BGS NEWSLETTER

British Geriatrics Society
Improving healthcare for older people
Issue 82 | August/September 2021

How are you?

Our workforce wellbeing **special issue**

In this issue

WELLBEING
Special Issue

In this issue

Cover: White and Red Candles on White Surface © Pexels/Nataliya Vaitkevich 2021.

President's column

We made the decision in early April that all BGS educational events and conferences would be run virtually for the rest of 2021. We recognise the limitations of virtual conferencing for some of our members who report missing the ability to network with colleagues from across the four nations.

Nonetheless, we faced and continue to face, uncertainty about the feasibility of running large conferences in indoor venues. Professor Chris Whitty, when he spoke with me in April, predicted a further wave of COVID in the autumn of 2021 that may potentially impact on our professional as well as personal lives. We felt it was safer to defer bookings in conference centres until 2022 when we hope that our new normal will include the ability to meet in bigger venues. I do also continue to hear comments from colleagues about the benefits of virtual conferencing, with many now booking study leave to take time away from their place of work and focusing on keeping up-to-date with our conference offer from the comfort of their own homes, catching up later on sessions that they may have missed. BGS offers a 12 month catch-up period after registering for a conference which is significantly longer than many other organisations. You can register to view events on demand, or revisit events that you attended, by visiting **www.bgs.org.uk/events**.

I was delighted to be invited to speak at both the BGS Wales and BGS Scotland National Meetings in the spring of 2021 and the combination of prerecording sessions and live question and answer sessions allows some interaction. I hope those of you who attended our virtual events have managed to fill in our feedback forms. We do take note of positive and negative comments and are constantly updating and adapting our conference programme. A big vote of thanks to our Events Team at BGS lead by Geraint Collingridge and our BGS Meetings Committee chaired by Divya Tiwari.

On a similar theme, having held all our BGS Trustee Board Meetings on Teams since the start of the pandemic, we finally met mostly in person (with a few colleagues joining virtually) in July. I realised that due to the pandemic I had not visited Marjory Warren House since I became President, and rather than travelling on trains and planes to get to London, I have been using Teams and Zoom to meet with BGS members all across the four nations. I was delighted to have a catch-up recently with Mike Azad who is the new Chair of the English Council. We discussed the importance of ensuring that Geriatric Medicine remains a speciality delivering more than simply acute care, whether that acute care is within a hospital setting or in hospital at home. The skills and knowledge of geriatricians and their teams are important in managing frailty, rehabilitation, delivering outpatient services for chronic health conditions such as Parkinson's disease and supporting older people in the community. Recovery of these services post COVID will be important to reverse the impact of lockdown and isolation on older people over the last year and a half.

This *BGS Newsletter* is focusing on the wellbeing of the workforce in the recovery post pandemic. We had undertaken a second round of our membership survey and published the results in *Through the visor 2*, and we have included details of this within this *Newsletter* (see page 12). The second wave for many members was more difficult than in the first wave, although there were improvements in provision of PPE and much clearer guidance on testing both of patients and of staff. Staff shortages are clearly associated with increased stress and anxiety at work and our highly motivated workforce find it difficult when they are not able to deliver high quality personalised care for patients due to staff shortage. We must continue to press for a growth in both medical and nursing student numbers, and also to cultivate supportive environments where people can thrive throughout their professional lives. Professor Michael West spoke of compassionate leadership within the NHS at our Spring Meeting (and he has also written an article on this topic on page 18). The importance of kindness and listening to concerns, allows organisations to improve patient care. I hope you have taken time to look after yourself this summer and had a break from work. We do spend much of our professional lives supporting patients and their families when they are going through difficult times with illness, disability and even death. This is demanding work, which is so important to do well, and we need to recognise when our emotional energy is running low and recover to ensure our empathy is not diminished.

We have also published two other important documents which members should be aware of and share with their teams and networks. *Ambitions for change: Improving healthcare in care homes* was written to help improve the quality of healthcare for care home residents. It builds on our highly-accessed guidance for managing COVID-19 in care homes, setting out our ambitions for improving the healthcare provided to residents as we move beyond the pandemic. It also suggests 11 priorities for decision-makers to consider. You can read more about this on page 8. We also recently launched *Right time, right place: Urgent community-based care for older people,* which was put together to help health professionals to navigate the options for providing urgent care to older people which can be delivered at home, avoiding unnecessary emergency hospital admissions. There are lots of models that currently exist and this document provides a useful summary. You can find out more on page 11.

'The importance of kindness and listening to concerns allows organisations to improve patient care.'

I cannot finish the *BGS Newsletter* without reiterating the amazing achievement of *Age and Ageing* in increasing its impact factor from 4.91 to 10.66. The last couple of years have seen many more submissions to *Age and Ageing* and the demanding task of reading, critiquing, editing and selecting the best of these for *Age and Ageing* falls to Professor Rowan Harwood as Editor, and his extended editorial team, supported by Katy Ladbrook. It is hugely gratifying to see this has been recognised with the increased impact factor which is an unprecedented annual change. I hope that you are enjoying accessing *Age and Ageing* in an electronic format (see page 6 for more information). This has allowed us to increase the number and length of articles. Well done to all involved.

