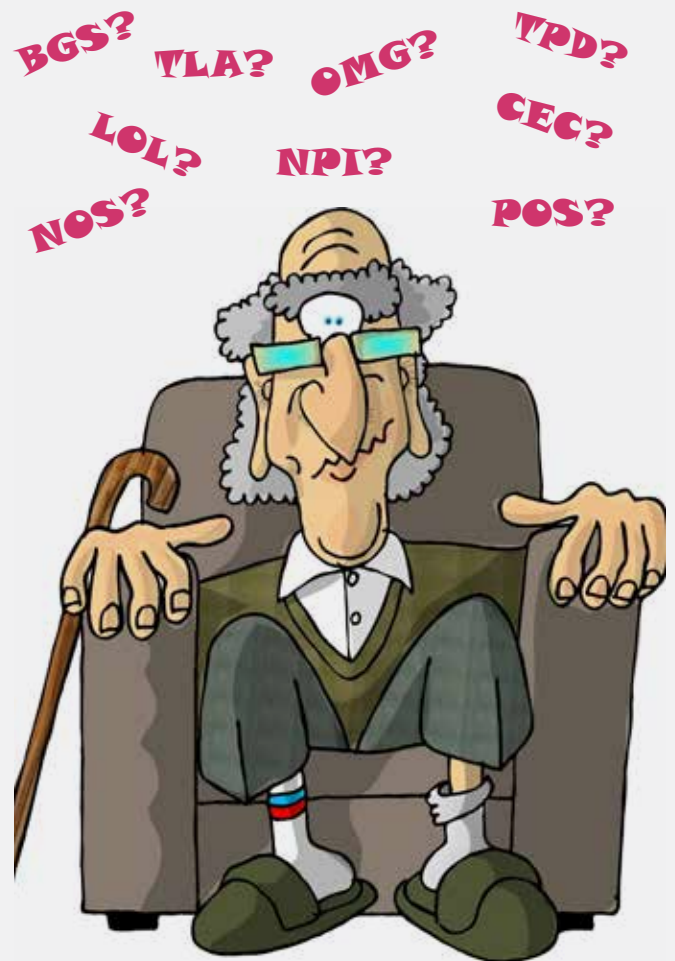
There seems to be something deeply lodged in the human psyche which makes us reach for a TLA rather than other possible abbreviations, although it should be recognised that this is fairly specific to Anglophone Western cultures. Sometimes this is taken to faintly ludicrous extremes; for example in my previous job I noticed that people with chronic chest disease were being referred to something called “TRC”. On enquiry this turned out to be “The Respiratory Centre” at our regional tertiary hospital. Anyone who feels the need to include “The” in an acronym is trying too hard! Nonetheless, they are everywhere and this is not necessarily a Good Thing.

To give two recent examples from my own experience:

I was about to see a lady in my “falls and funny turns” clinic and looked up a recent discharge summary from her brief admission to the local Big Hospital. It was noted that she had been referred to the “AVM clinic”. Gosh, I thought – she has a suspected arterio-venous malformation! Not much I can do about that in my small community hospital. It was only when the lady kindly showed me her appointment letter for the Audio-Vestibular Medicine clinic that I realised that there might be some benefit in her seeing me that day.

This is an example of the first big problem with TLAs: there are only 26 letters in English. Even though this gives 17,576 possible TLAs there are in practice far fewer likely combinations and duplication is both common and potentially detrimental to patient care.

I was sitting in my MDT meeting when someone told me that the reason why a discharge was delayed yet again was that we were “waiting for ASC to complete the PCA for the DST for CHC”. It occurred to me that this was a perfect example of the other big problem: TLAs are a barrier to



TLA = Three Letter Acronym

communication and thus to mutual understanding among professionals and between us and our patients.

This latter example is the less obvious but potentially more harmful in the long term. TLAs are essentially a type of jargon, in that they allow precise and rapid communication between those who share a certain knowledge base (good) while at the same time excluding those who lack that knowledge (not good). Doctors, however, are not best placed to complain about this. Medicine has a long and inglorious history of exclusionary jargon, all the way from writing in Latin through “balloting” the kidneys – this does not mean they get the vote – to current terms from genomics making their way into routine practice.

We are, I think in a good place to push back now though. Most of the pressure to use TLAs is coming from outside Medicine and many of them are really not adding much, even for their users. Patient-centred care is a strong force at the moment and one cannot claim to be involving patients in decision-making if they have no clue what we are talking about.

Frazer Anderson
Consultant Geriatrician
Southern Health NHS Foundation Trust

The GERIATRIC 5Ms – Giants for the Next Generation

The Geriatric 5Ms took social media by storm in the UK last year. Originating from Dr Mary Tinetti’s keynote address to the Canadian Geriatrics Society (CGS) in April 2017, this simplified communication framework aims to describe key core competencies in Geriatrics in a manner that those outside the field will better understand and remember.

Deconstructing the complexity of Geriatric Medicine in five easy steps, the GERIATRIC 5Ms (<http://bit.ly/5MsCGS>) – standing for Mind, Mobility, Medications, Multi-complexity, Matters Most - brilliantly and succinctly articulates the Geriatricians’ approach to their patients. These are the ‘Geriatric Giants’¹ for the next generation encapsulating the frailty syndromes with the potential to unite our specialty under one umbrella across the globe.

Geriatricians often struggle to articulate what sets us apart as specialists in managing complexity, frailty and health in old age. In Britain the specialty has a strong and proud history and has evolved to provide broad knowledge and expertise across health and care systems (<http://bit.ly/GMUKHist>). Geriatricians contribute the most to general internal medicine, are consistent pioneers of health care system development inside and outside hospitals and often assume roles in clinical leadership and medical education (<http://bit.ly/GMFHJ>). Underpinning all of these skills and the development of new care models, is the Geriatricians’ approach to care.

The GERIATRIC 5Ms are an important construct which could serve as the cornerstone for communicating our values to colleagues, allied healthcare professionals and students alike.

How the GERIATRIC 5Ms have travelled the world

Since Dr Tinetti’s introduction, the GERIATRIC 5Ms have been presented to readers of the *Journal of the American Geriatrics Society* and to BGS members via the BGS blog (<http://bit.ly/5MsBGS>). For those BGS members on social media the GERIATRIC 5Ms captured hearts and minds and were crowned the ‘Geriatricians’ salute’ and as a ‘high five to Geriatrics’. They have since travelled the world and have been disseminated internationally via the International Association of Geriatrics and Gerontology

(IAGG) newsletter. In addition, the GERIATRIC 5Ms are now used in medical education and clinical forums in an increasing number sites in the USA, Canada, Australia and New Zealand.

The GERIATRIC 5Ms have even learned a new language. The French version of the GERIATRIC 5Ms was developed in consultation with Dr José Morais, from McGill University, Past-President of CGS.

GERIATRIC 5Ms©		
English		French
MIND	Mentation, Dementia, Delirium, Depression	MENTAL
MOBILITY	Impaired gait and balance, fall injury prevention	MOBILITÉ
MEDICATIONS	Polypharmacy, De-prescribing, Optimal prescribing, Adverse medication effects and medication burden	MÉDICATION
MULTI-COMPLEXITY	Multi-morbidity, Complex bio-psycho-social situations	MULTI-PATHOLOGIE
MATTERS MOST	Each individual’s own meaningful health outcome goals and care preferences	MULTI-PATHOLOGIE

What next for GERIATRIC 5Ms?

The GERIATRIC 5Ms will continue their journey across the world, giving a high five of positivity wherever they go. We hope that Geriatricians everywhere will find the GERIATRIC 5Ms helpful in their advocacy on behalf of our specialty. We are certain Geriatricians in the UK will embrace this useful tool as they continue to enrich the specialty’s history and inspire the next generation of geriatrics giants.

James Adams

Consultant Geriatrician, Royal Surrey County Hospital NHS Foundation Trust

Frank Molnar

President, Canadian Geriatrics Society

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Normal pressure hydrocephalus: treatment seeks disease

If you have been revising for the MRCP, DGM or Geriatric SCE exams recently, then there's a high chance you will have come across a question much like this...

An 82 year old woman presents with a history of falls over the last six months. During this time period she has developed urinary urgency and incontinence. A gradual reduction in memory has also been noted by her daughter. She was found to have a small stepping gait with difficulty turning round. Only mildly increased tone in both legs is found on neurological examination. She scores 24 out of 30 on the MOCA test.

What is the most likely diagnosis?

- A. Vascular dementia*
- B. Alzheimer's disease*
- C. Progressive supranuclear palsy*
- D. Parkinson's disease*
- E. Normal pressure hydrocephalus*

In case you hadn't guessed, the correct answer is supposed to be 'E' because this patient has the 'classic triad' of gait, urinary and cognitive symptoms suggesting normal pressure hydrocephalus (NPH). But is it? Is it really the 'most likely'? Definitions of a disease typically revolve around finding a pathological process in a part of the body that produces an identifiable combination of symptoms and signs. Which parts of this are true for NPH?

Pathological process

Despite being over 50 years since NPH was first described, no neuropathological features specific for it have yet been identified. Autopsy studies of the brains of people diagnosed with NPH during life show that they have a combination of neurodegenerative disease and vascular lesions.¹⁻³ Brain biopsies taken at the time of neurosurgery have found Alzheimer's pathology in 26 to 41 per cent of people diagnosed with NPH.^{4,6} Elevated levels of cerebrospinal fluid (CSF) tau protein compared to control subjects, suggesting neurodegeneration, have also been detected.⁷ There is a strong correlation with a diagnosis of NPH and having vascular risk factors, especially hypertension.^{8,9} There is also an associated reduction in cerebral blood flow.¹⁰ Periventricular white matter lesions are very commonly detected. Those seen on MRI scans of people with a diagnosis of NPH are indistinguishable from those caused by cerebrovascular disease.¹¹

Many believers in the existence of NPH talk of abnormal CSF dynamics (despite normal pressure) leading to progressive enlargement of the cerebral ventricles. Yet no difference in CSF dynamics has been found in people labelled as having NPH compared to people with Alzheimer's disease.¹² It is said that brain imaging shows ventricular enlargement out of proportion with the degree of cerebral atrophy. The Evan's ratio is typically used to define ventriculomegaly. It is calculated from the widest frontal horn diameter divided by widest part of the inner aspect of the cranial vault on same image. It is described as increased if > 0.3 . Of course it also increases due to any cause of cerebral atrophy and in normal ageing. An Evan's index > 0.3 is found in 21 per cent of people aged over 70 and 36 per cent of people aged over 80.¹³ Let's not forget that NPH is thought to be a non-obstructive cause of hydrocephalus, so why would ventricles enlarge but other structures be relatively unaffected even if CSF pressure was elevated?

Some NPH advocates include "disproportionately enlarged subarachnoid space hydrocephalus" in their diagnostic criteria.¹⁴ This is a term for narrowing of cerebral sulci over the apex coupled with widening of the Sylvian fissure. Presumably they believe it is caused by some unknown gravity-defying force despite CSF pressure being normal (call an astrophysicist – could there be dark matter lurking within our grey matter?). Or, if you look at it the other way, there is more marked cerebral atrophy in the temporal lobes, which you might see in Alzheimer's disease, for example.

