NEWSLETTER

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THANK YOU

Whether you are caring for older people, redeployed, delaying training, conducting research, sharing good practice, supporting colleagues or shielding. We thank every single BGS member for the vital role they play.

In this issue

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President's column

Since I wrote my last column for the *BGS Newsletter*, we have seen the world in which we live change almost unrecognisably.

I could never have imagined when I started my presidency that the BGS focus from early 2020 would be on a new pandemic that affects older people disproportionately, and that we would have to cancel our Spring and other conferences and re-prioritise our efforts.

As the global COVID-19 pandemic has taken hold, entire nations, health systems and individuals across the globe have had to adapt and react at incredible speed to do whatever is possible to tackle the emerging situation, testing their skills, strength, determination and resilience to its very limits.

Nowhere has this been felt more acutely than for those involved in the healthcare of older people – and for you, our members, many of whom have been tackling the pandemic at the front line, dealing with the most vulnerable and susceptible patients both in hospitals and in the community.

There are also those of you who are working tirelessly behind the scenes to undertake research, to support colleagues or to contribute to co-ordination or management efforts.

For many of us, we have witnessed the way in which we work change dramatically and quickly. Transformations which might have previously taken months or years have suddenly occurred in a matter of days. Restructuring of services and redeployment or upskilling of staff, , have seen the NHS completely transform in just a few short weeks.

'It is with deep sadness that we have learnt that fellow members of our BGS community are among those lives that have been tragically lost.'

'I am very proud to see that BGS members have risen to the challenge with resolute determination, making a marked difference to the response effort for this disease through their many and varied roles.'

The statistics on mortality make sobering reading, and it is with deep sadness that we have learnt that fellow members of our BGS community are among those lives that have been tragically lost. I have personally written condolence letters to the families of those healthcare professionals, that we are aware of, who have been treating older patients and have themselves died with COVID-19. Please let us know of anyone in our community you know has passed away in such sad circumstances.

I was also very saddened to hear of the recent death of Professor Archie Young who had been one of the UK's leading academic geriatricians prior to his retirement. I had the pleasure of meeting Archie several times as I supervised his wife Susie Dinan's PhD, and he was one of the most humble and nice men one could find. A full tribute to Archie will be published in the next edition of the *BGS Newsletter.*

In the immediate weeks that follow, our priority must be to continue to see older people through this pandemic as best we can. To continue to innovate, collaborate and communicate with our colleagues to ensure the best possible outcomes for our patients and for each other – and in particular, continuing to understand what positive outcomes for older people living with frailty look like. The central role of advance care planning and end of life care conversations for all our patients and their families is as important as ever.

I am very proud to see that BGS members have risen to the challenge with resolute determination, making a marked difference to the response effort for this disease through their many and varied roles. Many members have also worked hard to produce high quality guidance and information alongside their escalating clinical duties. This has been widely used by colleagues to help them to deliver the best care for their patients at this challenging and unsettling time. Our resource series on 'Coronavirus and older people' (**www.bgs.org.uk/COVID19**) has been accessed more than a quarter of a million times, highlighting the central role of older people's healthcare and the valuable contribution of BGS members during this pandemic.

Eventually, this pandemic will pass, and in the months and years that follow we must not let society or leaders forget how seriously older people have been affected by this crisis. The BGS will continue to fight hard to ensure that the basic proponents of good care for our patients are properly resourced and informed, raising standards of care through research, education and sharing good practice. We owe it to our patients, both those who have emerged from the pandemic and those who we have sadly lost, to be prepared to fight anything on this scale which ever again threatens to affect them so terrifyingly and so devastatingly.

We call on you, as members of the BGS, to help us in this task. You have been outstanding in your response to this crisis, but our work doesn't end there. As a community of multidisciplinary health and care professionals, we will continue to be needed as essential voices advocating for the value of excellent care for older people.

Older people need more than ever to be seen as valuable members of society, whose outcomes, aspirations and quality of life are not assumed by an arbitrary age cut-off point. The BGS has acted promptly whenever we have come across any evidence of ageism during the pandemic, whether it was misuse of the Clinical Frailty Scale in local clinical pathways or an inappropriate poll in a well known journal about prioritising treatment for younger people.

The excessive deaths in care homes have been tragic. The initial UK response to protect the vulnerable care home population was totally inadequate, with too little and too late action in terms of testing and appropriate PPE. We have strongly lobbied key people in the NHS and used the media to advocate for older people and we have worked closely with other influential organisations such as the Royal Colleges. We are working with the National Clinical Director for Older People to get the Ageing Well part of the NHS Long Term Plan programme back on track and indeed we are lobbying for the timescales to be brought forward.

Now that the peak of the curve has passed we are also aware of the need to counter the negative consequences of the lockdown on many older people, particularly the physical deconditioning and the mental health issues arising from social isolation and loneliness. The BGS is trying to influence government to be proactive on these issues and also lobbying terrestrial television to develop programmes specific for older people to encourage safe physical activity and exercise.

We need to ensure that our patients have access to a properly resourced NHS and are provided with a lasting solution to the crisis in social care, to ensure that they are as well supported as possible for as long as possible.

We must also continue to lobby for optimal support to healthcare and care workers in the hospitals, rehabilitation facilities, community and care homes who are involved in caring for older people, and that includes appropriate PPE for all for as long as it is required.

Finally I would like pay special thanks to all the BGS office staff who have been working from home but have been as active as ever to keep the BGS wheels running, often working through weekends when we have had to comment on and deal with urgent issues that have arisen in the public domain.

I would like to end with a special THANK YOU TO ALL OF YOU for being MAGNIFICENT in these unprecedented times. This issue is dedicated to you.

Professor Tahir Masud
President, BGS

Care homes after COVID-19: Let's work together

This reflection on the historical context which led to the current social care crisis and the devastating impact of COVID-19 in care homes was originally posted by immediate past BGS Scotland Chair, Patricia Cantley, as a thread on Twitter.

How did we end up in this situation, with care homes so vulnerable and unsupported?

It's worth remembering some of the history here. I started my training in Geriatric Medicine back in 1992 and there were some pretty major changes happening around then. I'm going to quote some information from The Kings Fund - I hope I get it right, but very happy to be challenged.

There was a revolution in service provision as a result of the 1989 White Paper, Caring for People, (enacted in the 1990 Community Care Act) which declared that local authorities should be the brokers and care managers of social care, but not necessarily the direct providers.

This led to a huge growth in the independent sector, which now provides the majority of state-funded residential care and 69% of adult domiciliary care contact hours, compared with just 2% in 1992.

Private nursing homes were springing up all over the place in the early 1990s to meet this new need. Or, viewed more in economic terms, to corner this new market.

The old NHS 'long term care' facilities were shutting, and as I started to get my first lessons in NHS management, I learned that there was to be 'resource transfer' from the NHS, to Social Care, to help fund people in these new care homes, and also (ideally) in their own homes.

Of course, both sides felt hard done by. The NHS needed to keep some money from closure of long term hospitals, to provide for people who might need to return for acute care - and Social Care Departments found themselves trying to do a 'loaves and fishes' job to make the money go round.
Both were right of course. People did return for acute care (there was a junior Registrar who presented this at a BGS meeting in 1995...! Who could that be?), but the growth in the need for social care was huge, and increasing. It was a recipe for trouble.

Of course, this wasn't a black and white issue - some of the old NHS facilities were pretty ghastly! And the idea of supporting more people at home or in more homely environments was a good one.

Many lovely care homes developed, often with small numbers of residents. The rules about everyone having modern facilities and en suite bathrooms came later, so a lot of these homes really did feel like proper homes.

Also on the positive side, many more people were supported at home with 'packages of care.' The care sector blossomed and matured from the days of the 'home help' as the carers started to do more and more personal care for their charges.

Not everyone was happy though. A proportion of the population was now being asked to fund their own care. Those with enough money in the bank were now expected to meet the costs of the care home they were moving to. Unlike the 'free at point of need' NHS hospitals.

Many of those people were the very same ones who had bought their council houses in the Thatcher years, not so long before. They were shocked that they were now considered to have assets, which would be taken into account to pay for care. (That hadn't been part of their plans...)

There are lots of political aspects to this, but the end result was that a whole lot of people were in new institutions, funded variously on a private basis, or from government via social care. These places were now completely divorced from NHS care and oversight (with some exceptions).

'It's only recently, in my experience, (in the last decade or so) that the NHS and councils have really woken up to the fact that we need to help the care homes who are struggling.'

Many of the smaller care homes have of course since closed, and ironically, the ones remaining are often large institutions with remarkably similar numbers to those pre-1990s NHS hospitals.

I've become aware over the last few years of some wonderful examples of care homes and how well they look after their residents. Just have a glimpse at the work of **@CoxonGeorge** **@weejenhen** and others to see heartwarming stories of a great quality of care home living.

Likewise, medical care has moved on from the random inputs of several different GPs into each home on an ad hoc basis (another Registrar project in 1996!) and most care homes have a relationship with a local GP practice. Again some great examples, e.g. **@KeebleM** and **@DavidAttwood12**.

However the basic premise remains that the money for care in the nursing homes comes from a mix of private and social care funds, channelled to the private provider of that care home.

It's tricky to provide high quality care on the council funds alone, so most have a mix of incomes.

The provider has to meet a whole lot of high standards these days, set by Care Commission and others, pay a decent wage to their employees, and yet also set a competitive rate for their 'customers.' That's a really hard ask.

It's only recently in my experience (in the last decade or so) that the NHS and councils have really woken up to the fact that we need to help the care homes who are struggling.

They are now as much part of the system as the old hospitals used to be. Lose them and the system collapses.

So we have support teams, and inreach teams and all sorts of 'special measures' teams - but the homes are still (mostly) privately run. So there's a divide. Who provides dressings for people with wounds, etc? It's blurred at the residential/nursing care home edges.

And all the while, we're arguing politically in the background over how to fund this system. There are so many options, but none of them are cheap. The care homes struggle on, outside the NHS, but now with people so much more dependent than the ones from the 1980s hospitals.

Until now, in 2020, when the system is under more strain than ever before. And then on top of that, arrives the COVID-19 virus. The nightmare begins.

I could talk endlessly about all this, and I haven't even touched on the issues faced by those with learning disabilities and who are in care from a younger age.

Something needs to change though after this chapter in history. But what? Wouldn't it be nice if we could create a better tomorrow out of all this?

People are now starting to think about care homes, who is in them and how they aren't just amorphous older people. They are mums, dads, aunties, uncles, grandparents and friends. Rightly we are grieving.

In grief, there is denial, then anger, blame and regret.
Let's work through these and when we get to the harder stages of resolution and acceptance, let's try to look at care homes in a new way. As real homes, looked after by colleagues caring for our older citizens.