Dr Jennifer MA Burns
President, BGS
@Burns61Jenny

Coming soon: A new-look newsletter!

From next issue, your regular *BGS Newsletter* will have a new look - and a new name!

Your membership magazine will still contain all the news, views, features and updates that you are used to, but with a fresh new look and feel.

There will also be some changes to the way it is accessed via the website, making it easier to revisit past themed content and share it more widely to your colleagues.

Above: Some mocked-up example covers in the new format

The magazine will also lead with themed special issues to help address the things that concern you and the older people you care for.

We can't wait to see what you think of *Agenda* - your new-look Newsletter! Please email editor@bgs.org.uk if you want to be involved.

People power

It was a joy to attend the BGS Trustee Board at the end of July – the first time we have met in person since January 2020. After an extraordinary 18 months it was good to celebrate our achievements and take time to reflect on the challenges and opportunities ahead.

As we worked through the agenda I was conscious of the careful balance between our function as a professional organisation supporting the interests of our members and our responsibility as a charity with a mission to improve healthcare for older people.

This year it has been clear to see how these objectives are mutually reinforcing - how the knowledge, skills, passion and energy of our members sustain our Committees, Councils and Special Interest Groups (SIGs) and generate the research, guidance and best practice required to drive up quality of care. I have the pleasure of supporting the Policy and Communication Committee (PACC). I'm always impressed with how Sally (BGS Policy Manager), Amy (BGS Publications and Website Editor) and Marina (PR and Communications Manager) artfully cascade our resources and help us increase our collective influence on policy and delivery of healthcare for older people.

Of the many excellent resources BGS published in the last year I suggest three have enormous potential to influence policy and commissioning of health and care right now.

'As we push the boundaries of the art of the possible in the community, we need a workforce that is integrated, capable and fit for frailty.'

- Building on the success of the highly valued guidance on managing the COVID-19 pandemic in care homes, our ***Ambitions for change: Improving healthcare in care homes*** document lands at a time of increasing pressure for reform of adult social care and a global focus on long term care. You can read more about the report and what its 11 recommendations are on page 8, or read the ambitions in full here: **www.bgs.org.uk/ambitionsforchange**.

- ***Through the Visor 1 and 2*** highlight the physical, mental and emotional trauma sustained by the workforce during the pandemic. This has huge implications for staff wellbeing and retention and for training. You can read the reports here: **www.bgs.org.uk/throughthevisor.**

- Our reports on ***Capturing beneficial change from the COVID-19 pandemic*** illustrate much potential from greater collaboration and information sharing across teams and care settings, more specialist support closer to home, integrated working with social care and Third sector partners, and technology enabled care and decision support. These changes should be retained as we implement new models of care in integrated systems. You can read more here: **www.bgs.org.uk/policy-and-media/beneficial-innovations-from-covid-19.**

Integrated, capable and fit for frailty

I see workforce as the golden thread that runs through all of the above topics. As we push the boundaries of the art of the possible in the community, we need a workforce that is integrated, capable and fit for frailty. Yet preventing and managing frailty is a new area for many community practitioners. For example, a study of the current management of frailty by community nurses in Scotland suggests this is largely reactive, influenced by professional judgement and intuition, with little systematic training in frailty-specific screening and assessment. A related survey of workforce leads from 10 Health and Social Care Partnerships in Scotland, the Scottish Ambulance Service and the independent sector body Scottish Care highlighted the need to upskill our existing workforce to identify and manage frailty and to support staff from all disciplines to make the shift to proactive and integrated care and support that is attuned to the specific needs of people with frailty, and their family carers. That means all staff need to be competent in identifying and managing frailty syndromes, and many need skills in case management, care coordination, reablement and rehabilitation as well as relational skills for person centred practice and collaboration with partners.

Beyond eLearning

I welcome the development of eLearning modules on frailty, including our excellent BGS offer (see **www.bgs.org.uk/elearning**). However I am thoughtful about the extent to which self-directed elearning can address the more relational aspects of care. The Frailty Matters project led by the University of the West of Scotland developed a combined coaching and educational programme that makes sense of frailty in the reality of both community professionals and people living with frailty. Combining technical knowledge and relational skills-building with peer support and coaching was

valued by district nurses. Participation by citizen co-coaches offered valuable insights into empowering and supporting individuals with frailty to manage their conditions and live the lives they want to live. The person-centred approach supported staff to develop their skills and confidence in shared decision making and in self-management and health behaviour change. We know attention to these relational aspects of care enhance staff motivation, wellbeing and retention. These aspects need much nurturing at a time when the health and care workforce is pandemic weary and many have lost the joy of work.

