British Geriatrics Society
Improving healthcare for older people

Through the visor

Reflecting on member experiences of the COVID-19 first wave

Foreword

Pressure on the workforce providing healthcare for older people is nothing new. We have known for many years that we are not training enough people to care for our rapidly ageing population and this is something that BGS has long been concerned about. The COVID-19 pandemic has exposed workforce shortages and challenged healthcare professionals in ways we could never have imagined. A highly contagious virus that affects older people more than any other population group has meant that BGS members and their colleagues have faced situations beyond what they could have trained for or anticipated.

When we set out to conduct this survey, we were in what has turned out to be the calm between storms. The first wave of the pandemic had come to an end and although some areas were starting to see the second wave take hold, many told us that their services were returning to normal. While many of the concerns detailed in this report are about the practical aspects of managing a pandemic such as access to personal protective equipment (PPE) and COVID testing, the toll that the pandemic has taken on the physical and mental health of our members is obvious.

We will conduct another survey in the Spring of 2021, and we hope of course that the practical concerns will have been ironed out by then, perhaps replaced by new concerns about vaccinations, recovery and the backlog of non-COVID cases. But it is clear to us that the emotional wellbeing of our membership will be an ongoing theme.

Through this report, we outline what BGS members told us about their experiences of working through the pandemic and how the BGS will respond to some of the concerns raised. We are a small organisation and we can't fix everything but we can make a start to support the needs of our members over the coming months and years. It will be important for Governments, the NHS and social care employers across the UK to take significant and sustained action over the coming years to support the recovery of the health and social care workforce. It is vital that this issue is taken seriously to mitigate the chances of a mass exodus of staff across health and social care. The pandemic also exposed years of failings by successive Governments to address the crisis in social care. While an independent taskforce on adult social care has recently reported in Scotland and the Welsh Government have published a White Paper outlining their plans for social care, despite decades of promises, there has been no progress on a sustainable solution for social care in England. It is essential that this is prioritised by the Government, especially as it is highly likely that the number of people requiring social care support will increase in the wake of the pandemic.

What has come out more clearly than anything in this survey is the dedication and passion of BGS members across the four nations and across disciplines in caring for our older population. We thank you for your commitment and the sacrifices that you and your families have made during this most challenging time.

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Executive Summary

As the country moved out of the first wave of the COVID-19 pandemic, the British Geriatrics Society (BGS) issued a survey to its members with the ambition of understanding more about their experiences of working through the pandemic and what their concerns are going forward.

This is the only survey that has been carried out across the four nations of the UK which captures the views of the multidisciplinary team working with older people across various acute, community and primary care settings. The survey was carried out over a five week period in October and November 2020 and attracted 425 respondents.

Respondents told us about the practical experiences of working through the pandemic, including variable access to PPE and COVID testing for both staff and patients and the challenge of negotiating a pandemic where guidance was changing all the time. The pandemic shone a light on the challenges faced by care homes across the country, with often devastating consequences for care home residents and staff. Members told us about the difficulties faced by care homes and in particular the issues surrounding discharge of care home residents from acute hospitals back to care homes and the varying requirements for these patients to have negative COVID tests prior to discharge.

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

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

The survey was conducted towards the end of the first wave of the pandemic and respondents shared their concerns about preparing for the second wave and how BGS could support them through this period and beyond. The need for psychological and peer support for members came through strongly as did a need to provide support to trainees, in particular addressing missed training opportunities throughout the pandemic.

The actions BGS will take to address the issues coming up through the survey are set out at the end of each section of this report. We will also conduct a follow-up survey in late Spring 2021 to establish what has changed since the end of the first wave and which themes have persisted through the second wave.

Introduction

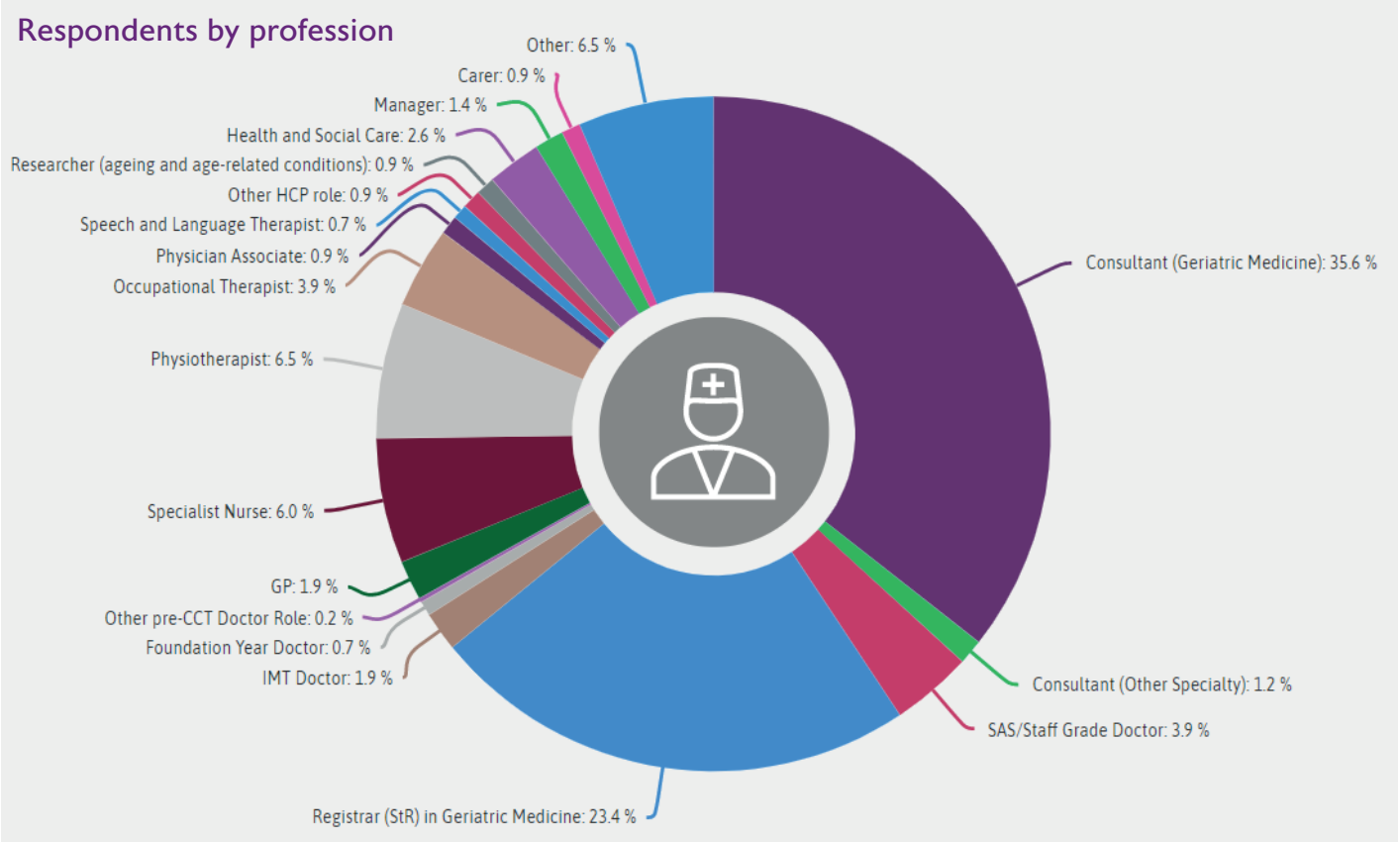
The impact of the COVID-19 pandemic on the UK's older population has been profound, with 90% of COVID-19 deaths occurring in those aged over 65. It stands to reason, therefore, that healthcare professionals caring for older people will be among those most affected by the pandemic.