Symptoms and signs

Those in favour of NPH as a disease process report it causing a gradual onset over more than three months of one or more of:^{10,15}

- Gait disturbance – typically described as symmetric, higher level, apraxic, small stepping and with associated freezing and start hesitation. Parkinsonism that is symmetrical and without associated tremor is also said to be common.¹⁶
- Cognitive impairment – typically in the pattern of a frontal-subcortical dementia.
- Urinary frequency, urgency or incontinence.

Anyone who has spent time on an elderly medicine unit will be aware that the so-called 'classic triad' of these symptoms is very common in frail older people. All have been described in those with neurodegenerative and cerebrovascular disorders. None is specific for NPH. So is it a diagnosis of exclusion? Not at all, it is often described as a diagnosis of inclusion. Guidelines still accept NPH as a possibility when clear signs of brain atrophy or if other diagnoses present (e.g. cerebrovascular disease) so long as they are subjectively assessed as 'mild'.¹⁰

Tap test

The tap test involves removing 30-50ml of CSF via lumbar puncture with assessment of gait and possibly cognition before and after the procedure. An alternative option is external lumbar drainage but this is a more complicated and time-consuming process that has a higher risk of

complications (e.g. bacterial meningitis). It is suggested that people who improve following one of these tests are more likely to get better following shunt surgery. Exactly what is a significant benefit, can vary but has been described as any of a greater than 10 per cent improvement in timed-up-and-go (TUG) test, three-point improvement in Mini-Mental State Exam or more than one point improvement in any domain of the NPH rating scale.¹⁰ Alternatively, 'responders' may be judged only by subjective rather than objective criteria.¹⁷

A cynic may describe this as a process for selecting for surgery those with the greatest placebo response. In some people a sham procedure has been shown to produce significant benefit.¹⁸ But as it happens, these tests are poor predictors of response to shunting, which has led to the recommendation that 'non-responders' may go on to have a repeat test, do a different type of test or just go for shunt surgery anyway.^{10,19} This rather questions the value of doing any test at all.

Diagnostic criteria

Diagnostic criteria have been developed by American-European and Japanese groups.^{10,15} As a brief illustration, someone classified as 'probable' NPH would typically have gait disturbance plus at least one other symptom of the 'classic triad' and ventriculomegaly seen on brain imaging. 'Possible' cases would have just gait disturbance or both cognitive and urinary disturbance. 'Unlikely' cases would have fewer or no symptoms plus no ventriculomegaly. In addition, the Japanese criteria define 'definite' NPH in

people who improve after shunt surgery.¹⁰ However, subtle differences in the schemes have led to them having a poor correlation with each other. In one study the Japanese criteria aligned better with a neurologist's opinion, and the American system classified three times more people as 'probable'.²⁰ If the available diagnostic schemes were widely implemented then a large proportion of frail older people would be likely to be labelled as 'probable' or 'possible' NPH. Of course there are many other possible explanations for the observed clinical features. Among this long list, it is of interest that some authors consider the differential diagnosis of NPH to include urinary tract infection.¹⁵

Epidemiology

Given that lack of any valid diagnostic test, it is unsurprising that estimates in NPH's prevalence vary from the higher end of 1.3 per cent of people aged over 65, 2.1 per cent of people aged over 70 and 5.9 per cent of people aged over 80 years, but also down to the low end of 0 per cent (e.g. the author's view).^{13,21} Much like cerebrovascular and neurodegenerative diseases, it is more commonly diagnosed in older people. The mean age of onset is estimated to be 85 years with men and women affected in equal numbers.¹³

Surgery

So, there are no specific symptoms, signs or test results that can be used to diagnose NPH. Perhaps unique in medicine, belief in its existence mainly comes from a perceived response to treatment. The insertion of a shunt

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to divert CSF away from the cranial vault has become an accepted practice. Although you may ask why this would be effective if pressure in the system is already normal. Most importantly, there have been no randomised controlled trials (RCT) of shunting for people with suspected NPH. Neurodegenerative disorders and cerebrovascular disease cause profound symptoms and have few therapeutic options. It is entirely understandable that people affected, and those close to them, would be keen to explore their options, especially if one simple procedure could 'reverse' the pathological process. In such a situation we might expect the aura of neurosurgery to have huge potential for placebo effect.

Observational studies often cite response rates of up to 80 per cent immediately after surgery. However, the definition of a 'responder' is variable. It may rely purely on a subjective feeling of improvement by a patient or their carer or an objective measure in any test (e.g. a 10 per cent improvement in TUG time).²² So, when looking at results there needs to be some caution in how response is calculated. The actual magnitude of the improvement may only be small and may not translate into significant benefits for the individual. In an analysis of studies recruiting 883 patients, 59 per cent improved to some degree after shunting but only 29 per cent were judged to have prolonged or significant improvement.²³ One study found that 21 per cent of people with an improvement in functional testing did not have an improvement in quality of life.²⁴ Another analysis of 145 patients before and one year after shunt surgery showed no

overall improvement to their quality of life.²⁵ A comparison of people diagnosed with NPH who did or didn't have surgical treatment showed a 37 per cent mortality rate over five years, irrespective of whether shunt surgery was performed (mean age at start of study = 73 years).²⁶

Shunting cannot be described as a cure and does not prevent deterioration (as you might expect – pressure was already normal). At best it transiently makes symptoms less pronounced (believers are usually happy to accept improvement as proof of concept yet dismiss deterioration as due to progression of co-morbidities). Studies that have used longer follow-up periods have shown that response rates decline over time but with much heterogeneity. At 12 months 52-71 per cent are said to be improved but this falls to 25-65 per cent at three years.^{27,28} Of course, there needs to be some caution in assessing these figures as data from longer term studies may be unreliable due to high drop-out rates.

NPH should definitely not be described as a reversible cause of dementia. Measures of cognition are less likely than gait to improve following shunting.²⁶ A study with a follow up period of just under five years found that 80 per cent of 'shunt responders' developed cognitive impairment, with 46 per cent meeting criteria for a diagnosis of dementia (mainly Alzheimer's or vascular).²⁹ Those with cognitive impairment prior to surgery are the most at risk of going on to be diagnosed with dementia.

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Despite the relatively modest longer term outcomes and lack of RCT evidence, some people remain convinced that shunt surgery is a useful treatment. We should not underestimate the power of placebo effect – for centuries it helped perpetuate many medical practices that we now consider archaic such as cupping, blood-letting, emetics, and, quite poignantly, the practice dating back to Neolithic times of trepanning the brain to release evil spirits. Alternatively, it could be that some of the people treated successfully actually had elevated CSF pressure prior to the procedure.³⁰ This may explain why occasional cases seem to be dramatically improved. Finally, shunting could be beneficial by increasing cerebral blood flow through reduced intracranial pressure. Interestingly, a small randomised study (n=14, six-month follow-up period) of people with cerebrovascular disease suggested an improvement with shunt insertion (open compared to initially ligated shunts).³¹ Yet the same was not found in a cohort of people with Alzheimer’s dementia (n=164, nine-month follow-up period).³²

However, coupled to the uncertainty of benefit, there is also a high rate of complications. These include headache, infection, subdural haematoma and death. Typically some form of complication is experienced by 30-40 per cent of people with serious events in around 15-25 per cent (e.g. requiring further surgery) and permanent neurological damage or death in around 2-6 per cent.^{10,23,27,33,34} If ever there was a treatment crying out for a high-quality RCT to evaluate if any genuine benefits offset the risks then surely this is it.


Conclusion

NPH fails to meet the basic criteria of a disease – i.e. an identified pathological process in a part of the body that produces a specific combination of symptoms and signs. There is no coherent explanation for why normal CSF pressure in a non-obstructed system would produce ventricular enlargement. Neuropathological evidence suggests that people diagnosed with NPH actually have a mix of cerebrovascular and neurodegenerative disease. The ‘classic triad’ of symptoms are all very common in frail older people and well explained by a combination of these pathologies. To believe in NPH is to believe that some people improve with shunting despite there being a lack of RCT evidence to support this potentially harmful procedure. In short, there is no identifiable clinical entity of NPH. It should be removed from curricula and exam papers. In its place we should promote the better understanding and management of the many genuine problems that challenge frail older people. Whether shunt insertion could be beneficial for some people with a normal CSF pressure and clinical evidence of cerebrovascular or neurodegenerative disease is a question that could only be answered by well-designed RCT studies.

Henry Woodford

Northumbria Healthcare NHS Foundation Trust

British Geriatrics Society
Improving healthcare for older people



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2018 Oncogeriatrics (6 - 7 Dec TBC)	TBA (see BGS for regular updates)





The British Heart Foundation SENIOR-RITA Trial

Despite significant advances in diagnosis and management, coronary artery disease remains a significant worldwide cause of morbidity and mortality, particularly in older adults, with a steep increase in mortality in those aged ≥ 70 years old.¹⁻³

The clinical pattern of acute coronary syndrome (ACS) is different in older patients, with a larger proportion of non-ST elevation myocardial infarction (NSTEMI) versus younger patients with an established inequality in outcome after management, with 30-day mortality being 10-fold higher in older adults.⁴ This cohort of patients are largely under-investigated, meaning evidence to inform management of ACS is very limited, with over half of all trials of coronary artery disease performed in the past decade failing to enrol those aged ≥ 70 years old.⁵ This means evidence-based guidelines fail to take into account age-specific differences in physiology, therefore their application to this age group may be inappropriate.

Our population is ageing, and it is likely that this proportion of older adults, with their poorer outcomes, will further increase over the coming decades. However, despite the increased risk faced by older adults, the rate of invasive management including coronary angiography and percutaneous coronary intervention (Figure 1) of NSTEMI declines with age, commonly due to fear of complications or futility in older adults by doctors. These patients who are likely to gain the most benefit through coronary angiography and angioplasty are least likely to be referred, and instead are managed conservatively with medical management alone. There is an established inequality with an incremental decrease in evidence-based therapies for ACS management with increasing age across England and Wales.⁶

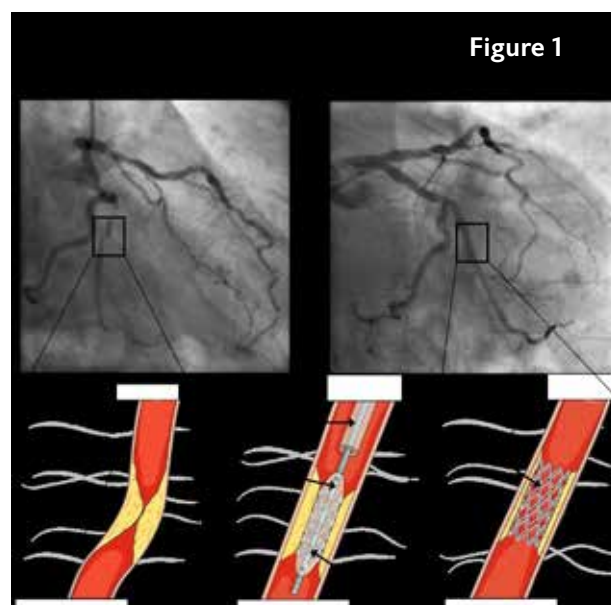


Figure 1
The invasive management of non-ST elevation acute coronary syndrome. In an 81 year old male, the initial diagnostic angiogram shows severe stenosis of the obtuse marginal coming from the left circumflex artery, leading to myocardial ischaemia. A) Stenosis of coronary artery. B) Percutaneous advancement of a coronary catheter, through which a balloon and undeployed stent is advanced. C) Inflation of the balloon and opening of the occlusion, with deployed stent left behind to ensure patency of the vessel. Coronary angiograms courtesy of the ICON1 Invasive Sub-study (unpublished), used with permission.