Building technical knowledge and competence in frailty is a great start but I suggest we should be more ambitious. How can we create learning communities that inspire professionals to deliver the best possible care for people with frailty? What can we learn from the approach adopted by the Health Foundation's Q Community? Is it time to mobilise our members as a Frailty Q Community?

Anne Hendry
BGS Deputy Honorary Secretary
@AnneIFICScot

BGS Strategic Plan: Where are we now?

We are roughly midway through the three-year period covered by the BGS Strategic Plan for 2020-23. At the recent BGS Trustee Board meeting, held in person for the first time since January 2020, we took a look at our strategic objectives and explored whether we needed to make any adjustments.

The COVID pandemic was not in sight when BGS members approved the Strategic Plan at the AGM in November 2019, but it has of course had a huge impact on citizens and health services worldwide. We started by updating our analysis of the context, looking at political, economic, social, technological and environmental issues that had an influence on healthcare for older people and the work of our members. The pandemic has led to nearly 130,000 deaths in the UK, 90% of them in people aged over 65. This devastating toll has only served to underline the importance of the BGS's mission – improving healthcare for older people – and of the need to continue to strengthen our advocacy for more person-centred, joined-up services, our role in supporting professional development and clinical best practice, and our responsibility to share research, knowledge and expertise with specialists and non-specialists.

Our Strategic Plan mid-course review reaffirmed the five strategic objectives we had set back in 2019. Our committes, which lead the four outward-facing objectives, will make some adjustments to priorities in light of the pandemic and other changes in the external environment. For example, we want to build on our early engagement with NHS England to influence the design, communications and workforce planning for the new programmes being implemented as part of Ageing Well. We want to capitalise on the success of *Age and Ageing* and of the leap forward, as a result of COVID, in research studies undertaken in care homes and elsewhere which include older people as research participants.

Following the wider reach and positive feedback on our COVID resources, the Frailty Hub, and Silver Book 2, we have started creating a new Delirium Hub. It's a critical time too to influence the development of new advanced clinical practice roles, and to promote the BGS's education and training offer through online events and eLearning.

In particular, we'll be having a strategic focus on high-quality healthcare in care homes - see **www.bgs.org.uk/ambitionsforchange** for our recent report on this topic.

Under the three cross-cutting objectives – stronger digital, stronger regions and stronger community – we have made some great steps forward. The COVID pandemic has accelarated digital developments with the BGS making a fast transition to delivering online events, remote meetings and other virtual services. Growth in membership numbers over the last 18 months has signalled that people value their membership and want to be part of the BGS community, as much for peer support and shared resilience as for the specific services and discounts. The pressure on our members over the long months of the pandemic has meant redeployment, extra hours and the cancellation of study leave. We hope the BGS has provided some solidarity and support in this exceptionally challenging time.

The need to take a strategic long-term approach to planning the workforce providing healthcare for older people has been growing in urgency over recent months, and the Board decided to prioritise this as a new fourth cross-cutting objective for the second half of the Strategic Plan period. The pandemic has highlighted the shortage of skilled professionals delivering health and social care for older people. This is not just a short-to-medium term COVID issue, but a pressing need to deal with the long-term demographic certainty of more people living for longer with complex health needs. The BGS will be working with key stakeholders to develop and advocate for a strategic approach to recruitment, retention, training and support across the different professions specialising in older people's healthcare. Our two workforce reports from the pandemic, *Through the Visor 1 and 2*, attest to the toll on healthcare professionals and the importance of a sustainable approach.

Thank you for your part in building a vibrant, relevant community of healthcare professionals united by a commitment to improving healthcare for older people. We depend on our multidisciplinary members across the four nations working in different care settings to be active contributors to the BGS mission, as trustees, committee members, SIG and region organisers, and officers. As we enter the second half of our Strategic Plan period with these renewed priorities, we are grateful for your continuing support for the work of the BGS.

Sarah Mistry
BGS Chief Executive
@SarahMistryBGS

Age and Ageing: Introducing your new digital journal

We are proud to announce that *Age and Ageing* successfully evolved to a fully digital journal at the start of 2021.

Over the last year, we have been making the transition from print to online, news of we have shared with you via this *Newsletter*, e-bulletins and the journal itself. We have been working with our publisher, Oxford University Press (OUP), to ensure the online journal does not merely replicate what the print version would offer. The greater flexibility of this medium means we can include supplementary audio and video material, extended tables and diagrams, reference lists and of course the opportunity for sharing and linking options, all of which will enhance the experience of using the journal.

Over the last year, the number of papers submitted to the journal has been increasing significantly. The Editorial Board continues to maintain a high bar for acceptance, but the quality and volume of papers is such that your July issue of the journal would have come to 423 printed pages; twice the size of issues last year. Switching to monthly online publishing provides a more flexible and sustainable publication format for the future.