In order to explore and capture the impact of the pandemic on healthcare professionals working with older people, the BGS conducted a survey of its members. We believe it to be the first survey to capture the views of professionals providing health and social care for older people across the four nations of the UK and across a range of settings including acute and community hospitals, primary care and care homes.

The survey was open to BGS members over a five-week period from 2 October 2020 to 9 November 2020. The survey was conducted through SurveyMonkey, which facilitated binary yes/no questions and analysis. Many of the questions also offered a free text option to allow people to expand on their answers and share their experiences.

We appreciate that, since conducting this survey, the situation with the pandemic has moved on, with many areas facing more challenging circumstances than they did during the first wave. These survey results are a reflection of the first wave of the pandemic. We intend to run another survey during Spring 2021 to gauge how things have changed for BGS members through the second wave of the COVID-19 pandemic.

The report outlines what our members told us about their experience of working through the first wave of the pandemic and what the BGS intends to do to address some of the concerns raised. It must be



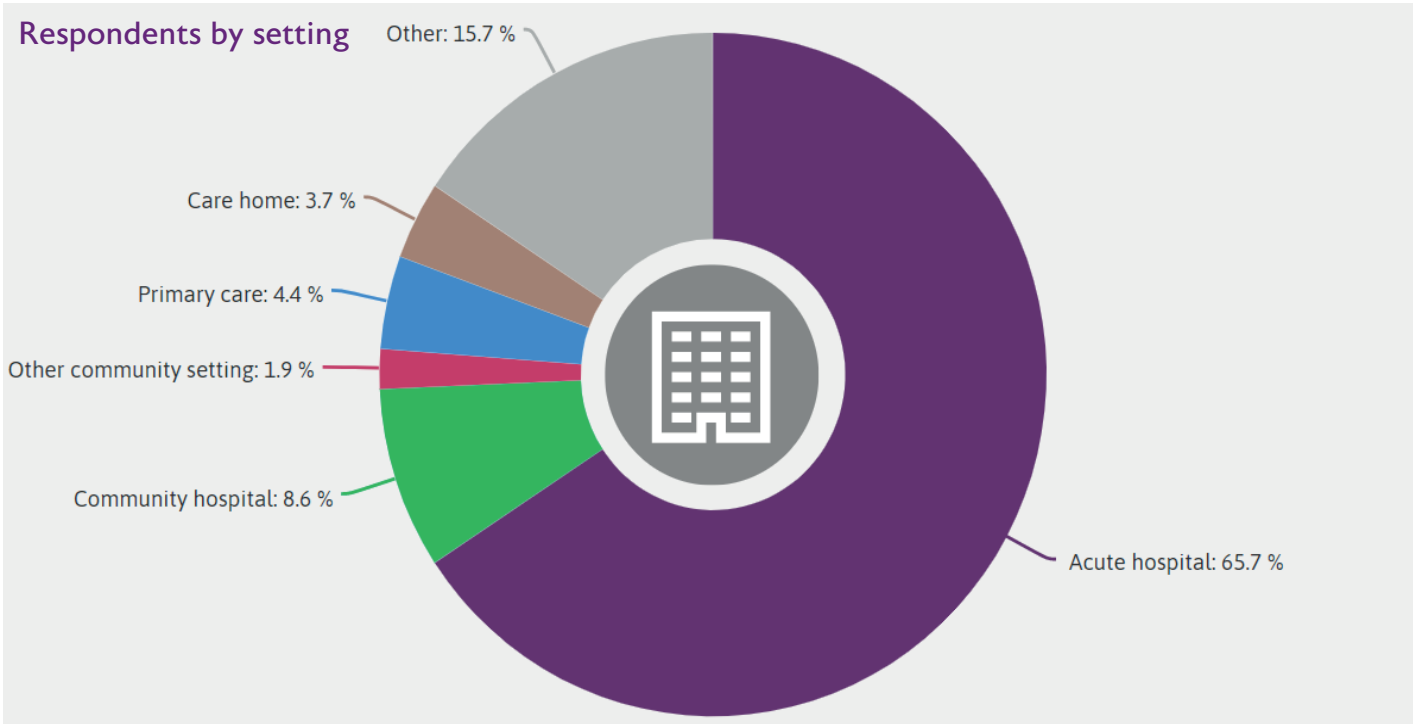
acknowledged however, that the BGS is a small organisation with limited resources. In outlining how we are going to respond to the concerns raised in the survey, we have identified action we can take which is practical and helpful while also being realistic and within our means.

