BGS NEWSLETTER

British Geriatrics Society
Improving healthcare for older people
Issue 80 | March/April 2021

Stepping Up

Rising to the challenges of the past year through innovation, collaboration and education

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Nurses and AHPs during COVID
How members of our BGS Nurses and AHPs Council have adapted and evolved to continue to support older people during the pandemic

Through the visor
A new BGS report highlights the unique experiences of BGS members during the COVID-19 first wave

Learning together
We celebrate the relationship between the BGS and the Royal College of Physicians London and look at development opportunities for members

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Cover: 'Dad on ladder' © Amy Brewerton 2021

President's column

In my first Newsletter as President, written in early December, I predicted that the COVID-19 pandemic would dominate healthcare for the next few months.

That issue would have dropped through your mailboxes in early January when my prediction would have seemed an understatement of the impact of the rapid surge of cases in the ongoing second wave. Our members continue to be front and centre of the NHS response, both in acute hospitals and in the community. In contrast to the first wave, we now have a better understanding of the illness and thankfully some effective treatments. The message from geriatricians about 'atypical' presentations such as delirium in older adults has been acknowledged, and universal testing of all acute hospital admissions is now standardised.

However the impact on the older patients we are caring for remains devastating. Preventing nosocomial transmission has been challenging, particularly as hospitals are busier than during the first wave as we try and maintain urgent elective care. Many of us are now undertaking twice weekly staff testing to reduce the risks of onward transmission to patients. I am aware that despite widespread provision of the advised PPE, levels of staff infection with COVID remain a concern and raises questions about the degree of protection offered, in acute, primary and community care. I discuss these concerns with our colleagues across other specialities and disciplines and we will keep a watchful eye on the evidence base for current guidelines.
We have welcomed the roll-out of COVID vaccinations with priority for those most vulnerable to adverse outcomes, particularly residents of care homes. BGS produced statements on vaccination in early December and reacted quickly to the JCVI/ CMOs' recommendations to vaccinate as many people in priority groups as possible with the first dose, accepting that this delayed administering second doses for up to 12 weeks. We asked for a robust and open evaluation of the outcomes of this policy change and assurance that second vaccine doses would be delivered by 12 weeks.

I was delighted to see such high uptake of the vaccination both in the most vulnerable older people, and among the professionals who care for them. While there is still more to be done in delivering widespread vaccination, the progress is encouraging, and the extraordinary efforts of the NHS staff and volunteers involved in the vaccination rollout are to be commended.

As President of BGS I am on the board of EuGMS and we have agreed to share learning on the impact of vaccination across Europe. It can seem as if we are in a race against one another to vaccinate when in reality we need the safety net of vaccination to be spread across all nations.

Workforce survey

The last year has been extremely tough on our workforce as we try and respond to the pandemic. I read the results of the recent RCP survey and was not surprised to see the heightened level of stress reported, with 1 in 4 doctors reaching out for support with mental health. Our own BGS survey, conducted among doctors, nurses, allied health professionals and other colleagues working with older people, noted that over 80% of respondents felt more stressed or anxious than before the pandemic. The findings from the survey are presented in our new report, *Through the visor: Reflecting on member experiences of the COVID-19 first wave,* which you can read more about on page 6. I can see the exhaustion on faces of colleagues as we continue to deliver care in difficult circumstances. We would all like a break, time to process these experiences and to be re-energised for our 'normal' working lives. Thank you for all you have been doing and continue to do.

It seems timely to recognise that the workforce needs a fresh approach with more emphasis on wellbeing and policies that help us thrive rather than just survive at work. We will be calling for governments to increase training numbers for geriatric medicine and widen the opportunities for training in older people's care across the professions. Time is required in our job plans to teach medical and nursing students, to support and train future consultants, to attend conferences and other learning events. This has benefits for the future of the NHS and also for wellbeing at work, Wellbeing is more than just an emailed link to a mindfulness app. We will be picking up these themes at the virtual BGS Spring Meeting (28-30 April).

Policy work

In my first couple of months in the role as President of BGS I have spent time speaking to chairs and members of BGS committees and councils and also reaching out to other stakeholders such as Caroline Abrahams, Charity Director of Age UK, Dr Mani Krishnan, Chair of the Faculty of Old Age, RCPsych, Professor Andrew Goddard, President of the RCP London and Professor Jacqueline Taylor, President of the RCPSG Glasgow. We also have regular discussions with Dr Adrian Hayter, NCD for Older People's Care at NHS England.

'I have been humbled by the fortitude our older patients display when we meet them in hospital and elsewhere. The trust they and their families place on us to deliver the best possible outcome is part of the reward, but also responsibility, of our roles.'

I expected that my Presidency would have involved a lot of travel from my home in Glasgow, but it has been a definite positive to be able to use video links, Zoom and Teams to 'connect'. It is not quite the same as meeting in person but it is good to have this option. I hope you will understand our recent decision to adapt our Spring Meeting planned for April in Belfast to a further virtual meeting. We aim to maintain some networking with our colleagues in the Irish Geriatric society but may miss the 'craic' in the dinners after conference.

In other policy developments, the Government has published a White Paper outlining plans to reorganise the NHS in England, specifically focusing on increasing integration. While we welcome this focus, we are disappointed at the lack of any specific plans to support older people or address the ongoing crisis in social care. We also feel that this reorganisation is badly timed, given the ongoing pressures on NHS staff.

Scotland and Wales are scheduled to hold parliamentary elections in May. Health is a devolved issue meaning that health policy is set by the Scottish Parliament in Scotland and the Senedd in Wales. This is an important opportunity for BGS to engage with the political parties in those nations to ensure that older people's healthcare is central to their commitments on health.

Finally, as President Elect for BGS I attended the RCP Medical Specialty board meetings on your behalf. These were held fortnightly over the last year and ably led by Professor Donal O'Donoghue, who sadly died from COVID-19 in early January. We pay tribute to him and his contribution to older people's healthcare through his work with the RCP on page 16. It is a reminder of the human cost of the pandemic and we need to continue to look after one another and stay strong together.

Thanks again for all you are doing in your own communities.

Dr Jennifer MA Burns
BGS President
@Burns61Jenny

New and updated BGS website resources

Resources on our website are continually added, reviewed and updated. Visit www.bgs.org.uk to view the latest updates.

- COVID-19: Frailty scores and outcomes in older people
  www.bgs.org.uk/CovidFrailty
- COVID-19: Vaccinations and older people
  www.bgs.org.uk/vaccineQAs
- Remote consultations during COVID-19 and beyond
  www.bgs.org.uk/RemoteConsultations

To be continued...

BGS Honorary Secretary David Attwood muses on the topic of continuity, and how there are often missed opportunities when it comes to the care of older people.

Winter is an important time for the BGS and its members. In addition to an amazingly successful meeting in late November (which was our first fully online national conference), we bode a fond farewell to our outgoing BGS President Professor Tahir Masud, while giving our incoming President, Dr Jennifer Burns, a massive welcome.

A key aim of BGS is influencing national policy, and I asked our new president Jenny what she felt were the most important areas for us to focus on. She felt that one of our organisation's key goals should be to strive for "continuity of care for older people."

This ambition makes perfect sense; continuity across healthcare providers becomes increasingly important for people with multi-morbidity, frailty, or are psychologically and socially vulnerable. However, when it comes down to it, what does continuity actually mean?

For most, it means having a continuous therapeutic relationship with a clinician (also called relational continuity).

'The older person I start on a diuretic in primary care becomes your older person who has been hospitalised with falls, secondary to a multifactorial and interdependent problem list.'

We often have this in General Practice and it is highly valued by clinicians and patients alike. However, there are threats to this model of continuity. What happens to the patient if their GP is on holiday or retires, for example? At a wider level there are also changes in the healthcare and workforce landscape, such as increasing patient demand and more of the workforce working less than full time, which also impact on relational continuity.

As a result, the 21st Century NHS has evolved another type of continuity, called informational continuity, where healthcare information is shared among professionals and wider organisations for the benefit of patient care.

We see it in patient records; on a ward round doctors will often go back to the Post Take Ward Round to see what information the Consultant wished to transmit before moving on to the next patient. We see it when a GP receives a discharge summary from hospital.

I once recall being at a regional conference where I was told of an absolutely outstanding service being delivered in a hospital, where older people who were admitted who were receiving an assessment and frailty diagnosis on arrival followed by a Comprehensive Geriatric Assessments (CGA) if they had moderate or severe frailty. The service sounded person-centred, and holistic, and I was mesmerised by the patient stories, richness of information gathered and the enthusiasm of the speaker. At the end I put my hand up "once you complete the CGA do you share with the GP?" I asked eagerly. "No" was the response. It was filed away in the paper notes and sent to the hospital archives.

Wherever we work, whether it is on a hospital ward, or a GP surgery, we are no longer independent 'islands of activity.' Our society, with its rising number of older people, brings with it rising complexity. The days of treating one isolated, single organ condition have long gone; the older person I start on a diuretic in primary care becomes your older person who has been hospitalised with falls, secondary to a multifactorial and interdependent problem list.

So how can we achieve better continuity in our 21st Century NHS? As the above case illustrates, to meet the complex biopsychosocial needs of older people, our bricks and mortar 'healthcare islands' have to change and become more adaptive and interdependent with each other.

At the root and branch of this lies a focus on building trusting relationships between professionals in acute and community providers, and developing shared IT systems that drive better informational continuity.

The beautiful truth is that both these goals are achievable in our time.

David Attwood
BGS Honorary Secretary
@DavidAttwood12

Have you recently joined the BGS?

Are you one of the growing number of people who have joined the BGS in recent months? If so, we are delighted to welcome you to the BGS community. It is a shame that we may only get to see you on screen thanks to the pandemic, but we look forward to saying hello to you in person at a future face-to-face national meeting or other BGS event.

The BGS is a multidisciplinary community of healthcare professionals united by a commitment to improving healthcare for older people. We celebrate the diversity of our membership, with more than 4000 members from the wide range of professions who specialise in older people's healthcare. They come from the four nations of the UK and work in the community, primary and acute care, delivering high-quality person-centred care. We also have members based overseas who have a passion to advance and learn about the healthcare of older people.

If you're new to the Society, it can seem a bit daunting to get involved. There is a lot going on, so choose where you'd like to start. Maybe you have an interest in a particular sub-specialty such as falls or movement disorders? Sign up for the relevant Special Interest Group (SIG) via your member profile and you'll start to receive e-bulletins and find out about specialist meetings. We have a Trainees' Council, a Nurses and Allied Health Professionals Council and a GPs group, where you can find people in the same profession as you and benefit from regular communications, webinars and updates. Closer to home, you could get involved with your local region. If you work in England, you'll belong to one of the fourteen regions. You can get to know your regional community through their website pages, regular e-bulletins and virtual meetings held from March onwards. Nation meetings are also held in Wales, Scotland and Northern Ireland, so check out our events pages for those dates, and contribute to the Society and its aims wherever you are based.

Older people have borne the brunt of the COVID-19 pandemic, with 90% of the deaths occurring in people aged over 65. This has highlighted more strongly than ever the need for good health and social care for older people. One of the BGS's most important roles is to advocate for national, regional and local policies that serve the needs of older people. Now is a crucial time to ensure that a sustainable social care solution is put in place, that the Ageing Well programme is properly implemented in England, and that the backlog of missed appointments, delayed treatments and increased frailty brought on by months of deconditioning is addressed. Please write to your MP as part of our #BGSFairCare campaign, and consider getting involved with our policy work and campaigning.

Are you a researcher rather than a frontline clinician? Check out our research resources, read Age and Ageing in full, or skim our new Table of Contents to pick out interesting articles. Are you a retired member who no longer works clinically? Thank you for all the work you have done in the NHS over the years and for continuing to share your expertise.

We are revamping our e-bulletin for retired members and are keen to hear what aspects of the Society you value most. Are you new to geriatric medicine? We have great education and training resources, including e-learning modules and a diverse events programme. Our Spring and Autumn meetings are amazing places to pick up new knowledge and engage with the latest debates, and now you can access the session content for 12 months after the meetings.

If you feel inspired, why not join a group or committee as a member or even an officer? There are many roles at different levels, with the opportunity to contribute actively to the Society's goals. The staff team of twelve will provide induction and information to support you. We love it when people offer their time and energy to BGS work; many people say they derive professional satisfaction, new networks and great opportunities as a result.