The difficulty in recruiting older patients to clinical trials is well recognised, with this leading to significant issues with applicability of best practice guidelines to this age group with the majority based upon studies performed in younger patients. Older people are frequently ineligible for participation often owing to restrictive exclusion criteria. As a population burdened with both co-morbidity and polypharmacy, researchers often eliminate these patients from trials, striving for “clean medicine”.⁷ This approach is, however, flawed as these are the very patients we need to learn more about in terms of disease management. Other common barriers shown to prevent the recruitment of older patients, especially the oldest old (≥ 85 year old), include cognitive impairment and the ability to give valid consent, frailty, and gatekeeper influence.⁸⁻¹⁰ The Improve Cardiovascular Outcomes in high-risk patients with ACS (ICON) study, demonstrated the feasibility of recruiting this older population to clinical research involving cardiovascular

disease. Although enrolment of this population remains challenging, the contribution of these patients and the enthusiasm which they commonly have for involvement in research cannot be ignored, particularly given the ageing population with a significant cardiovascular disease burden.¹¹

The British Heart Foundation SENIOR-RITA trial aims to bridge the gap in current thinking and provide evidence for the best management of NSTEMI in this older age group. The randomised control trial will recruit 2,300 patients aged 75 years old and over nationally across the UK in 40 hospitals and allocate them to either current best medical management alone or medical management combined with coronary angiography, followed up with either percutaneous coronary intervention or coronary artery bypass grafting as appropriate.

The study design has paid particular attention to the complex comorbidities seen in older adults. Those with significant co-morbidities are included, in particular cognitive impairment and frailty; patients who would usually be denied invasive management due to the lack of evidence, paradoxically due to their exclusion from previous studies. It is important these patients are included, as both frail adults and those with cognitive impairment have recognised increased risk of adverse outcomes after NSTEMI.^{12, 13}

They will be followed up over five years, with the primary outcome being the impact of a routine invasive strategy versus conservative therapy on one-year incidence of cardiovascular death and further non-fatal myocardial infarction. The comprehensive follow-up will also include

secondary outcomes which are particularly important in the management of cardiovascular disease in the ageing population such as length of time spent at home, frailty, cost to the NHS and social services and gains in quality of life. Professor Jeremy Pearson, Associate Medical Director at the British Heart Foundation, said: "This trial marks a landmark study in improving the care of older heart attack patients. Co-ordinating patients, research staff and clinicians across 40 sites is no mean feat and it will help answer important questions that doctors have when deciding whether to treat older, frailer patients with stents or bypasses. Treatments can often carry a risk and there is much more to be done to make sure treatments are suitable for every kind of patient. A heart attack still has the power to devastate a person and their family and we need to keep funding research to find the breakthroughs that will make a difference."

Benjamin Beska

Academic Foundation Programme Doctor in Cardiology, Newcastle upon Tyne NHS Hospitals Foundation Trust and Training Fellow, Institute of Cellular Medicine, Newcastle University

Lucy Lawson and Amina Khan

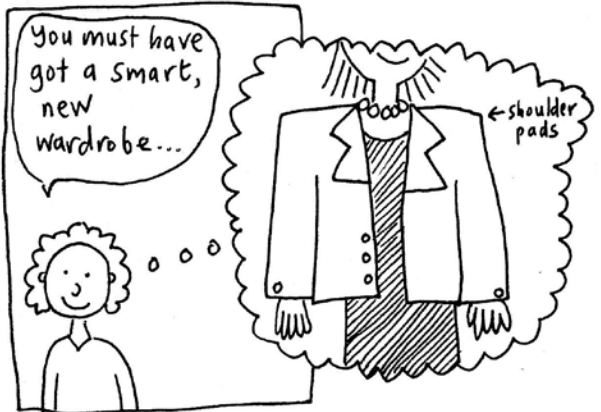
Intercalating fifth year medical students, Newcastle University

Vijay Kunadian

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The Older Person Whisperer says: I did this comic just after I got my consultant job, about six years ago. I hope it rings true for new consultant geriatricians. I'm not sure if things are different in other specialties but I thought about this comic the other day, when a colleague from another medical specialty was complaining that they had to do a ward round with one F1, and I had just done the majority of my post take ward rounds on my own.

Who am I?

Some misplaced items, a forgotten name,
It happens to everyone, old age is to blame!
I push it towards the back of my mind,
And yet.. more memories become harder to find.
I'm asked "Which doctor are you here to see?"
Patiently waiting, the nurse smiles at me.
Is it too late to turn back and go home?
I fumble in my brain for a name unknown
I see the GP and explain my concerns.
"Is it just lack of sleep, my thyroid... or could it be worse?"
I undergo testing, and become more anxious.
This is just normal routine.. right? Do I need all this fuss?

I hear my diagnosis; my blood runs cold.
I struggle to take in what I've just been told.
"Alzheimer's Disease". It sounds so final.
My husband squeezes my hand, his support vital.
I just cant focus on what's being said,
Because I'm silently praying inside my head.
Discussing medications I don't understand,
I feel like I'm drowning, sinking in quicksand.
"Who am I?" I think on that quiet journey home.
I'm a wife, mother, grandmother... yet feel so alone.

We keep it a secret in those first few months,
We're trying to protect the ones we love.
I disguise my illness behind a mask of smiles,
Although I'm pained with anguish all the while.
We continue with life and pretend everything's fine.
False normality lending a false lifeline.
But each morning I ask, as I stare in the mirror,
"Who am I?"... Each day my answer less clear...

I return to the GP.. She looks at me sadly
"Disease progression".. I just feel so angry.
Not just angry.. I feel scared.. depressed.
Is it time to lift this secret from my chest?
"Who am I?" I repeat my ritual question,
I'm only 68, my life not yet done.

I struggle each day, I'm easily frustrated.
I feel so alone, I feel alienated.
I struggle to get dressed, get confused over money..
I leave the cooker on, I'm becoming so clumsy.
"Who am I?" I repeat after a particularly bad day.
A grandmother to four... but my mind starts to stray.

A gradual decline over the next three years,
My family and I have shared so many tears.
We've cried due to anger, we've cried due to sorrow,
We've cried due to fear of the unknown tomorrow.

I'm no longer at home, but I'm unsure where.
I just sit here all day in this green armchair.
"Who am I?" I ask myself once more...
For the first time my answer is truly unsure.

I'm surrounded by faces I do not know,
My personality no longer on show.
I hear people speak, but I cant really make sense,
I've lost all my charm, all of my confidence.

"Who am I?" The words I used to ask so often,
But now I pass on this torch, please.. don't let me be forgotten.

And award winning poem by Lauren Jones - dedicated to all those whose lives have been touched by dementia

Lauren Jones applied for the Primary Care Creativity Prize last year. The aim of the competition was for students to reflect on the impact of disease and healthcare in primary care in the form of poetry, video, painting/drawing etc., with the top five entries being awarded prizes.

Lauren is currently in her fourth year of medicine, however alongside her studies she had extensive experience working as a Health Care Assistant (HCA). Although most of her time is now spent working on Accident and Emergency, she initially started by working on the medical wards, where most of the patients were older. It was there that she came to appreciate how difficult life can be for patients with dementia. Aside from her normal duties as a HCA, she often spent time doing one-to-one with patients who were very confused or agitated, and seeing how much of an impact this had on their families during visiting hours gave her insight into the wider impact dementia can have.

When thinking about what to do for her entry into the Primary Care Creativity Competition, Lauren reflected on her experiences both as a HCA and as a medical student. She found the devastation of dementia to be an issue close to her heart. She had seen both staff and family members become very frustrated or upset with patients, and she wanted to remind people of what it must be like as an individual living with dementia. She wanted to draw attention to the human being behind the condition of dementia. When a patient is unable to articulate how they feel and explain their behaviour, it can make people fear not only the disease itself, but in some circumstances they fear the patient too.

It was Lauren's hope that by giving a passing voice to the vulnerable patient, struggling to express him or herself, the wider community might empathise with that person and remember that he or she has lived a life that is worth remembering and to keep that memory alive, even when the patient is unable to.

The BGS speaks to the incoming President of the Royal College of Physicians London



Like many in his year at medical school, Dr Goddard came from a medical family and harboured desires to be a forensic pathologist until working for David Rubenstein at Addenbrooke's showed him the joys of hospital medicine. A run of GI related SHO posts led to a career in gastroenterology and meeting a Nottingham girl (his future wife) took him to the East Midlands. After starting as a College Tutor in Derby he worked his way up through the Royal College of Physicians (RCP) London system and was named as President to follow Jane Dacre on 26 September. Colin Nee spoke to him about his hopes for his time in office.

CN: You are about to start your 4-year term as President. When you look back in 4 years' time, how will you judge your success?

I want to be remembered more as a Bevan than a Lansley. Both pushed through change at a time of need. One got it wonderfully right, the other horribly wrong. If we have more doctors on the ground, and trainees and consultants feel their working lives are better I will be happy.

CN: Do you foresee significant changes at the College during your term?

We are building a second home in Liverpool so will be much less London-centric. This is a great opportunity but will have its challenges. There is a new curriculum to implement, which is much needed. However, we must ensure that specialty training is not damaged as a result of it. The RCP London needs to be seen as relevant to trainees and consultants. Much of this is about visibility and providing useful support.

CN: What's the most important thing you hope the College will achieve under your leadership which will make a difference to the lives of older people who need to access healthcare?

Better integration of health and social care with fewer stranded patients would be a good start. Improved training for all doctors on the issues facing an ageing population with a better understanding of how to improve the quality of life for older people will be a focus.

CN: Your previous roles within RCP mean that you have a deep understanding of workforce pressures within geriatric medicine. In your new role will you be willing to have the difficult conversations necessary to enable resources to be directed to where they are really needed, namely, geriatric and acute medicine, and not just the –ologies?

The great thing about workforce is that there are lots of data to support the argument for change. I think the difficult conversations are more likely to be with the non-medical specialties and yes, I'm up for it. However, a collaborative approach will be far more successful than a confrontational one.

CN: With the geriatric medicine being the biggest general specialty within the College, what are the principal areas of connection between the RCP and the BGS presently, and what do you see as being the principal areas of collaboration in the future?

We should work together to cement geriatric medicine into training, acute services and out-patients. Recruitment and retention in the specialty are a priority and we should share our learning.

CN: You recently surveyed the specialist healthcare societies, including BGS, about how we can all get the most from our relationship with the College. What do you see as the optimal relationship between the College and the specialist societies?