Let's work together.

Patricia Cantley
Consultant in Medicine of the Elderly, Midlothian Health and Social Care Partnership; Former Chair, BGS Scotland
@Trisha_the_doc

New BGS guidance: *End of Life Care in Frailty*

Covering the final year of life in people living with frailty, new BGS guidance addresses issues such as uncertainty, advance care planning and law and ethics, as well as management of common symptoms and considerations for specific settings. It is the result of 18 months' work involving more than 30 contributors.

Co-Editor of the guidance, Eileen Burns, explains the scope and need for this resource.

Most of us will die in old age, and currently many of us will not have been prompted or given the opportunity to reflect on our wishes regarding the end of our lives.

In society and healthcare today, death is often seen as a failure, and yet we will all die. The rise of single organ specialism and technological healthcare has led to improvements in survival but also to people living for longer with multiple conditions. Sometimes the narrow view of specialism may lead to clues missed and to time and resources wasted in pursuit of the wrong goals.

Where do we wish to die? As we perhaps develop frailty, how do we wish our doctors, nurses and other care givers (including family members and friends) to respond to our needs?

Will the healthcare we receive be appropriate and in keeping with the optimisation of our comfort, with an overt recognition that we are coming to the end of our lives?

'Recognition of severe frailty is an indicator that consideration of the wishes of the patient regarding their care and advance care planning (if not already commenced) needs to begin.'

Too often the clinical response to an acute deterioration in a frail older person is a protocol or pathway-driven move into an invasive - and sometimes distressing - interaction, without pause to reflect on the values of the older person.

What is their understanding of their current situation? What is their preferred approach? Good end of life care cannot be provided by a single service or indeed by healthcare alone, as it involves the person, their family, their friends, carers and the cultural context in which they have lived and wish to die. At all times we must strive to put the person at the centre of our decision-making and construct services to suit them not us.

The aim of this guidance is to support clinicians and others in considering the needs of and providing high quality care for frail older people as they move towards the end of their lives. It aims to prompt and support timely discussions about preferences for care, ideally at a time which facilitates the input of the older person themselves.

If the older person lacks capacity, the section on ethics and law in this area provides clarity as to who must be consulted and the principles which guide decision making.

Uncertainty is frequently present in prognostication for frail older people. We may have evidence that this person belongs to a group of individuals for whom there is a 50% likelihood of death within the next 6 or 12 months, but such tools cannot accurately identify the risk of death for any given individual.

Many of us will be familiar with the conversation with a family regarding the uncertainty of outcome and risk of proximity to death when a family may tell us that this is the third or fourth time a doctor has told them their mother is likely to die. However, older people themselves tell us they value honest open communication with a recognition of uncertainty when it exists.

Recognition of severe frailty is an indicator that consideration of the wishes of the patient regarding their care and advance care planning (if not already commenced) needs to begin. Patients with severe frailty have a high risk of death within the next 6 months. Higher risk of death is seen in frail patients in the community (whether within their own homes or living in care homes), and in acute hospital admissions. Thus, recognition of severity of frailty is an essential complementary part of identification of risk of death.

There has been a huge growth in the literature on frailty over the last 10 years. Patients presenting with falls, 'off legs' and delirium are frequently living with frailty. These patients are often prescribed multiple medications with high risk of adverse drug reactions. They are at increased risk of unwanted effects of an acute hospital stay (inpatient delirium and falls, pressure injury, malnutrition and incontinence).

The disciplines of geriatric medicine and of palliative care share many of the same values and aims. Both are firmly rooted in person-centred care and both aim to improve quality of life for the recipient of care, utilising the skills of a multidisciplinary team. Comprehensive assessment, case management and collaborative working are core to both.

'Uncertainty is frequently present in prognostication for frail older people.'

Geriatric medicine strives to restore and optimise function, especially after an acute deterioration. In palliative care more emphasis is laid on symptom control and the alleviation of psycho social distress and spiritual concerns. Integration of the skills of both areas with the aim of enabling the older person to live as well as possible, with the highest level of independence and with optimisation of management of troublesome symptoms provides the best opportunity for the maintenance of physical and cognitive function and autonomy (including important decision making around end of life care) for as long as possible – where possible until the time of death.

We hope to bridge the gap between geriatric medicine and palliative care and to address the particular issues which may affect older people dying with frailty - some of which may not be considered part of the usual remit of either specialty. The care of older people in the last phase of their lives is provided by a wide range of individuals. Spouses and other family members, supported by district nurses and GPs, are often the main providers of care. Specialists such as geriatricians and palliative care consultants working in multidisciplinary teams may also have a significant role within the community, hospital or hospice settings.

The aim of this guidance is to provide practical advice to help those staff working with frail older patients so they can provide their patients with the best opportunity to live and die well.

Eileen Burns
Consultant Physician and BGS Past President
@ EileenBurns13

To access the new guidance *End of Life Care in Frailty* in full, visit www.bgs.org.uk/EOLCfrailty

Join the new End of Life Care Special Interest Group (SIG)

To coincide with the release of the guidance on End of Life Care, BGS has also launched a brand new Special Interest Group (SIG) for those who have a particular interest in issues around the end of life in older people.

Chaired by Prem Fade and Caroline Nicholson, the SIG is hoping to bring together similarly interested members to take forward the issues raised in the guidance and participate in wider conversations with stakeholder organisations.

How to join

1. Visit the SIG page at **www.bgs.org.uk/eolcsig**.
2. Click the pink '**Join the SIG**' button. (This will be on the right hand side of the page if using a desktop or laptop PC, or towards the bottom of the page if on a mobile).
3. Log into your BGS account (if not already logged in).
4. This will take you to the 'Update personal details & SIG membership' page. Scroll to the bottom of this page and select '**End of Life Care SIG**.'
5. Review your other SIG memberships and personal details on this page and update if necessary.
6. Click 'Save' at the bottom of the page. You are now a member of the SIG!

Remember that you can join as many SIGs as you like, and you can change these at any time by following the steps above or by going to your '**My Account**' page.

The paper boat

We have chosen the image of a paper boat to illustrate our End of Life SIG and guidance. But why a paper boat?

In July 2018, we published a blog by Patricia Cantley, the then-Chair of BGS Scotland, entitled 'The paper boat.' In it, she describes an analogy for frailty that she uses with relatives:

"*When I am talking to a family member about their older relative, I sometimes liken their clinical situation to a fragile yet beautiful paper boat sailing round a pond of their choice. If the weather were to remain fair with barely a trace of wind, then there was no reason to think that the boat would go down, and indeed it might sail on for quite a while."*

"If, on the other hand, the wind got up, or worse, if it started to rain, that frail wee boat would go over quite quickly with little we could do to save it."

This gentle analogy for the of end of life in frailty resounded with many of you, and it remains one of our most-shared blogs to date.

To read Patricia's blog, visit: www.bgs.org.uk/blog/the-paper-boat.

EuGMS Congress in London postponed by a year

BGS members will know that London was to have been the location for the three-day annual conference of the European Geriatric Medicine Society (EuGMS) in November 2021, with the BGS acting as the local host.

The EuGMS Congress will now take place in London in November 2022 instead.

COVID-19 has inevitably disrupted plans for many events, and that includes the next EuGMS Congress which was due to take place in Athens in Autumn 2020.

The EuGMS has therefore taken the decision to shift the location of its next three annual conferences back by a year. Therefore, in October 2021, the Congress will now take place in Athens.

BGS President Tash Masud had been working with various BGS members to plan sessions for the EuGMS Congress in London. Now that the London Congress has been delayed to September 2022, the preparation of sessions has been paused and will resume again a year from now.

The exact September 2022 dates for the Congress at the ExCel Centre in London will be confirmed soon.

Please note that in light of the EuGMS decision to defer its London Congress, the BGS plans to adjust the locations of its own conferences in Autumn 2021 and 2022. As soon as dates and venues are confirmed, we will let you know.

Sarah Mistry
CEO, British Geriatrics Society
@SarahMistryBGS

BGS in the media during the COVID-19 pandemic

The COVID-19 pandemic has significantly raised the public profile of geriatric medicine and the work of professionals specialising in the care of older people. Recently the media has been eager to explore many of the issues central to older people's healthcare that had previously been overlooked.

The Society has reacted to this increased interest by providing BGS spokespeople to appear on a variety of high-profile media outlets including 5 News Tonight, Channel 4 News, the BBC Today Programme, the Telegraph and the Sunday Times.

While the pandemic has created some unique opportunities to communicate the Society's core values and our members' expertise to a wider audience, this spotlight also comes with inherent risks. As an apolitical organisation we must be incredibly cautious about putting forward spokespeople for interviews where they are left no option but express an opinion about political concerns, on behalf of the BGS. We also have wider a duty of care to maintain a balanced, education driven narrative which does not feed into misinformation or public panic.

Behind the scenes, guiding the decision-making process, is our responsibility to protect the reputation of our members, the specialty and the Society. This responsibility has always been central to our engagement strategy with the press, but it has never been more salient. Poor decisions when dealing with the media have the potential to harm our relationships with key stakeholders, and our credibility with decision makers. During this period of increased public interest, we have declined some high-profile media opportunities, but all the potential benefits and risks were carefully considered before doing so.

During this critical period for older people's healthcare, we will continue to publicly advocate for the issues important to our members, and engage with the media in a friendly, productive and positive manner. We are incredibly proud our spokespeople and we would like to thank them for their energy, hard work and willingness to speak on behalf of the BGS during this critical time for older people's healthcare.

These are some highlights of how the BGS, and its spokespeople, have been engaging with the press during the pandemic. We will continue to keep you up to date with all the latest media developments via **@gerisoc** on Twitter and in our regular e-Bulletins.

BGS media highlights since the start of the COVID-19 pandemic:

BGS President, Professor Tahir Masud, was quoted in the ***Telegraph*** on 10 March discussing COVID-19, visits to older people and the delivery of medicines in the event of any enforced self isolation.

BGS President, Professor Tahir Masud. was interviewed on ***Channel 5 News Tonight*** on 12 March discussing COVID-19, general medical advice and extra precautions older people can take to stay safe.

BGS President, Professor Tahir Masud, appeared on ***Channel 4 News*** on Sunday 29 March discussing COVID-19 and the importance of remembering older people are individuals and chronological age should not be the sole deciding factor regarding treatment.

Dr Mark Roberts, Chair of BGS Northern Ireland, BGS Blog 'Facing a new reality – challenges for acute care of older people' was quoted in the ***Telegraph*** article 'Fearful families of elderly coronavirus patients insist they remain in hospitals' on 21 March.