We are delighted you have decided to join the BGS. We hope you find it a place of shared values, solidarity and peer support, where you can feel part of a community that helps you to deliver the best possible care for older people.

Thanks for joining us and getting involved!

Sarah Mistry
BGS Chief Executive

Through the visor: Reflecting on member experiences of the COVID-19 first wave

As the country moved out of the first wave of the COVID-19 pandemic, BGS issued a survey to its members with the ambition of understanding more about their experiences of working through the pandemic and what their concerns are for the future.

We believe this is the only survey that has been carried out across the four nations of the UK which captures the views of the multidisciplinary team working with older people across various acute, community and primary care settings.

The survey was carried out over a five week period in October and November 2020 and attracted 425 respondents. They told us about the practical experiences of working through the pandemic, including variable access to PPE and COVID testing for both staff and patients and the challenge of negotiating a pandemic where guidance was changing all the time.

The pandemic shone a light on the challenges faced by care homes across the country, with often devastating consequences for care home residents and staff. Members told us about the difficulties faced by care homes and in particular the issues surrounding discharge of care home residents from acute hospitals back to care homes and the varying requirements for these patients to have negative COVID tests prior to discharge.

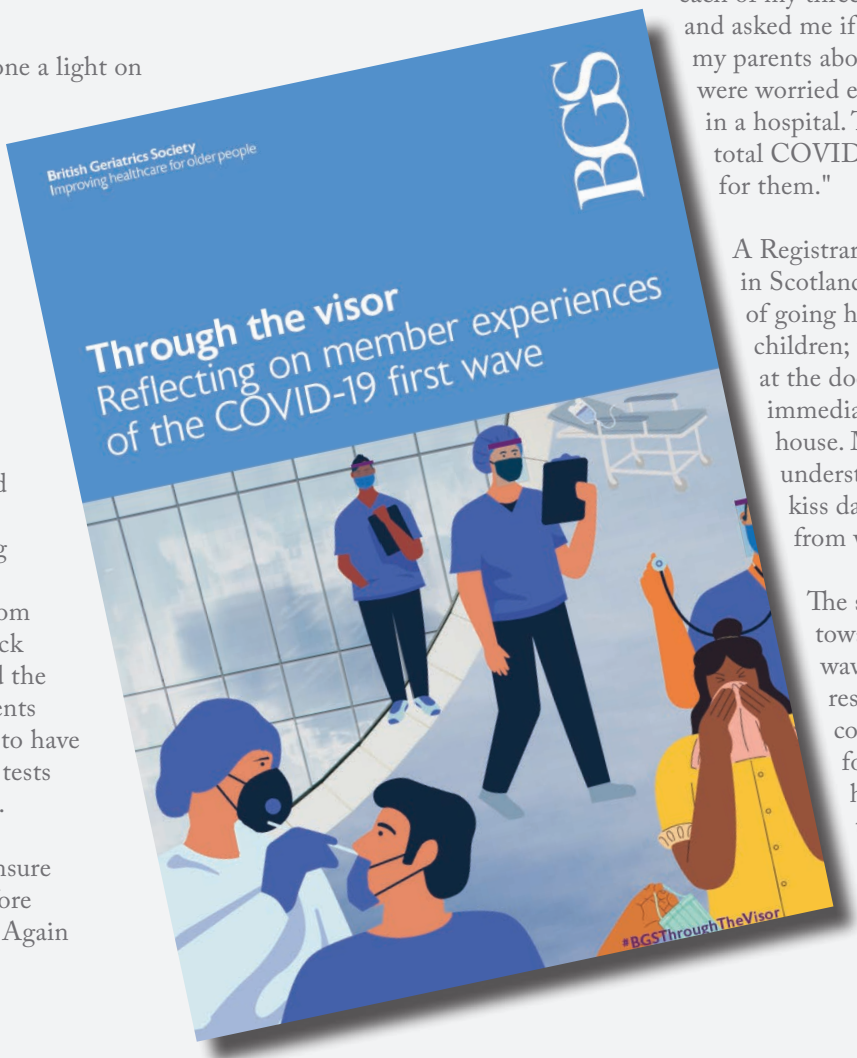
"We do have to ensure negative swab before being discharged. Again the duration between test and discharge varies and tends to be guided by the NH [nursing home]," a Registrar in Geriatric Medicine in England told us. "For example, a patient has a negative test a day ago. But a NH may state they want two negative swabs before being discharged to them. Lots of variability."

A majority of respondents reported that they were either redeployed during the pandemic or had changes made to their job plan or rota. This took a range of forms including working in a different setting, covering COVID wards, acting up to take on more responsibility or changing working hours to help respond to the pandemic. Many respondents commented that they were covering for sick colleagues. A significant number of people told us that they took time off during the first wave of the pandemic and a majority of those tested positive for COVID.

"As senior management I did revert back to being a nurse to help when staffing was reduced by 30%," said a Care home nurse in Scotland.

By far the most prominent theme to come out of the survey is the significant mental and emotional toll that working through the pandemic has had on BGS members and their families. Respondents told us about experiences of dealing with excessive death and the lack of escape from the pandemic outside of work as it engulfed society. Feelings of sadness and exhaustion were evident in many of the free text responses throughout the survey.

One Consultant in Geriatric Medicine in England shared a sobering anecdote: "At some point near the start of it, each of my three children crept into my lap and asked me if I was going to die. I lied to my parents about what I was doing – they were worried enough as it was that I was in a hospital. The idea of being hands-on total COVID would have been too much for them."



A Registrar in Geriatric Medicine in Scotland told us: "I was afraid of going home due to my young children; they couldn't even hug me at the door. Had to have a shower immediately stepping into the house. My 2-year-old still doesn't understand why she can't hug and kiss daddy when he returns home from work."

The survey was conducted towards the end of the first wave of the pandemic and respondents shared their concerns about preparing for the second wave and how BGS could support them through this period and beyond. The need for psychological and peer support for members

came through strongly as did a need to provide support to trainees, in particular addressing missed training opportunities throughout the pandemic.

"We are living in a time of uncertainty watching/caring for colleagues and patients whose mortality and morbidity are adversely affected by COVID. We need time to come to terms with the impact of COVID on our physical and emotional wellbeing," a Consultant in Geriatric Medicine in England said.

"[There is] zero time for training trainees apart from in acute wards," commented another, this time in Scotland.

BGS has published a report detailing what members told us in the survey and outlining what actions we will take to try to address some of your concerns. However, we appreciate that, since conducting this survey, the situation with the pandemic has moved on with many, if not all, of our members facing more challenging circumstances than they did in the first wave. The survey results and subsequent report are a reflection of the first wave of the pandemic.

We intend to run another survey during Spring 2021 to gauge how things have changed for BGS members through the second wave of the pandemic and what your concerns are for the future. We urge you to keep an eye out for the second survey when it comes and ensure that you take part.

The report from the first wave can be found at:
www.bgs.org.uk/ThroughTheVisor

BGS Autumn Meeting 2020: Prize Winners

The BGS wishes to congratulate the following prize winners from the BGS Autumn Meeting 2020. If you missed the event, you can catch up with on-demand video and presentation access online at www.bgs.org.uk/events

Best Clinical Quality Platform Presentation

- The Geriatric Medicine Research Collaborative
  Improving delirium screening and recognition through quality improvement crowdsourcing: results of a panspecialty multi-centre project

Elizabeth Brown Prize for best Scientific Platform Presentation

- Sarah Combe
  Conversations on living and dying: facilitating advance care planning for older people living with frailty. A qualitative study

Eva Huggins Prize for best Nurse/AHP Poster

- Juliet Butler
  End PJ paralysis initiative on Derwent Ward

John Brocklehurst Prize for best Clinical Quality poster

- Leah Hickson
  A quality improvement project on oxygen administration within the geriatrics COVID-19 cohort ward

- Clare Baguneid
  Improving the identification and management of delirium in older surgical patients

Norman Exton-Smith for best Scientific poster presentation

- Rose Penfold
  Heritability of Temperature and the Effects of Ageing on Temperature Regulation: An Observational Multi-Cohort Study

- Altug Didikoglu
  Longitudinal change of sleep in the elderly and its associations with health

For details on submitting an abstract for consideration at an upcoming BGS meeting, please visit www.bgs.org.uk/abstracts

The Silver Book II, written by leading international experts in frailty and hosted by the British Geriatrics Society, addresses a wide range of urgent care issues specific to older people. Aimed at clinicians and other healthcare professionals working in emergency departments and urgent care, this updated resource is presented in a highly accessible digital format and is free of charge.

Since the original Silver Book was published in 2012, the demographic predictions for global ageing have continued unabated, and almost all health and social care professionals now encounter older people living with differing levels of frailty, on a daily basis. Older people have a higher prevalence of multiple conditions, including dementia and disability, and evidence shows that they are admitted to hospital more frequently, have longer stays and occupy more bed days in acute hospitals, compared to other patient groups. The COVID-19 pandemic has further complicated this picture and exponentially increased the need for high quality urgent care for older people.

The Silver Book II addresses the specific needs of older people in the first 72 hours of an urgent care episode. It aims to:

- Help healthcare professionals understand the issues relating to older people accessing urgent and emergency care in the first 72 hours irrespective of geographical setting and provider group.
- Describe the challenges of health and social care for older people at the interface between primary and

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Quality urgent care for older people

ALL NEW AND UPDATED FOR 2021!

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secondary care, and pre-hospital and in-hospital care.
- Outline best practice in urgent care for older people.
- Improve satisfaction and outcomes for older people and their families and carers in urgent care.
- Improve satisfaction and delivery of care by staff.

The Silver Book II aims to give healthcare professionals working in urgent care the knowledge to recognise and effectively treat non-specific presentations. It provides best practice in the management of delirium, falls, 'silver trauma', continence and skin integrity.

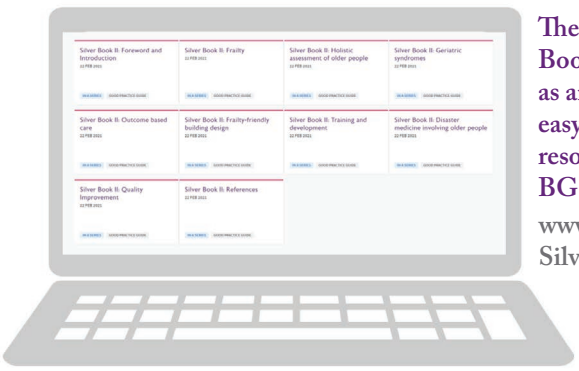
Other important, but often overlooked, topics covered in the publication include mood disorders, substance misuse and 'elder abuse'. For many older people with severe frailty and urgent care needs, the end of life phase can be measured in months rather than years, so being able to identify this transition, and adapt from curative to palliative approaches is also addressed.

It is encouraging that health and social care professionals' understanding of caring for older people has increased substantially in recent years, and concepts associated with frailty have become increasingly mainstream. The Silver Book II aims to bridge remaining gaps in knowledge and to promote key areas of best practice for a global health and care audience.

Professor Simon Conroy, Professor Chris Carpenter and Professor Jay Banerjee led the development of the publication with contributions from leading experts in a number of countries including the Netherlands, Israel, Poland, Sweden, Switzerland, Spain, Taiwan, Vietnam, the United States and the United Kingdom.

Simon Conroy, Professor of Geriatric Medicine at the University of Leicester and co-lead author of the Silver Book II, said: "We are delighted to see the Silver Book II launched. Written by clinicians for clinicians, we hope this resource will be of help and perhaps some inspiration to colleagues supporting the care of older people with urgent care needs across the world."

Dr Jennifer Burns, President of the British Geriatrics Society, added: "We are delighted to launch the Silver Book II in collaboration with leading experts in the field of frailty. While this free-to-access online resource will be of particular interest to those working in emergency medicine and urgent care, all healthcare professionals caring for older people will find it relevant. The COVID-19 pandemic has only served to reinforce the ongoing need for high-quality care for older people. I commend this excellent guide to best practice in urgent care and encourage all doctors, nurses and allied health professionals to read it via the BGS website and use it to inform their care for older people."



The full Silver Book II is available as an accessible, easy-to-use online resource on the BGS website:
www.bgs.org.uk/SilverBook2

How nurses and AHPs have risen to the COVID-19 challenge

Throughout the past year, nurses and allied health professionals (AHPs) have adapted to necessary urgent change in response to the pandemic. The BGS Nurses and AHPs (NAHP) Council are extremely proud of how our membership have risen to the many challenges to ensure older people's health and social care is prioritised and older adults receive the best possible access to services.