About our respondents

We received 425 replies from across the four nations of the UK along with a handful of responses from countries outside the UK.[1] Out of the UK responses, 65% were from England, 27.6% from Scotland, 4.8% from Wales and 2.6% from Northern Ireland.

The biggest group of respondents by profession were consultants in geriatric medicine (35.7%), followed by registrars in geriatric medicine (23.4%). Out of our nurse and AHP members, physiotherapists were the largest group responding (6.5%), followed by specialist nurses (6%).

The majority (65.8%) of our respondents reported that they worked in an acute hospital with a significant number of people (15.7%) answering



'other'. Many of those who answered 'other' explained that they have roles in intermediate care or work in an integrated role working across acute and community services.

The majority of respondents (80.3%) identified as white or Caucasian with the second biggest ethnic group identified as Asian or Asian British (12.5%). A further 3% identified as being from mixed or multiple ethnic groups and 2.1% identified as Black, African, Caribbean or Black British.

68.8% of respondents stated that they worked fulltime with 26.3% saying that they worked less than fulltime. 4.6% chose the 'other' option and described various flexible working arrangements that they have arranged with their employers.

Experience of treating patients in the first wave of the pandemic

This section of the report will discuss the experiences of our members in providing treatment to patients during the pandemic, looking mostly at the availability of personal protective equipment (PPE) and testing for both staff and patients.

79% of respondents reported that they had access to PPE, although this did vary across the four nations, ranging from 69% in Wales to 100% in Northern Ireland.[2]

There was a slight variation in access to PPE according to the settings that respondents worked in. 77.3% of those working in an acute hospital and 79% of those working in a community hospital or other community setting had access to appropriate PPE. This rose to 91.7% for those working in care homes and 100% of those working in primary care.[3] Many respondents commented that access to PPE improved as time went on but they experienced difficulty accessing appropriate supplies at the beginning of the pandemic. Respondents reported that conflicting messages were given, particularly at the beginning with staff being actively discouraged from wearing some items of PPE.

'Followed PPE guidelines, but initially (ie, before PHE recommended wearing facemasks) members of the team were discouraged from wearing their own surgical masks by members of the infection control team, who complained that "you [the doctors] are scaring people unnecessarily", even though said doctors tried to explain their reasons for wearing their own, personally paid-for PPE.'
Registrar in Geriatric Medicine, England

'Not initially. We were actually banned from wearing surgical masks, a locum SHO was sent home for it.'
Registrar in Geriatric Medicine, England

Many respondents also questioned what counts as 'adequate PPE' and highlighted that much of the PPE available would not have passed as 'adequate' according to guidelines issued by the World Health Organization (WHO).

'It was classed as adequate by the trust but did not conform to WHO guidelines.'
Advanced Practitioner, England

'It depends what you class as adequate PPE. If you mean a surgical mask, apron and gloves then yes, but if you mean gown, FFP3 mask then no.'
Registrar in Geriatric Medicine, England

Respondents raised concerns about access to eye protection in the early stages of the pandemic, stating that this was usually the component of PPE that was missing.

'Adequate access to surgical masks, gloves but eye protection was variable – often not available or we were reusing outwith guidelines.'
Registrar in Geriatric Medicine, Scotland

'On occasions there was no eye protection available i.e. disposable face shields/visors. We had already opted to use goggles instead.'
Consultant in Geriatric Medicine, England

It is important to note that despite the well-publicised difficulties that many faced accessing PPE, some of our respondents have reported that they always had access to the appropriate PPE and, indeed, felt that PPE was at times too plentiful.

'Full PPE boiler suit, goggles, FFP3 masks, gloves, aprons, even disposable seat covers for my car.'
Advanced Nurse Practitioner, England

'Initially no. We were rationed masks. Now there is so much PPE that I feel it is being unwisely used at times, eg, to wear a mask to walk 5 paces down a corridor to a kitchen for milk and then it be disposed of and then to be told to put another on to walk back.'
Specialist Nurse, England

76.7% of respondents had access to COVID testing for staff with symptoms. This varied across the four nations, ranging from 67.7% in England to 93.8% in Wales.

Access to staff testing also varied significantly between work settings, with only 41.7% of those working in care homes able to access testing compared with 76.6% of those working in an acute setting.

The comments from respondents suggest that there was variability in the timing of tests and knowledge of pathways which led to much confusion.

Many respondents reported difficulty in accessing testing, even for staff with symptoms at the beginning of the pandemic, although most reported that the situation had improved significantly by the time of the survey.

Respondents also reported logistical difficulties in accessing testing as it was not always available at locations that were convenient to NHS staff.

'If I had become symptomatic I wouldn't have been able to access [testing] as [it] was only done in a remote DGH on the other side of 'my' DGH to the city I was commuting from. It would have been too far to attempt to drive unwell (45+ miles).'
Registrar in Geriatric Medicine, Scotland

'We had to go through local testing centres that did not prioritise NHS staff and may have been some distance away.'
Specialist Nurse, England

72.6% of respondents felt that there was a clear policy on testing older people admitted to acute care, although this varied slightly by nation, ranging from 62.5% in Wales to 75% in Northern Ireland.