Dr Mark Roberts, Chair of BGS Northern Ireland, was interviewed on ***BBC Radio 4*** 'Inside Health' on 1 April discussing COVID-19 and the importance of getting the 'right patient to the right place at the right time' regardless of their age.

Professor Adam Gordon, BGS Vice President for Academic Affairs, was quoted in the ***BBC News*** article Coronavirus cases 'in half of Scottish care homes' on 11 April. He discussed the importance of remembering that care homes are communities, and that loneliness and social isolation can result in worse health outcomes for older people.

Former BGS President, Professor David Oliver, wrote an opinion piece for the ***Financial Times*** 'The intensive care unit is not the best place for all Covid-19 patients' that was published on 18 April. In the article he discusses why public moral outrage about limiting medical treatment in some coronavirus cases is misplaced.

BGS President, Professor Tahir Masud, was quoted in the ***MyLondon*** article 'London coronavirus: 24 brave London NHS workers who have died of COVID-19' regarding the death of BGS member Dr Anton Sebastianpilla. He was quoted saying "Dr Sebastianpillai had worked for more than

40 years in geriatric medicine and was a devoted and respected geriatrician. On behalf of the British Geriatrics Society, I send sincere condolences to Dr Sebastianpillai's wife and son."

An excerpt from ***BGS's 'Quest for Quality'*** guidance was published in the **Telegraph** article 'Why Britain ended up as the one of the worst in the world at fighting coronavirus - the experts' views' on 1 May.

Former BGS President, Dr Eileen Burns, was quoted in the ***HSJ*** article 'The Ward Round: The NHS shuffles its workforce pack for covid phase 2' on 1 May. She is quoted saying "How do we deploy the scarce resource of the geriatricians between an acute hospital where covid and standard geriatric presentations are coming in and thinking and planning for geriatric input in the community".

Former BGS President, Dr Eileen Burns, was interviewed on the ***BBC Radio 4*** Today programme on 3 May discussing COVID-19, government advice for over 70s to take extra precautions and why all older people are 'not exactly the same'.

Former BGS President, Dr Eileen Burns, was quoted in the ***Sunday Times*** article 'Coronavirus lockdown: set free healthy over-70s, say doctors' on 4 May. She is quoted saying that while there was a case for frail older people to be shielded for longer, those who were free of any underlying health conditions might not be prepared to sacrifice "one of the precious years they have left on the off-chance that might mean they don't pick up the virus".

Professor Adam Gordon, BGS Vice President for Academic Affairs, was interviewed on ***BBC Radio Cumbria*** discussing the difficult balance between protecting care home residents from infection while also ensuring they can exercise and have human interaction.

BGS member Dr Graham Ellis was interviewed on *BBC News* on 7 May discussing Hospital at Home, the benefits for patients and how the service has been expanded in light of the COVID-19 pandemic.

Chair of BGS Northern Ireland, Dr Mark Roberts, was interviewed on ***BBC Newsline*** and quoted in the BBC article 'Coronavirus in care homes' on 8 May discussing COVID-19 and the importance of remembering that for some older people compassionate, person-centred care is end of life care.

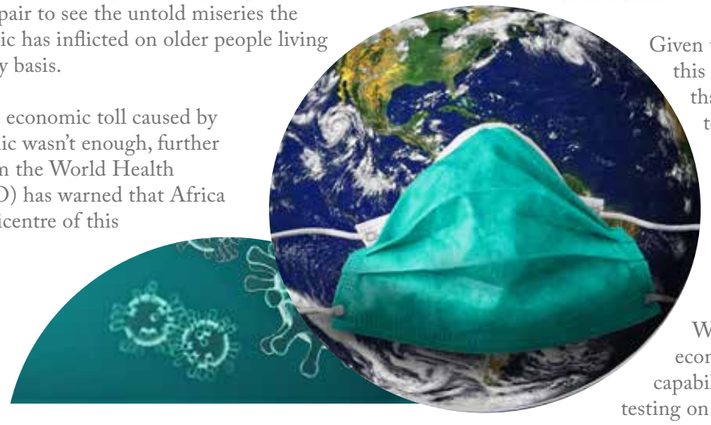
Marina Mello
Communications, PR and Media Manager

COVID-19: What the world can learn from a global crisis

Is there anything we learn as a result of the coronavirus pandemic about how international collaboration could help reduce global health inequalities, asks BGS member Rajesh Dwivedi.

Working as a geriatrician in a large teaching hospital, I have felt beyond despair to see the untold miseries the COVID-19 pandemic has inflicted on older people living with frailty on a daily basis.

As if the human and economic toll caused by this virulent pandemic wasn't enough, further depressing news from the World Health Organization (WHO) has warned that Africa could be the next epicentre of this current pandemic.



According to UN officials, it's likely the coronavirus pandemic could kill at least 300,000 people in Africa and push nearly 30 million into poverty.[1]

Having spent my youth in India, I am only too aware of the existing inequalities in health, living and working conditions between developed and developing economies, which have been cruelly exposed by this pandemic.

This virus respects no borders, affecting both the rich and poor with equal vengeance.

As is often the case, the preparedness and priorities of all the nations are slightly different depending on the stage of the pandemic in their respective regions, healthcare infrastructure, economy and their current demography.

Each country seems to be in a race against time to procure more testing kits, personal protective equipment (PPE) for their healthcare professionals, ventilators, drugs, etc - with the world becoming an open market where the highest bidder owns access to some or most of the facilities, as the happenings of the past few weeks and months have shown.

'Can any nation emerge as a victor from this pandemic until the very last infected case has recovered, regardless of whether this case is from the northern or southern hemisphere?'

While this has been an opportunity to witness researchers working together in international collaboration, what we are also seeing are countries conducting their own research in silos in order to win their individual battle at a time when people are dying across the globe.

But can any nation emerge as a victor from this pandemic until the very last infected case has recovered, regardless of whether this case is from the northern or southern hemisphere?

Needless to say, COVID-19 has vehemently exposed how unprepared the world has been to deal with a pandemic on such a scale.

Given that we are all in this together, isn't it vital that the world comes together as one global unit to fight this virus and be better prepared to deal with the next that might be just lurking around the corner?

While developed economies have the capability to carry out mass testing on their population to identify, isolate and treat those who are unwell; other nations simply cannot afford mass testing because of their prohibitive costs and the bottlenecks incurred in the supply of reagents necessary for testing at a time when most of the nations are vying to obtain this capability for their population.

The only realistic option for the less developed economies, therefore, is to prolong their lockdown in an attempt to flatten the curve as their poor health infrastructure isn't prepared to tackle a full blown outbreak. The resulting economic recession and deteriorating livelihoods means rising poverty, malnutrition, poor health care outcomes and loss of lives of both the young and the old.

The WHO has drawn some harsh criticisms regarding its handling of this pandemic, with its funding withheld by a major contributor which could further limit its effort at this crucial juncture.
With the utmost of respect for all the painstaking work done by WHO over the years, it's important to realise that this organisation is dependent on voluntary contributions

'Given that we are all in this together, isn't it vital that the world comes together as one global unit to fight this virus and be better prepared to deal with the next that might be just lurking around the corner?'

by major economies to sustain its role, which is more of a technical and advisory nature rather than in the actual organisation and management of such pandemics.

It has never been more important than now for the world to unite to create a global system of surveillance, detection testing, and pharmacological response through the creation of an international task force which can deal with future pandemics for the benefit of all the nations.

The current arrangement where each nation, rich or poor, is left to fend for herself isn't suitable to deal with this or any future pandemic. Such an international task force should include representatives from all the countries with funding in proportion to each country's Gross Domestic Product (GDP).

The main objectives should be early and independent survey of an outbreak, central co-ordination, and distribution of protective equipment throughout the world in proportion to extent of the outbreak and prompt multicentre enrolment of patients in Randomised Controlled Trials (RCTs) of potential treatments as well as piloting vaccine development in different parts of the world so that its not left to the whims of a privileged few or the greed of a giant pharmaceutical company to make it unaffordable for the masses as the world will fail again.

It's time that the developed economies join Africa and Asia standing as equal partners and build international solidarity at this crucial juncture. A global body representative of a major chunk of the world population such as G20 is aptly suited to lead this task force with enhanced power to prosecute nations with sanctions if transparency is not observed.

Going by the happenings of the past few weeks, the last thing the world needs is to accept the current status quo which will only be a harbinger of the next, possibly more lethal, pandemic.

Reference

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Rajesh Dwivedi
Consultant Physician in General and Geriatric Medicine and Honorary (Consultant) Assistant Professor, University of Nottingham School of Medicine

Coronavirus and older people: Top five BGS COVID-19 resources

Since mid-March, BGS has published 14 resources on the COVID-19 pandemic, which have been accessed more than 250,000 times. The series can be viewed at: www.bgs.org.uk/covid19

1 Managing the COVID-19 pandemic in care homes for older people

The COVID-19 pandemic raises particular challenges for care home residents, their families and the staff that look after them. This guidance has been developed by the BGS to help care home staff and NHS staff who work with them to support residents through the pandemic.

2 Coronavirus: Managing delirium in confirmed and suspected cases

Some of our members were alerted to difficulty in managing patients with delirium testing positive with COVID-19. This consensus advice was drawn up by experts from the BGS, the Royal College of Psychiatrists and the European Delirium Association. It should be used in conjunction with local policy and governance practice employed within your own organisation.

3 Coronavirus: Current information and advice

As part of our duty of care to members and others working on the frontline of older people's healthcare, we are sharing advice and guidance about the outbreak of coronavirus. This is a compilation of current official UK/global advice and publications relating to the worldwide outbreak of COVID-19.

4 BGS statement on the COVID-19 pandemic

As the COVID-19 pandemic gathers pace in the UK, the BGS has issued this statement for healthcare professionals on the particular issues that older people face in relation to the virus and the importance of maintaining high-quality patient care.

5 COVID-19: Dementia and cognitive impairment.

This brief guidance was developed by Alistair Burns, National Clinical Director for Dementia at NHS England/Improvement, and has been incorporated into NHS England publications. This guidance is applicable to those with dementia and anyone with cognitive impairment resulting from conditions which affect the brain.

Examining ageism in the health and social care sector

Luke Price is an Evidence Manager at the Centre for Ageing Better. The Centre's recent report, *Doddery but Dear*, summarised what existing research tells us about the role and impact of language and stereotypes in framing old age and ageing in the UK. In this article, Luke discusses some of the key findings.