This has required an attitude of being open to change, courage to try new ways of working with limited preparation and planning time and strength to keep going during the most difficult and darkest of times. For those of us in leadership roles, we have needed to show a willingness to share our vulnerability that at times we don't know the answers, and that the uncertainty and exhaustion affects us.

This article highlights just some of the stories from members of our BGS NAHP Council (from across England, Wales, Scotland and Northern Ireland) can share of how their careers have been affected by the pandemic. It conveys a sense of the art and science which nurses and therapists weave into their daily clinical practice to compliment the biomedical model. Some colleagues stepped up into leadership roles and used their professional voice to advocate for older adults as whole systems adapted to work together. Others had to adapt to shielding at home and finding valued new ways of working.

We haven't covered every example such as the research nurses being redeployed to intensive care, community nurses being seconded to urgent response teams and the gerontology nurses who have found themselves caring for young adults as their wards become dedicated to people diagnosed with COVID-19.

There are so many examples, but we hope this selection gives us all a brief insight into some of the highs, lows, challenges and triumphs our BGS NAHP Council community have experienced in the last year and we wish to thank them all for their continued essential contribution, flexibility, hard work and leadership during this pandemic.

Lucy Lewis
Chair, BGS NAHP Council

Angeline Price: Advanced Practitioner in Peri-operative care of Older People undergoing Surgery (POPS)

My experience of the COVID-19 pandemic has been different to most. My usual role is split 50/50 between a medical ward and delivering a POPS service in general surgery.

In the early phase of the pandemic, personal health reasons meant I needed to move away from face-to-face clinical practice. Although able to continue remotely in managing some aspects of the POPS service, it was frustrating being unable to work clinically alongside colleagues caring for COVID-19 patients. Circumstances forced me to explore alternative ways of working, presenting the opportunity to develop my role across all four pillars of advanced practice.

I joined a research collaborative, contributing to the COVID-19 in Older PEople (COPE) study; a multi-site study of patients admitted to hospital with COVID-19. At Salford Royal we recruited 430 patients, and I gained experience in data collection and validation. I subsequently contributed to developing manuscripts outlining the findings of this study, co-authoring seven papers and gaining experience in the submission process as first author on the protocol paper. Building from this experience, I registered Salford Royal to the COVIDCollab study that I had seen advertised via the BGS newsletter. As Site Principal Investigator I managed a team of collaborators and recruited 200 patients. Following on from this work, I contributed to the Salford COVID-19 mortality review, presented at the Clinical Effectiveness Committee and now lead on quality improvement projects focussed frailty and delirium, and their significance in COVID-19.

The work I have undertaken has given me the confidence to write academically, raising awareness of the advanced practitioner role in both clinical practice and research. Although fortunate in the opportunities that presented to me over the past few months, I would urge others to proactively explore ways in which to develop skills across all four pillars of advanced practice.

In the context of shaping older people's care, it's vitally important for our multidisciplinary professional voice to be heard.

Anna Chainey: Consultant Practitioner Trainee in Frailty

I am a consultant practitioner trainee in frailty with Health Education England and have a passion for transformation and the provision of excellent care and services to populations of people.

As a result of the training that I have received within the consultant practitioner development programme and work undertaken during my redeployment in wave one of the COVID-19 pandemic, I now work operationally, as COVID Services Manager for Dorset Healthcare.

I am responsible for the strategic organisation and delivery of COVID services from Dorset Healthcare, including the large vaccination centre for Dorset, long COVID clinics, virtual ward support pathways for inpatients and members of the public who have had COVID, and the development and integration of the Care@Home pulse oximetry model for COVID-positive patients to reduce the risk of mortality due to silent hypoxia. This work requires me to use whole systems leadership, diverse communication skills and quality improvement methodology to support small, rapid changes as well as my knowledge of operations management and senior clinical experience.

The COVID work that I undertake, requires a multi-agency, multi-system approach that necessitates significant continued input from the integrated care system in Dorset, to support an ever-changing healthcare demand and requirement.

I feel privileged to be able to undertake this work whilst also continuing with my Consultant Practitioner Development Programme and would encourage more senior clinicians to undertake positions of senior leadership as the credibility and clinical assurance that can be brought to positions of leadership by senior clinicians ensures that holistic, person centred services are maintained.

Jo Jennings: Advanced Clinical Practitioner in Physiotherapy

'Bad luck' has meant that I have a health condition that requires me to shield. Having spent my career developing my clinical knowledge and skills, it's hard leaving my colleagues working clinically while I work from home.

Rationally I know this is the right approach, but I still feel guilty; that I have abandoned my colleagues and patients at a time they needed me the most.

I've been able to support my colleagues by offering informal supervision, delivering online teaching, writing protocols, developing e-learning packages, and delivering virtual simulation sessions. I've also delivered evening webinars with the West Midlands Chartered Society of Physiotherapy and the Advanced Practice Physiotherapy Network.

I don't miss leaving the house at 7am to travel to work but working from home does have its drawbacks. Somehow, a day of back to back virtual teaching or meetings is more tiring than it would be face to face. Without careful management it can feel that you are not 'working from home', but 'living at work'.

I have learnt that time away from work in the evenings or on days off means I function better, enabling me to support my family and colleagues more effectively. Now I put the laptop away in a drawer and 'walk home' on the treadmill or outside, reflecting on the day like I used to in the car on the way home. This has helped me to draw a line between work and home.

While schools have been shut, I have adopted a more flexible approach to my children's schoolwork. They do the work they like in the day and then the rest with me after I've finished work. I have found making time to speak to friends on the phone or via Zoom very helpful too.

Shelley Ripper: Community Frailty Practitioner

I write this from my sofa as I complete another period of isolation with my family, as we recover from COVID-19 for a second time. I have been overtaken by feelings of guilt and fear since the pandemic began and this has just confirmed how at risk my family are because of the passion and commitment I hold for my job.

However, their ongoing encouragement and support has led me to accept all the opportunities given to me over the last year. In March I was an enthusiastic community staff nurse with a hunger for development. Despite the challenges of the pandemic, it allowed me to step into a more senior role across two community disciplines providing opportunities that may not previously have been available.

As pressure on community services increased I was offered a secondment opportunity to a Band 6 role working across community nursing and the Frailty Support Team (FST). This hybrid encouraged integration as we promoted the 'one team' approach. Working with the Consultant Practitioners within the FST provided the chance to see the benefits of advanced and consultant practice in the community, how it improves person centred care and increased my curiosity of this clinical speciality. I now have a permanent FST B6 post which has continued to provide opportunities. Joining the FST in a more senior role has given me the chance to support junior members of the team through this challenging time, role modelling and providing mentorship when much formal training has been paused.

My Consultant Practitioner encouraged me to join the BGS and I have found the up-to-date COVID-19 resources and Frailty Hub invaluable. I have co-authored an article with a colleague and have commenced an MSc in Specialist Community Practice, funded by my organisation and Public Health England.

Julie Whitney: Consultant Practitioner and Clinical Academic

I am a physiotherapist by background and a clinical academic. I usually work clinically as a consultant practitioner in gerontology which involves taking a falls clinic, care home outreach and leading on research in our department. I am also a university lecturer which consists of teaching, supporting and assessing undergraduate and postgraduate physiotherapy students as well as research.

Generally speaking, since the start of the pandemic, I have just had a more intense version of my usual job. The clinical work in care homes ramped up to ensure all residents had fully worked up individualised advanced care plans, and that those with COVID got the right care in the right place.

In the hospital, the emphasis switched from clinics to working on the frontline, supporting in any way possible. This has included working with the therapy teams, supporting wards with care tasks and assisting communicating with relatives.

The university side of work has been equally busy. We had to switch our curriculum to online delivery with very little time to plan or prepare. All research had to either pause or change substantially.

However, there have been some exciting opportunities in research into

Deborah Sturdy OBE: Chief Nurse for Adult Social Care (England)

The International Year of the Nurse 2020 was supposed to be a global celebration focusing on professions, growth and innovation in nursing but this didn't come to fruition.

However it did provide, through the challenges of COVID-19, the backdrop to showcase nursing at its best. For social care, the government press conferences meant the nation looked at care homes under the microscope every day on their televisions up and down the country - and there was no escape from the realities faced in these nurse-led services.

Nurses and care workers across social care can stand proud for all they have achieved in adapting, creating solutions and innovating in their roles.

For some there has been a sense of isolation, sometimes feeling abandoned or alone. It has been tough to manage especially while providing care and support to those who need it, their families and each other. The pace of change and directives, infection and prevention control updates and PPE access at the start of the pandemic as it gripped the nation was a huge shift which was met with pragmatic realism.

The adult social care sector worked together to gather solutions in a demanding environment beyond what any of us would have imagined.The workforce across social care have learnt new skills, gained a new respect and from this we need to build and maintain those and the newfound confidence.

Since taking up the post of chief nurse for adult social care I have taken part in virtual visits and met staff who have been working throughout the pandemic.

They have shared stories of how they have adapted and tried to create a sense of normality during times that are anything but normal; creating a summer beer garden, and stories of how staff have been supported with mountains of chocolate and support from colleagues, families and the whole nation. The flexibility of staff and their commitment and determination are inspiring.

The impact of COVID-19 has been immense, and the need to recover essential. The first dose of these life-saving vaccines has been offered to people living at more than 10,000 care homes with older residents which is incredibly heart-warming to see. Vaccines offer the best form of protection against the virus and I strongly recommend all those in nursing who can receive the vaccine take it - they are the best way to protect people from coronavirus and will save thousands of lives and allow us to continue to be there for family, friends and the people we care for.

We need to recognise what nurses and care staff across 15,000 settings have done, we need to invest in their futures, build their resilience and promote their phenomenal contribution without machines, medical teams and robust infrastructures. They must not become the unsung heroes, they need and should be held in the highest professional esteem for all they have done.

I am delighted to be able to represent them and to work with the government and continue to do everything we can to support them.

'Nurses and care workers across social care can stand proud for all they have achieved in adapting, creating solutions and innovating.'

COVID, particularly looking at the effects COVID has on older people and how rehabilitation can support recovery. Our team at Kings was involved in collecting data for the COVID-Collab study, we ran a focus group for COVID survivors and are currently working on a scoping review of remote rehabilitation interventions.

The good thing about the ubiquitous online meeting is that it has encouraged the development of new collaborations from different ends of the country to plan future research projects and share knowledge and expertise. An example of this was contributing to a report on the effects of lockdown on the health of older people, which recommends televising exercise for frail older people on terrestrial TV.

I imagine, I am feeling like many others, in that this past year has been a whirlwind. The relentless online meetings, the cancelled annual leave, (and the homeschooling – argh!) but what will stay with me the most is the sheer intensity with which the virus has claimed the lives of our older patients; the heartbreaking telephone conversations with loved ones and the tears in the eyes of the ward staff as they've had to do last offices numerous times a day.

It has been a pleasure and a privilege to be with some of those patients in their last moments, especially when I had to be a poor stand-in for relatives who couldn't be there.

As the vaccines have come to fruition, I have been supporting the programme both in the clinic and care homes. I have taken on extra shifts to vaccinate, because it feels like such a positive and hopeful thing to be involved in right now.

'What will stay with me the most is the sheer intensity with which the virus has claimed the lives of our older patients... the heartbreaking telephone conversations with loved ones and the tears in the eyes of the ward staff as they've had to do last offices numerous times a day.'

Stacey Finlay: Intermediate Care Nurse

At the beginning of COVID-19 pandemic, I didn't know what to expect. Due to this uncertainty, myself and colleagues within the Intermediate Care Unit I work in decided to plan for the worst-case scenario, which would be potentially a large proportion of our patients becoming incredibly sick and possibly dying.

Thankfully, the tsunami we prepared for did not hit our unit, but the preparation allowed for us to examine and improve our practices in relation to detection, assessment and management of the deteriorating patient.