All BGS members, but perhaps especially those who miss receiving their printed edition, should check out these options for reading the journal:

- **Your online subscription.** As a BGS member you have a subscription and can access all of our content going back to 1972. Go to **www.academic.oup.com/ageing** and sign in via the BGS option (see image above right).
- **New Issue Alerts.** Subscribe to receive the latest table of contents directly to your email inbox - sign up at: **www.academic.oup.com/ageing/pages/content_alerts**
- **Browse by subject.** Articles can be filtered by subject to help you browse within topic areas (see below).
- **Online collections.** Curated for you by members of the editorial team and guest authors. Two new collections are launched per year on hot topics, and two more collections are published to accompany the programmes of the BGS conferences. You can browse these exclusive collections at: **www.academic.oup.com/ageing/pages/web_collections**
- **Featured content.** For the skim-reader! With each issue we provide a one-line layman summary of some of the key articles highlighted for readers by the Editor. **www.bgs.org.uk/resources/age-and-ageing-journal**

If you have any feedback or have queries regarding your online access please contact Katy on **aa@bgs.org.uk.**

Monthly issues starting Jan 2022

To meet the needs of our growing journal we are moving from bi-monthly to monthly digital publication. This will divide our issues into a more digestible size and allow us to coordinate table of contents announcements with other monthly communications. We will continue to publish all articles as soon as possible in the Advanced Access section of the journal's website (**https://academic.oup.com/ageing/advance-articles**). Then, at the end of each month, the content will be collated into an issue. Table of contents pages will be published each month on the BGS website and you can subscribe to New Issue Alerts (see previous section for information on how to sign up for these).

Monthly issues will better suit our pace of content, but the transition may be a bit uneven: we are expecting the January 2022 issue to be larger than usual as it must encompass all the content which is accepted between the two production formats. This will start our year with a bang! We hope readers will enjoy the new monthly format in 2022.

A golden year ahead: A&A turns 50

In 2022 *Age and Ageing* journal will celebrate its 50th year. First published in 1972, the journal is now established as the leading international clinical geriatrics journal. We are marking this half-century with a year of specially commissioned commentaries from eminent authors reflecting on what has been achieved and where they envision we will go next.

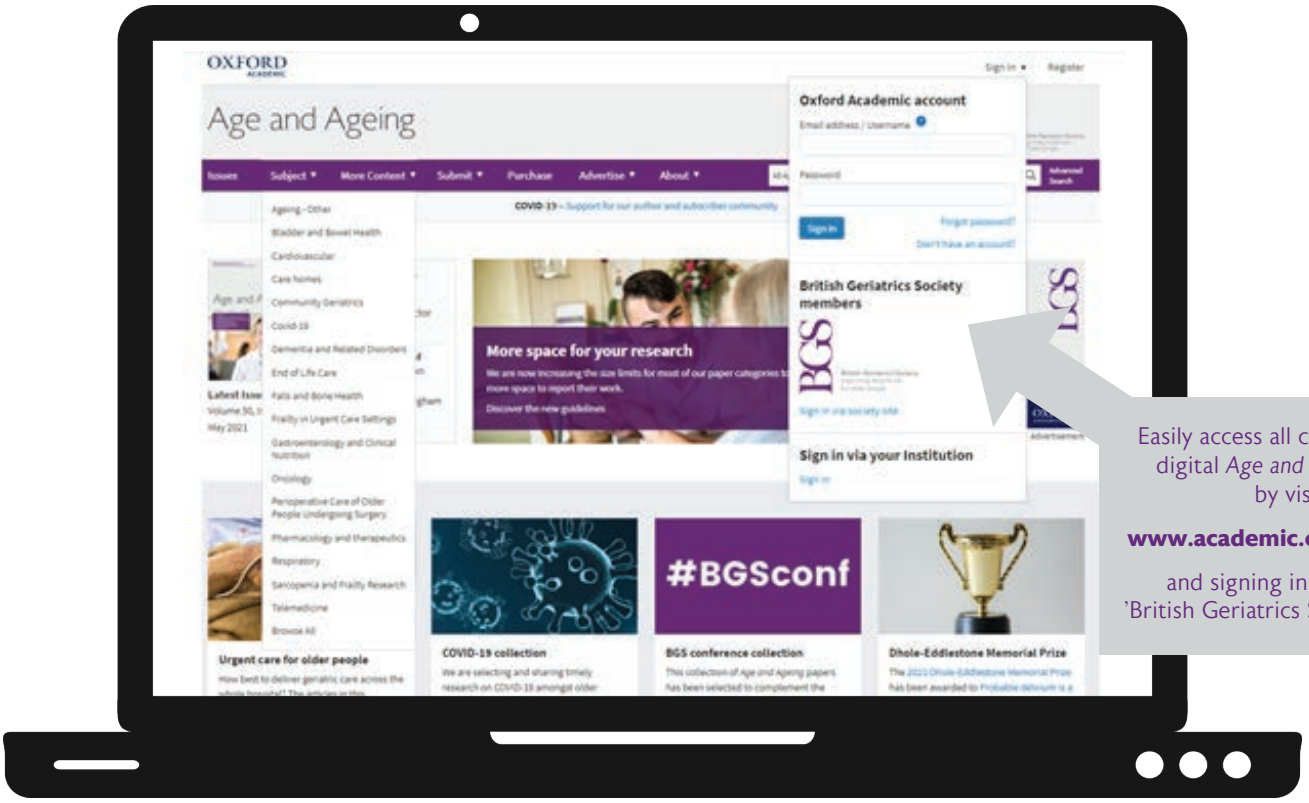
We look forward to presenting our readers with these articles throughout the year and giving representation to the rich range of topics and geographic regions which have contributed to the success of the journal and to the improvement of healthcare for older people.