The age profile of our society is rapidly changing. Within 20 years the number of people aged 65 and over will have increased by more than 40% and the number of households where the oldest person is 85 and over is increasing faster than any other age group.[1] Despite this profound demographic change, ageism is still rife - with one in three people in the UK reporting that they have experienced age prejudice or age discrimination.[2]

Recent events have thrown this figure into sharp relief, with narratives surrounding COVID-19 often drawing on ageist stereotypes to suggest who is and who isn't worthy of care.

Ageism is a combination of how we *think* about age (stereotypes), how we *feel* about age (prejudice) and how we *behave* in relation to age (discrimination). As well as affecting our attitudes and behaviours to others, it can also affect how we feel about our own process of ageing[3] and can have wide-ranging negative consequences.

Drawing on a literature review conducted by the University of Kent for the Centre for Ageing Better, this article looks at some of the evidence found on ageism in the health and social care sector. While most of the evidence was quite negative, this doesn't mean that examples of good practice don't exist. In fact, if anyone reads this and thinks "we are doing this differently" then please do get in touch as we'd love to hear more.

What's in a stereotype?

Much like other 'isms', ageism is often premised on stereotypes, which can be positive and/or negative. A combination of different stereotypes can lead us to think, feel or act differently towards those that we perceive as 'other'.

Broadly speaking stereotypes about later life and ageing in the UK tend to be more negative than positive, regardless of context. There are two different forms that stereotypes can take: descriptive and prescriptive.

Descriptive stereotypes represent assumptions about what we think an individual or group will be like. In the context of later life, we might assume that older people are more polite[4] at the same time as thinking that they are less physically able.[5] Older adults are therefore often seen as being likeable (warmth) but having low competence (see Figure 1) – exemplified by the cliché of them being 'doddery but dear'.

Prescriptive stereotypes represent assumptions about how we think an individual or group should (or shouldn't) behave. Common examples of prescriptive stereotypes include the notion that older people must pass on power to younger people, that older people shouldn't consume too many resources, and that older people should not engage in activities that are seen as traditionally for 'younger' people.[7] When older people go against these prescriptive stereotypes, they can face criticism or 'backlash'[8] which can lead to social exclusion.[9]

Ageism in the health and social care sector

Like in most other societal contexts, attitudes towards older people in the health and social care sector are predominantly negative.[10] This is often premised on ideas such as ageing being a process of inevitable decline and death, and stereotypes of older people as generally likeable (high warmth) but frail, weak and/or overly dependent (low competence).[11] This mixed evaluation can lead to seemingly benevolent but ageist behaviours in healthcare settings, such as patronising or infantilising talk and dismissing older patients' concerns.[12]

Research shows that many people, including health professionals, see pain and ill-health as a natural and inevitable part of getting older.[13] This leads to age being seen as a proxy for health, which can lead to a variety of negative consequences; for example, older people are more likely to be over or under medicated for pain management than other groups, less likely to be screened for sexually transmitted diseases or substance abuse, and less like to be on organ transplant lists.[14]

> 'Older people are more likely to be over or under medicated, less likely to be screened for sexually transmitted diseases or substance abuse and less like to be on organ transplant lists.'

Due to the pandemic, healthcare professionals are having to make a whole host of difficult decisions. However, it is of the utmost importance that these decisions are not influenced by bias – conscious or otherwise – in order to ensure the best outcomes for older adults.

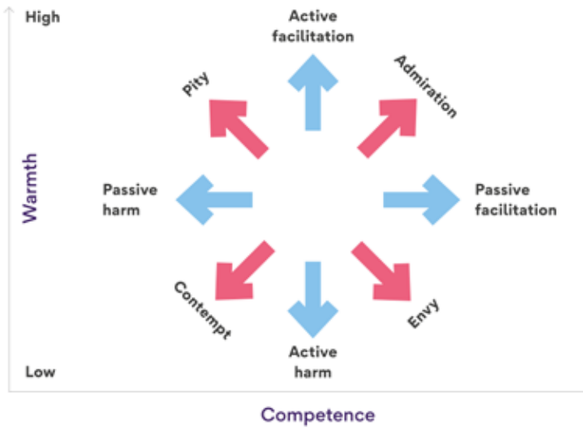
Negative stereotypes about those in later life can also become internalised by older people themselves. For example, it might lead to someone not believing that they can recover from a certain illness and therefore influence engagement with rehabilitation and other health-related behaviours.[15] Some research has also found an association with having a younger subjective age and better health, potentially implying that those who view their own ageing process more negatively may end up with worse health outcomes.[16]

Conclusion

Much like the rest of society, negative ideas about what it means to be old are fairly common in the health and social care sector, which can have potentially huge negative effects on those in later life.
In order to ensure that older people get the best care and support they possibly can it is imperative that we consider our own (sometimes unconscious) biases that might affect the way in which we think about and act towards those in later life.

However, combating ageism is not just an individual effort: properly addressing the issue will require action at an individual, systemic and societal level.

Figure 1. The Warmth/Competence stereotype and behaviour matrix[6]



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Luke Price
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Improving hydration in older people

The Wessex AHSN Healthy Ageing Programme works with partners to add value to the ageing well agenda by evidencing and sharing best practice. Over the past two years, they have undertaken a number of projects aimed at improving hydration in older people living in the community. Consultant Dietitian, Annemarie Aburrow, explains their approach.

In 2018-19, Wessex Acedemic Health Science Network (AHSN) ran a project in collaboration with Hampshire County Council (HCC) with the aim of improving hydration and associated outcomes with residents in 17 HCC-owned care homes. Based on the successful approach used by the 'Hydrate in Care Homes Project' developed by Kent Surrey Sussex AHSN,[1] it focussed on recruiting and training 'Hydration Champions' within each home to raise awareness of hydration, and actively encourage staff and residents to work together, with a focus on fun and creativity. We also provided regular support workshops to keeps homes engaged.

Rather than recommending a set amount of drinks per day, we promoted 'optimal' hydration - achieving the best possible level of hydration for an individual dependent on their current circumstances, even if this didn't lead to optimum hydration.

The project resulted in a small improvement in slips, trips, falls, and fractures relating to falls, although data limitations made it a challenge to conclude that this was a result of this project.

Qualitative data, however, showed improvements in wellbeing of residents (including improved mood and engagement) and staff hydration.

Improving hydration in domiciliary care

While working on the care home project, HCC also raised the issue of hydration in people receiving domiciliary care at home, and asked us to collaborate with them on a project to adapt the approach to this setting. We worked with two agency branches in Hampshire, providing training to their care staff and linking the 'Reliance On a Carer' (ROC) hydration care assessment tool[2] to appropriate care. Evaluation of the Droplet smart hydration system,[3] a drinking reminder, was included. We are currently analysing the data from this project, and while we may not be able to demonstrate improved outcomes, we will report on the unique challenges of this setting. We will also be publishing

Hydration inspiration!

Here are some fun and creative ideas you could try out in your setting, which could include community settings and acute wards.

Smoothie rounds
Get creative with different recipes each day. Themed days worked well - e.g. Milkshake Mondays, Tutti-fruiti Tuesdays, Smoothie Saturdays, Sundae Sundays.

Smoothie-making competitions
If you have the space, get patients/residents creating their own recipes with a range of ingredients. You could even make this into a recipe book.

Themed hydration stations (drinks trolleys)
These could include things like freshly made mocktails and a fruit kebab hedgehog.

Structured drinks rounds
Prioritise at least seven different opportunities for drinks rounds each day to help increase the chance of improving fluid intake.

Time for tea at 3
Staff and patients/residents enjoy a hot drink at 3pm together. This is a chance to sit down together and may help improve engagement and communication.

'Hydration is such a basic part of care, but one which is often sadly overlooked - it is everyone's responsibility.'

recommendations for others who plan to run similar projects in this setting.

E-learning toolkit

During the face-to-face hydration training to carers in care homes and domiciliary care, it became clear that while carers thought they already knew about hydration, there was still a lot to learn and many myths to debunk. It was apparent that a more flexible and accessible way of training was needed to be sustainable longer term.

In 2019, we carried out a scoping exercise to understand the most engaging format for carers. As a result, we have created a new E-learning toolkit, which includes a basic module on hydration, links to recommended resources, Grandad's Story (a case study video on how easy it is to become dehydrated), and a leaflet for the public. It aims to promote clear, simple and relevant evidence-based messages. While the toolkits aimed at community carers, it is suitable for all carers, including those in acute care settings.

Conclusion

We hope that the new E-learning module and associated toolkit will be taken up widely. While it is aimed at community carers, the key messages are also suitable for staff working in acute settings. Hydration is such a basic part of care, but one which is often sadly overlooked - it is everyone's responsibility.

For more information, please visit:
wessexahsn.org.uk/hydration-at-home

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Annemarie Aburrow
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Hydration myths

Although it is well known that drinking enough fluid is important for everyone and especially older people, there are many misconceptions around hydration, drinking and thirst.

Thirst is a good indicator of whether an older person needs a drink: FALSE

The sense of thirst reduces with age, so an older person does not necessarily feel thirsty when they are becoming dehydrated.

Urine colour is a good indicator of hydration status: FALSE

While urine colour can be a useful indicator of hydration status in younger people, research shows that there is no correlation between urine colour and dehydration in older people.[4] The use of urine colour charts in particular is not appropriate in this age group. This is because as kidneys age, their ability to concentrate urine reduces. In addition, many older people will be on medications that affect the colour of their urine.

In fact, while a range of signs are traditionally used to identify dehydration (e.g. tiredness, confusion, headache), research[4] has shown that none of the commonly used clinical signs and symptoms usefully discriminated between people with or without dehydration.

Instead, we should assume that all older people are at increased risk of dehydration, and should be promoting good hydration at every opportunity. Dehydration in this age group is most commonly related to reduced intake which is often chronic. Consequently, the only way to definitively identify this is to undertake a blood test for serum osmolality.

Water is the most hydrating drink: FALSE

You don't just have to drink water - there are plenty of alternatives. All non-alcoholic drinks (and alcoholic drinks with less than 4% alcohol content, e.g. low alcohol beer) count towards your fluid intake.[5] There are lots of options to make drinking fun and creative, e.g. fruit juices, smoothies, milkshakes and fizzy drinks.

Caffeinated drinks like tea and coffee may irritate the bladder, and increase the frequency or urgency of passing urine, so choosing decaffeinated versions may help.

Avoiding drinking reduces night-time incontinence: FALSE

Not drinking enough can produce concentrated urine which irritates the bladder, increasing urgency and frequency Someone may initially need the toilet more often after increasing the amount they drink, but this should settle after a few days.

Cultural and spiritual aspects of end of life care in Sikh patients

Providing sensitive and appropriate care to older people at the end of life is not only vital to the experience of the older person themselves, but to their family, friends and wider community. Sumanjit Gill explains some of the considerations that may be appropriate when caring for older people of the Sikh faith.