This started with the recommendation from NICE that all adults with suspected or confirmed COVID-19 should be monitored with an early warning score system, such as the National Early Warning Score 2 (NEWS2). The Unit Consultant and I agreed that NEWS2 monitoring could and should be undertaken for those with suspected or confirmed COVID-19, but we also agreed that the standard parameters within NEWS2 could dictate that our patients require escalation, when in actual fact the observations that are triggering a NEWS2 score requiring escalation are normal and acceptable for their age and other co-morbidities. From there, myself, the unit consultant and the manager set out on a journey to find a way we could use NEWS2 to detect and assess for deterioration in our specific patient group of over 65-year-olds requiring intermediate care, without setting them up for unnecessary escalations of care or interventions.

We worked collaboratively over many months to formulate a way of using RESTORE2 (Recognise Early Soft Signs, Take Observations, Respond, Escalate) – a tool to support the monitoring of physical deterioration and the escalation of unwell adults in nursing homes in our intermediate care centre – and together produced a hybrid tool that uses elements of RESTORE2 incorporating NEWS2. We have also developed a new handover pro-forma to ensure that information about patient's individual triggers, TEPs and any acute issues are communicated clearly between shifts to ensure continuity of care. Most recently we have developed and implemented a 2-minute safety brief that is completed at twice a day with members of the MDT to ensure everyone is aware of any active risks to them or patients within the unit.

Working throughout the pandemic has been the most challenging time of my life but it has also given me the opportunity to work collaboratively to formulate a system that will help to ensure our patients and our team are as safe as possible during these times, and to lead my nursing colleagues in the implementation of these new systems.

As a nurse, I have never felt more tired than I have working through the coronavirus pandemic but I have also never felt prouder to be a part of developing, implementing and reviewing a system that is aiding the early detection of illness in our patients and helping to keep them, and the team, safe and could potentially be used in other similar settings to ensure the safe and effective care of older adults.

Jacqueline Thompson: Nurse Consultant, Older People

As a nurse consultant for older people working in the Dundee Enhanced Community Support Team (Acute), a Health and Social Care Partnership, in the North East of Scotland, our service acts as a rapid response.

A multi-professional team assess older people, living with frailty, in their own homes, to avoid an unplanned admission to hospital. As the pandemic unfolded in March 2020, collectively we saw this as an opportunity for our service to shine, by supporting our community of older people at home, and assisting our acute hospital by avoiding hospital admissions. Our small team has two Advanced Nurse Practitioners, a GP with a specialist interest in older people, a consultant geriatrician and myself.

We refreshed our pathways in line with emerging best practice guidance pertinent to COVID from Scottish Government and Health Protection, Scotland. While many community services were moving onto using digital platforms to undertake initial patient assessments, we did not feel that this would be helpful in assessing older people with cognitive and sensory impairment. We felt we could not be diagnostically as accurate in more complex people living with frailty without a undertaking physical assessment and performing necessary diagnostic procedures. We, therefore, made appropriate risk assessments early in the pandemic about our team wearing PPE and scrupulously cleaning our equipment between home visits and patients to do our utmost to avoid cross infection of a respiratory virus we will still learning about.

For much of 2020 and indeed now in 2021, the Scottish Government has advised no routine visiting in Scottish hospitals - aside from exceptional circumstances. We have found this prohibition of visiting has changed the public's perception of hospital admission. They may have previously felt admission was safer, but the thought of being seperated from loved ones during admission felt inconceivable for some. This has enabled people to be treated and care for at home according to their wishes.

A particular strength of our team is in end life care at home either due to advancing frailty, dementia, cancer with or without a COVID positive test. We have been able to respect older people and families wishes to support end of life care well at home.

The COVID pandemic has undoubtedly brought us many challenges however, the public acceptance of using models of healthcare in the community which offer a real alternative to hospital admission has been enormously satisfying.

'A particular strength of our team is in end life care at home either due to advancing frailty, dementia, cancer with or without a COVID positive test.'

BGS Nurses and AHPs Council: Looking forward

Looking forward, the Nurses and Allied Health Professions Council really want to see our professional voice continue to contribute to the important multiprofessional agenda for older peoples healthcare.

Contributions from Council members here have focused on a wide range of responses to the pandemic, they highlight the very tip of the iceberg in regards to the wider impact members have made these last twelve months.

The Council's Committee are keen to hear from many more members and support them to raise their professional voices, here, but also across the Society's network of regional meetings and in all of special interest groups. This last year we have strengthened our representation across these forums and looking forward to this next year will establish three new virtual communities of practice, forums for the wider council membership to connect, collaborate, and develop themselves and others with a focus on advanced practice, research, and leadership.

We know that the contributions of Council members will continue to increase, their voices with join with our multidisciplinary family responding to the challenges we face in leading and delivering the healthcare agenda for older people.

BGS members who work as nurses or AHPs are automatically enrolled as a member of the Nurses and AHPs Council. To find out more of get involved, visit www.bgs.org.uk/nurses-and-ahps-council

Frazer Underwood
Vice Chair, BGS NAHP Council

This collection of articles has been curated and edited by Emma Matthews, BGS Nurses and AHPs Council Policy and Communications Committee Representative. We wish to thank to all those members who took time to share their experiences.

If you would like to share your own reflections of working during COVID, or the innovations and lessons that have resulted from it, please email editor@bgs.org.uk.

10 reasons not to miss the **BGS/IGS Spring Virtual Meeting**

This year's BGS Spring Meeting was due to have been held in Belfast, held jointly with the Irish Gerontological Society (IGS). COVID-19 had other ideas. As it is still too soon to safely deliver a full meeting face-to-face, our programme for the 2021 BGS Spring Meeting will be online, delivered in collaboration with the IGS.

Here are 10 things to encourage you to participate in the joint BGS/IGS Spring Meeting (28-30 April):

1. Innovation in content and delivery: The virtual model

You will be able to hear the latest developments in high quality healthcare of older people, innovative services and research to improve outcomes for our ageing population - without leaving your front door. Our virtual sessions will cover CPD topics such as major trauma, dementia, stroke, renal disease and transplants in older people. You can re-watch these sessions for up to 12 months.

2. Special interests

In recent years at the BGS Spring Meeting, the first day of the conference has been focused on core competencies in geriatric medicine, planned by our Special Interest Groups (SIG). This Spring the focus will be on Dementia, and also on Major Trauma in Older People.

3. COVID-19 updated

There is no denying this has been a year like no other, with older people accounting for 90% of the deaths from COVID. Now COVID-19 is better understood, vaccines have been developed and rolled out at incredible speeds, and the prospect of restrictions easing provides encouragement to us all. We'll cover all the latest developments in treating older people with COVID-19, the implications of 'long COVID' and how to minimise exposure for the most vulnerable.

4. Building resilience

Now, more than ever, healthcare professionals are under pressure to cope well with stress, respond to adversity and recover from setbacks. We will address what you can do to take care of your physical and mental wellbeing, hearing from Dr Caroline Elton on Wednesday. On Friday we can hear from Professor Michael West CBE, a Senior Visiting Fellow at The King's Fund on what system changes are needed.

5. Experimentation: The Virtual Fringe

The BGS Virtual Fringe is an experiment in addressing the modern inhumanities of life in hospital through a humanities approach. Drawing upon art, poetry and culture for inspiration, the fringe will be part virtual exhibition, and part guided sessions to help you explore your mind, refresh and grow.

6. Abstracts

At this Spring Meeting, we will accommodate the loss of the opportunity to talk to authors in person by providing advance access to enable you to browse research abstracts. Platforms and posters will be uploaded in advance, to watch or read on demand. We'll celebrate the best with a live President's poster round.

7. Social programme

We plan to help you practice what you preach and get on the right path to avoid the onset of frailty, with our social and fitness programme during the conference. We hope you get time to reflect, relax and look after yourself more than at an in-person conference. Mahatma Gandhi once said "there is more to life than increasing its speed" so in the spirit of that, a virtual cocktail session and other less physical activities are also planned.

8. Key speakers

This year we welcome Professor Karen Andersen-Ranberg and Professor Garret Fitzgerald as Guest Lecturers. Professor Andersen-Ranberg will focus on telehealth and preventive geriatrics to avoid acute hospital admission. Joining her will be Professor Garret FitzGerald from The FitzGerald Lab at the University of Pennsylvania, delivering a lecture on "Time to reflect; molecular clocks, sex and age". We also have participation from eminent figures such as Professor Ken Rockwood and Professor Chris Whitty in the sessions on COVID-19.

9. Continuing Professional Development

The BGS Spring conference has CPD accreditation with the RCP, providing up to 18 hours of CPD hours for attendees joining live and for 4 weeks post meeting. Being a BGS or IGS member offers you reduced attendance fees for the conference.

10. Get involved with the BGS and IGS and shape the future

Our Societies must play an important part in advocating for and providing high-quality, person-centred care for older people. There are lots of opportunities for you to raise your voice, share experiences and get involved to effect change.

We look forward to seeing you online on 28-30 April at the BGS/IGS Spring Meeting.

Register now at www.bgs.org.uk/events

BGS and RCP: Working together to support the future of older people's healthcare

Many of the geriatricians in the BGS membership are also members of the Royal College of Physicians. The Royal College of Physicians (RCP) London covers England, Wales and Northern Ireland. Founded in 1518, it is the oldest Royal Medical College in England and has 40,000 members, out of which Geriatric Medicine is the second largest specialty. The Royal College of Physicians Edinburgh and the Royal College of Physicians and Surgeons Glasgow both currently have geriatricians as their President. In this article, we celebrate the long collaboration the BGS has enjoyed with the RCP London, and we also fondly remember Donal O'Donoghue, RCP Registrar, who died recently from COVID.

The BGS has a long and productive relationship with the RCP, working together to ensure that high-quality care is provided for older people, and that the voice of those who specialise in older people's care is fairly represented. This has been vital during the COVID-19 pandemic with its particular challenges for the health and care of older people.

RCP Council

The BGS President sits on the RCP Council and attends regular Council meetings. This forum is where important policy decisions of the RCP are made. The RCP is an influential organisation, and the RCP President has regular meetings with high level NHS personnel and politicians, including the Health Secretary, making this an effective way to ensure the views of BGS members are heard. The leadership of the RCP extends beyond its physician membership, influencing care across the entire NHS and impacting the whole multidisciplinary team. The importance of this high-level relationship was highlighted during the COVID pandemic, when we were able to raise issues with the RCP about misuse of the Clinical Frailty Scale, workforce shortages and PPE concerns.

Medical Specialties Board

The BGS President Elect attends the RCP Medical Specialties Board, where operational matters are discussed and where we can work with other specialties on areas of mutual interest. Important topics covered here include CPD, the MRCP examination, improving quality of care for medical patients in the NHS, the role of internal medicine and ethical issues.

The senior officers of the BGS and RCP meet separately several times a year. This is a useful forum where we learn from the RCP President and Registrar about policy and practice developments that are relevant for our specialty. It gives us the opportunity to feed back views on issues or matters of concern for our members. An example of how this close association helped was during the development of the new three-year IMT programme that has replaced the previous two-year core training programme for junior trainees. BGS members lobbied hard to ensure that every trainee should receive training in Geriatric Medicine, and we were pleased when a minimum of four months' Geriatric Medicine training was made mandatory in all IMT training programmes.

Specialty Advisory Committee

The Specialty Advisory Committee (SAC) in Geriatric Medicine is an RCP body which is involved in setting high quality training in Geriatric Medicine for trainees, as well as writing and regularly updating the curriculum. The BGS Education and Training Committee works closely with the SAC and helps to operationalise decisions made in the SAC through giving advice to our members, including the training programme directors.

Specialty Certificate Examination

The Specialty Certificate Examination (SCE) is now a compulsory component of assessment for Certificate of Completion of Training (CCT) for all UK trainees whose specialist training began in or after August 2007 in one of 11 specialities, including Geriatric Medicine. The exam is planned and administered by the MRCPUK. The BGS is involved through the Education and Training Committee, with a representative on the SCE steering group. Our other key role is in supporting our Higher Specialty Trainees (HST) members, feeding back improvements and issues needing to be addressed via our Trainees Council, and candidates' experiences after each SCE. BGS involvement with the exam is predominantly via our Education and Training Committee, under its Chair Professor Mike Vassallo, with representation from a lead specialist, currently Dr Adam Harper. There are also representatives on the Education and Training Committee from HST, currently Dr Rebecca Winter and Dr Sarah True.