Again, many respondents reported a change in policy throughout the pandemic with only symptomatic patients tested at the beginning of the pandemic, over time moving to routine testing of all patients admitted to hospital.

'Again, this changed over time. Initially, guidance was to test patients based on travel/contacts and PHE symptoms. This later changed to PHE symptoms, later to clinician judgement, and finally to testing all admitted acute care patients.'
Registrar in Geriatric Medicine, England

However, many felt that older people were tested using the same policy as other adults and testing was based on symptoms rather than age. Many respondents felt that this was incorrect and that older people should be tested due to their increased risk of developing COVID and the high likelihood of COVID presenting differently in this population compared with others.

'I had begged our infection prevention team to help us to separate admission of older people with atypical COVID from others who were non-COVID but bed managers ignored the recommendations.'
Consultant in Geriatric Medicine, England

'Policy changed throughout. Delirium was never a criterion for testing older adults, only respiratory symptoms or pyrexia. Now all admissions tested irrespective of presentation.'
Registrar in Geriatric Medicine, England

30.6% of respondents stated that testing was available for symptomatic patients in the community. It is important to note that many respondents (53%) chose the 'not sure' option for this question. This is possibly because a large proportion of our respondents work in the acute setting and may have limited knowledge about policies in the community. Again, access to testing in the community varied per country. The comments from respondents suggest that access to testing in the community was variable and changed over time.

'Patchy. Some testing services closed as wider community need grew. Some mobile units, difficult to sustain, limited resources.'
Consultant in Geriatric Medicine, England

'Actively discouraged by ops managers due to capacity of testing team. COVID team very happy to implement workarounds! However outside of remit and not resourced for the number of housebound suspected COVID patients. Inflexible management not taking on board that atypical presentation very common in frail population.'
Specialist Nurse, England

Similar numbers reported that symptomatic testing was available for care home residents with 29.5% across the country saying this was available. Again, this varied from country to country ranging from 25% in Wales to 55.6% in Northern Ireland.

As with the community testing, a large proportion of respondents stated that they did not know about access to testing for symptomatic care home residents. Guidance changed many times regarding care home testing and the guidance that was available was interpreted differently across the sector. Some people reported that even when the guidance had changed to enable more testing in care homes, access to it was variable and there was a lack of clarity regarding how tests would be carried out.

'As above, this took some time to organise for all, some homes (particularly those part of larger chain companies) were more assertive in requesting tests.'
GP, England.

'There was some testing but lack of clarity of pathway how to arrange, who would take swab, getting result.'
Advanced Nurse Practitioner, England

A source of great anxiety in the care home sector during the first wave of the pandemic was the discharge of patients from acute hospitals to care homes who had not received a negative test result. 61.3% of respondents reported that patients being discharged to care homes received a negative COVID test result prior to discharge.

This was variable between countries, ranging from 53.1% in England to 100% in Northern Ireland. Many respondents commented that this policy, like many other things, changed over time and that requirements of care homes varied significantly.

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

'Often not. We discharged many positives to care homes to make room for many more coming in. The care homes would isolate patients on their return.'
Registrar in Geriatric Medicine, England

Some respondents commented that despite a patient returning a negative test before discharge, the patient would be isolated for two weeks when re-entering the care home. Respondents questioned the necessity of both the negative COVID test and the isolation in the care home.

'Care Homes wanted the patients to have a negative test before they accepted the patients back, but then isolated them for 14 days anyway in case they developed symptoms. Surely if they can isolate the patients the negative test is a waste of money, as it only proves they were negative at the time the swab was taken. However, patients are then awaiting results, sometimes staying in hospital for a further 24 hours before they are discharged.'
HCP, England

'Despite negative tests on discharge, all residents are kept in isolation for 14 days on admission in a care home.'
Health and social care, England

BGS Actions

It was clear from the feedback given in this section that constantly changing guidance and lack of consideration of how the virus would affect older people from both Government and local health bodies was a source of confusion and frustration for many members.

BGS has made progress during the pandemic with access to decision makers but during the early stages of the pandemic, it was not clear where advice to Government on COVID in older people was coming from or indeed, if any was being provided at all.

The BGS will lobby for a seat on relevant groups and committees to ensure that older people's healthcare is represented at all levels.

The pandemic has at times exposed ageism within society, particularly when decisions have had to be made about access to hospital and intensive care treatment and it has been suggested that someone's age could be a contributing factor in this decision-making process.

BGS is opposed to ageism in all its forms and will speak out against it at every opportunity. The #BGSFairCare campaign sought to protect the rights of older people during the second wave of the pandemic and we will continue to raise these points with Governments and decision makers.

Impact of COVID-19 on BGS members

While the previous section has looked at the practicalities of working through the pandemic and the resources that BGS members had available to them, this section will look at the impact that working through the pandemic has had on the professional and personal lives of our respondents. For the vast majority of our members, the pandemic will be the most significant event of their career and most members will have faced situations over the last year that they have never faced before.

40.2% of respondents took time off work during the pandemic. This was fairly consistent across disciplines, ranging from 39.4% for consultants to 43.7% for nurses and allied health professionals (AHPs).

Of those who took time off, 71.3% stated that it was because they had tested positive for COVID. There was more variation across disciplines here with 58.8% of nurses and AHPs testing positive for COVID compared with 80.6% of consultants. Many others who took time off did so because they experienced symptoms of COVID but testing was not available or they were advised to self-isolate while they waited for a test. A small number of respondents highlighted that they took time off work (sometimes unpaid) due to exhaustion or because of the impact of the pandemic on their mental health.