Last year I had the opportunity to represent the Sikh community in a discussion about end of life care in differing religious groups in the United Kingdom. I am indebted to the guidance given by the lead for the Sikh Chaplaincy, which is a voluntary service that attempts to provide a service to all in patients across the UK.

I hope that by writing this article I can share some of this knowledge and help to improve the care of dying patients for those of the Sikh faith and culture.

History of the Sikh religion

Sikhism is a relatively young religion – it was founded just 550 years ago by the first guru, Guru Nanak. It began at a time of great conflict in India between Muslims and Hindus, and while it started as a spiritual movement it developed with time (and nine further Gurus) into a strong military force determined to protect the human rights of all individuals to practice and live by whichever faith they had chosen.

It is based on the principles of universal fraternity, equality, service, social justice and is a monotheistic faith. The Gurus may have worked miracles but they were not to be worshipped, and deification and ritualism were discouraged, as was the cruelty of the caste system.

The identifiers of the Sikh faith are the '5 Ks' - Kara (steel bangle), Kesh (uncut hair), Kangha (comb), Kacha (shorts) and Kirpan (sword) which historically provided them with a distinctive appearance, which reduced confusion when in battle and also created a sense of belonging.

‘There is nothing in the scriptures which forbids organ donation and this is open for discussion, although there is a strong cultural resistance to this which may not be easily overcome.’

Key considerations

- Provide early clear communication about the end of life and signpost issues which may arise around feeding, fluids, pain management.
- Broach the subject of resuscitation early and encourage advanced decisions.
- There is no religious reason to refuse organ donation so this can also be discussed.
- Ask the family if they would like to be referred to a Sikh Chaplain for additional support.
- If there is a language barrier use a translator rather than a family member wherever possible.
- Ask for a named representative of the family to lead on communication with the medical team.
- Produce a death certificate as quickly as possible.
- For a predicted weekend death then ask the on call team to see the patient whilst they are alive on Friday to avoid delays.
- Arrange for a side room so scriptures may be recited or played as an audio recording.
- Ensure kitchen staff are informed to ensure vegetarian meals are provided.

The centre of worship is the Golden Temple in Amritsar, Punjab which has become the most visited tourist attraction in the world, generating millions each year, and it remains the seat of power and authority as it houses the Akal Takht (throne of the timeless one).

Sikhs are vegetarian and one of the hall marks of the gurdwara (Sikh temple) is the free kitchen which provides food for those from any background, feeding millions of people every year.

There was failed attempt to appropriate this by the Indian army in 1984, infamously ending in the assassination of Indira Gandhi which has fuelled ongoing tension in India and calls for an independent Sikh state. Over time the Sikhs built their empire – Maharaja Ranjit Singh was the most well known king, who fought in two world wars and managed to hold on to their land and wealth (which included the Koh-i-Noor diamond) until British colonialism and partition triggered one of the largest massacres and numbers of displaced persons of all time.

Sikhs now number 30 million in total, make up 2% of the population of India and have settled all over the world, with 432,000 living in the UK. Most Sikhs in the UK are from the Punjab region of India or East Africa and tend to be Punjabi-speaking, with the largest populations in Leicester, North West London, Bradford and Leeds. They have the highest rate of private home ownership of any community and are over-represented in professions such as IT, Medicine and Law.

‘The end of life is thought to result in either reincarnation or the attainment of moksha, and the soul is enabled to do this by the recitation of scriptures as the person is dying.’

Families and older people

Families are large, have a complex structure and can provide social and financial support. Traditionally, children would be expected to provide care for elders within multi generational households. With Westernisation, this system is now in flux, which can at times cause conflict - but the original value system has held for many of the post-immigration generations.

Discretion about family matters is valued, but unfortunately an unwillingness to disclose information does harbour the potential for abuse to go denied or hidden. On a more positive note, there is strong emphasis in the religion on the equality of women and (dependent on the socio-political climate of the culture they are living within) women are to be respected in the same way as men.

The place of worship is a gurdwara which is a hub for the community in addition to providing free meals, library services and faith-based teaching.

Medical and end of life care

The Sikh community, while valuing life, do not tend to hold strong held beliefs about resuscitation or palliative care – this is open for discussion and there is an acceptance of Western medicine and the authority of medics within their field. There is nothing in the scriptures which forbids organ donation and this again is open for discussion, although there is a strong cultural resistance to this which may not be easily overcome.

The end of life is thought to result in either reincarnation or the attainment of moksha (ascension and release of the soul) and the soul is enabled to do this by the recitation of scriptures as the person is dying which can be provided by the family, a community elder, an audio recording or a Sikh chaplain. During this time attention should be paid to maintain the '5 Ks' and cleanliness to maintain purity.

After death the body is washed and dressed by close family members and cremated as soon as possible in a formalised ceremony which involves an open casket.

Sumanjit K Gill
Consultant at the Royal Free NHS Trust & University College London Hospital; Senior Teaching Fellow at University College London

Embedding a prevention of delirium system in routine ward care

A recent study published in *Age and Ageing* outlines a system of care to help prevent hospital delirium in older people. One of the study's authors, Dr Elizabeth Teale, explains more.

About 20% of the nearly 6 million older people admitted to hospital every year in the UK will experience delirium. This is an unpleasant experience for patients and their families, and is associated with poor outcomes. Prevention of delirium is therefore highly desirable and there is research evidence to suggest that delirium can be prevented by about one third, using multicomponent interventions that target delirium risk factors in hospitalised patients.

However, the research studies are mostly 'proof of concept,' single centre and non-randomised. Ideally, the evidence base should be predicated on large, multi-centre, pragmatic, randomised trials: that is, robust 'real world' evidence. Moreover, although National Institute for Health and Care Excellence (NICE) delirium guidelines advise that delirium prevention multicomponent interventions should be offered to people at risk of delirium in hospital, there is little advice on how this might be achieved in terms of implementation, delivery or content. To address these issues, we developed the Prevention of Delirium (POD) system of care. The work was funded through an NIHR Programme Grant for Applied Research and comprised a sequence of three studies to develop (Project 1), pilot test (Project 2), and then provide preliminary evidence of effectiveness (Project 3) of the intervention. POD is based on the Hospital Elder Life Program (HELP), predominantly in use in the US, augmented by the NICE guideline. Our work involved developing methods for implementation and delivery of POD that could be locally adapted and embedded in routine ward care. In this way, we hoped to achieve successful and sustained introduction of the new system of care without the need for new resources.

In the current edition of *Age and Ageing*, we report the findings from the feasibility trial (Project 3), including a separate paper that describes aspects of adherence to POD in routine care. The study consented 714 patients at risk of delirium in 16 wards (elderly care and orthopedic trauma) located in eight NHS hospitals. We are grateful to the patients and local staff who agreed to take part.

'We found that nearly three quarters of the patients on elderly care and orthopaedic trauma wards were at risk of delirium.'

The study is one of the largest randomised trials to investigate a multicomponent delirium prevention intervention, and the first successfully concluded multi-centre trial. There were several unknown issues in the design and conduct of a study of this complexity and it was therefore purposefully designed as a pragmatic feasibility trial. Thus, the trial does not provide a definitive answer to the question 'does the POD system of care reduce delirium incidence compared with usual care?' Instead, our study examined some practical and methodological questions: can the intervention be implemented into routine care, and what are the key factors influencing this; is it possible to recruit and retain sufficient at risk older people; is it feasible to collect the proposed outcome measures; and, what is the estimate the number of patients and centres required for a future definitive trial?

The POD system of care was presented in a handbook format but with an emphasis on local learning and flexible adaptation through study sessions, audits and development of local materials. We found that implementation of POD in a multi-centre context was possible. Adherence to the intervention was medium or high in all but one of the eight wards randomised to receive the intervention. Key factors affecting implementation had been identified in our earlier work and included: adequate staffing levels as recommended by the Royal College of Nursing and NICE; a named person responsible for the implementation process; and, dedicated time (one day per week for three months) of a senior experienced nurse to lead the changes in ward practice.

The overall consent rate was 16% and we demonstrated that performing a definitive trial to evaluate POD is achievable in a population of hospitalised older people at risk of delirium. We found that nearly three quarters of the patients on these elderly care and orthopaedic trauma wards were at risk of delirium.

The primary outcome was new cases of delirium as assessed by the Confusion Assessment Method (CAM). We were able to train 37 research assistants to perform the CAM (and other outcomes) assessments. The CAM was collected on 90% of the specified occasions. The adjusted odds ratio for delirium incidence for the patients randomised to the POD system of care compared to usual care was 0.68: that is, a reduction of delirium by about one third. This finding is entirely consistent with previous studies, however, the 95% confidence limits were unsurprisingly wide (0.37 to 1.26) as the study was not powered to provide a definitive evaluation of POD. Indeed, a definitive cluster randomised trial would need to be far larger than any previous study. We calculate that a future definitive cluster randomised trial would need to recruit 5,220 patients in 26 two-ward hospital clusters. Although this would represent a substantial trial, we have demonstrated that it could be done.

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To read the full Age and Ageing article, *A multicentre, pragmatic, cluster randomised, controlled feasibility trial of the POD system of care*, go to https://tinyurl.com/podage

BritishGeriatricsSoc @GeriSoc
BREAKING NEWS! 'Protecting older people from **#COVID19** must not come at the expense of their health and wellbeing', warns the British Geriatrics Society

Twittersphere!

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

Yvonne Chun PhD @DrYvonneChun
@YoungGeris Geriatricians have both broad and specialist skillsets that make us in demand more than ever! **#proudtobeGeriatrician**

BritishGeriatricsSoc @GeriSoc
Nurses contribution during **#COVID19** has shown how the profession is at the forefront of healthcare innovation and had a greater impact on patient care than ever before **#IND2020 #InternationalNursesDay2020**

Adam Gordon @ adamgordon1978
Care Homes featured in BMJ News last week and this week @thelancet - we must use this increased focus on the sector to ensure that the necessary support is in place ahead of any future COVID surges

Annabel Rule @annabelrule
Call out the many therapy teams providing additional support to care homes as part of covid response! Do you have any experiences, resources or outcome measures that could be shared? Keen to chat! **@theRCOT @thecsp @GeriSoc**

Bola Owolabi @BolaOwolabi8
With many thanks to @GeriSoc for the amazing support in the development and publication of this important resource for care home staff caring for people at increased risk of falling. Very much appreciated. Please share with your networks https://tinyurl.com/fallsposter @AgeingWellNHS

BTS @BTSrespiratory
COVID-19 page update. We have published the new BTS guide to follow-up respiratory care for patients recovering from COVID-19 pneumonia, and updated our Guidance on Venous Thromboembolic Disease **http://bit.ly/3a6Dr5L**

laramitchell @laramitchdr
Talking about dying is hard-many of us will have to have these conversations. Here's a framework, concepts + phrases to support health + care staff in open, honest + compassionate conversations. Full 7 min video here: **https://vimeo.com/404554818 #COVID @SQSFellowship @openchangeuk**

Charlotte Squires @CharSquires
I'd love to see more BGS blog submissions from nursing and AHP colleagues - please consider picking up a pen/keyboard to share your expertise. Student submissions are also extremely welcome.