Mock SCE exam questions can be found on the BGS website (**www.bgs.org.uk/mockSCE**) or by searching for Mock Specialist Certificate Exams on the BGS or RCP website. The BGS Trainees Council also arrange for an SCE preparation session each year before the SCE is held. If you would like to get involved more you can do so by standing for one of the BGS officer roles. Details can be found on the BGS website at **www.bgs.org.uk/roles**.

Diploma in Geriatric Medicine

For some years, the BGS has collaborated with the RCP in the delivery of the Diploma in Geriatric Medicine (DGM). This is a written and clinical exam which aims to

'test comprehensive clinical knowledge and practical skills in geriatric medicine at a level appropriate for the provision of expert practice in the care for older people in primary and secondary care settings.' The DGM is designed for individuals who have not completed higher specialty training as geriatricians, and it has typically been GPs and psychiatrists who comprise the highest proportion of past candidates.

We are pleased to have agreed with the RCP that the DGM should be opened up to any registered health professional who wants to demonstrate their knowledge and expertise in the healthcare of older people. This includes nurses, pharmacists, Physician Associates, therapists and other allied health professionals. The BGS signed a new collaborative agreement with the RCP in early 2020. The RCP administers the exam and awards the qualification. Professor Mike Vassallo is the current Chief Examiner, and other BGS members are involved setting questions and acting as examiners for the clinical examination. A Development Group of those from different professions meets regularly to consider how the exam should evolve. With the opening-out of the exam to a wider candidate pool, we have been looking at the balance of questions, the context of primary and secondary care, and the scope for adapting the exam in light of the restrictions enforced by COVID. Making more elements of the exam virtual rather than face-to-face helps to improve accessibility and reduce costs, but we are keen to retain a clinical exam to test patient-facing skills in a live setting.

The DGM is a medical exam and it is important to maintain its comprehensive scope while making it accessible and relevant for a multidisciplinary workforce caring for older people. Currently the DGM counts towards a third of the credits needed for the MSc in Gerontology at Kings College London. We are looking into the potential for other such linkages, including the new Advanced Clinical Practice curriculum for the care of older people. There are various courses of study to help people prepare for the DGM exam, and it is possible the BGS may endorse one or more of these preparatory courses in future. International candidates can sit the exam, providing they meet the eligibility criteria, so we will also be looking to extend our marketing to encourage those specialising in healthcare of older people overseas.
Working with the RCP, the BGS will be promoting the DGM over the coming months. As part of your own continuing professional development, why not have a look at the exam content and see whether you might be interested to sit the exam? Details of exam dates for 2021 and requirements are on the RCP website:
www.rcplondon.ac.uk/diploma-geriatric-medicine

Expanding medical school places

In January, the RCP published a report 'Double or quits: a blueprint for expanding medical school places'. The report looks at how to implement such an expansion, including a blueprint for growth covering the model of provision, the costs, challenges and opportunities. The BGS warmly welcomed the report, agreeing that the challenges facing the NHS workforce are significant, and supports RCP's plan for the next 10 years to address these issues. The call to double the number of medical school places from 7,500 to 15,000 per year, at an annual expense of around £1.85bn, while costly, is necessary if we are to meet the needs and realities of our health and care system.

The specialty of geriatrics continues to face workforce shortages, especially in regions of the country with lower population densities. The BGS hopes this proposed expansion in the number of trainees will help meet the system-wide challenges highlighted in the report, many of which relate to the UK's ageing population. We also strongly support the RCP's call for medical schools to review their curricula to ensure they create cohorts of doctors with a broad base of skills, especially those relating to the care of older people.

Consultation responses

The RCP often calls upon the BGS to feed into consultation responses on issues which affect older people, which includes guidance from bodies such as the National Institute for Health and Care Excellence (NICE), as well as reports from other professional societies and public bodies. These requests are fed back through BGS officers and Special Interest Groups (SIGs), ensuring the voice of BGS members and the specific needs of older people in particular are considered as part of the response. During the pandemic, due to the need to accelerate the publication and dissemination of new information, the number of these consultations increased, and BGS members and other stakeholders were still able to contribute to these important documents. The RCP has issued a formal thank you to all those involved in its consultation responses from the BGS, praising in particular their commitment and willingness to provide feedback in their own time, under extraordinary pressure. The letter can be viewed on the BGS website here: **www.bgs.org.uk/RCPconsultletter**

Tahir Masud
BGS Past President

Sarah Mistry
BGS Chief Executive

Geraint Collingridge
BGS Director of Learning and Professional Development

Remembering Donal O'Donoghue (1956-2021)

Professor Donal O'Donoghue held the post of RCP Registrar before his sad death from COVID-19 on 3 January 2021. BGS members who were fortunate enough to cross paths with him during his career in renal medicine and his time at the RCP share their memories of an extraordinarily well-liked friend and colleague.

In his 30-year career as a Consultant Nephrologist, Donal was also the inaugural President of the British Renal Society, President of the Renal Association, and the first National Clinical Director of Kidney Care at the Department of Health between 2007 and 2013. He had also served as the Chair of Trustees of the charity Kidney Care UK since 2016. He is survived by his wife Marie, their three children and four grandchildren.

'I worked with Donal for 4 years in the Department of Health when I was National Clinical Director (NCD)for Older People's Services and he was in the equivalent role for kidney disease and chaired the regular NCD meetings. We were close colleagues again at RCP London when I was Vice President and he the Registrar, and we carried on chatting even after I left the RCP in 2019. We were both Mancunians and football lovers (he Red, I Blue) and shared many a chat about football over a pint. Not only was he hugely respected by fellow nephrologists, but he was a very kind, wise and supportive man who was unfailingly helpful to other doctors, including me. He was a lovely man, a good colleague and friend and great company. His contribution to his own speciality and to the wider medical profession was immense."

David Oliver
Former BGS President and former RCP Vice President

"Donal was a true gentleman and was always very supportive of BGS efforts to improve care for older people."

Tahir Masud
BGS Past President

"As President elect for BGS I attended the RCP Medical Speciality board meetings. These were held fortnightly over the last year and ably led by Donal. He displayed in our meetings a real dedication for high quality care for all patients. His ability to listen to views from all and bring us to agreement on a common path was phenomenal, and all with gentle good humour. We will miss him and send our sincere condolences to his family and to all his colleagues."

Jennifer Burns
BGS President

'I had the great privileged to work with Donal in my RCP role. He was enormously wise and his guidance and support were invaluable. He was approachable and generous with his time. He was a role model of an excellent clinician and colleague. I miss him terribly."

Jane Youde
BGS Clinical Quality Committee Member and
RCP Clinical Director of Audit and Accreditation

'Every time I spoke to Donal, he inspired me. He was an amazing clinician, an expert researcher who translated evidence in routine clinical care and a brilliant advocate for both patients and colleagues. He was amazingly supportive and kind, and in the coming years, I am sure I will often think 'What would Donal say?' "

Jugdeep Dhesi
BGS Clinical Quality Lead

'I met Donal at meetings with the Royal College of Physicians. I always found him to have a very positive and constructive approach to problem solving. He used to listen carefully and come up with sensible suggestions. Nothing was too much of a problem and I felt he always gave reassurance that there is always a solution and a way forward. I will miss that positive influence he always gave. May he rest in peace."

Mike Vassalo
BGS Vice President for Education and Training

'Donal always impressed me with his team working and inclusion. Trying to 'fill his shoes' as interim RCP Registrar, this has been confirmed time and time again. His network was immense, his development of others was at the core of what he was about. As well as his family, he put three things at the heart of everything he did – strong relationships with medical specialties, 'one RCP,' and in particular patients. He is sorely missed."

Peter Belfield
Interim RCP Registrar

The RCP hopes to hold a memorial event in the summer to celebrate and honour Donal's life and achievements. Donal's family have requested that any donations be made to Kidney Care UK, and be used to continue his efforts to support kidney patients and their families.

Donations in Donal's memory can be made at **www.justgiving.com/campaign/Donal**.

British Geriatrics Society: Learning and professional development to support better healthcare for older people

The BGS is a medical society and charity of more than 4500 members united by a mission to improve healthcare for older people. Our members are nurses, doctors, therapists, researchers, pharmacists and allied health professionals who work in acute, primary and community care across the four nations of the UK.

Our Strategic Plan 2020-23 commits us to supporting continuing professional development of those specialising and working in healthcare of older people. We aim to influence the uptake, quality and relevance of education and training in geriatric medicine and healthcare for older people.

Some highlights from our recent work

- Delivery of a comprehensive programme of national, regional and sub-speciality meetings providing **high-quality expert content and CPD** based on a rolling curriculum; three-day virtual conference (November 2020) delivered successfully with 1000+ multidisciplinary delegates.
- Making **meeting content available for 12 months online** so that delegates can engage with it at a time of their convenience.
- Supporting the **development of the new Geriatric Medicine curriculum**, by providing specialist input on content, and stakeholder feedback on proposed changes.
- Collaborating with the Royal College of Physicians London and the Federation of Royal Colleges on **the delivery of the Specialist Certificate Examination in Geriatric Medicine, and the Diploma in Geriatric Medicine**, the latter now being broadened to be accessible to statutorily-regulated health practitioners wishing to demonstrate their skills and knowledge in working with older people.
- Supporting the **growth of Advanced Clinical Practice**, by contributing to the Advance Clinical Practitioner curriculum for older people's health, and providing a forum for peer support.
- Providing **support and information for trainees**, through the BGS Trainees' Council and website resources, particularly on COVID in older people.
- Producing **e-learning modules** on core and innovative curriculum areas such as frailty and peri-operative care that can be accessed through the BGS website and are aimed at consultant, registrar and ACP levels.
- Working with international organisations (European Geriatric Medicine Society, International Association for Geriatrics and Gerontology, European Academy for Medicine of Ageing) and UK-based organisations (Chartered Society of Physiotherapists, Old Age Faculty of Royal College of Psychiatry, Age Anaesthesia Association etc) to **promote and share educational content**, and to ensure collaborative learning.

Plans for 2021 onwards

- Collaboration with Training Programme Directors across England Deaneries on sharing regional training content, trainee dates and resources.
- Suite of e-learning resources (delirium, continence, onco-geriatrics currently in pipeline) and other learning modules to support health professionals in primary and secondary care.
- Development of learning resources for care home nursing staff, and primary care teams providing clinical support to care homes.
- Training and resources to support delivery of NHSE 'Ageing Well' programme.

January 2021

Twittersphere!

What's been trending on the @GeriSoc Twitter feed lately? Don't forget to follow us for all the latest news and updates!

SuzyH @SVH00
New #CovidVaccine vaccine #novavax 89% efficacy in interim analysis, including against new UK variant. Importantly 27% participants aged >65 too! Thank you to all participants and staff who made this possible! @RDEResearch @UofE_Research @exeterageing @GeriSoc

Anna Dixon MBE @DrAnnaDixon
Those who work past state pension age by choice more likely to be well educated. Those who need to work for financial reasons often least able to because of health and type of work avail. Need to support people with health conditions to stay in work #geribookclub

Adam Gordon #ivehadthevaccine @adamgordon1978
The @NIHRresearch PROTECT trial launches today - help us test treatments to prevent and reduce the severity of COVID-19 outbreaks in care homes. We are recruiting homes now for what will be the largest ever trial in care homes. Sign up to hear more at: https://protect-trial.net

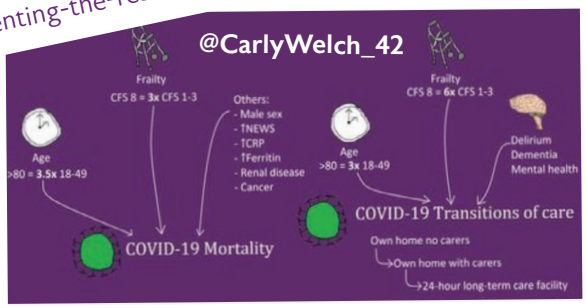
Asan Akpan @asanakpan
On this International women's day I remember & celebrate Dr Marjory Warren who created the first medicine 4 OP unit in the UK. https://bgs.org.uk/marjory-warren

Geriatric EM Europe @GeriEMEurope
Important work: the #silverBook2 is out! An international #milestone for #geriEM #geriED. Get inspired and disseminate!

Kathryn Mannix @drkathrynmannix
Everyone over 60 gets an invitation from @NHS every 2 years for bowel cancer screening with an explanatory leaflet available in many languages. If we can do that, we can offer Advance Care Planning too. How about it, @NHSImprovement @DyingMatters @GeriSoc @rcgp @RCPLondon?