Counting the environmental impact

A 400-page *Age and Ageing* journal is approximately 1.5cm (0.5 inches) thick and weighs nearly 1kg.

Switching from sending printed journals to BGS members to providing content in a purely digital format will save 1.4 million sheets (21 tonnes) of paper a year, the equivalent of around 600 trees. This reduces our carbon footprint by an estimated 500,000kg – or the same as around 500 transatlantic flights!

A 400-page Age and Ageing journal (pictured with an apple for scale)



Easily access all content from the digital *Age and Ageing* journal by visiting

www.academic.oup.com/ageing

and signing in where it says 'British Geriatrics Society members'

Making an even bigger impact

The growth in the journal's output has been matched by an improvement in the impact, citation and usage of our published material. Last year we had 2.3 million article downloads and we are delighted to announce a significant increase to the journal Impact Factor score, from 4.902 to 10.668. *Age and Ageing* now ranks 3rd out of 51 in the journal category for Geriatrics and Gerontology. The CiteScore results are even stronger with A&A ranking 3rd out of 99 journals in the category with a CiteScore of 9.6. We are the most highly cited clinical geriatrics journal. This is a huge achievement and we are grateful to the hundreds of authors and reviewers who work so hard to maintain high quality and to produce such impactful work. We mark this success with a new online collection of our highest cited papers and a glowing endorsement from our Alfonso Cruz-Jentoft, an author of our highest-cited paper. See the links on the opposite page to access the collection.

Open Access discount for BGS members

Don't forget that we offer a 20% discount on the Open Access fees for members of the British Geriatrics Society who submit papers for publication in the journal. If you are a BGS member and would like to apply this offer, please email Katy (**aa@bgs.org.uk**) with your membership number. If you would like to join the BGS to take up this discount (and the many other benefits of membership), please email Disha (**membership@bgs.org.uk**). More details about the BGS and our membership rates can be found at **www.bgs.org/join.**

'Last year we had 2.3 million article downloads and we are delighted to announce a significant increase to the journal Impact Factor score, from 4.902 to 10.668.'

Editorial superstars

The recent successes for the journal are very gratifying, but the additional work has put pressure on the Editorial Team. We would like to record our thanks to the team who have powered through a very demanding time. Every month since March 2020 has been a record-breaking month for submissions to the journal, which the Associate and Deputy Editors have absorbed on top of a busy clinical workload and the disruptions which we have all experienced at home and at work. Thank you!

Adam Gordon
Andy Teodorczuk
Arduino Mangoni
Ben Jelley
Caroline Nicholson
Emma Vardy
Harnish Patel
Jagadish Chhetri
Jonathan Hewitt
Jugdeep Dhesi
Kristian Pollock
Mike Kelly
Nathalie van der Velde
Neil Pendleton
Raj Rajkumar
Roman Romero-Ortuno
Roy Soiza
Ruth Hubbard
Sian Robinson
Simon Conroy
Stuart Parker
Susie Shenkin
Terence Ong
Terry Quinn
Tizzy Teale
Vicky Haunton
Wilco Achterberg

To build resilience and capacity in the Editorial Board we are expanding to 30 Associate Editors and five Deputy Editors. There have already been some excellent nominations and we are pleased to be welcoming **Claire Steves** and **Luis Miguel Gutiérrez-Robledo** as new Associate Editors. Please email **aa@bgs.org.uk** for more information about opportunities within the *Age and Ageing* journal editorial team.

Ambitions for change: Improving healthcare in care homes

BGS members are of course well aware of the toll that COVID-19 has taken on older people across the UK and nowhere has this been seen more than in care homes. We know that the pandemic has been particularly challenging for care home residents and colleagues caring for them – both in terms of the number of COVID deaths in care homes as well as the impact of lockdown on the physical, mental and emotional wellbeing of residents.