Without the specialist societies the RCP will be impotent. It is always tricky trying to balance the needs of the thirty-one different medical specialties and ensure that everyone feels they have been listened to, been influential and are valued. The more the RCP works with each Society, including the BGS, the more likely this is to succeed. The RCP can use its influence to highlight the needs of individual specialties but should also allow those specialties to take centre stage and stand alone when needed.

CN: The BGS has been at the forefront of engaging with non-physician healthcare professionals. We actively recruit nurses, AHPs and physician associates into membership, and nurses/AHPs have a seat on our Board. Would you like to see this approach spread more widely across the specialist societies?

Yes, I would. It seems inconceivable that ward and clinic working will look as it does now, in ten years' time. We should learn from early adopters of nurses and other Health Care Professionals to see how best to use a diverse workforce. Allowing them the opportunity to lead and influence is important.

Colin Nee
CEO, British Geriatrics Society



BGS 2018 Spring Meeting Conference Report

Ignoring older patients' potential for personal growth could be a form of ageism, according to Prof John Gladman, professor of the medicine of older people at Nottingham University Hospitals. "People can still have personal growth independent of the negatives of physical decline and social loss and we should be asking ourselves how we can encourage that."

"Instead of seeing ourselves as knights in shining armour who are going to solve all their problems, perhaps we could be asking our patients, 'how are you going to deal with this so that you can grow?'"

His challenge was issued as part of his Marjory Warren lecture on the theme of the meaning of life expectancy. Increases in the latter were now so familiar that we had stopped being astounded by it.

"For most of evolution man lived for around 45 years until about 150 years ago when something very strange began to happen: life expectancy started to go up. In evolutionary terms that's the blink of an eye."

The first steep rise between 1850 and around 1960 was primarily due to control of infectious diseases. The second phase was the growing number of older people. "It used to be that if you were 65 you might have another ten years. Now if you're 65 you might have 26 to 28. This fits very much with my clinical experience. When I started, most of my patients would be in their 70s; now it's routine for me to see people in their 90s."

But although we were spending a lot more years in old age many of those years could be spent in poor health. "I certainly fear uncompressed morbidity," Prof Gladman confessed. "I'm closer to it now, it's no longer just someone else. In fact some of my patients are slightly younger than I am."

Geriatricians needed to promote health ageing. Lifestyles, public health, education and economics were all influential but we should also ask what was the opposite of frailty. "The concept of resilience is used a lot in childhood and in psychiatry and it might be useful in geriatrics as well," he added. There were different kinds of resilience, the ability some people had to overcome challenges and bounce back, including psychological, cultural and social as well as physical, and geriatricians could play a role in improving it.

It was encouraging too to see the 'happiness U bend' revealed by various surveys which showed that many people in old age returned to the happiness levels of childhood and youth after dips in mid-life.

Although having children was not a necessary component of happiness, most older people developed generativity: the concern to nurture, guide and ensure the wellbeing of future generations and ultimately to leave a lasting legacy.

"You can talk about such goals with your patients. And talking about what someone has achieved and what they're proud of, rather than just what they can't do now can be a therapeutic aspect of taking a history."

He had already learned from patients that although personal growth was negatively linked to loneliness, it could also be positively associated with sadness because it involved meeting a challenge and learning from a difficult experience.

The Nottingham meeting had opened with a subject also beyond the purely medical when Dr Adrian Treloar, consultant and senior lecturer in old age psychiatry at Oxleas NHS Foundation Trust, had spoken about living well and spirituality.

Living well and spirituality

Every major religion apart from Buddhism believed in an eternal soul yet we were often very poor at 'doing' spiritual care, Dr Treloar told the audience. An audit of dying in 2016 had found that only 15 per cent of patients capable of discussing their spiritual needs had documented evidence of any such discussion during the last episode of care. Few people got to see a chaplain when they were not dying and chaplains regretted they were usually only called at the last moment and not before.

We should all ask ourselves what we would want if we were suddenly found to be dying. Our priorities might vary even according to the time of year - did we want to get to Christmas, for example - but we might also want the opportunity to think about God. End of life care was centrally important, both to the dying and their families, and at such times spiritual care could become very important. "It can get neglected and forgotten though," he added. "We often struggle with it in a secular age or we fear that by raising the question we might be disciplined. But we do need to ask how we might bring it in."

Living well also meant appropriate supportive and palliative care and the swift diagnosing of any underlying problems. To leave depression, which affected around a third of people with dementia and psychosis, which in turn affected between 20 and 50 per cent as the last things to treat, could be a serious error that left them in severe distress.

Home Care

The Oxleas advanced dementia service combined physical and mental health expertise to look after patients at home. As well as the benefits to patients, there were substantial cost savings by reducing the number of hospital admissions. Seventy five per cent of the 200 men and women they had cared for to date had been able to die at home, others had been admitted for only a few days at the end of life.

“We can do so much more now at home than we used to be able to do with often just simple measures like hoists or hospital beds or pressure cushions. And carers are helped by having someone as a single source of support and advice. We’ve had very positive feedback. And it’s also very rewarding for the staff who ‘get it’.”

Dr Treloar was the first speaker in a day-long Special Interest Group on dementia which looked at many aspects of the condition. Continuing with the end of life subject Claire Bamford, senior research associate at Newcastle University, described the SEED initiative – Supporting Excellence in End of life care in Dementia.

The aim was to support specialist nurses in the community to identify and deliver effective aspects of care. Intervention was tailored to the individual and the local context with families and patients being signposted to services and practitioners as necessary. All parties were involved in discussions about planning for the future with nurses keeping in contact with families after the patient’s death for help and support.

One goal was to reframe distress as the need for comfort and to identify what that looked like for each person. Often these were simple things: having hair brushed, petting a dog, watching birds, listening to music, being in a garden. Notes on comfort care were regularly updated so that when, for instance, a woman who had always enjoyed a glass of Baileys found she could no longer swallow drinks, the cook made her a Baileys mousse.

Dr Nathan Davies, senior research fellow at University College London, then spoke of the attempt to create ‘rules of thumb’ for practitioners caring for someone with dementia at the end of life. Existing guidelines tended to be cancer specific, only dealt with the final two or three days and rarely elicited the views and experiences of family and carers.

The dementia rules wanted to correct this. It was important to start conversations as soon as possible after diagnosis and then to continue to review the patient’s situation. If he or she became agitated and restless what had changed? If the cause could not be identified then was there a non-drug treatment which might help like music, massage or aromatherapy? Or should a pain relief trial be instigated?

Towards the end of life, treatments and interventions should only continue if they maintained comfort or had a positive

impact on quality of life. “For example, we might stop these big pills that the patient has difficulty swallowing or check whether in providing routine care we might be doing things like changing sheets that don’t need changing and only disturb the patient.”

Fall related injuries in dementia

The second session was devoted to research into the disease with Dr Louise Allan, clinical senior lecturer at Newcastle University, outlining the ongoing DIFRID study - Developing an Intervention for Fall Related Injuries in Dementia.

There was certainly a need for effective intervention: up to 90 per cent of such patients would have at least one fall in a 12 month period, be around ten times more likely to fall than other old people, less likely to recover well, be more likely to be hospitalised and for longer and to need increased care afterwards.

The project was giving participants 22 therapy sessions including strength and balance exercises, dual tasking and functional activities over 12 weeks.

Another study into repetitive calling out by older patients in an acute hospital was described by Jessica Beaver, PhD researcher at Nottingham University who had both observed the subjects of her study and talked to their families and healthcare professionals. There was some recognition that calling out might stem from an unmet need but there was often a sense of futility too that nothing could stop this persistent and disruptive vocal behaviour. One need, Ms Beaver suggested, was for the introduction of a set of protocols so that all the right options could be explored.

Another PhD researcher from Nottingham University, Emily Cousins, sounded some positive notes in her talk on the arts and dementia. There was, she said, so much going on including music, singing, drumming, dance, painting, poetry and crafts. “The arts are about entertainment but they can also give huge empowerment.

“There’s no formal scientific way of quantifying this - how can you measure eyes shining or souls soaring - but we can observe the effects. A person may have lost the ability to communicate verbally, for example, but someone reads them a poem and the words come flooding back.

“Singing can bring physical benefits but also mental and social ones too: confidence, meeting new people, feeling part of a group. One woman who has joined a Singing For the Brain group said meeting other people with dementia had made her feel not so different after all.”

There was also encouraging news from the section on cognitive rehabilitation where Prof Linda Clare, professor of clinical psychology of ageing and dementia at Exeter University, told how a large trial on 475 people with Alzheimer’s, vascular or mixed dementias of mild to moderate levels had shown promising results.

Half had been given treatment as normal, the other half had received ten home visits from a therapist over three months followed by four more visits over six months. The approach

was collaborative with the therapist assessing what a person could do, how their environment hindered or supported them and what they needed to do to reach their goals which might include daily living tasks, retaining information, finding belongings, using appliances and gadgets and keeping in contact with family and friends. Reaching those targets might involve new learning, relearning, the use of compensatory strategies or assistive technology. Attainments were assessed after nine months.

“Research showed therapists enabled the development of rehabilitation strategies, improvement in daily activities and in quality of life,” said Prof Clare. “With the right support mild to moderately cognitively impaired people can adjust, learn strategies and new skills. This could be a useful component of post diagnosis care. The next steps could be to develop self help and self management packages for people and their families.”

The previous speaker Dr Reinhard Guss, consultant clinical psychologist in the Faculty of the Psychology of Older People at the British Psychological Society, had described cognitive reserve and resilience and how some people had more both in the ‘hardware’, the size of the brain and the number of connections in it, and in the ‘software’ which was related to education, occupation and lifestyle.

Intelligence could mean people passed several levels of assessment even though they might be struggling. On the other hand a demanding job might flag up weakness earlier than someone living in easy retirement with simple routines.

It was vital, however, to assess correctly a person’s strengths, weakness and potential. “It should give people the best chance of making the most of their abilities at an early stage. If we have a good understanding of someone at the outset we can tailor the interventions. Poor quality assessments are costly for those they are attempting to assess, for service providers and for society.”

VOICE

Earlier the meeting had heard from Rebecca O’Brien, speech and language therapist at the University of Nottingham, about communicating with people with dementia and some of the problems and solutions highlighted by VOICE : VideOing to Improve Communication and Education.

The aim of the study was to analyse a collection of 41 films ranging from two to 30 minutes in length of patient/professional encounters in an acute hospital to better understand what was actually happening.

Twenty five per cent of hospital beds were occupied by people with dementia which affected communication skills anyway but the hospital setting – noisy, busy, unfamiliar – made the symptoms worse. This could lead to worse outcomes for patients with increased stress and reduced job satisfaction for staff.

VOICE had run a pilot training programme in improving communication which involved facilitators leading small groups in experiential, didactic and reflective learning over two days a month apart. Attendees said they found it informative, enjoyable and relevant.

A before and after example was shown later in the conference in the workshop ‘how to communicate better with your patient’. In the before video a doctor was trying to take a history from a stroke patient with asphasia but struggling to understand. In the after training video he had given the patient pen and paper so he could draw a diagram.