British Geriatrics Society @GeriSoc
NEW #COVID19 RESOURCE: This page via @GERED_DOC brings together studies specifically examining the link between #frailty and COVID-19 outcomes in acute care. It is intended that it will be updated every month following a review of the literature https://bgs.org.uk/covidfrailty

Carly Welch @CarlyWelch_42
So proud of all the work of @GeMResearchUK @CovidCollab in this great piece of work! If you haven't read the article (or even if you have) please do read this blog! https://bgs.org.uk/blog/presenting-the-results-of-the-covid-collaborative



Lucy Lewis @LucyLew79
Live footage of @silviecom registering membership to @GeriSoc That's 6 of us from the Lymington #frailtysupporteam with automatic membership of #NurseAHPcouncil from student to consult nurse. Have you told your MDT colleagues about us and encouraged them to join?

The BMJ @bmj_latest
"The most prominent theme to come out of the survey was the significant mental and emotional toll that working through the pandemic has had on our members and their families" @Sparklystar55 and @SallyGreenbrook @GeriSoc

Dan Thomas @dan26wales
Chris Whitty is @GeriSoc conference key note spreaker! Such a shame it is virtual otherwise would be queuing all night to ensure a space in the conference mosh pit

Esther Clift @EstherClift
@captaintommoore RIP. So very sad to hear this. Was so inspired by his biography. @GeriSoc - a great ambassador for having a goal and getting on with it. #TomorrowWillBeAGoodDay

Enhancing generalist skills development for the healthcare workforce: A new era for training

The need for doctors with generalist skills has been brought into sharp relief by the COVID-19 pandemic, which has required large groups of medical professionals to respond to change on a system level and communicate better across organisational boundaries. The system responded at rapid pace by providing specific training and a redeployment structure to work differently, in order to meet an acute need across the population.

The pandemic has provided Health Education England (HEE) with fresh opportunity to consider how to integrate this learning into medical education reform, driving forward beneficial change for future healthcare. The compelling argument for change is particularly timely due to the recent establishment and increasing maturity of integrated care systems across the country. By building on adapted and newly brokered system-wide collaborations, improved responsiveness and innovative partnerships, the potential to empower future generations of doctors to deliver enduring, high quality patient care has never been more pertinent.

Figure 1: Generalist skills: benefits for future healthcare professionals

- Co-deliver 'whole person' care for patients with multiple conditions;
- Be fluent in shared-decision making and personalised care;
- Become authentic and collaborative leaders and colleagues with structured education in human factors and team science;
- Understand and address the population health and care needs of the communities they serve by harnessing data, technology and contemporary research methodologies;
- Apply their learning to reduce health inequalities and address local health priorities and specific needs such as homeless health, modern slavery and other social justice agendas;
- Become system literate across organisational boundaries with cross-cutting interests and skills in informatics, digital health and epidemiology.

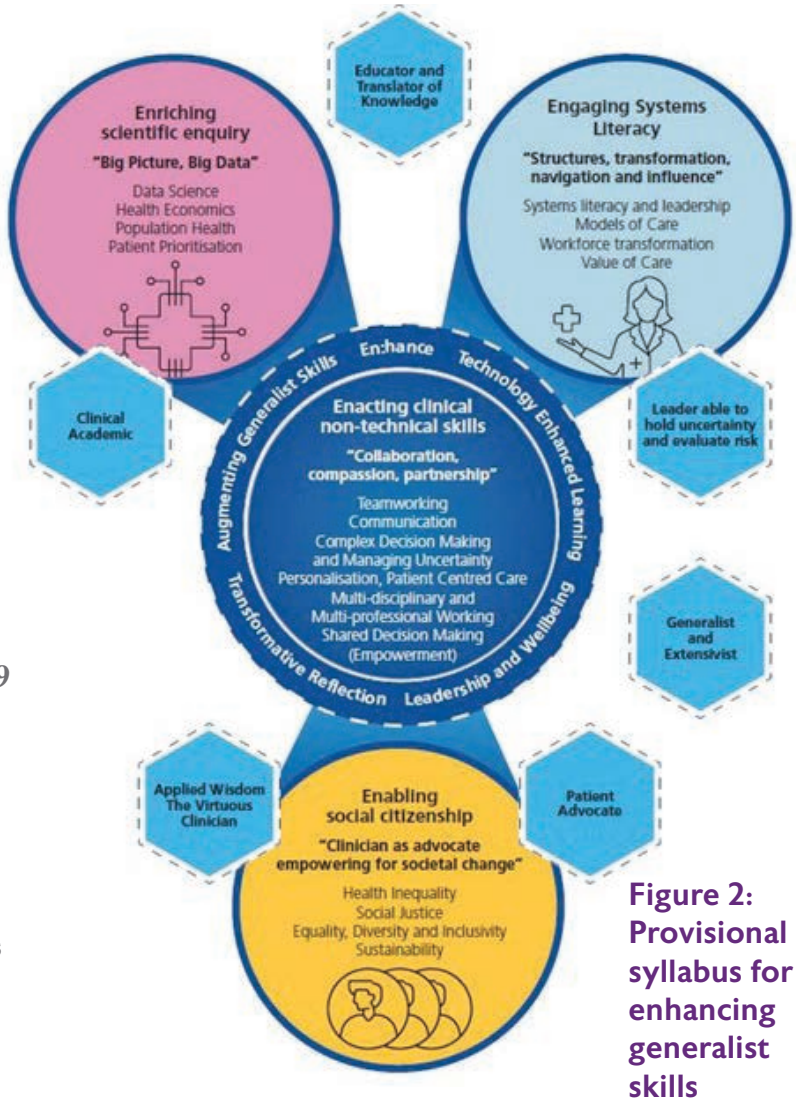


Figure 2: Provisional syllabus for enhancing generalist skills

Following in the footsteps of the NHS Long Term and People Plans, and through significant engagement with key stakeholders and partners, HEE's Future Doctor Programme (**tinyurl.com/heefutdoc**) established a co-created vision of the unique behaviours and skills of future doctors and their role in multi-professional teams, as well as system changes needed to attract, train and retain the future medical workforce.

Enhancing generalist skills, augmenting specialism to improve patient care

HEE are now building upon the findings of the Future Doctor programme, lessons learnt during COVID-19 and successful implementation of previous Medical Education Reform Programme (MERP) initiatives to embed 'generalist skills' (see Figure 1) - one of the key needs identified in stakeholder work - firmly within medical education and professional development.

HEE aim to do this by developing a wraparound professional development offer to enhance current foundation, core, and run-through specialty training pathways (see Figure 2). The outcomes aim to develop the generalist skills of doctors with test beds being established in each of the seven HEE regions. The programme will complement current training, focusing across the first five years of postgraduate medical education, closely aligned with key health and care needs identified at a population level in each region or locality. Shared learning across regions and

The geriatric physician perspective on enhancing generalist skills

"As a geriatrician whose work spans the acute medical take, ambulatory services, the inpatient ward, the outpatient appointment and community services, the value of doctors confident in generalist working shines through. As RCP College Tutor, I am worried we are not teaching future consultants enough about managing and risk and sharing uncertainty, the importance of care coordination, of removing silos and of an individualised approach to patients.

"This work is about providing a breadth of generic skills to manage patients with specialist support where appropriate but without pinging off a referral to yet another specialty every time a new problem arises. It is about identifying a deteriorating patient and having the skill and initiative to start advance care planning conversations without needing a palliative medicine physician. It is about having more personalised care, coordinated by a physician of any speciality, and working together in a more joined up fashion. It is about working with other specialties but having the ability to have shared decision making-conversations in an area that might not be your primary specialty. It is the understanding of both the opportunities and limitations of working in unfamiliar healthcare settings like the community.

"The focus on these skills that the enhancing generalist skills programme sets out to achieve is a really important step forward to ensuring our doctors reaching CCT are equipped for this kind of working in the NHS."

Dan Furmedge
Consultant Physician, Geriatric and General Internal Medicine, Guy's and St Thomas' NHS Foundation Trust

different health and care professions will be maximised, enabling new learning opportunities to be accessed through collaboration with integrated care systems and workforce transformation teams.

This education will be underpinned by an emphasis on the application and contextualisation of the GMC Generic Professional Capabilities through novel and innovative blended learning opportunities, combining the theoretical and experiential in a specifically crafted programme. As part of this development we are working with stakeholders and partners across the healthcare system to shift the culture, so that these enhanced generalist skills become increasingly valued and rewarded within a wide range of flexible and sustainable career paths. The wraparound elements of the programme will have a strong focus on wellbeing and self-care, flexibility and work-life balance, clinical leadership development and promote digital literacy for all (a theme detailed within the Topol Review: **https://topol.hee.nhs.uk**). It is important to emphasise that enhancing generalist skills is not about re-writing or amending established curricula or training courses; or creating a new 'specialty' of generalism. The newly revised curricula contain these elements within the stated generic professional capabilities; the art of integrating the enhanced programme with the more directly clinical aspects of training lies with experienced clinicians provided with the time and educational tools to support transformative reflection that translates into action. The augmented skill set amplifies rather than diminishes the role of either the specialist or the general practitioner. Participating in this programme will enable future doctors to work synergistically with both GPs and specialists to meet patients' medical and social needs across healthcare settings (Figure 3).

'The augmented skill set amplifies rather than diminishes the role of either the specialist or the general practitioner.'

Enhanced generalist skills can help all doctors have a robust, future-proof training experience, encouraging innate curiosity and sustaining an appetite for lifelong learning through fully explored and personally relevant enquiry, so that they become empowered to effect change within the communities they serve. In doing so, future doctors will be able to improve outcomes for their patients and the population, meet the changing expectations of and from the health and care system, and have rewarding, stimulating and satisfying medical careers.

Figure 3: Benefits for patients of augmented generalist approaches across healthcare

- Fewer care contacts for individual conditions
- Improved continuity of care
- Improved patient experience
- Safer and higher quality of care
- Increased access to community-based clinics, MDTs and diagnostics
- Social care, health prevention and health inequalities comprehensively addressed
- Streamlined communication across all health and care settings
- Fairer access for all patients to innovative interventions, including research and development activity, across the whole population.

If you have any queries or would like to speak to us about our work, please contact the team via email merp@hee.nhs.uk

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Opening the door to LGBTQ+ individuality: Part 1

This is the first part of a two-part series describing the work at King's College Hospital to make the Department of Clinical Gerontology more inclusive of LGBTQ+ patients. Part one discusses the rationale for this project, while part two (next issue) will cover some of the outcomes of these interventions and plans for the future.

February this year was LGBT+ History Month. In writing this, we will emphasise some historical context behind the project. We also highlight some broader aspects of person-centred care which can be applied in other areas to hopefully make healthcare a more inclusive place for people of varied experiences and backgrounds. We gave the project the allegorical title – "Opening the Door" to represent the spirit of inclusiveness and as a hat tip to colleagues in Opening Doors London. It is our contribution to the tradition of person-centred care, dedicated to the empowerment of the young LGBTQ+ people of the mid-twentieth century who harnessed the zeitgeist of their time to create a more egalitarian world for us today.

Introduction

Just over 50 years have passed since the Stonewall Riots of 1969 – a series of events which were central to the subsequent LGBTQ+ rights movement. This movement was led by the LGBTQ+ youth of the 1960s and 1970s – people who are now in their seventies and eighties. These people lived through a time when homosexuality was criminalised. They experienced discrimination at every level of society – physical violence, loss of friends and family, loss of jobs and income – much of which was state-sanctioned. Additionally, they were subjected to institutional level discrimination – arrest and prosecution, medical experimentation and harmful therapeutic interventions such as electric shock and conversion therapies. Since that time, tremendous progress has been made to rectify this inequality. The people who involved in Stonewall who are alive today have witnessed a social revolution. LGBTQ+ people are considerably freer than they were 50 years ago and have gained important civil rights, such as marriage equality. Nevertheless, these experiences have left their mark.