'At the beginning I had two weeks off – lost sense of taste and smell – but no testing was available. it was later established that I had antibodies.'
Physiotherapist, England

'At the end of Covid rota I felt so exhausted I wanted to resign as I was already struggling to work 12 PA contract and I was not allowed to drop to 10 PA despite having the agreement to do that prior to Covid. I am now on leave without pay since 1st July for 6 months.'
Consultant in Geriatric Medicine, England

Mindful that the majority of respondents were medical staff, this finding demonstrates the burden of front-line acute care that geriatricians undertake. This is not surprising given that even before the pandemic the RCP London Consultant Census found that 18% of geriatricians contributed to relieving the burden on General Internal Medicine (including the acute unselected take), the highest of any speciality.[4]

Nearly a third (28.5%) of respondents told us that they were redeployed to a different role or a different work setting during the pandemic. This varied between disciplines with only 16.9% of nurses and AHPs being redeployed, compared with 37.4% of consultants. Some healthcare professionals started working in services that provide care in people's homes (such as Hospital At Home services) or worked to support residents and carers in care homes. Others were deployed to COVID wards within their normal place of work or were providing cover for colleagues who had moved to COVID wards. Some respondents reported returning to clinical duties from other roles to help care for patients during the pandemic.

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

'Re-deployed to the acute medical unit to work an emergency rota, so only worked general internal medicine covering the acute take/ emergency ward cover/respiratory support unit for COVID+ve patients.'
Registrar in Geriatric Medicine, England

Respondents also reported increases in different ways of working, particular the use of Near Me[5] or Attend Anywhere clinics.[6] 77.4% of respondents reported a change to their rota or job plan during the pandemic. Again, this was lowest among nurses and AHPs (69%) and highest for consultants (89.4%). Those who chose to describe these changes in the comments told us about an increase in out-of-hours working, cancellation of scheduled clinics and treating all adults as opposed to older adults.

'We extended the day-to-day working patterns, dropping any outpatient/community sessions. A late shift was introduced in order to provide more OOH cover to support ward admissions overnight.'
Consultant in Geriatric Medicine, England

'Just my "job plan" changed in that I was no longer able to attend outpatient clinics or visit community-based areas such as care homes or other rehab hospitals.'
Registrar in Geriatric Medicine, England

'Night shifts, unselected take instead of geriatric take. Full shift rota.'
Consultant in Geriatric Medicine, Scotland

'Went from working 1 in 12 weekends to working 1 in 5 weekends. NHS Grampian decided to cohort frail older people on a different site, and to split our team of staff into a "red team" and "green team." I was in the "red team" and worked on "red site" and primarily on screening/assessment ward. Very different work. Lots of pressure with our team being split.'
Consultant in Geriatric Medicine, Scotland

Some respondents highlighted smaller patient numbers in some areas, necessitating a change in personnel to ensure that the resource was allocated where it was most needed.

'Front of House frailty team was reduced to minimal numbers during the first wave, as the number of attendees to A&E was reduced. Surplus staff were redeployed to provide more support to the elderly care ward areas, where there were more gaps due to sickness.'
HCP, England

'Had a non- clinical day every week as within the cancer treatment centre we were not admitting / treating patients. There were hardly any patients on the wards. Staff were given projects to do.'
Occupational therapist, England

We have heard anecdotally about some BGS members in particular who usually work less than full time (LTFT) volunteering to increase their hours during the pandemic. However, the numbers of those who normally work LTFT whose job plans or rotas changed during the first wave was similar to other members at 70.2%.

While some respondents reported volunteering to change their hours and responsibilities to respond to the pandemic, others reported having these changes imposed upon them.

'Emergency covid rota with increased on call commitments. I did 100% on on call even though I am 80% LTFT.'
Registrar in Geriatric Medicine, Wales

'Went from 9 PAs to 11PAs, holiday cancelled, worked Wednesday-Saturday for 5 months, 10 hour shifts. Looked after patients of all ages on CPAP in HDU setting.'
Consultant in Geriatric Medicine, England

'Imposed without negotiation by the Trust, had to work twilights, nights, long days and from 1 in 9 weekends to 1 in 2 weekends resident oncalls. Also without extra pay.'
Consultant in Geriatric Medicine, England

63.8% of respondents told us that they experienced an increase in the intensity of their work during the first wave of the pandemic. This was felt most acutely by consultants with 66.2% reporting an increase. 56.1% of trainees told us that they experienced an increase in the intensity of their work. The vast majority (85.9%) of BGS members responding to the survey told us that they were a lot or moderately more stressed during the first wave of the pandemic. This varied slightly between disciplines with 81% of trainees telling us they were a lot or moderately more stressed compared with 90.1% of nurses and AHPs.

We also asked about the impact of the pandemic on family members and most respondents reported increased stress and anxiety among partners, parents and children. Concerns included worrying about the respondent's safety, needing to juggle childcare, worrying about contracting COVID and financial worries as family members were furloughed or made redundant.

While some respondents told us that having partners working from home reduced some of the pressure regarding childcare and home-schooling children, others reported that their partners also worked in the NHS or were key workers in other sectors and, as such, this added to the stress levels of the family.

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

'Double keyworker family so children attended keyworker childcare provision which they did not enjoy, making it very difficult for me to then increase working hours. Home schooling on days off.'
Consultant in Geriatric Medicine, Scotland

BGS Actions

We are publishing a position statement on flexible and less than full time working to help individuals and organisations understand the benefits of flexible working and how to support colleagues who work flexibly.

It will be important for BGS to ensure that measures that were implemented to cope with a crisis, e.g. longer hours, more requirements to work anti-social hours, extra hours without pay, do not become routine. We will be monitoring this going forward.