The strategies could often be that simple but all involved ‘communication ramps’: the means to write and draw, the interpretation of gestures and expressions, the offering back of suggestions as to what patients were trying to say.

“Assume all communication is meaningful and show this in your response,” said another workshop speaker Dr. Suzanne Beeke, a senior lecturer at University College London. “Say ‘do you mean..’ rather than ‘I’m not quite following that..’.

“Imagine you were suddenly parachuted into a foreign country where you only had a few words of the language. You’d still have communication strategies. And people with asphasia can be remarkably inventive and creative with the limited linguistic resources they have left.

Such resourcefulness was shown in a video of a woman who had no verbs but was still capable of expressing how much she had enjoyed a trip to London. In another a man was managing to convey his ideas about using Skype to his wife who was adept at picking up and reflecting back to him what he was trying to say.

“With training and practice the conversational partner, professional or family, can learn effective strategies,” Dr Beeke added.” Despite the severity or type of asphasia we can get ourselves skilled up and skill up others in the workforce.

Other videos shown and discussed at the workshop included one of a doctor carefully and tactfully broaching the subject of a terminally ill patient’s fear of death. Another showed how an occupational therapist was able to get a patient with dementia to complete a task. In a third one doctor had problems closing an encounter with a patient but in a fourth another was able to do it very smoothly.

Hearing loss

Another interesting use of a video clip to make a point came in the session on hearing loss when Dr Helen Henshaw, senior research fellow at Nottingham University’s Biomedical Research Centre, used a scene from The Flintstones cartoon with the volume steadily diminishing to demonstrate the experience of increasing deafness.

“Hearing loss is not deadly but it is very disabling. It impacts on the individual, on society and on all aspects of healthcare provision. It’s important in any clinical interaction that patients can hear and act on what they hear but doctors might not be right in assuming that they can.”

The problem was widespread and costly: 11 million people in the UK had significant hearing loss with a cost to society of around £30bn. The incidence increased with age affecting 70 per cent of the over 70s. The prevalence also increased with other conditions including diabetes, kidney and cardiovascular disease.

It was associated too with an increased risk of dementia: twice for mild hearing loss, three times for moderate and five times for severe. Both conditions might stem from the same neuro-degeneration or there might be a cascade effect where auditory problems led to depression and decreased sensory input or the connection might stem from cognitive overload where the effort to hear distracted resources away from memory processes.

Sufferers were also more likely to experience falls, accidental injuries and social isolation. Even when people manage to attend social gatherings they often could not participate or became exhausted by the effort to do so.

Managing the problem with hearing aids could be very effective but uptake was poor – only an estimated one in three who needed help sought it – and frequently delayed: people often struggled for years before they got one.

Hearing tests, she believed, should be routinely included in cognitive assessment and CGAs. “Make hearing loss the first and last thing you consider when interacting with older adults. Ask them ‘how can I help you hear?’ Aid understanding by facing the patient in good light without background noise and not covering your mouth. And check they have heard and understood by getting them to repeat back key information.” C2Hear was a free online multimedia support package which might prove helpful.

The next speaker Dr Brian Crosbie, research fellow at the Centre for Dementia at Nottingham, University, outlined some of the problems – and possible solutions – for care home residents with both hearing loss and dementia.

Aids worked as pieces of technology and generally improved mood, communication and social engagement but there were lots of practical difficulties surrounding their use, including loss, maintenance and breakages. Nearly 90 per cent of users needed help which meant a lot of work for frontline staff. Some residents might not tolerate their aids or not want them in all the time. The care home environment itself was often not ideal for communication being too noisy and visitors frequently did not realise they were shouting or all talking at once.

Specialist training for staff which encouraged leadership, promoted person centred care, developed communication skills and workable procedures and increased knowledge about various devices had produced good results.

“Staff need to feel competent and knowledgeable about hearing loss and hearing aids and to be given permission to use those skills. They are then more likely to spend more time helping the residents which reduces isolation and involves them better in routines and activities.”

One of the attractions of the BGS meetings is that attendees

often get the opportunity to hear advice from someone who is not a doctor but who has relevant experience and expertise. This was the case with the second guest lecturer Peter Homa, chair of the NHS Leadership Academy, and the holder during his career of a variety of top health service management posts.

One of those, he admitted, he had resigned from after seven weeks. “I realised very quickly that both my colleague and I wanted to be chief executive. I’d known that intuitively but I’d suppressed it out of vanity. In facing difficult decisions after that, I never made the same mistake again. It is important to make sure your heart and your head are aligned.”

His theme of leadership included other examples from his own life and work including what he called ‘scar tissue.’ “These are the things I wish I’d known when faced with difficulties and what I’ve learned from them,” he told his audience. “When things go wrong ensure that the impact of the learning is greater than the impact of what went wrong.”

It was often helpful to imagine how the future might work out. “When you’re looking at your life story imagine you charted it with the ten most influential people and events and then ask what would be the ten next most important events. That can be a way of creating your own strategic plan. Most of us don’t do that and then we wonder why we don’t have the life we wanted.

“Look at environments in which you flourish and those in which you struggle. Use your personal and instinctive values as your satellite and conduct yourself accordingly. You can’t solve every problem so do what is consistent with your values.”

You could not lead others before you could lead yourself, he added, so it was important to understand your weaknesses as well as strengths and to know what you needed around you to compensate for those weaknesses. “When applying for jobs always select those you work for far more carefully than they select you. You’re entrusting yourself and your family to an organisation or individual so make sure they’re worth it.”

Other tips included looking after yourself with a fitness regime, doing less more thoroughly especially early in your career, always being authentic and knowing when to change. Most people waited until they failed at something but the time to change was at the top of the Sigmoid curve: at peak performance before any decline could set in. There were always abundant opportunities to improve if you chose to take them. “It’s not what happens to you it’s how you take it. As Robert Kennedy said ‘only those who dare to fail greatly can ever achieve greatly.’”

In leading teams it was important to avoid short term answers to long term questions; to encourage and treasure genuine

constructive criticism; to appoint people more able than yourself and support them to excel. "And seek to understand before seeking to be understood."

Other subjects the meeting covered were telecare and telehealth, tissue viability, NHS management, renal medicine, respiratory medicine, clinical effectiveness and education and training. Presentations included one on delirium given by Dr. Thomas Jackson, honorary consultant in geriatric medicine at Birmingham University and the winner of the BGS Rising Star award; one on older adults with HIV where geriatric syndromes were occurring at earlier ages than among the general population; and one on the new techniques being used to quantify muscle mass and turnover in sarcopenia studies.

The other day long SIG was on stroke and topics included thrombolysis for the older stroke patient, managing the very elderly hypertensive, carotid artery intervention, spasticity, vascular cognitive impairment, visual impairment, anticoagulation and the prevention of aspiration pneumonia.

Half a morning was devoted to orthogeriatrics and osteoporosis where Prof Opinder Sahota, professor of orthogeriatric medicine at Nottingham University Hospitals, spoke about the burden of the estimated 65,000 vertebral fragility fractures in the UK : back pain, spinal deformity, decreased lung capacity, loss of appetite, sleeping problems, decreased activity, more bone loss, increased fracture risk, increased lung problems, co-morbidities and increased mortality.

It was vital therefore to break this downward spiral using where appropriate percutaneous vertebroplasty, basically an injection of cement into the spine. As an example he cited the case of an 82 year-old woman, normally fit and well, who had suffered acute back pain after some light gardening. As a video of her showed, she was able to stand and take a few steps the day after the procedure and was walking normally by day five.

"It was a remarkable recovery. The message is: not everyone should have it but for a group that is struggling you should think about early augmentation."

He also called for increased awareness of sacral fractures which could be less easy to spot.

He was followed by Prof Mike Stone, consultant physician and director of bone research at University Hospital Llandough, who talked about the role of chronic kidney disease, which affects five to ten per cent of the population and is increasingly common with age, in causing mineral bone disorders.

The last speaker was Dr. Stanley Ralph, consultant anaesthetist at Derby Teaching Hospitals, who looked at peri-op optimisation of hip fracture patients. Such fractures were the most common serious injury in older people and cost the NHS and social care around £1bn a year. They were also incredibly painful.

Treating them as soon as possible was key: fast track admission through the emergency department within four hours, early surgery within 36, followed by early mobilisation

and care by a multi-disciplinary team. Operating early improved pain, lowered the risk of pressure sores and raised the chances of a return to independence. "There's a good saying 'the sun shouldn't set twice on a hip fracture'".

With x-rays to illustrate his talk Dr Ralph listed the various kinds of hip fractures, the procedures for dealing with them, usually via keyhole surgery with local anaesthetic blocks, and the attendant risks, particularly those associated with the potential for blood loss.

An afternoon was given over to falls with Prof Rowan Harwood, consultant geriatrician at Nottingham University Hospital, speaking about PrAISED, Promoting Activity Independence and Stability in Early Dementia; Prof Pip Logan, professor of rehabilitation research at Nottingham University outlining FinCH, the Falls in Care Homes study; and Julie Whitney, clinical lecturer at the department of gerontology at King's College Hospital looking at fall prevention exercise interventions for frame users.

In many of the sessions attendees who totalled nearly 500 over the three days chose to use the online Slido system to ask questions or make comments anonymously.

There were 139 posters including the president's top ten selected by BGS president Dr Eileen Burns who interviewed each researcher about their findings and two sponsored symposia. The first, sponsored by Vifor Pharma, looked at iron deficiency in the older co-morbid patient and in cases of heart failure. The second, sponsored by Daiichi Sankyo dealt with anticoagulation in the elderly.

Attendees were offered a drinks reception on the first night, a free walking tour of the city and a get together on the second evening at The Old Library in the Conference Centre with a finger buffet, an informal table tennis championship and an art table where guests could try out their creative talents by creating Picasso style pictures.

Liz Gill
Freelance Journalist

Prize Winners

Eva Huggins Prize for best poster presented by a nurse or AHP: Jane Horne [Improving trial recruitment in care homes: the falls in care home (FINCH) experience]

John Brocklehurst Prize for best clinical quality poster: Ruth Baker [Improving the quality of electronic discharge summaries for older adults with a hip fracture]

Fergus Anderson Prize for best scientific research poster: GEM Research UK [Mouth care: do we care? a one-day national flash audit of mouth care practice in hospitalised older adults]

Elizabeth Brown Prize for best platform presentation: Amelia Joseph ["To dip or not to dip": a quality improvement project to improve the diagnosis and management of urinary tract infection in care homes]



Delivering good nutritional care for people with dementia

Over 850,000 people in the UK have dementia, many of whom struggle with eating and drinking. As dementia progresses, eating and drinking difficulties are a major factor contributing to poor health, frailty and reduced quality of life.

By the time someone with dementia moves into a care home, they may already be experiencing significant weight loss and other nutrition-related problems. This may trigger further physical and mental deterioration, which means that supporting people living with dementia to eat and drink well, can be quite a challenge for busy care and nursing staff.