Approaching later life can be associated with several concerns, such as financial insecurity and physical disability. Being older and LGBTQ+ is associated with some additional unique worries. Older LGBTQ+ individuals experience considerable health inequality, with a higher chance of living alone, of having no children to care for them and are at higher risk of being smokers and of misusing alcohol and other drugs. They are also at higher risk of several health conditions. In addition to this, having experienced institutional discrimination, many older LGBTQ+ people are intrinsically fearful of accessing healthcare and law enforcement systems. The difficulties associated with older age become compounded by those of being LGBTQ+ and can leave people feeling 'doubly invisible'. Older LGBTQ+ people also, having lived with a lifetime of discrimination, often face self-stigma. They may therefore be in the position of never having told anybody their true identity and now must decide if it is worthwhile coming out, risking ostracisation, or to live the rest of their lives in the knowledge that nobody ever knew who they truly were. Secret-keeping like this has been shown to reduce wellbeing and life satisfaction and to increase fatigue and social isolation. Given the hardships faced by our older LGBTQ+ patients through their past interactions with healthcare, we have a responsibility to provide a service in which they definitively know that they are valued and will be treated respectfully.

Ensuring that the individual needs of patients are met cannot be achieved with a one-size fits all model of healthcare. It requires that we recognise those things which most concern our patients and offer compassionate, personalised care. Eminent humanistic psychologist Carl Rogers described the person-centred approach to psychotherapy, which led to the development of person-centred care in medicine. Person-centred care aims to place the patient and their needs – expressed or otherwise – at the forefront of their healthcare experience. The importance of this has been recognised. An

'Just over 50 years have passed since the Stonewall Riots of 1969, a series of events which were central to the subsequent LGBTQ+ rights movement. This movement was led by the LGBTQ+ youth of the 1960s and 1970s – people who are now in their seventies and eighties.'

illustrative example is the *This Is Me* document published by the Alzheimer's Society. The work which we describe below is a further iteration of this method of care provision.

The King's experience

Almost two years ago, a group of doctors working in the Department of Clinical Gerontology in King's College Hospital noticed that there was very little open messaging to suggest that our department was appreciative and inclusive of our LGBTQ+ patients. We knew that they were out there, but none of us had much first-person experience of interacting with them on a personal level. We wondered why this might be and if, perhaps, they felt that their personal experiences were irrelevant; or worse, that they would experience prejudice if they disclosed their LGBTQ+ identity. We wondered if we could do something to show them that our department recognised their existence, respected them and wanted them to feel comfortable. We also wanted to know if there was a way to find out who they were.

With this in mind, we joined together with the team in a local charity for older LGBTQ+ individuals – Opening Doors London (ODL) – to see if we could change things. We devised a programme which we aimed to introduce in our department that would make it more inclusive for LGBTQ+ older people who used our service. In recognition of this initiative, we hope to be awarded the Pride In Care standard offered by ODL to services which implement measures to improve LGBTQ inclusivity.

Opening the door

We conducted a survey of our patients to find out what their experiences were, what they felt we did well and how we could improve. We disseminated this via Twitter and through local LGBTQ+ charities, asking LGBTQ+ patients who had attended King's in the past six months to describe their experience to us. Our results were compelling. Bear in mind when interpreting these – we should be aiming to achieve perfect scores in these areas. Our patients should feel like they are always treated in as respectful a manner as they expect:

- 35% of patients reported moments when they felt uncomfortable about their sexuality during their patient experience and 20% reported moments when they felt uncomfortable about their gender identity.
- 52% of patients felt that they were always treated with courtesy and respect.
- 15% felt that the level of courtesy which they were shown was related to their sexual orientation and 17.5% to their gender identity (the gender identity was not specified).

We also received some powerful qualitative feedback which helped to inform our actions:

- "…Nurses prioritised hetero partners…not a single A&E or ward staff member had a lanyard or any indicator of being LGBTQ friendly…It was isolating, frightening and added to an already horrible near death experience…"
- "…I felt unable to be myself due to the type of language used within departments…"
- "Being black and gay has its challenges and when you are faced with prejudice within the medical system, its [sic] definitely a moment for more anxieties"
- "…please continue to prioritise LGBTQ training"

Importantly, there were many positive responses about the care delivered also. We have highlighted some of the negative responses as these serve to highlight the work which is still required.

With these results in hand – it was clear that some action was required. In the second part of this series, we will describe the interventions which we have carried out, the outcomes which we have seen and our plans for the future.

The authors are keen to connect with others working in healthcare who have suggestions on how we can bring work on LGBTQ+ inclusivity to a wider audience or who are interested in implementing changes in their own workplace and would like to collaborate. Please contact Dr Patrick Hogan on p.hogan@nhs.net to discuss further.

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Department of Clinical Gerontology, King's College Hospital, London

Dr Andrew Crowe
Department of Sexual Health, King's College Hospital, London.

Dr Lucy Mealey
Department of Clinical Gerontology, King's College Hospital, London

Dr Michael Brady
Department of Sexual Health, King's College Hospital, London; National Advisor for LGBT Health, NHS England

Professor Ben Thomas
Research and Policy Officer, Opening Doors London

Dr Dan Bailey
Department of Clinical Gerontology, King's College Hospital, London

COVID-19: We must leave no one behind

As part of the largest humanitarian network in the world, British Red Cross are not unfamiliar with large scale emergencies. But last year, the charity – alongside healthcare professionals across the globe – began to respond to a crisis like no other, explains their Chief Executive Mike Adamson.

One year on from the start of the pandemic, the impact of COVID-19 continues to cause enormous challenges. The physical, mental, social and economic impacts have been – and will continue to be – very damaging for millions of people, especially the most vulnerable in society, including older people. You do not need me to point out that the UK has an ageing population. Our Independent Living services report the most common age range of people it supports is now 90-99 years old.

Much of this support is practical - shopping, transport, medicine drops - but during the pandemic I heard increasing stories of staff and volunteers being asked to help with incredibly personal requests. Norman, 81 a terminally ill cancer patient in Manchester was unable to hold a pen and asked for help to write a last love letter to his partner. Elsewhere, one of our volunteers took someone to the beach to feel the sand for one last time as their dying wish.

Like most of you as geriatricians, in our work, we don't see a condition, a broken leg or a chesty cough, we see a person. Such simple acts of kindness like these can make a real difference. But you'll know that all too often they don't happen. Many older people feel isolated and unsupported in even their most basic needs. As a geriatrician explained so perfectly, the question should not be 'what is wrong with you?' but 'what matters to you?' Our recent research with Healthwatch England, exploring almost 600 people's experiences of leaving hospital during COVID, found that around one in five felt unprepared to leave hospital. It is not uncommon for people we take home from hospital to face problems like having no food in the fridge, no heating, or no way to move around their home safely.

Without support at home, and with the additional challenge of the COVID-world we live in, these small issues are huge barriers to people's wellbeing and recovery.

Social distancing, and lockdown restrictions, have meant that many people's already limited informal support networks have dissipated. And we know that formal care and support has sometimes stopped too. Too many people are also feeling lonely and left behind.

Today, more of us need care but fewer of us get it. The funding of care is unfair and under increasing pressure; our emergency response structures and other public services are in need of modernisation; too often we act as a sticking plaster, act in silos, and don't treat people as a whole. Our population's needs are very different today from what they were when these systems were built.

It's clear what needs to be done - we've been talking about it for decades:

- Invest more in care and support in the community
- Invest more in prevention
- Work in a more integrated, joined up way
- Address health inequalities

I know these solutions are complex and costly, but small steps towards this can be made simply. When people leave hospital, we think a simple checklist should be introduced into the discharge process that would enable us, and other support services, to better determine people's physical, practical, social, psychological and financial needs. A more human approach. It's not that this doesn't happen in some places. The issue is consistency.

'Like most of you as geriatricians, in our work, we don't see a condition, a broken leg or a chesty cough, we see a person.'

‘It is not uncommon for people we take home from hospital to face problems like having no food in the fridge, no heating, or no way to move around their home safely.’

Another key theme is the need to invest more in wrap-around support, for example, routinely offering emotional support to people who are in receipt of food, or to people going in and out of hospital for medical reasons. Or to recognise the non-clinical reasons why a small number of people make such intensive use of health services.

When you start from the perspective and experience of people and places rather than institutions, it’s impossible to ignore the importance of non-clinical interventions and the importance of working across specialisms and systems to deliver this effectively.

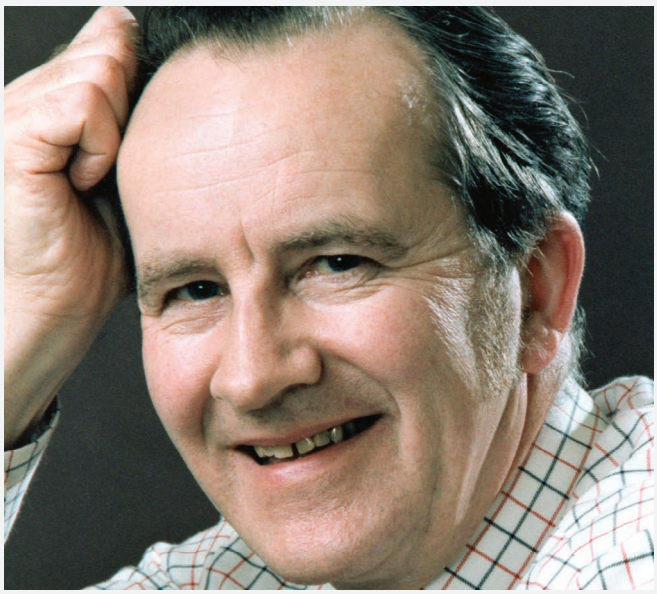
Each of us can have a role to play in adopting this ethos:

- Seeing someone first and foremost as a person and not a condition
- Asking partner organisations for help
- Actively reaching out to communities and people in vulnerable situations, or
- Simply asking people about their relationships or what matters most to them.

This year the Red Cross is involved in one of the biggest humanitarian responses the UK has seen in recent history, supporting the roll-out of COVID-19 vaccines to help bring an end to this pandemic. But we are also helping people with more than that – we help them feel human.

We continue to address loneliness, isolation, health inequalities and poverty to make sure that no one is left behind.

Mike Adamson
Chief Executive, British Red Cross



Dr James Leeming (1927-2021)

The dedicated geriatrician and former Secretary of the BGS (1976-1978) sadly passed away in January this year.

Dr James Thompson Leeming was at heart a Mancunian and spent much of his professional life in the vicinity of the City. He was educated at Manchester Grammar School, where he had been awarded a Foundation Scholarship, and received his medical teaching at Manchester University.

After qualification and house posts, he served his time in National Service in the Canal Zone. Following demobilisation, he was appointed to various junior medical posts in the Manchester area. One was working for Dr Dent at Crumpsall Hospital, an old workhouse infirmary, where he first encountered geriatric patients: an experience which influenced his future career. During this period, he passed the MRCP examination, and worked in a haematology department researching into the causes of iron deficiency anaemia, which became the basis of his MD. Further research followed at the Johns Hopkins Hospital, Baltimore. On return to the UK, he held various senior registrar posts including another appointment at the Crumpsall Hospital.

In 1963, he was appointed Consultant Geriatrician at Bolton Hospital, where he was kept very busy and carried out as many as 30 domiciliary visits per week. He achieved very significant reductions the average length of inpatient stay. He visited the local Delaunay Workhouse Infirmary and was troubled by the conditions. In 1966 he moved to the Withington Hospital. There he remained doubtful about the value of the then current philosophy of progressive patient care, doubting the wisdom of moving patients from ward to ward as their condition changed. In 1977, he moved to Manchester Royal Infirmary and welcomed the arrival of Professor Brocklehurst. During his consultant appointments, he was seconded to the Health Advisory Service (precursor of the Care Quality Commission), visiting the geriatric services in Devon, Cornwall and East Anglia. Later he was seconded to the Open University as medical advisor for their new course on the care of old people.

He took early retirement, was chairman of the local Rotary group and worked enthusiastically with various voluntary organisation concerned with the care of older people.

He was a long-standing member of the BGS and was the Society’s Secretary in 1976 until 1978. He was elected FRCP in 1972 and awarded the Society’s Founder’s medal in 1996. He passed away on 22 January 2021.

Obituary by Dr Michael Denham
BGS Historian and Archivist

Ageing, health and hormesis: What does it all mean?

Suresh Rattan is a biogerontologist, and the Editor-in-Chief of the journal *BIOGERONTOLOGY*. Here he summarises his incredibly well-received guest lecture at the BGS Autumn Meeting 2020, in which he talked about the biological basis of ageing and old age alongside trends in ageing interventions, health promotion and healthspan extension.

Biogerontologists most commonly describe ageing and old age as the process and the period of progressive decline, loss and failure of biological structure and function.