During the pandemic, BGS sought to support care homes with the publication of guidance on the treatment of COVID in a care home environment. Now that we are hopefully moving out of the worst of the pandemic, we are building on this guidance with the publication of *Ambitions for Change: Improving healthcare in care homes.*

In this document we aim to outline how care is currently provided in the diverse care homes sector and how the pandemic has changed the way that older people receive healthcare. As initiatives emerge to enable older people to receive hospital-level healthcare in settings outside of hospital and this document argues that this level of healthcare should be available to older people living in care homes.

However, it must always be remembered that care homes are not temporary places of accommodation nor are they mini-hospitals – they are the places that older people call home and that should always be respected. Care home staff put a lot of effort into making sure that older people are happy and comfortable in the care home and the move towards providing healthcare in a care home environment should never overtake this.

We have tried to make recommendations in this document that both acknowledge the skills already held by care home staff and visiting healthcare professionals and are aimed at making life easier for those providing healthcare in care homes and improving the experience of older people living in care homes. Our recommendations include ensuring that staff working in care homes and those visiting have the skills they need to provide appropriate care for older people.

We have aimed throughout the document to value first and foremost the care provided by staff working in care homes as they know the residents best and are likely to have a good understanding of what the resident wants and needs. We particularly focus on the role of the care home nurse, stating that the care home nurse should be a key member of the care home multidisciplinary team and that care home nurses should be encouraged to train as advanced clinical practitioners.

While the care home sector varies between the four nations, we believe that our recommendations can be applied across the UK and there are lessons that we can learn from all systems. However, care homes do not exist in a vacuum – they are part of a wider social care system which is in desperate need of reform and additional funding. While the social care systems also vary across the four nations, plans for

Our 11 recommendations

1. The NHS across the UK should work with care homes to **roll out and fund programmes to enable enhanced healthcare services to be provided in all care homes.** This support should include investment in IT infrastructure that enables relevant data to be accessed by all professionals involved in care delivery. Additional support should be provided to care homes which are struggling to implement the changes.

2. Governments across the UK should dedicate **appropriate funding for the development of care home staff** to ensure that they have the knowledge, skills and competencies to support residents with frailty and complex needs.

3. **Comprehensive Geriatric Assessment (CGA) should be routine for older people entering care homes** to ensure that their needs are met. This enables proactive assessment with a focus on quality of life rather than depending on reactive crisis-driven care. Care plans produced as part of CGA should be recorded in residents' care home and primary care records.

4. A **definition of a care home multidisciplinary team (MDT) should be developed and standardised across the UK,** as part of **Enhanced Health in Care Homes** (EHCH) in England and through similar initiatives in the other nations, with the overall aim of allowing CGA to be conducted as described.

5. All members of a care home MDT, including those employed by both the NHS and care homes, should undergo **specific training in the care of older people**. This should include nurses employed by care homes, so that they are enabled to play an active role in the care home MDT.

6. Regardless of where they live, care home residents should be able to access **NHS-funded rehabilitation, equipment and other services** according to their needs, in the same way that an individual living in their own home would.

7. Education providers should develop and define **specific core competencies** for each of the professional groups regularly participating in the care home MDT and consider the development of accreditation for these individuals.

8. UK Governments should commit funding to ensure that all care homes have access to support allowing **care home residents to receive care in situ that would otherwise have been provided in a hospital setting**. This includes extensivist care provided by registered nurses employed by care homes as well as that provided by visiting healthcare professionals. Care home staff should be involved in the design of all new initiatives to support healthcare in care homes.

9. Healthcare systems should be set up to ensure that providing **healthcare within a care home environment is the default option** if at all possible, unless the resident prefers other alternatives. We know that there will be exceptions to this and in some cases, hospital treatment will be the best option for a resident. **Care home residents should never be denied hospital treatment where there is a clear health benefit to be achieved that outweighs the risk of harm associated with hospitalisation.**

10. UK Governments should commit to ensuring that linkable **datasets for long-term care are developed with the aim of improving the quality of care received by residents.** This may include implementing the recommendations of the DACHA (Developing resources And minimum dataset for Care Homes' Adoption) study if shown to be relevant to all four nations. Data collection has implications in terms of resource and staff time so the benefit of collecting the data must justify the burden placed on staff.

11. Governments in the UK should set out plans to **support care homes to harness digital technology** to help them improve the care they provide to their residents. This support should include financial assistance to enable care homes to purchase the equipment they need as well as training for care home staff to ensure that they have the skills to use the technology to its potential.

reform are afoot in both Scotland and Wales and this is a long-awaited government promise in England. While we have made some suggestions for how healthcare in care homes can be improved and steps that both care homes and the healthcare professionals working in them can take to better serve residents, the real action needs to be taken by governments to better support care homes, their staff, residents and the wider social care sector.

We are very conscious that at the BGS, our expertise is limited to the delivery of healthcare and we have limited the scope of this document to this area. We are very aware that while we have some care home staff within our membership and more members who work in care homes through their work in primary and community care, this is not an area in which we have traditionally carried out a lot of work. We have involved people who work in care homes in the writing and reviewing of this document and we sincerely hope that they find it useful.