Anne Hendry @AnneIFICScot
Thanks to colleagues for contributing to our international Delphi on intermediate care in collaboration with @Advantage_JA and **@IFICInfo** special interest group. So timely as we seek to scale new models of care. **https://rdcu.be/b4hnW**

Cliff Kilgore @kilgore_cliff
As a consultant in older people's healthcare I have been impressed by many advanced practitioners who have stepped into extended roles due to covid 19. I am trying to collate data on this and would be grateful if any would share their work with me **@GeriSoc @theRCN @RCNOPF**

Atypical COVID-19 presentations in older people: The need for continued vigilance

Dr Tarun Solanki is a Consultant Geriatrician at Taunton and Somerset NHS Foundation Trust and National Council Chair of BGS England. He has been involved in geriatrics for almost 30 years with a broad range of experience in the speciality. In this BGS blog, which has been viewed 30,000 times since it was published in April, he explores some of the atypical presentations of COVID-19 in older people.

The landscape of healthcare has dramatically changed as a consequence of the COVID-19 pandemic. All acute trusts, primary care organisations and social services have had to remodel their working patterns in order to manage the rising number of patients with COVID-19. Many staff will have been redeployed to areas which may be unfamiliar to them. This is true for senior and junior medical staff, nursing staff, allied health professionals and support staff on the wards.

The majority of systems will have specific areas where potential patients with COVID-19 are triaged. These triage areas are separate from the usual admissions areas in emergency departments, medical and surgical admissions units. In the UK, the current triage is based on presence of fever, cough, shortness of breath and fatigue.[1] In addition, it is recognised that some patients may present with anosmia. Such patients, if requiring hospitalisation, will be admitted to a specified COVID-19 cohort ward and all staff on these wards will be aware of the risk of infection transmission to them and to others. Furthermore, the staff will be aware of the need to ensure appropriate PPE is utilised as per the latest PHE guidance.

Geriatric medicine has always recognised that older people may not present with typical symptoms and it is apparent that this is the case with COVID-19. Furthermore, older people have also been recognised has having a greater risk of infection and death from COVID-19. While there is little research data, frontline experience both in the UK and in other countries suggests that many older people may present atypically and therefore slip through the triaging net. These patients are likely to be admitted to a general medical or a Care of Older Peoples ward. It is therefore important that staff on these wards are aware of the atypical patients and remain vigilant to the risk of infection.

COVID-19 results in a massive cytokine storm which results in a variety of symptoms including fever, fatigue, loss of appetite, myalgia and arthralgia, nausea, vomiting, diarrhoea, rash, tachypnoea, tachycardia seizures, headache, delirium, tremor and loss of coordination. On the basis of the pathophysiology of COVID-19 infection it is clear that its manifestations may be legion.

In a recent Twitter survey, the common atypical presentations reported in older people were delirium (hypo and hyperactive), diarrhoea, lethargy, falls and reduced appetite. Interestingly a number of respondents also reported that fever, cough and breathlessness were uncommon in older adults, and that even in the absence of breathlessness, hypoxia was a common feature.

Those with significant experience in dealing with COVID-19 patients have noted that even when there are other plausible causes of presentation, e.g. CAUTI, these patients turned out to be COVID positive. Another respondent noted that if there is even the slightest doubt over a negative COVID swab result, with ongoing clinical suspicion that the patient may have COVID-19, there should be no hesitation to repeat this after 24-48 hours.

Guidance from the Regional Geriatric Program of Toronto succinctly summarises the atypical presentations in older adults:[2]

- Typical symptoms of COVID-19 such as fever, cough, and dyspnoea may be absent in the elderly despite respiratory disease.
- Only 20-30% of geriatric patients with infection present with fever.
- Atypical COVID-19 symptoms include delirium, falls, generalized weakness, malaise, functional decline, and conjunctivitis, anorexia, increased sputum production, dizziness, headache, rhinorrhoea, chest pain, haemoptysis, diarrhoea, nausea/vomiting, abdominal pain, nasal congestion, and anosmia.
- Tachypnoea, delirium, unexplained tachycardia, or decrease in blood pressure may be the presenting clinical presentation in older adults.
- Threshold for diagnosing fever should be lower, i.e. 37.5°C or an increase of >1.5°C from usual temperature.
- Atypical presentation may be due to several factors, including physiologic changes with age, comorbidities, and inability to provide an accurate history.
- Older age, frailty, and increasing number of comorbidities increase the probability of an atypical presentation.
- Older adults may present with mild symptoms that are disproportionate to the severity of their illness.

> ‘Geriatric medicine has always recognised that older people may not present with typical symptoms and it is apparent that this is the case with COVID-19.’

On the basis of the current knowledge and experience it is important to recognise that presentation of COVID-19 may be atypical and patients may slip through the normal screening process and may inadvertently be admitted to a general medical ward rather than a COVID-19 cohort ward.

It is therefore imperative that all staff on such wards remain vigilant, ensure appropriate PPE is utilised as per the PHE guidance. It is also important that local guidance on managing such patients with suspected COVID-19 are adhered to. Furthermore, if the first swab test is negative and there is clinical suspicion of COVID-19 then it is important that a repeat test is requested.

This pandemic has resulted in very different working patterns for many of us and we may be working in areas which are unfamiliar. In order to ensure that we manage our patients appropriately and efficiently it is important to recognise the atypical presentations of COVID-19 and by doing so we can ensure we maintain the safety of patients and staff.

It is imperative that staff on general wards are appropriately trained to recognise these atypical presentations and also have the appropriate PPE to ensure their personal safety as well as their colleagues.

References

1. BMJ visual summary – COVID-19: remote consultations 25th March 2020
2. COVID-19 in Older Adults, University of Toronto

Tarun Solanki
Consultant Geriatrician,Taunton and Somerset NHS Foundation Trust; Chair, BGS England

Age and Ageing: Free collection of COVID-19 papers

***Age and Ageing* has received many submissions on COVID-19. We select what we publish on the basis of importance, novelty, quality of design and interest to geriatricians, and have maintained these standards for the papers we have included here.**

Time and circumstances have made it hard to undertake rigorous research on COVID-19 among older people, and we applaud those who have tried. We urge support for, and inclusion of, older people in WHO Solidarity, NIHR Recovery and other drug-treatment trials, and the principles underlying COVID-19 research and older people, published by the British Geriatrics Society. We also value reflections on practice, including from some leading names in geriatric medicine. Never before has the need to distill medical knowledge and share it widely at pace been so important.

Professor Rowan Harwood
Editor-in-Chief, Age and Ageing

Papers in this free collection include:

Clinical Review
- COVID-19 in Older People: A Rapid Clinical Review

Quality Improvement Report
- COVID 19 outbreak organisation of a geriatric assessment and coordination unit A French example

Case Reports
- Atypical presentation of COVID-19 in a frail older person
- Commentary
- COVID in Care Homes - Challenges and Dilemmas in Healthcare Delivery
- Ageism and COVID-19: What does our society’s response say about us?
- Frailty in the Face of COVID-19

Editorial
- Delirium: a missing piece in the COVID-19 pandemic puzzle

Letters to the Editor
- Can the COVID-19 crisis strengthen our treatment escalation planning and resuscitation decision making?
- Older people and epidemics: a call for empathy

To read the papers in this free collection, please visit: www.bgs.org.uk/covid19aaa

Training during the COVID-19 pandemic: Your questions answered

One result of the current COVID-19 pandemic is uncertainty about what will happen for those doctors currently in training. Geriatric Medicine StRs, and Internal Medicine Trainees and Foundation Year doctors are faced with challenges around exams, training and progression, which may be causing them considerable anxiety.

The BGS Trainees' Council committee and VP of Education, Professor Mike Vassallo have compiled some FAQs to help provide some clarity on what you can do, and what is being done to minimise the disruption to progression.

You can reach the chair of the Trainees' council committee, Dr Carly Welch, via **trainees@bgs.org.uk** or you can email Geraint Collingridge, as the BGS secretariat representative for the Councils' committee on **g.collingridge@bgs.org.uk**, with further questions or resources to share.

All doctors in training (StRs, clinical fellows, IMT, Foundation year doctors and medical students) who are members of the BGS are in the Trainees' Council.

The following areas are currently covered in the FAQs:

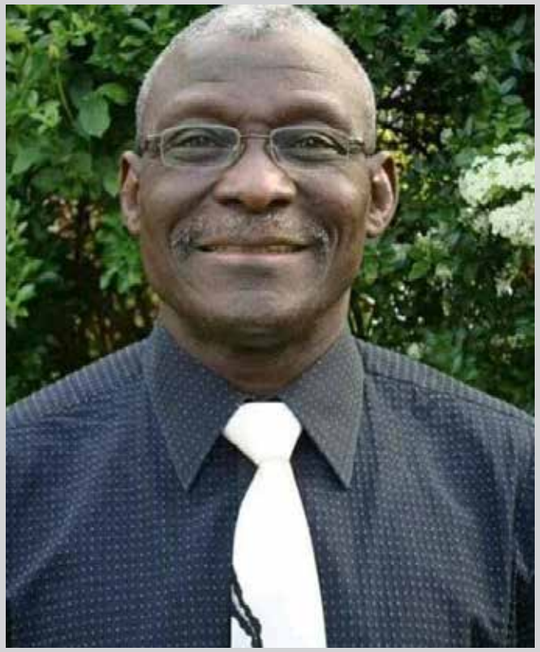
- ARCPs
- Competencies
- Curriculum Changes
- Redeployment
- Rotation
- Redeployment
- Replyment counting towards training
- Completion of training
- Training requirements not met
- PYA delayed
- New geriatric medicine ST3 posts
- Applications for St3
- Cancelled PACES exam
- ARCP competencies not completed
- Academic training
- Return to academic work
- COVID-19 research
- Out of programme
- Clinical service counted to training
- Return to OOP
- Cancellations of future OOP
- COVID-19 Training opportunities within Geriatric Medicine HST

For answers to common questions on these topics, please visit: www.bgs.org.uk/resources/covid-19-trainees-faqs

In memory of our BGS heroes

The BGS has been saddened to learn that some of our members have been among those who have been tragically lost to COVID-19. We pay tribute to the legacy of these heroic individuals and their lasting contribution to their patients and to the Society.