This 'downhill' biological perspective is founded in the representation of the life of an organism as grossly divided into two phases: the first phase of birth, growth, development, maturation and reproduction; and the second phase of post-reproductive survival until the eventual death of the individual.

In evolutionary terms, the first period of life is termed as the essential lifespan (ELS) of a species, that is necessary and sufficient for the continuation of generations. ELS of a species has evolved under genetic selection and regulation through hundreds of genes involved in the basic metabolic and maintenance pathways. Such ELS-assurance processes, also known as the longevity-assurance genes or vitagenes, comprise the overall survival ability of a biological entity.

Ageing and old age, as defined above, set in and get manifested mainly during the period of survival beyond ELS, which for human species is about 45 years.

It is the great achievement of modern economically rich societies having biomedical and other social resources that a majority of the people can expect to, and do, live to much longer lifespans than ELS. However, the extended lifespan has generally not been accompanied by an equally extended 'health-span'.

The aim of this short write up is to give a quick overview of and reminder about what the science of the biological basis of ageing has amassed with respect to why and how ageing happens, and what can and should be done to maintain, recover and enhance health and health-span.

‘Physical exercise, dietary habits, sleep pattern, and social and mental engagement seem to be the pillars of good health and longer survival.’

Ageing as the shrinkage of the homeodynamic space

The concept of homeodynamics refines upon and expands the traditional term homeostasis – a term based in the 'body as a machine' paradigm. However, the dynamic nature of information and interaction networks, and the emergent properties and the complexity of biological systems, are better expressed by the term homeodynamics. My concept of homeodynamic space includes the dynamic and interactive abilities of a biological system in order to survive and meet the demands of its constantly challenging internal and external milieu.

The main biomarkers of the homeodynamic space are stress responses, damage control systems and the processes of constant remodeling. The homeodynamic space describes the overall ability of an individual, which can be analysed as the phenotypic parameters (for example robustness and resilience) of an individual’s or subsystem’s performance with respect to a specific perturbation.

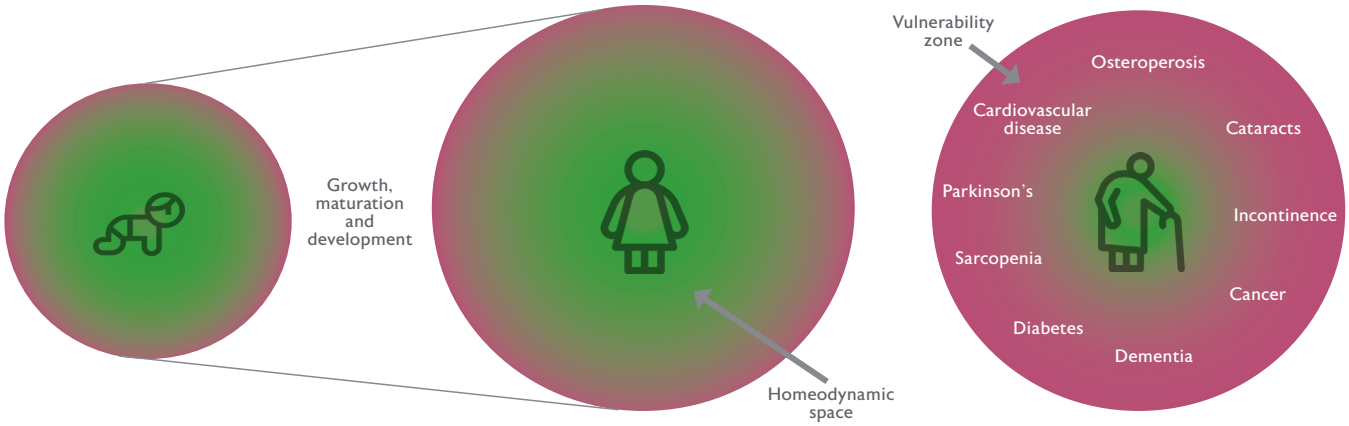
It is very important to remember that, as all other biological processes, the three components of the homeodynamic space have not evolved to be perfect, and are prone to the occurrence and accumulation of molecular damages. Such imperfections of the molecular processes, along with a progressive increase in entropy as ordained by the second law of thermodynamics, are the ultimate reasons for the failure, collapse and demise of a living system. The duration of the maximum lifespan of an individual and the timing of its death are only indirectly determined by the limitations of the longevity assurance genes comprising the homeodynamic space. Evolution has not selected for any self-destroying and ageing-causing gerontogenes. At the genetic level, ageing is the failure and/or dysregulation of the longevity assurance gene networks, and is manifested in the shrinkage of the homeodynamic space.

Health and hormesis

Health could be defined as a state of absolute physical and mental independence in the activities of daily living (ADL), which, however, is an idealised and unattainable condition. Being healthy in practical terms, therefore, means having adequate physical and mental independence in ADL – a state that may vary widely but can be established objectively. Furthermore, this pragmatic definition of health allows and encourages the use of all kinds of medical, nutritional, technological and other strategies for maintaining, facilitating, recovering and enhancing health. Healthy ageing thus implies having adequate independence in ADL, even in the presence of chronic diseases, which may be managed by biomedical, psychological, and societal interventions.

Ageing interventionary approaches that successfully have shown significant health-promoting effects are more or less holistic. Physical exercise, dietary habits, sleep pattern, and social and mental engagement seem to be the pillars of good health and longer survival. Such interventions have multiple, pleiotropic and cumulative effects, and cannot be reduced to some simple and linear relationships of one molecular target at a time. Hormesis is one such promising

Figure: Ageing as the shrinkage of the homeodynamic space



holistic approach towards health and ageing-modulation. Hormesis is characterised as the life-supporting beneficial effects resulting from the cellular and organismic responses to repeated and transient exposure to mild stress.

Moderate physical exercise is the paradigm for stress-induced physiological hormesis. Oxidative stress during physical exercise leads to the production of many more free radicals, acids and cell damage, in response to which the cellular maintenance and repair pathways become stimulated and not only protect from the damaging effects of stress but also initiate adaptive and health-beneficial processes. Similarly, low level, transient and repeated exposure to radiation, hyperthermia, hypothermia, nutritional deprivation, and numerous plant-derived metabolites induce physiological hormesis. All such conditions which can induce hormesis are now known as hormetins, and are effective under the general principle of 'stress of choice' as physiological hormesis. Hormetins can strengthen the overall homeodynamics manifested as enhancement of other abilities, including cognition, hormonal balance, immune response, memory, resilience and robustness.

Strengthening and maintaining homeodynamic space is an achievable goal for healthy ageing.

Suresh IS Rattan
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Forever changes: Another year on in community and primary care

In the March/April 2020 edition of the BGS Newsletter, as the pandemic was gaining pace and changing our lives forever, Rod Kersh's article *General reflection: A general physician and geriatrician in general practice* was published. A year on, everything is different, as he describes in this follow-up piece.

In a space of a few weeks, the relationships I was kindling with the older people in our surgery were transformed into harried phone calls and occasional text-messages. My morning clinics stopped.

In the beginning of the pandemic, I moved from working in the surgery Monday, Thursday afternoon and Friday to working for our integrated community trust full-time (Rotherham NHS Foundation Trust).

We took on more community beds and I was the responsible geriatrician.

I will not rehash all that passed - the familiar issues with PPE and COVID testing, the fear, anxiety and uncertainty.

Like many, the first wave of the pandemic although terrifying was also a period of great creativity and collaboration, buoyed along by a 'Dunkirk Spirit'; our community teams found alternative ways of working that had held us back for years.

Within days we had gone from hand-delivered prescriptions to emailed handwritten scripts, followed shortly after by SystmOne, demonstrating a never-before-known agility that allowed community prescriptions to be sent direct to pharmacies. Zoom was taking off, I held meetings with doctors in training, community matrons and others,

Outside Athorpe Lodge local care home where the intermediate care unit is based

Rod taking his PCR test

supporting a rollout of admission avoidance documents – person-centred and developed with patients or their relatives to help keep people out of hospital (as distinct from the blanket 'do not admits' we heard about in the media). Regular community team meetings allowed us to support one another.

When summer arrived, I returned to a very different surgery.

I can't remember when I decided it was safe for me to go back to the care home, realising that the potential harm and miscommunication working via Zoom and WhatsApp Video then MS Teams was greater than the risk I posed myself or my patients from infection.

In my care home, we had successfully passed lockdown one then two without a single case of COVID; it was only when a patient who had not transferred to the care of our practice (via the Enhanced Health in Care Home NHSE programme) was admitted to hospital with constipation and returned with COVID that we were affected.

Six residents died.

During this outbreak I did visit the care home. By this time I was visiting two other homes on a weekly basis (our intermediate care facility and our step-down red beds). I was PCR testing once a week as well as near-patient testing.

I heard rumours that some GPs were not visiting their care homes at all beyond video calls and paramedic hot visits arranged by the GP Federation.

During the summer, in the surgery, we recruited two more GPs and a third returned from maternity leave. We became a training practice and work was becoming sustainable again – we no longer had locums and I could feel the quality of care, a factor of continuity of care, increasing.

At the start of this year, I was appointed director of the newly established Community Division in Rotherham, ending a decade of community subservience to general and acute medicine where the ways of working and needs of our patients were managed alongside A&E, AMU and other acute specialties. I dropped a day in the surgery and now only work Thursday afternoon and Friday.

I spend much of my time speaking with patients, carers and relatives. I often feel guilty, as I am able to spend time with the husbands and wives of those who are locked out of the care home.

In this past year, I have signed too many death certificates. I have had too many conversations about death and dying. I reviewed our data on the number of my patients dying in our intermediate care facility – out of 48 deaths, 45 were in the community with what I believe was high quality end of life care. All had admission avoidance documents, unnecessary drugs and treatments were stopped, and relatives were facilitated to visit. I completed my first community mortality review, something hospital colleagues have been undertaking for years.

How many anti-hypertensives, hypnotics and anticholinergics have I discontinued since last March? The care homes now know to record lying and standing blood pressure without me asking – something I could only dream of happening in hospital.

I have one patient who after a year in the care home on a Fast Track pathway, enquiring as to her prognosis; I arranged a repeat CT that showed that her metastatic pancreatic cancer had disappeared. She thinks I am great; we now just have to sort her out-of-control diabetes.

In geriatric medicine, at least when working on wards or in acute clinics, longer-term relationships with patients are their families are not a hallmark of the service. I now know and am on first-name terms with many of my patients and their sons and daughters; I receive emails enquiring about outcomes of tests or assessments.

I have developed relationships with local authority staff as we talk on our weekly calls, establishing ways to support care homes. I have seen that the acute hospital, like the NHS juggernaut, is slow to change and develop. Our community services are agile and constantly open to innovation and growth.

My hopes for the future? I would like community medicine to be on an equal footing with hospital medicine. I'd like a trainee, I'd like to do more, keep more people out of hospital, manage greater complexity, respond more quickly. I will not begin to predict or anticipate what will happen in the next 12 months. Perhaps we will still be picking up the pieces - not of the pandemic but of the consequences of the lockdown, the lonely and socially isolated people, and the deconditioned. Perhaps the hospital might have gained a better understanding of the value of community services in facilitating reductions in length of stay, in maintaining flow.

Perhaps.

Rod Kersh
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British Geriatrics Society
Improving healthcare for older people

BGS

Spring Meeting 2021

28-30 April 2021, ONLINE

The **BGS Spring Meeting 2021** will be held in association with the **Irish Gerontological Society**.

The meeting will cover core competencies such as Dementia and related mental health topics, have a focus on innovations in digital health and explore acute stroke medicine.

It will also be a forum for the latest scientific research and the best clinical practice.

This conference will cover core areas of interest to all specialists responsible for the health care of older people.

For the latest information visit www.bgs.org.uk/events

Upcoming Regional BGS Meetings

Trent Spring Meeting 2021
22 April 2021
www.bgs.org.uk/events/trent-spring-meeting-2021

SW Thames Spring Meeting 2021
20 May 2021
www.bgs.org.uk/events/sw-thames-spring-meeting-2021

Mersey Region Spring Meeting 2021
16 June 2021
www.bgs.org.uk/events/mersey-region-spring-meeting-2021

BGS Scotland Spring Meeting 2021
16 June 2021
www.bgs.org.uk/events/2021-scotland-spring

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