Respondents told us about how they did not see as much of their family during the pandemic, either because they were working longer hours and weren't at home as much or because they were trying to protect their families from contracting COVID. For most respondents, the family members that they did not see were those who they did not live with but some described not seeing young children as they went to stay with relatives for the duration of the first wave.

'My family members just had to get used to not seeing me, as I didn't want to put them at risk. Many of my family (even the younger siblings) have underlying health conditions.'
HCP, England

'Family were aware that I was very tired and emotional due to the stress. After the initial lockdown was lifted, I still declined to socialise outside of the family due to concerns about COVID and nursing positive patients.'
Specialist nurse, England

'My children went to stay with my sister and mum for 5 weeks. I could only see them in the garden and on walks.'
Consultant in Geriatric Medicine, England

'Husband had to work from home full time whilst also providing full time child care to our toddler. Toddler regressed in development. Husband had huge stress burden from juggling work and childcare as I worked longer hours. Both caught covid from me.'
Consultant in Geriatric Medicine, England

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

We are aware that people from BAME backgrounds are at higher risk of developing COVID-19 than other ethnicities.

However, this does not appear to be borne out in the stress levels felt among respondents from BAME backgrounds – this group did not report higher levels of stress than the overall results and only two people mentioned this as a factor when asked how the pandemic affected their families. We will probe this further in our second survey.

'Pregnant wife stressed, Asian parents stressed.'
Consultant in Geriatric Medicine, England

'My wife was worried due to my age and BAME background and lack of PPE initially.'
Consultant in Geriatric Medicine, Wales

40.9% of respondents are participating in research trials looking at treatments of COVID-19. This varied significantly between disciplines with only 13% of nurses and AHPs taking part in research compared to 57.4% of consultants. This may be because consultants are more likely to work in an acute hospital setting and have more access to research trials whereas nurses and AHPs are more likely to be working in the community.

The vast majority (85.9%) of those who said that they were participating in research said that they were taking part in recovery trials, compared to only 9.2% and 4.9% taking part in vaccine trials and blood plasma trials respectively.

A small number of respondents commented that they were taking part in other types of research trials.

Looking forward

We asked respondents a number of questions about how the services they work in had coped with the 'end' of the first wave and resuming normal service for patients. As mentioned earlier, this survey captures a specific moment in time in the autumn of 2020 and we understand that the comments given do not reflect

the experiences of working through the second wave of the pandemic. It is also worth noting that at the time of the survey, some areas were seeing an uptick in COVID cases and, as such, any 'return to normal' had ceased. 52.4% of people said that at the time of answering the survey, their service had returned to 'normal' or pre-COVID working. This varied across disciplines with 61.6% of trainees reporting a return to normal compared with 46.2% of nurses and AHPs. We heard that community-based services were the slowest to return to normal which may be why fewer nurses and AHPs say that they returned to a pre-COVID level of working. Some of those who changed their hours to work through the first wave of the pandemic reported a return to their normal hours but other changes to their role remained in place.

'We did [return to normal] for a short period of time but now ramping up again. New rota in past two weeks to cover COVID ward and respiratory assessment unit.'
Consultant in Geriatric Medicine, England

'Returned to LTFT hours, however job plan still impacted. There had been some shift toward re introducing clinics etc however in region with significant second wave.' Registrar in Geriatric Medicine, England

'We have just gone into second shutdown, no visitors to the ward, staff being reassessed for risk. Staff where possible working from home.'
Specialist nurse, England

Some people commented that as services returned to normal, they were trying to catch up on the waiting lists that had developed while the first wave of the pandemic progressed. They reported that many of the patients they were seeing in the initial post-lockdown period were more ill than otherwise would have been expected. This was partly attributed to deconditioning occurring during lockdown and partly to people delaying seeking medical attention during the first wave.

'Still increased workload supporting people with dementia, older people and their carers and those with safeguarding needs. Also trying to catch up with routine work of memory assessments and dementia reviews and carers health checks but long waiting list and working differently.'
Specialist nurse, England

'Marked increase in caseload as those who didn't attend during phase 1 are now much sicker. Also, significant deconditioning due to shielding, reduced care packages and minimal community rehab teams currently in place.'
Physiotherapist, Scotland

'Briefly restarted NEW referrals clinic to catch up backlog – while still running telephone returns – still have all other infection prevention commitments – so more work than normal – and continually involved in planning with Infection Prevention and Control Team as well as rest of team to deal with extra work load arising from second wave plus resumption of core services – so meeting volume very high. Unable to focus on any strategic areas which were in development before – pause on corporate level activity to deal with crisis.'
Consultant in Geriatric Medicine, Scotland

The survey asked how people's work had changed since the beginning of the pandemic and overwhelmingly, and perhaps not surprisingly, the most common comment related to the use of video conferencing technology to conduct clinics and meetings. While some people highlighted the positive impact of remote working, such as increased flexibility, others flagged that video and telephone consultations can make it difficult to build a rapport with a patient. While some respondents said that it was difficult to conduct remote consultations when working with patients at home, others commented that they were trying to incorporate remote working into Hospital At Home services. Some respondents flagged that ongoing and increased use of PPE slowed down their ability to care for as many patients or as quickly as they normally would.

'Remote consultations in my clinical work, and working from home much more flexibly in my leadership and Federation roles.'
GP, England

'For our team it's business as usual, you can't care for someone in their home over the internet!'
Physiotherapist, England

'Hospital at home so we are still seeing patients at home. Trying to reduce the number of visits we do but also trying to be flexible in how we work with remote consults. Telephone reviews.'
GP, Scotland

'Trying to get back to normal, but have increased PPE, increased patient load as COVID has isolated our patients.'
Foundation Year Doctor, Scotland

Although the survey did not specifically ask about education and training, some respondents commented that training opportunities were reduced during the first wave of the pandemic and had not yet resumed.