Dr Alfa Sa'adu



The BGS community was immensely sad to hear of the death in March of Dr Alfa Sa'adu from coronavirus. Dr Sa'adu was an eminent and committed geriatrician who had a long and illustrious career working in hospitals in Hertfordshire and London.

Dr Sa'adu was born in Nigeria and graduated from the medical school at University College London in 1976. He became a consultant and later acting clinical director of the department for care of older people at West Hertfordshire Hospitals NHS Trust.

He also worked as medical director and consultant physician at Ealing Hospital. He stepped down as medical director of the Princess Alexandra Hospital NHS Trust in 2016 and had been working part-time at the Queen Victoria Memorial Hospital in Welwyn, Hertfordshire.

He was a past President of the Royal Society of Medicine Geriatrics and Gerontology group, and was an active member of the British Geriatrics Society, having been Chair of the North West Thames Region and an examiner for the Diploma in Geriatric Medicine.

Devoted to furthering geriatric medicine both in the UK and Nigeria, Dr Sa'adu was a passionate and principled advocate for better healthcare for older people.

Paying tribute to Dr Sa'adu, BGS President Professor Tash Masud said: "We were heartbroken to hear of the death of our colleague, Dr Alfa Sa'adu. It is a measure of his commitment to caring for older people's health that he continued to work as a locum after retiring. He had worked in many different hospitals across his eminent 40-year career, and was an educator and advocate who enthused others with his love of medicine. We send sincere condolences to his family and to Dr Sa'adu's wide network of friends across the profession."

BGS Vice President for Academic Affairs, Professor Michael Vassallo added: "I am so shocked and saddened to hear this devastating news. I met Alfa on several occasions. His good humour, commitment and enthusiasm in promoting Geriatric Medicine and good patient care was inspiring. This is a very sad loss to the profession and his family, and his contribution will always be remembered."

Dr Medhat Atalla

It was with great sadness that the BGS community learned of the death of Dr Medhat Atalla on 22 April, following treatment for COVID-19. Dr Atalla was a hugely popular and respected consultant geriatrician practising at Doncaster and Bassetlaw Teaching Hospitals NHS Trust. He had been a member of the BGS since 2006. Below is an excerpt of a tribute from his colleagues at Doncaster Royal Infirmary.

Dr Medhat Atalla obtained his Bachelor of Medicine and Surgery Degree from the prestigious Ain Shams University in 1981. He practised medicine across three continents; Africa, Asia and Europe. Dr Atalla had been a Consultant Physician and Geriatrician at Doncaster Royal Infirmary since 2011. He was a Fellow of the Royal College of Physicians (Edinburgh). He was also an examiner for MRCP (UK) PACES examinations and enjoyed the role immensely.

Dr Atalla was greatly respected and loved by all who knew him. Dr Andrew Oates (Consultant Geriatrician & Clinical Director) had known Medhat since he was a Specialist Registrar in Geriatric Medicine. He remembers him as an extremely hardworking colleague who was very enthusiastic about his work and a quick learner. Dr Oates said 'he was a truly wonderful person to have in the department'.

Nursing staff fondly remember his personal touch. He addressed everyone he worked with by their name. He was very meticulous; he reminded the staff to record lying and standing blood pressures and would often chase staff with the observations sheet in hand to ensure it was competed which always made them laugh. Staff nurses always kept at least one tendon hammer hidden on the ward at all times available for his use. They say he had a great ability to make everyone comfortable, and his smile would light up the room. He always provided the best care for his patients, whilst taking care of the staff. He was their trusted friend and they knew it.

Dr Rekha Ramanath wrote "To me he was a very special friend and a fantastic colleague to work with. We worked together for the last 10 years in perfect harmony. He was a

gentleman, and addressed me and all his colleagues by our surname. He grinned cheekily every time I reminded him to call me Rekha rather than Dr Ramanath. He worked until he developed symptoms of COVID 19. He came to me when he needed assistance and considered me part of his close-knit family. I was with him holding his hand whilst he took his last breath. Our family from Egypt was with us on Facetime."

Dr Atalla deteriorated rapidly after developing symptoms of COVID-19. He was cared for by nurses and doctors who had worked by his side. He will be sadly missed, forever honoured and remembered by all of us.

BGS President Professor Tash Masud added in tribute: "We were fortunate to have someone of Dr Atalla's compassion and commitment providing such expert care for older patients. The lovely tributes paid by his colleagues clearly demonstrate the regard in which he was held. News of his death has been incredibly sad for his colleagues, patients and the geriatric medicine community across the country."

"During a career spanning many years and different countries, he demonstrated great commitment to improving healthcare for older people, and changed countless lives for the better. On behalf of the British Geriatrics Society, I send sincere condolences to his sister, brother and extended family in Egypt, and to all who knew him."

Dr Anton Sebastianpillai

The BGS learned with great sadness of the death in April of Dr Anton Sebastianpillai from complications of coronavirus.

Dr Sebastianpillai was an experienced geriatrician who had had a long association with Kingston Hospital in south west London as a consultant.

A spokeswoman for Kingston Hospital NHS Foundation Trust said: "It is with great sadness that I confirm the death of a consultant geriatrician who was part of the team at Kingston Hospital."

Dr Sebastianpillai completed his last shift on 20 March and was cared for at Kingston Hospital's intensive care unit until his death.

Dr Sebastianpillai did his medical training at Peradeniya Medical School in Sri Lanka and qualified in 1967. In an obituary notice, he was referred to as a "distinguished alumnus" who had authored an illustrated history of Sri Lanka.

In a tribute to Dr Sebastianpillai, Professor Tash Masud, said: "The loss of a doctor who spent his professional life caring for older people is heartbreaking news.

"Dr Sebastianpillai had worked for more than forty years in geriatric medicine and was a devoted and respected geriatrician. "

"On behalf of the British Geriatrics Society, I send sincere condolences to Dr Sebastianpillai's wife and son."

If you are aware of other BGS colleagues who have been sadly lost during this difficult time or want to pay tribute to the extrordinary work of any members of our amazing community, please do get in touch at editor@bgs.org.uk.

This year marks the 200th birthday of Florence Nightingale. Touched by the incredible work of our members and against the backdrop of the COVID-19 pandemic, BGS Office and Business Manager Mark Stewart was inspired to write the following piece of creative prose which is dedicated to all the healthcare professionals who continue to follow in Florence Nightingale's footsteps.

The Nightingale

She knew the truth of it. A tenet of her faith, of her very vocation. A lesson largely ignored. That Death comes to us all, good or bad, rich or poor. Dowsing the light as he approaches in silent stealth, extinguishing candle flames easiest of all, with bony fingers that none can deny. Until only the darkness remains, and the hooded face steeped in shadow, those two eyes like black suns, as polished as a raven's wing. Tunnels to a nether world from which none return. No starless night ever as bleak, no endless hour before a dawn that never comes. In such smothering totality, the merest spark, as of a star loosed from its orbit, a blessed reprieve.

Her light when it comes shining in that darkness like a summer dawn, drawing a whimper from lips that long ago abandoned all hope of prayer. Salvation delivered as much by her presence as by any medicine she may bring, remedies rationed thinner than food. Carrying the lamp, that imperishable article of her devotion, that not even her mortal foe can banish.

A solitary figure, lantern held high. An eye that sees all in pain. Mercy incarnate. Mother, sister, wife. A cool palm upon the brow, a hand upon the shoulder. A smile for the forsaken. The gift of humanity. A message delivered to every bed she visits. You are not alone.

She cannot save them all, for many have already lost too much. Limbs, eyes, their very intestines, the viscera without which no man is whole. Or have forsaken the will to live in this strange land so far from home with its fetid humours, where even the horses fall sick, overcome by maladies for which there is no cure.

And some never return from that valley of the dead. Cannons to the right, cannons to the left. Sending back only riderless mounts, eyes rolled white in terror at the things men do.

But she heals those she can. Never allowing her beacon to expire. The lamp chasing Death from the tent as the dawn does the night, banishing the stalker of souls, the redeemer of debts long overdue.

Her name known to all.

The nightingale that sings before the dawn.

God bless you, Florence. God save your soul.

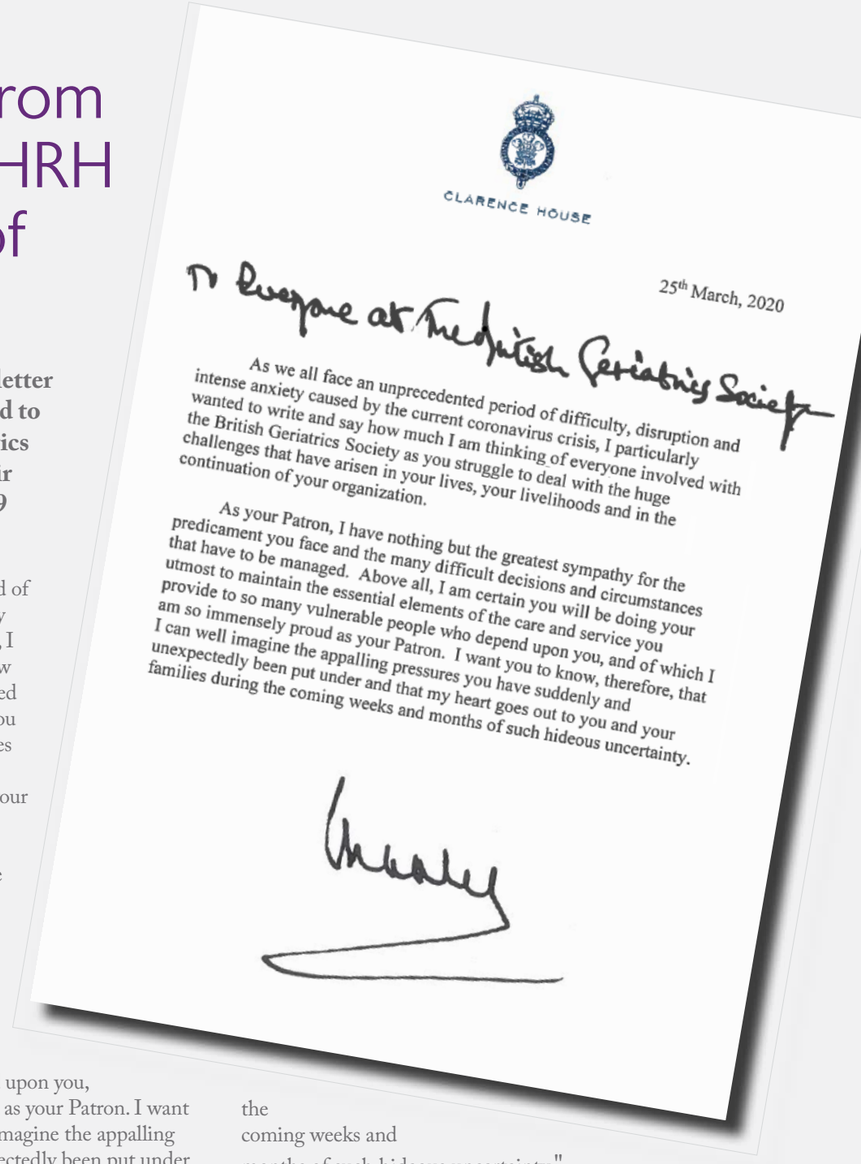
In memory of Florence Nightingale (1820-2020) on the 200th anniversary of her birth. And dedicated to all those healthcare professionals who have been doing so much to protect us all in the COVID-19 pandemic.