We look forward to continuing to work together with our colleagues in care homes to ensure that older people living in care homes have access to the same high quality healthcare as other older people. BGS's mission is, after all, 'Improving healthcare for older people' and this applies to all older people, regardless of where they live.

Sally Greenbrook
BGS Policy Manager
@SallyGreenbrook

British Geriatrics Society
Improving healthcare for older people

BGS Virtual Events: On Demand!

Available for 12 months post-event

If you can't join our virtual meetings live, you can now watch unlimited sessions **on demand for up to 12 months** after the original broadcast. This access is included for people who registered for the original meeting, or you can register to view any time after the event.

Currently available meetings include:

- Autumn Meeting 2020
- Spring Meeting 2021
- Cardiovascular SIG Meeting 2021
- Trainees Meeting 2021
- Scotland Spring Meeting 2021

With more events being added as they happen!

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

British Geriatrics Society
Improving healthcare for older people

Call for Abstracts

For BGS meetings in 2021-22

The BGS is inviting abstract submissions for upcoming meetings, including:

- BGS Northern Region Meeting 2021
- BGS Spring Meeting 2022
  (check website for opening date)

Abstracts are encouraged and will be considered as either platform presentations or posters to be displayed at the meeting. For current deadlines and full details on how to prepare and submit an abstract, please visit the BGS website on the URL provided below.

For deadlines and submission details visit www.bgs.org.uk/abstracts

Right time, right place: Urgent care for older people in the community

The BGS is committed to improving healthcare for older people, in the most appropriate setting for the individual. In recent years there has been an increasing focus on the healthcare that is provided outside the acute hospital environment, either in the patient's home or in a community setting. Various models have emerged, particularly for the provision of urgent care out of hospital.

Our new publication, *Right time, right place: Urgent care for older people in the community*, outlines the offers and services currently delivered across the country in pursuit of a broadly similar aim to provide appropriate, timely, high-quality care when an older person experiences a crisis or urgent need.

BGS does not advocate one particular approach and instead we have set out principles which we believe should be fundamental in ensuring older people's needs are met. There is significant inconsistency between the different urgent care offers available, both in terms of what they deliver and the language used to describe them, and this can lead to confusion. We acknowledge that this is a constantly changing environment and that there is a lack of consensus around definitions of services and provision in different parts of the country. We are calling for coordination and consistency in the clinical process of care so that older people can be supported as close to home as is possible with reliable high-quality appropriate care which meets their needs and wishes. We also recognise the importance of considerations of cost-effectiveness in a context of limited resources. The document aims to describe the role of urgent care within the ecosystem of older people's care and details some examples of how urgent care can be provided outside the hospital environment. It provides tips for BGS members who want to start providing this type of care to their older patients and calls on commissioners and governments to make the provision of care at or near to home easier for healthcare professionals and patients.

While the BGS is a four-nations society, we have taken the decision to focus on England in the publication, although some of the themes are likely to be relevant to colleagues in other parts of the UK. This is an area where the situation is significantly different across the four nations.

For example, plans are underway in England as part of the NHS operational and planning guidance for 2021/22 to put in place an 'Urgent Care Response' (UCR) to a two-hour target across all Integrated Care Systems (ICSs) by April 2022, while Health Boards in Scotland are required to establish Hospital at Home (H@H) services. 'Acute care at home' services have been introduced in Northern Ireland while '@Home' services provide similar care in Wales.

While implementing services to provide urgent care at home requires dedicated local capacity, support is needed from central bodies and ICSs to make this a reality across the country. In order to make this happen, we call for:

- Commitment to implementing our principles to deliver a high-quality person-centred experience of urgent care for older people.
- Coordination and linkage of services to enable delivery of coherent and efficient services for people living with frailty.
- Sharing of good practice, so that all regions and local areas are supported to learn from each other, coalesce around a common language and avoid duplication and fragmentation of services.
- Communication between providers so that proactive and reactive services are joined up, and patient records are shared with appropriate information governance in place.
- Appropriate resources to be identified to ensure all people living with frailty have clear, effective and sustainable alternatives to hospital admission where appropriate.
- Investment in technology to ensure excellent communication between primary, secondary and community care.

The BGS believes this vision is within reach if there is the will to make it happen. Nine out of ten deaths from COVID during the course of the pandemic were in people aged over 65. As services gradually resume post-COVID and the long-term effects of the pandemic become apparent, now is the critical time to 'build back better' and seize the opportunity afforded by the NHS Long Term Plan, with its focus on delivering more care for older people closer to home.

Ensuring that the urgent care initiatives described by BGS are coordinated will reduce duplication and enable older people living with frailty to receive assessment, diagnosis and treatment appropriate to their urgent care needs.

To read the document in full, please visit www.bgs.org.uk/righttimerightplace.