With funding from The Burdett Trust for Nursing, researchers from Bournemouth University (Professor Jane Murphy and Joanne Holmes) have been exploring this issue to understand how to improve the delivery of nutritional care for people with dementia living in care homes. As a result of their research project, key themes were identified that have informed the development of a new conceptual model to guide improvements for nutritional care in care homes¹. The seven identified domain areas were person-centred nutritional care (the overarching theme); availability of food and drink; tools, resources and environment; relationship to others when eating and drinking; participation in activities; consistency of care and provision of information.

We recognised there was a need for research in this area as there were no evidence-based approaches or training



Prof Jane Murphy

programmes to provide staff with information about good nutrition.

People with dementia may need much longer to eat due to poor co-ordination or becoming tired more easily. Others may be losing their appetites or facing difficulties with chewing and swallowing. As dementia progresses, many people become less able to sense thirst so may be unaware they are dehydrated.

We worked together with local council, care homes and charities to explore the issue and have now developed a workbook and training film packed full of ideas for staff to try out that can be used at any time. It has been a great experience working in partnership with all these organisations as we've been able to gather different perspectives and ideas. It has helped us to create a much richer resource than we could have produced on our own.

Through this evidence-informed model, the team has since implemented new education and training tools (workbook, film and leaflet) for caregivers to improve their knowledge, understanding and delivery of nutrition in dementia. A new guide designed for all care staff will also be available via the website soon.

The tools help to explain the importance of good nutrition and provide staff with lots of practical tips and ideas to try out. These include:

Keeping people interested in food by getting them involved in food preparation activities, including growing their own fruit and vegetables; eating meals together with carers, which allows people to copy actions if they're struggling to remember how to eat; adapting the physical environment to create an improved dining experience using colours, smells and lighting used at meal times.

The resources have been used by health and social care staff in the UK and have already helped people with dementia to eat and drink well. Further evaluation work has shown that

this is transforming practice and the wellbeing of people, with dementia with staff implementing more person-centred approaches to nutrition-related care and importantly, it is leading to weight gain in people who were at risk of, or were losing weight.

All the resources are all freely available from the website www.bournemouth.ac.uk/nutrition-dementia.

Jane Murphy

is Professor of Nutrition, a Registered Nutritionist and Dietitian and co-leads the Ageing and Dementia Research Centre at Bournemouth University

Reference

1. Murphy JL, Holmes J, Brooks C. Nutrition and dementia care: Developing an evidence-based model for nutritional care in nursing homes. BMC Geriatrics 2017 17:55. doi: 10.1186/s12877-017-0443-2 <https://bmcgeriatr.biomedcentral.com/track/pdf/10.1186/s12877-017-0443-2>

Loneliness in older people and its impact on health

13th June 2018,
Wellcome Collection, London



British Geriatrics Society
Improving healthcare
for older people



Sessions include:

- Epidemiology of loneliness
- Primary care and the issue of loneliness
- Loneliness and the impact on mental health
- The inter-relationship between loneliness and medical illness
- The potential of technology to help alleviate loneliness in older people
- What can be done to prevent older people from being lonely

Some of the speakers:

- Alistair Burns, University of Manchester, National Clinical Director for Dementia and Older People
- Helen Stokes-Lampard, Chair of RCGP
- Nicole Valtorta, University of Newcastle
- Sanja Thompson, University of Oxford
- Eiman Kanjo, Nottingham Trent University
- Kellie Payne, Campaign to End Loneliness

BGS on the small screen!

Continuing our work towards a higher profile for our Society and Specialty...

There have been a number of positive communications developments for the Society including high profile TV appearances by our President Dr Eileen Burns, President-Elect Professor Tahir Masud and other BGS Members.

These appearances included...

Eileen Burns appeared on the Victoria Derbyshire Show on 1 March as part of an expert panel, which also included people living with dementia. The title of the programme was 'Living with Dementia at Home' and aired on BBC Two and the BBC News Channel.



The BGS collaborated with the Alzheimer's Society on their campaign highlighting the impact of delayed transfers of care on people with dementia at Christmas. **Eileen Burns** was interviewed on Channel 4's Evening News on 12 December discussing the issue.



BGS Member **Rowan Harwood** appeared on the BBC Two programme 'Hospital' on 24 April. The episode examined complex discharges for frail older people at Nottingham University Hospitals.



The Channel 4 programme Old People's Home for 4 Year Olds, which featured BGS Member Zoe Wryko as an on air expert, has been nominated for a BAFTA. The programme first aired on 25 July 2017 and garnered widespread coverage in the national press.



On 19 April Tahir Masud was filmed judging nominations for BBC's The One Show NHS Patients Awards. Patients, and their families, nominated people currently working in the NHS who have gone the extra mile. The programme will be broadcast later this spring.



Marina Mello
Communications PR and Media Manager

BGS Policy update - spring 2018



There have been lots of positive opportunities for engaging with key opinion formers and decision makers in the last few months. We have been busy making the most of these opportunities, as well as continuing to build and strengthen our links with other organisations that we want to work with.

Recent policy developments

New Ministers - Two new Government Ministers have been appointed to posts that are of direct relevance to our work:

- as part of the Prime Minister's reshuffle in January, Caroline Dinenage MP was appointed Minister of State for Health and Social Care. Her responsibilities include the Green Paper for Social Care and she is chairing the expert advisory group on the Green Paper which Eileen Burns is currently serving on. Each member of the expert group, including Eileen, had individual meetings with the Minister in January.
- Following publication of the final report from the Jo Cox Commission on Loneliness in December, the Prime Minister announced the creation of a new Minister for Loneliness, which Tracey Crouch MP and Minister for Civil Society has been appointed to.

Workforce Strategy, 2017-2027 - In December, Health Education England published a consultation on the development of its workforce strategy for the health and care workforce for England up to 2027. We submitted a full response which is available on the Policy Update section

of our website. In our response we set out our vision for an expansion of home and community based care, and flexibility in place of care for older people with fluctuating health conditions. We also highlighted the need for a focus on older people to be fully embedded in the core curriculum for all healthcare professionals, and joined-up and long-term planning for geriatric medicine.

New Strategy for Loneliness - A cross-government strategy on loneliness is currently being developed and will be published later this year. The aim is to bring together government, local government, public services, the voluntary sector and business to identify opportunities to tackle loneliness. BGS will feed into this via its membership of the Loneliness Action Group convened by the British Red Cross.

I attended the first meeting of the Loneliness Action Group on 27 February. The group is convened by the British Red Cross, to work collectively to address loneliness. The group's purpose is to take forward the agenda set out in the Jo Cox Commission's call to action report. The first meeting provided an excellent opportunity to influence strategy as it was attended by the two civil servants who are developing the Government's strategy and who were in full listening mode.

Parliamentary engagement

On 24 April, our President, Dr Eileen Burns spoke at a meeting of the All Party Parliamentary Group on Ageing and Older People. The group has been conducting an Inquiry into human rights and ageing, and this meeting focused on the right to good and adequate care. The group is aiming to publish its Inquiry in early June.

House of Commons Select Committee on Human Rights Inquiry into reform of Deprivation of Liberty Safeguards (DoLS): in February BGS sent in a submission to the Inquiry which was seeking views on the Law Commission's report and draft bill on the reform of the legal framework for DoLS. While having a small number of concerns we have welcomed the Law Commission's proposals which, if implemented, would result in a less bureaucratic and more streamlined process which places an emphasis on the 'protection' rather than 'deprivation' of liberty. <http://www.bgs.org.uk/policy-digest-m/resources/policy-digest/house-of-commons-select-committee-inquiry-into-the-right-to-freedom-and-safety-reform-of-deprivation-of-liberty-safeguards>

House of Commons Joint Inquiry into the long-term funding of adult social care by the Select Committees on Communities and Local Government, and Health and Social Care: the purpose of the Inquiry is "to identify funding reforms that will command broad consensus to allow progress in ensuring the long-term sustainability of both the health and care systems". In our submission we make clear that we believe sustainable funding of social care can only be achieved by placing patient-centred care at the heart of its design and that we need a model of care based on the wishes of older people themselves, with a recognition that this will require financial investment as well as redesign.

<http://www.bgs.org.uk/about/resources/policy-digest/house-of-commons-joint-inquiry-by-communities-and-local-govt-and-health-select-committees-on-long-term-funding-of-adult-social-care>

APPG Inquiry into improving access to hospice and palliative care. In April BGS submitted written evidence to this Inquiry. We highlighted the expertise, knowledge and skills of our members, in meeting the needs of frail older people as they approach the end of life. We called for greater investment in ensuring older people have access to specialist palliative care teams where appropriate regardless of diagnosis or place of care, as well as pointing to the current lack of capacity in specialist services to meet the increasing needs of our older population. The full submissions is available on our website, and we have just received notification that we are likely to be called to present oral evidence.

Other external policy engagement

In addition to the external groups and organisations we meet regularly with, there have been some positive opportunities to raise the profile of BGS and promote the work and expertise of our members.

Eileen Burns and I recently attended a ‘Summit’ event organised by the Fabian Society on Support and Wellbeing in Old Age, chaired by Barbara Keeley MP,

Shadow Minister for mental health and social care, and attended by Lord Filkin and a range of other influential individuals and organisations. The focus was on how, if extra money was available, it should be allocated.

The British Red Cross recently held a breakfast policy meeting, which I attended, on patient flow and the impact that volunteers can have on helping to ensure that hospital admissions and discharges are as smooth as possible for older people, particularly those people who live alone.

Working with you

I will be attending the BGS Scotland and Northern Ireland meetings in the next few weeks and hope to get to Wales later this year. I am keen to make sure I support you in any policy engagement and influencing work that fits with our strategic priorities. Please do get in touch if there are any aspects of this policy update or other policy developments you would like to discuss (email policy@bgs.org.uk).

Caroline Cooke
BGS Policy Manager

BGS Meetings - Social Media Engagement

Social media engagement during both the BGS Autumn Meeting 2017 and the BGS Spring Meeting 2018 were record breaking.

At the Autumn Meeting 2,241 tweeters from around the world participated via the hashtag #BGSconf. In total there were 10,802 tweets using the hashtag, which led to 35.018 million impressions globally (potential audience reached via their twitter account). Our twitter account @gerisoc led the pack with 1,310 tweets during Autumn Meeting, 2,479 mentions and 16.7 million impressions globally.

At the Spring Meeting 1,310 tweeters participated via the hashtag #BGSconf. In total there were 6,020 tweets using the hashtag, which led to 27.520 million impressions globally. This is an increase of 4.5 million impressions compared with Spring Meeting 2017. Our twitter account @gerisoc again led the pack with 1,218 tweets during the meeting and 1,672 mentions.

Marina Mello
Communications PR and Media Manager



Devolved Nations Report – Northern Ireland

Managing older people with frailty syndromes is, in common with other UK nations, rising up the wider Health and Social Care (HSC) agenda in Northern Ireland.

During March, a ‘Redefining Frailty’ workshop was hosted by the regional Public Health Agency, with input from NI BGS members in the design and delivery of the day. The aim is to coordinate better understanding of Frailty syndromes, to agree Frailty severity definitions and to explore options such as the electronic Frailty Index for Primary Care (which currently does not exist in Northern Ireland).