This is something that BGS has heard from members anecdotally, particularly through the Trainees' Council. We will explore this further in a follow up survey.

'Limited sub speciality training during this time period as clinics cancelled/ no community work etc.'
Registrar in Geriatric Medicine, England

'Rota and on call duties mostly stayed the same, possibly more sickness to cover. However clinics and other training opportunities were reduced or cancelled.'
Registrar in Geriatric Medicine, Scotland

'Reduced face to face clinic time. More online/phone consultations and adoption of a HOT clinic where GP can refer and we see/phone the patient within the same week. Really difficult to arrange specialty clinics (osteoporosis, continence, tissue viability) as they are running at significantly lower capacity and don't want too many people in one room. This has been difficult for achieving adequate specialty training.'
Registrar in Geriatric Medicine, England

Actions for BGS

Although we did not ask specifically about education and training in the survey, this featured significantly in the free text comments and has come up in anecdotal discussions we have had with BGS members over the last year. We will explore this issue in further detail in our follow-up workforce survey.

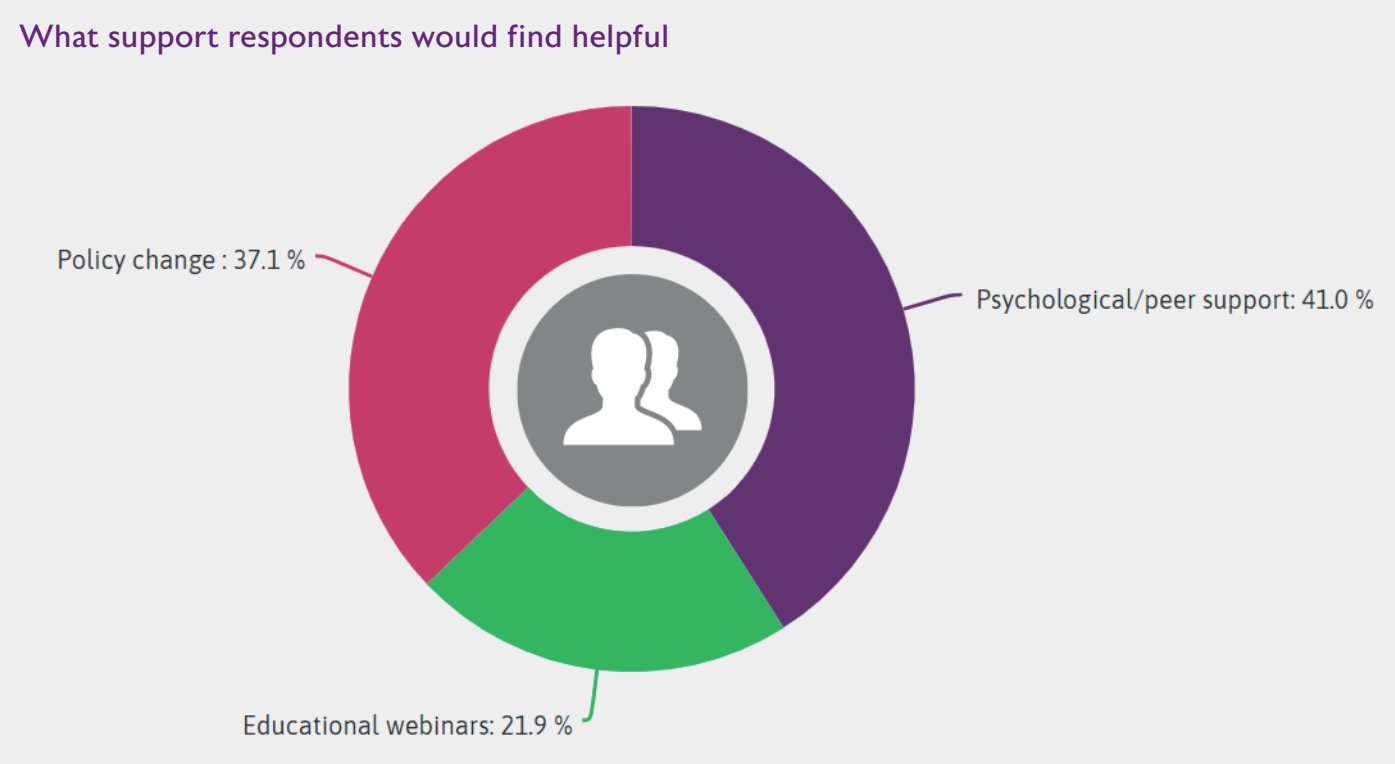
We are also aware that our trainees in particular are concerned about completing their training and are demoralised. The BGS Education and Training Committee will address this in their workplan and we will work to update our guidance to trainees, helping them to meet their training requirements during the pandemic. We will also look to feature the contributions of trainees in our communications going forward to highlight the valuable role that they have played during this crisis.

We asked respondents what would help to support them and their patients in the event of a second wave, giving three options for them to select from – more peer and psychological support, policy change or educational webinars. This question also included a free text box for respondents to comment. Those who thought that policy change would be helpful commented that the BGS should be at the forefront of lobbying for change, something that we have been working towards throughout the pandemic and will continue to do. Many of those who said that educational webinars would be helpful said that these should be about a range of topics and not just COVID. Having said that, we asked separately whether respondents had accessed any BGS resources during the pandemic and 48.3% told us they had accessed our COVID resource series.

Many respondents also reflected on issues addressed elsewhere in the survey around access to testing, PPE and guidelines, particularly for care homes. Others raised concerns about constantly changing guidelines making management of the pandemic more difficult and confusing, and stated that there is a need for consistent policies across the four nations of the UK to reduce confusion.