A message from our Patron, HRH The Prince of Wales

In March, the BGS received a letter from Clarence House addressed to everyone at the British Geriatrics Society, thanking them for their contribution to the COVID-19 pandemic. In it, he writes:

"As we all face an unprecedented period of difficulty, disruption and intense anxiety caused by the current coronavirus crisis, I particularly wanted to write and say how much I am thinking of everyone involved with the British Geriatrics Society as you struggle to deal with the huge challenges that have arisen in your lives, your livelihoods and in the continuation of your organization."

"As your Patron, I have nothing but the greatest sympathy for the predicament you face and the many difficult decisions and circumstances that have to be managed. Above all, I am certain you will be doing your utmost to maintain the essential elements of the care and service you provide to so many vulnerable people who depend upon you, and of which I am so immensely proud as your Patron. I want you to know, therefore, that I can well imagine the appalling pressures you have suddenly and unexpectedly been put under and that my heart goes out to you and your families during the coming weeks and months of such hideous uncertainty."



CLARENCE HOUSE

25th March, 2020

To everyone at the British Geriatrics Society

As we all face an unprecedented period of difficulty, disruption and intense anxiety caused by the current coronavirus crisis, I particularly wanted to write and say how much I am thinking of everyone involved with the British Geriatrics Society as you struggle to deal with the huge challenges that have arisen in your lives, your livelihoods and in the continuation of your organization.

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Looking after **your** wellbeing

We understand that the past weeks and months have been physically, mentally and emotionally challenging for our members, their colleagues, their patients and their loved ones.

We have included some resources on our website to help support your wellbeing in these challenging circumstances, but we are keen to hear from you to find out what else we can do to help you during these tough times and beyond.

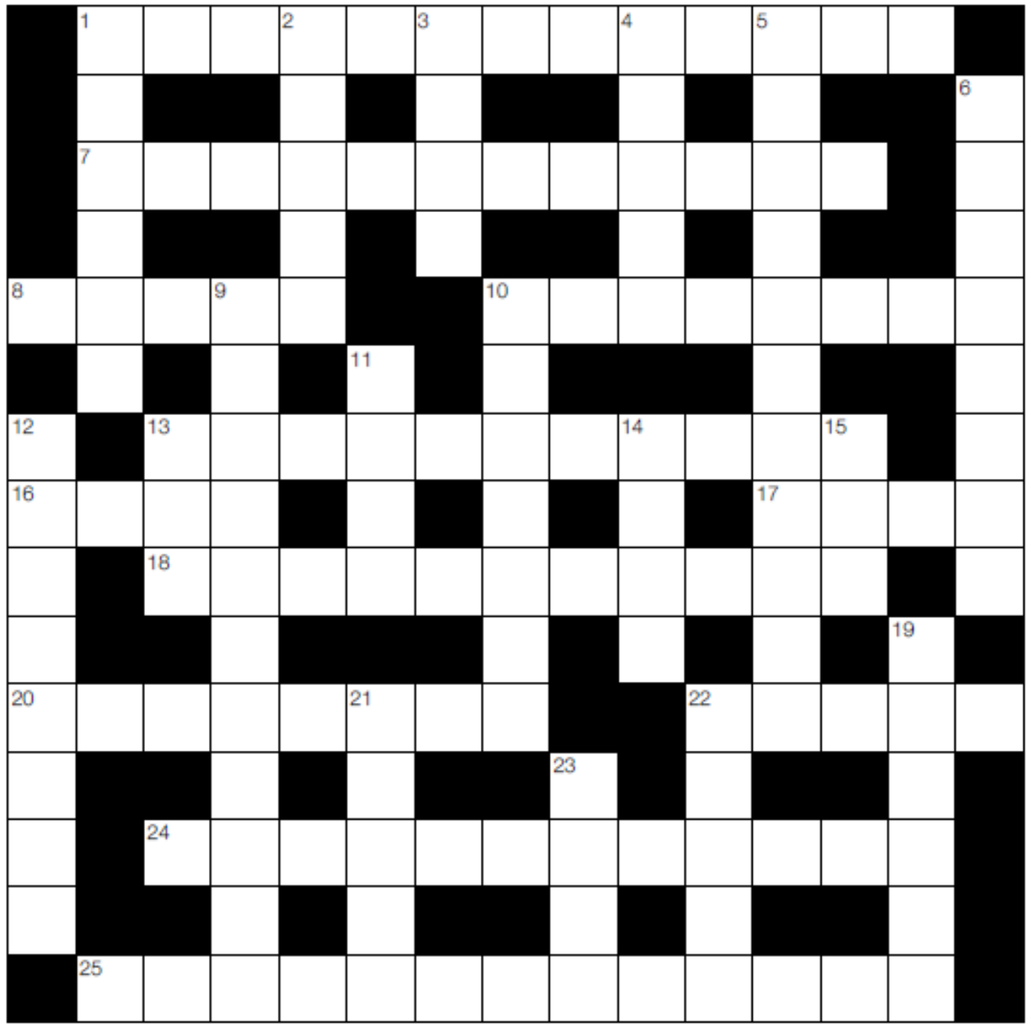
Some resources to support you

- **COVID-19: Health and care staff wellbeing**
  www.bgs.org.uk/resources/covid-19-health-and-care-staff-wellbeing
  This page provides links, resources and tools to help support personal wellbeing during a particularly challenging time for the health and care workforce.

- **COVID-19: Stress, coping and resilience**
  www.bgs.org.uk/resources/covid-19-stress-coping-and-resilience
  Scottish Quality & Safety Fellows, NHS Scotland, have put together some easy-to-follow tips on stress, coping and resilience during this difficult time which they have kindly allowed the BGS to share.

Geriatric cryptic crossword

Unwind with a cup of tea and a topical cryptic crossword compiled for the BGS by Gerontius. (Hint: Several of the solutions were founding fathers or mothers of British Geriatrics!)



Across

1. Founder is Little Woman in match maze (7,6)
7. Dodgy roll Ove threw for Founder (6,6)
8. Rule the sound of falling water (5)
10. Throw a sad dwelling (8)
13. Noble Founder might rule earldom (4,7)
16. Fibre care of Ireland (4)
17. River, thousand to consider (4)
18. Self-centred, I got elastic pants (11)
20. Left for dead? (8)
22. Broken timer has value (5)
24. A draft statue made into lipid (9,3)
25. Founder's pubs stayed after Mourinho? (6,7)

Down

1. Insect queen is parent (6)
2. German approves vehicle for Noah's grandson (5)
3. Unusual to be cooked like this? (4)
4. A dam, a bird (5)
5. Let go a note when it came out? (7,4)
6. Heats up before 1914 manuscript (3-5)
9. Founder was King six times and President twice (6,5)
10. Dazed and confused (7)
11. Cut and turn back tide (4)
12. Brummie, say, takes identity by mistake (8)
13. Relax, porky! (3)
14. Starting Leyton Orient odds cut (4)
15. Harper threw back fish? (3)
19. Boy detective hears toucans (6)
21. The hollandaise under my prawn starters could be a hit (5)
22. Make contents of commode leak (5)
23. Headless pagan needs scratching (4)

Solutions will be published online and in the next *Newsletter*. Let us know how you got on via Twitter by tweeting @GeriSoc. Good luck!

Notices

NOMINATIONS OPEN: BGS President Elect

The BGS is accepting self-nominations for the next President-Elect, who will serve a two-year term in the post ahead of two further years serving as President of the BGS.

This is a crucial, honorary role at the highest level of the Society. The post holder serves for 2 years as President-Elect, followed immediately by 2 further years as President. The precise responsibilities will be agreed between the new President-Elect and the President, and what follows is an outline of the role. As well as the duties outlined below, the President-Elect will be shadowing the President in preparation for her or his own term as President.

Self-nominations are invited for the post of President-Elect, to take office from 27 November 2020.

Prospective candidates (who must be full members of the Society) should self-nominate; there is no requirement to apply via your Region or Council. The only requirement is that a self-nomination must be supported, in writing, by at least five other BGS members who are eligible to vote at an AGM of the Society.

The candidate must submit a statement of consent, in writing, to the effect that: "I, XX, do hereby consent that my name be put forward for nomination to the post of President-Elect of the British Geriatrics Society for the period 2020-2022".

The statement of consent must be supported by statements of support from 5 other members of the BGS. These need to say: 'I support XX's nomination for the post of President-Elect of the BGS," and should be accompanied by a recommendation of up to 250 words detailing why the candidate, in the view of the supporting member, would be an effective BGS President.

If only one self-nomination which fulfils the rules is received by the closing date and time, that candidate will be deemed to have been elected unopposed. Should there be more than one nomination, a ballot of members will be held in June/July 2020. All candidates will be encouraged to submit a statement supporting their nomination, not exceeding 400 words, together with a photograph, which will be published on the BGS website as part of the election process. We will write to you on 16 June to request this if an election is going to take place.

Self-nominations and statements of support must reach the BGS Office & Business Manager, Mark Stewart (**m.stewart@bgs.org.uk**), no later than **5pm** on **Monday 15 June 2020**.

For a full description of the role and other important information regarding self-nomination, please visit www.bgs.org.uk/nominations-open-bgs-president-elect

BGS Meetings in 2020: Important information

The BGS plans to resume meetings from September 2020. We encourage delegates to register in advance if they plan to attend. You are currently able to join conferences virtually via a Livestream and Slido and we are developing a virtual event platform. If it becomes necessary, in line with guidance, to run events online only, please be reassured that we will contact registered delegates in advance, and you will be able to amend your registration or get a refund. For the latest information on the status of our events, please visit: **www.bgs.org.uk/faqs** and **www.bgs.org.uk/events.**

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