Some modest sums have been pledged to each of the five provider HSC Trusts for pilot schemes to improve care for older adults living with Frailty syndromes, with evaluations thereafter intended to inform scale up. Pilot schemes examples may include: enhanced assessment functions in EDs, structured priority prescribing initiatives for care homes, enhancing inpatient units to be more orientated to the psycho-social needs of those in later stages of Frailty syndromes or more upstream input for those in community with mild or moderate Frailty syndromes.

Cross organisation collaborations

Our annual Joint NI BGS / Royal College of Psychiatry meeting in January went well with good feedback and was hosted on this occasion by BGS NI. The overarching theme of talks was depression in older adults in both home and care home settings. Our Spring BGS meeting in May

is co-hosted with AGILE – the association for chartered Physiotherapists who work with older people. The previous collaboration on improving inactivity in older adults in hospital settings was well received by the multi-professional audience and we are hopeful that this meeting on the challenges facing older Adults with Frailty syndromes who present to Emergency Departments will also carry broad appeal and interest.

The ongoing prolonged absence since January 2017 of a functioning Assembly at Stormont has left a political vacuum, which is likely having an impact on the pace of transformation plans for moving care closer to the community, acute hospital services reform and making decisions, which in turn affects the prospect of expanding the workforce in specialties such as Geriatric Medicine (for which the case has persuasively been argued in previous independent workforce planning documents). In part due to this, most Health and Social Care Trusts carry vacancies for Consultant posts in an environment with increasing demand for Geriatric Medical expertise in secondary care including community Geriatrics / Acute Care at home models and emerging perioperative Geriatric Medicine posts.

Transforming ageing across borders

In Autumn of 2018, NI BGS is partnering with the Irish Gerontological Society at their Annual Autumn Conference in County Cavan in September. The theme is *Transforming Ageing across Borders* - with Brexit approaching this spices up the usual challenges of boundaries across primary and secondary care, inter-professional boundaries and organisational boundaries by adding a new (as yet unknown!) UK/EU boundary, particularly for older people living in border counties. Further information on this conference is available at irishgerontology.com.

Mark Roberts
Chair: BGS Northern Ireland



BGS Scotland

Responsibility for the NHS in Scotland is a devolved matter and rests with the Scottish Government. The Scottish Government sets national objectives and priorities for the NHS and signs delivery plans with each NHS Board and Special NHS Board, monitoring their performance.

NHS Boards in Scotland are currently all purpose organisations: they plan, commission and deliver NHS services and take overall responsibility for the health of their populations.

There are 14 NHS Boards covering the whole of Scotland, supported by 7 National or Special NHS Boards. Work on integrating health and social care has made progress with Integration Joint Boards in place across Scotland; however the pace and efficiency of change is reported by clinicians to vary quite widely between different geographical areas.

Workforce

There are consultant vacancies in most Board areas, with multiple vacancies in some hospitals, and resulting concern about the pressure on services and the financial burden of locum cover. In general the issue seems to be a shortage of trainees completing training – most geriatric medicine specialty trainees in Scotland move into consultant posts in Scotland post CCT but demand comfortably exceeds supply.

There are ongoing concerns around workforce projections,

with specialty recruitment less than we think ideal and many trainees taking longer than expected to complete training, due to time out for research, stroke specialty training, maternity leave etc.

Positives

1. Ongoing clear policy focus from the Scottish Government on the care of frail older people with support from Healthcare Improvement Scotland (HIS) and initiatives such as improving delirium care and frailty assessment across Scotland. HIS is now part of the iHub which brought together a number of quality improvement/guidelines/patient safety initiatives and this is going well. HIS appointed a clinical lead for older people with a funded sessional commitment to that work (Professor Graham Ellis) and he has been co-opted on to the BGS Scotland committee.

2. Considerable investment and support is being provided to improve the care of people who have dementia.

3. There is huge enthusiasm in the rural areas in the north of Scotland, particularly Tayside and Grampian, for improving community healthcare for older people and enhancing joint working between geriatricians and GPs – we had a very successful BGS Scotland scientific meeting in November 2017 in Aberdeen which included a session on this work. One of the GPs credited the initiatives with improving GP recruitment in her area. It would be good to share this more widely for joint learning and development with other similar areas across the UK.

Christine McAlpine
Chair: BGS Scotland



John's Campaign: three (and a half) years' old - Changing the culture of care?

In 2016, the BGS Newsletter carried an article on John's Campaign. We now report on the progress of the campaign and over this and the next issue, will be looking the its spread throughout the devolved nations.

The campaign was instituted by Nicci Gerrard and Julia Jones, after the publication, in the *Observer* newspaper on November 30th, 2014, of Nicci's article about the death of her father Dr John Gerrard.

John's Campaign advocates for the removal of all restrictions on family carers supporting their relatives in hospital and a positive attitude of welcome and collaboration throughout the health and care system. It places no duty on informal carers and imposes no specific procedures on professionals – other than making their welcome explicit. Dementia is a disability as well as an illness: access to this additional level of support (if available) should be a right for people living with dementia. Information, contacts and resources can be found on the John's Campaign website www.johnscampaign.org.uk

Positive opt in

Currently John's Campaign asks for a positive opt-in. Wards / hospitals / trusts / care homes / other institutions (e.g. ambulance service) pledge their welcome to carers in no more than 50 words which are published on the *Observer's* national Carers Welcome list as well as on the John's Campaign website. Over 1,150 locations across the UK have already made this commitment. Crucially, the response has come (in hospitals anyway) from individual nurses and patient-experience staff who see this change as both compassionate and sensible. Establishing this culture of openness and partnership-working has brought clear benefits to the individuals living with dementia and those closest to them (who need support themselves). It has also benefitted the participating institutions, changing the atmosphere of wards, increasing overall levels of satisfaction and making best use of current resources.

In all the devolved nations of the UK, there appears to be a majority acceptance of the John's Campaign principle in hospitals, though there is a long way to go in other areas of the health and care system. In Wales and Scotland a welcome to the carers of people with dementia in hospitals

will be underpinned by government policy. John's Campaign is supported by all four chief nursing officers as well as by charities (notably Age UK, Carers UK and the Alzheimer's Society), professional groups (such as the British Geriatrics Society and the Faculty for Psychologists for Older People) and Royal Colleges (such as the Royal College of Nursing and the Royal College of Psychiatry). The most recent to declare its support – the Royal College of General Practitioners – may be particularly influential.

In England and Northern Ireland there is some involvement from the regulators; those in the other countries have not yet been approached. This omission is one among many and highlights the first problem that needs to be addressed if welcome and support for the carers of people living with dementia is to become established practice everywhere.

Capacity

John's Campaign is run by two unpaid part-timers and a volunteer website manager. This has often been a strength; adherents cannot be passive, they see what needs to be done to implement the principle of welcome in their settings then get on and do it, using their own initiative and their professional knowledge. There is a willingness among participants to help each other, either by sharing of resources or advice and experience. John's Campaign has many friends and a particularly dedicated group of Ambassadors. However, this lack of capacity means that many potentially useful sources of help have not been systematically approached (Healthwatch organisations, CCGs, Health and Social Care partnerships, Care Associations).

In the large and diffuse world of residential care, lack of time for outreach and follow up means that messages are unlikely to reach the uninterested or unwilling and can leave some potentially interested individuals feeling isolated or unsupported. This may lead to a lack of quality and depth in their sign-up, which will then fail if they move on without embedding their good practice. This leads to a more serious problem.

Inequality

Because the implementation of welcome and partnership-working (symbolised in hospitals by the removal of visiting restrictions) depends on the understanding and initiative of people who have heard about the campaign, and those in strong networks, it has resulted in a degree of patchiness which is evident from the JC map and from the country and sector summaries reported in this and the next issue of the newsletter. Anyone who is interested in checking the situation in their own locality can use the search facility on the *Observer* list.

We need to make this cultural change universal – just as parents' rights to be with their children in hospital became universally accepted in an earlier generation.

We believe that, after three years, John's Campaign is close to achieving all that it can in its original incarnation and that it, and the people who support it – and those who will benefit from it – need action from top management, established networks and policy makers. Fortunately, in most of the UK countries, there are real possibilities that this will happen.

John's Campaign in Wales

Chief Nursing Officer Jean White has confirmed that, "John's Campaign is specifically referred to in the new National Dementia Strategy for Wales, published by Welsh Government." She added, "when the draft of the strategy was shared with key stakeholders the inclusion was warmly received".

The pioneering Health Board in Wales was Betsi Cadwaladr University Health Board (BCUHB), which has since removed all visiting restrictions from all its hospitals. Delyth Fon Thomas, the Ysbyty Gwynedd nurse who was the first to sign, is a delirium specialist and has surveyed the carers who have used the open visiting on her ward.

She concludes that, "Collaborative care leads to increased health and wellbeing for individuals living with dementia." Her research showed that carers benefitted emotionally and felt better able to fit their hospital time with the other responsibilities of their lives.

BCUHB and Powys Health Boards, Velindre Cancer Trust and Welsh Ambulance Service Trust are all fully signed up to John's Campaign, Aneurin Bevan University Health Board has all dementia wards signed and is energetically promoting welcome to carers throughout all areas of all its hospitals, Abertawe Bro Morgannwg University Health Board has begun the sign up process, Cardiff & Vale, Hywel Dda, Cwm Taf University Health Boards are all working towards implementation.

The Office of the Older People's Commissioner has been influential in pushing for this change and is now engaging with Public Health Wales to develop a community approach. So far, the only residential homes signed up in Wales come from HC-One and Hallmark as part of their overall support originating in England.

John's Campaign in Northern Ireland

Northern Ireland's CNO, Charlotte McArdle, is pleased by "the long list of areas that have been working to implement the campaign". There is some involvement in all the Health and Social Care Trusts except for the Ambulance service. Most notable, currently, is the Western Trust, which has implemented the welcome to carers through its residential homes as well as in its hospitals.

The establishment of John's Campaign in Northern Ireland

has depended crucially on Dementia Strategy Leads Seamus McErlean (Social Care Commissioner at the Health and Social Care Board) and Eleanor Ross (Nurse Consultant at the Public Health Agency). Among their successes they count getting reference to John's Campaign into both the revised nursing home and residential care home standards. These are monitored by the RQIA during regular inspections. They have also included John's Campaign awareness in their bespoke training for dementia carers and promoted it across a range of organisations, including to nursing directors and CEOs. A regional Delirium information leaflet has been produced which includes the important contribution of carers during a hospital admission. Team member Nichola Cullen from Belfast writes: "For my Delirium improvement work we have engaged across all 15 hospitals to promote extended visiting as part of improvement of experience for patient and their families/carers. We have included this in the regional Delirium information leaflet as well as staff training which has reached nearly 3000 staff in the past two years [...] I can confirm that in my engagement with care of elderly wards Belfast and Southern and South Eastern trusts definitely promote and use the campaign locally."

This is a more structured and thematic approach than in other UK countries, though in Northern Ireland too individual initiative has been crucial. Eilish Morris, manager of St Julian's Supported Housing Scheme in Omagh, was the first person in the UK to see the value of promoting this families-welcome approach outside the hospital setting.