It is clear from the responses that the psychological impact of the pandemic on those working within the NHS and social care is significant. Many people commented that there is a need for greater recognition of this and increased psychological support for NHS staff. It was also acknowledged that the pandemic impacts the whole of society, not just the NHS which makes it impossible for healthcare staff to escape from it when not at work.

'I think I naturally have my own way of dealing with things, which involves focusing on the things I can and cannot control. However, I have seen many of my colleagues suffering with immense stress and anxiety about things outside of their control. I find this hard and have concerns on how this will affect morale going forwards. I think psychological/peer support for those who really need it will help improve morale more widely going forwards.'
Registrar in Geriatric Medicine, England



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

'Headspace e.g. flexibility in the rotas to allow more time to recover from on calls – given that everyone is already tired and hasn't had any real respite from this since March. Even if we are not at work, life outside the hospital isn't normal so we cannot 'escape' the impact of covid. The mental strain therefore never really abates.'
Registrar in Geriatric Medicine, England

When asked for any further comments about the impact of the pandemic, respondents reiterated the huge emotional toll that COVID has had on BGS members with themes of sadness, frustration and exhaustion coming through strongly. People also told us how worried they are about the emotional impact of the pandemic on older people, particularly those living in care homes who were unable to have social contact during the lockdown. Respondents also expressed concern about how the pandemic has been managed at a national level and the impact of this on older people and other at-risk groups. There was also a concern about the media attention on COVID in care homes and a feeling that hospitals were being blamed for the situation in care homes.

Some people also commented that they felt that geriatricians in particular had not been as visible as colleagues from some other specialties such as those working in intensive care, despite geriatricians playing a significant role in the treatment of COVID patients in hospital.

'My over-riding feeling as a nurse is a profound sadness at the loss of normal social contact in care homes.'
Specialist nurse, Scotland

'I know there has been a lot in the press about blaming hospitals for introducing covid into care homes, and I spoke to a care home just last weekend who were initially insisting on 2x negative swabs for a lady who had never tested positive, and the care worker was reminding me that is was the hospitals' fault for causing covid outbreaks in care homes. I am finding it difficult to remember exactly what did and didn't happen at the start – would be possible with an adequate case note/records review. I get upset that hospitals get blamed for the care home outbreaks.'
Consultant in Geriatric Medicine, Scotland

'Complete lack of involvement of people of colour in decision-making especially as this group was severely affected. There was a BAME covid committee in our hospital of about 14 individuals but only 2 of those were BAME.'
Registrar in Geriatric Medicine, England

Actions for BGS

While we do not have the capacity to address the individual psychological needs of BGS members, there is more we can do to acknowledge their lived experience of working through the pandemic and caring for older people during this time. We will explore opportunities to share the experiences of individuals through our blog and newsletter so that BGS members have an opportunity to reflect on how the pandemic has affected them and their colleagues. Some of our members shared their experiences through a 'talking heads' section at the 2020 Autumn Meeting, and we will make those videos available to members.

We will explore whether there is a role for retired or otherwise non-clinical BGS members to offer peer support to colleagues who would benefit from speaking to someone who understands their role but has not been involved in working through the pandemic.

We are aware that individual NHS organisations will be providing support to their workforce and that there will be examples of teams across the country that have provided good support to their staff throughout the pandemic and going forward. We will endeavour to identify examples of good practice and publicise these through our communication channels.

We are exploring the potential of holding wellbeing and psychological support sessions at upcoming BGS meetings.

Conclusion

There is no doubt that the COVID-19 pandemic is the biggest challenge ever to have faced the NHS, and the impact on BGS members has been significant. As we come through the second wave of the pandemic, the headlines are full of vaccines and new variants and it does not seem as if the workload of our members will abate in the immediate future.

Even once the pandemic is over, there will be work to do to catch up with waiting lists and to care for a population of older people who have had COVID and are suffering the long-term impact or who have not had COVID but have deconditioned during the period of lockdown. BGS members will also be dealing with the impact of the pandemic on their own physical and mental health, as well as the impact on their careers and training. There is a significant role for BGS in providing support for our members as they come to terms with the experience of working through the pandemic and attempt to move forward, both personally and professionally.

Actions for BGS

The BGS will work to identify opportunities to highlight and profile the work of our members throughout the pandemic and publicise the role of healthcare professionals working with older people in treating COVID-19.

Through our #BGSFairCare[7] campaign we have sought to highlight the role of the older people's healthcare multidisciplinary team in facing the COVID-19 pandemic and will continue to lobby for our members to be recognised for the vital role that they have played.

References and footnotes

1. Two responses each from Mexico and Spain and one response from: India, Indonesia, Ireland, Israel, Italy, Saudi Arabia, Switzerland and USA.
2. It should be noted that there were far fewer respondents in Wales and Northern Ireland than England or Scotland. 11 people responded from Northern Ireland and 20 responded from Wales.
3. It should be noted that there were only 16 responses from care homes and 19 from primary care.
4. Royal College of Physicians, 2020. The medical workforce BC (Before COVID-19): the 2019 UK consultant census. www.rcplondon.ac.uk/projects/outputs/medical-workforce-bc-covid-19-2019-uk-consultant-census.
5. Near Me is a secure NHS video calling platform used by the NHS in Scotland for remote consultations (www.nearme.scot)
6. Attend Anywhere is a secure NHS video calling platform used by the NHS in England (https://england.nhs.attendanywhere.com) and Wales (https://wales.nhs.attendanywhere.com) for remote consultations.
7. #BGSFairCare - Protecting older people in the second wave (www.bgs.org.uk/faircare).

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Improving healthcare
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