Paula Thompson, team leader of the dementia team at Downe Hospital, the first nurse in Northern Ireland to sign up to the campaign, used it, with a suite of other initiatives, to improve the holistic care of her patients and also their end-of life care. She and her team have been rewarded by many grateful letters from families as well as an industry award from the Alzheimer's Society.

While the current NI Dementia Strategy is coming to an end there remains a commitment to continue to promote a more welcoming approach to carers as dementia discussions continue in to 2018 and beyond.

In the next issue, we will cover progress in England and Scotland.

Nicci Gerrard
Julia Jones
Founders of John's Campaign

Inmem

Dr Edward Knox

Dr Edward (Eddie) Knox, the last surviving member of the first generation of specialists in Geriatric Medicine in Northern Ireland, died on 13 January 2018.

He made a great contribution to establishing high standards of care for older people, in the early days working in some poor accommodation and with inadequate staff. He was born on 5 August 1924 and was brought up above his father's grocer's shop just off the Shankill Road, Belfast.

Eddie qualified in medicine in Queen's University, Belfast in 1947, and, after a year as a house officer in the Downe Hospital, Downpatrick, he spent three years in general practice in Killeel, Co Down. He then entered hospital training in chest medicine, becoming MRCP in 1955 and in 1961 obtaining his MD with commendation for a thesis entitled "Chronic bronchitis in the Waterside District of Londonderry". At that time, successful treatment for tuberculosis reduced the need for specialists in chest medicine and he changed his career plans. In 1961-62 he was a fellow in peripheral vascular disease in the Post Graduate Hospital of the University of Philadelphia. Returning to Northern Ireland, he continued his Senior Registrar training in general and geriatric medicine and was appointed Consultant in Geriatric Medicine to the Ulster and North Down Hospitals in 1967.

Dr Knox was a single-handed consultant responsible for 340 beds in five hospitals, including a newly built general hospital, a former workhouse, a community hospital and a converted large country house, as well as a day hospital, outpatient clinics, and a domiciliary service. Dr Knox was a skilful, caring and conscientious doctor and was held in the highest respect and great affection by his colleagues, patients and their families, and friends. He provided excellent treatment and care to older people in East Belfast and North



Down and kept up to date with developments in the care of older people. In addition to his busy clinical commitments, he taught medical students from Queen's University throughout his career. He became FRCPI in 1968 and was awarded the Distinguished Service Medal of the British Geriatrics Society in 1987.

Eddie retired in 1984. In his retirement, he continued his interest in his family and in the Irish countryside. His wife, Mabel, died three months before him. He leaves three sons, one deceased son, and seven grandchildren.

Robert Stout
Professor Emeritus of Geriatric Medicine
Queen's University, Belfast



Dr Arthur Alvarez (1930 - 2017)



Arthur's BGS membership number was number 8. On the 50th Anniversary of the Society, he was awarded a medal for 'Outstanding Service to Geriatrics'.

Arthur had difficulty getting a place at medical school in 1948, as ex-servicemen returning from the war were given priority. But Birmingham University rang up at the beginning of the first term and said, 'if you can be here by Tuesday, you have a place'. He flourished in this environment and took part in many sports and activities.

Arthur thought he would like to become a GP. After a year as a trainee he decided it was not for him. He spent three years at Pfizer in the medical department. However, Arthur missed his contact with patients and realised that if he wanted to get back to a clinical career it was time to do so.

Arthur went to discuss his future career with Dr Avery Jones. He had been his RMO at the Central Middlesex. During his time working for Dr Avery Jones, he was involved in early research into aspirin and its role in blood thinning.

Dr Avery Jones suggested a relatively new speciality to Arthur – geriatrics, and told him to go and see Dr Eluned Woodford-Williams in Sunderland. She appointed him as her Registrar and when the Senior Registrar left three months later, he was promoted to that post. He learnt a great deal from her and admired her work.

She was a tough boss but they respected each other and got on well. She told him, 'you can either be successful or popular but not both'. He was to prove her wrong.

Arthur was appointed to the first geriatric consultant post in Leicester. He had nine hundred beds in various small units across the county. He said it took him three months

to do his first ward round! Some of his patients, who were in the workhouse, had become too institutionalised to discharge. Amongst these were women who had originally been admitted for having an illegitimate child. Arthur ran multidisciplinary meetings to discuss patients, and clinics for relatives to work out how patients could be satisfactorily discharged.

No waiting lists

One of Arthur's aims was not to have a waiting list. He worked hard to ensure provision of care in the community for older patients, with appropriate medical support, so patients could come in when they needed to come in and be treated more quickly. Arthur served on several secondments to the NHS Advisory services, visiting other geriatric departments. He enjoyed leading multidisciplinary teams as part of this work and making suggestions as to how other departments might be improved. Arthur was an excellent doctor, loved by his patients and his staff for his kindness and concern for all.

As a result of Arthur's work, it was possible to set up an academic department of geriatrics in Leicester with the arrival of a new Medical School in 1972. When Arthur retired, there were eleven consultants, including a Professor in the department.

In 2005, while recovering from a cardiac bypass operation, Arthur was involved in a road accident in which he sustained a fractured odontoid peg and was fortunate to survive. His cervical spine was pinned, but, despite this disability, he remained active, took up sculpture, and maintained an irrepressible curiosity about the world around him. This included taking an early interest in Mindfulness before it gained its current popularity in the UK.

With time, Arthur began to realise that his health problems were more sinister than mere forgetfulness. He adjusted his life to face the onset of increasing dementia. His subsequent years provide an exemplar of how to live well in spite of chronic disability.

Arthur's interest in sculpture continued and this proved to be the mainstay of the final period of his life. He twice won first prize at the Royal Society of Medicine art exhibition and, also exhibited at other venues including the Royal College of Physicians. Remarkably, he continued to produce high quality work after many of his other cognitive abilities had failed him. Throughout his prolonged illness he remained positive and cheerful, never 'raging at the dying light'.

Jane Alvarez (wife of Dr Alvarez)

Evidence-Based Recovery In Older People

**An RSM event
London
30 May 2018**

This day meeting will explore recovery in older people and the evidence base behind impairing medical conditions. An expert panel will explore topics such as neurology, strokes and dementia in order to highlight ways these medical conditions can be managed and treated for older people to recover effectively.

Speakers include: Professor David Stott is the David Cargill professor of geriatric medicine in the Institute of Cardiovascular and Medical Sciences at the University of Glasgow.

Key speakers include Professor K Ray Chaudhuri is professor in neurology/movement disorders, consultant neurologist at King's College Hospital and King's College London, an Academic Health Sciences Centre and principal investigator at the MRC centre for neurodegeneration research at King's College London.

Mr Paul Ursell is a consultant ophthalmologist at Ashted Hospital in Surrey.

**RSM members: £45 - £135
Non members: £55 - £155**

<https://www.rsm.ac.uk/events/ggk04>

Diagnostic tests for osteoporosis

**Mellanby Course
13-14 June 2018
Sheffield**

Target Audience: suitable for clinicians (e.g. endocrinology, rheumatology, care of the elderly and clinical chemistry), laboratory scientists and nurses involved in the clinical management of patients at risk of osteoporotic fractures.

Day 1: Clinical Use of Bone Turnover Markers

Day 2: Identification of Vertebral Fractures

Delegates are invited to attend one or both days of the course.

Date: 13th and 14th June 2018

Venue: The Edge, Sheffield

Are you a clinician, allied health professional or laboratory scientist working in the field of osteoporosis or other metabolic bone diseases? If so you should be at this unique biennial course. The Mellanby Course applies the scientific knowledge and research expertise developed within the Mellanby Centre and within the National Osteoporosis Society to offer high quality training for clinicians, allied health professionals and laboratory scientists working in the field of osteoporosis and other metabolic bone diseases. The focus of the training is on two key topics: Bone Turnover Markers (BTM) and Vertebral Fracture Identification and participants are able to sign up for a single day or both days.

**For more information and to register for your place visit:
www.nos.org.uk/for-health-professionals/**

East Midlands and Trent Falls Symposium

**25 June 2018
Nottingham**

Speakers include, Professor Tash Masud (President-Elect of the BGS), Dr Stine Eriksen (University of Aalborg, Denmark), Dr Veronika Van Der Wardt (University of Nottingham), Professor Dawn Skelton (Glasgow Calendonian University), Prof Pip Logan (University of Nottingham), Dr Marta Rodriguea (Nottingham University Hospitals NHS Trust), Dr Jay Banerjee (University Hospitals of Leicester NHS Trust)

Topics include, Strength and Balance for health; Sedentary Behaviour and 'Activity Passports'; Reducing Falls in Care Homes; How do we diagnose frailty?; What can be done at the front door to reduce the falls burden?; and Rheumatology conditions and falls risk.

http://www.bgs.org.uk/pdf_cms/event_downloads/0718_trent_falls.pdf

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

BGS EVENTS

BGS South West Thames
17 May 2018, Worthing Hospital

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

BGS Movement Disorders
11 June 2018, Birmingham

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

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

BGS West Midlands Autumn
20 September 2018

BGS Mersey Autumn
26 September 2018

BGS Yorkshire Autumn
26 September 2018 Pinderfields Hospital

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

BGS Autumn Meeting
14 - 16 November 2018, London

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

Fragility Fracture

5 - 7 July 2018
Dublin, Ireland

FFN invites you to join the 7th FFN Global Congress 2018. The annual meeting is an international congress addressing the full pathway of care for fragility fracture patients. Its themes include perioperative care, surgical treatment, rehabilitation, secondary prevention, research and policy change.

This year's motto is "Patient centred multidisciplinary care".

<http://fragilityfracturenetwork.org/our-organisation/7th-ffn-global-congress-2018/>

Urgent care for frail older people

25 May 2018
Horizon, Leeds



British Geriatrics Society
Improving healthcare for older people

This is the inaugural event of a new BGS special interest group. The programme has been developed as a collaboration between the British Geriatrics Society, the Royal College of Emergency Medicine and the Society of Acute Medicine.

Topics include:

- Identifying frailty in acute hospitals using routine data
- HoW-CGA toolkit
- Improving patient outcomes in frail older people in the Emergency Department and AMU

Speakers include:

- Professor Simon Conroy, Geriatrician, University Hospitals of Leicester and Honorary Professor, University of Leicester
- Professor Stuart Parker, Wm Leech Prof of Geriatric Medicine and CRN Specialty Cluster Lead, Newcastle University
- Prof Graham Martin, Professor of Health Organisation and Policy, University of Leicester



Registration and programme available at <http://bit.ly/FrailtyUrgentCare18>

British Geriatrics Society
Improving healthcare for older people.

Join the British Geriatrics Society

We welcome all healthcare professionals caring for older people

#jointheBGS

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.

Six reasons why you should join the BGS:

- Latest research and best practice for CPD
- *Age and Ageing*, our high impact journal, is included for most members
- Discounts for all BGS conferences: most members recoup their annual fee if they attend just one major meeting
- Networking opportunities at national, regional and Special Interest Groups meetings
- Our national policy voice
- Access research and educational grants



To become a member visit www.bgs.org.uk or email our membership officer at membership@bgs.org.uk for further details. #jointheBGS

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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