Through the visor 2: Further learning from member experiences during COVID-19

At the end of July, BGS published a report from a second survey of members, describing their experiences of working through the COVID-19 pandemic during winter 2020-21 and beyond.

Last winter was an extraordinary time for older people's healthcare in the UK. Having been pushed to their limits by the first wave of the COVID-19 pandemic, as detailed in our earlier *Through the visor* report, for BGS members the winter brought even more challenging working conditions. While better access to personal protective equipment (PPE) and testing for both staff and patients was reported, concerns remained about the quality of the PPE being used.

> *"Dear God, don't let it happen again. I don't know if I can do that all again."*
> **- Speciality Doctor, England**

Respondents were also less likely to be redeployed or have their job plans changed during this wave of the pandemic. However, 78.5% said that their Continuing Professional Development (CPD) and/or Supporting Professional Activities (SPA) time was cancelled. Many commented that even if their study time was officially protected, in reality they were required to

Key findings from the second survey

When we published Through the visor in March 2021, we commented on the challenges that our members faced in the first wave of the COVID-19 pandemic, acknowledging that the report captured a specific point in time and that most people faced more challenging circumstances over the winter period.

We heard in our first survey about the practical challenges faced during the pandemic including access to personal protective equipment (PPE) and COVID testing as well as the strain that the pandemic had placed on individuals' emotional and mental health and that of their families. It is heartening to hear from BGS members via our second survey that, for the most part, the practical aspects of the pandemic have been easier to manage and that the introduction of the COVID-19 vaccination programme has been well-handled and smooth. However, the impact of the pandemic on our members' mental and emotional wellbeing has not lessened and we once again heard heartbreaking comments from our colleagues who have faced unimaginable working conditions and seen the pressures of the pandemic affect their families. Healthcare professionals who care for older people are exhausted, burnt out and experiencing stress and anxiety. We heard from several people who described increases in workplace bullying and a worrying number of colleagues suggested that they are considered leaving their profession, either taking early retirement or moving to non-clinical roles.

There has long been a crisis within the health and social care workforce and we have known for a long time that we are not training enough specialists in older people's care. We can ill afford for colleagues to leave the profession now, worsening the crisis. It is essential that the mental health of the workforce is taken seriously and that healthcare professionals are supported to come to terms with what they have faced over the last year, so that they can return refreshed to doing what they are best at – providing exemplary care for our ageing population.

"I have always loved my job [but] in the last few months I have thought frequently about giving up medicine... I hope the joy returns."
- Consultant, Scotland

work long, extra hours clinically and did not have time for study. In addition, of the 65% who were able to take planned annual leave, 76% said they continued to check in with work in some form.

The continued impact of the pandemic on BGS members' mental and emotional wellbeing was a resounding theme to emerge from the second survey. Six out of ten respondents raised issues of anxiety, stress, burnout and struggles in coming to terms with the huge numbers of deaths they have seen among both patients and colleagues during the pandemic. Compounding this issue, many patients and relatives were perceived as less tolerant with NHS staff and systems than they had been during earlier stages of the pandemic. Respondents also identified high levels of anxiety among their family members, attributed to worrying about both the respondent's health and the increased exposure to COVID infection due to the respondent's job.

BGS members also reported that they believe the standard of care they provide had deteriorated significantly as time and staffing pressures increased during the pandemic. The impact of the pandemic has left some members considering leaving their professions, either in the form of taking early retirement or moving into non-clinical roles.

Sally Greenbrook
BGS Policy Manager

Clare Copeland
BGS VP for Workforce

While many people enjoy a healthy old age, the demand for health and social care services for those over 65 continues to grow. The pandemic has highlighted the importance of ensuring we have the right workforce, suitably equipped with skills and knowledge to support the older population's health needs.

It is essential that steps are taken now to recruit and train more specialists in older people's healthcare across the multidisciplinary team and to ensure that the entire healthcare workforce, including specialists in other disciplines, have a good understanding of frailty, multi-morbidity and cognitive impairments. Investment must also be made in providing care in the community closer to home, improving quality of life for older people, and preventing escalation of dependency, saving money in the long-term.

We are proud of each and every one of our members. They have gone above and beyond the call of duty during the pandemic, working through the biggest public health crisis in the NHS's history with professionalism and compassion for the older people they serve. We thank them for their commitment.

BGS Newsletter Wellbeing special issue

Among the most stark and shocking findings from our *Through the visor* reports has been the tremendous negative impact on the wellbeing of the older people's healthcare workforce.

Although this comes as little surprise, with the added demands of a global pandemic which has disproportionately affected older people, some of the comments provided by respondents to our surveys have highlighted some of the uniquely personal ways people have been affected by what they have seen, felt, and experienced over the past 18 months.

The BGS recognises the emotional, physical and mental toll that our members have paid and continue to pay as services, patients and healthcare teams slowly start to rebuild and recover from the pandemic.

Last summer, we published an edition of the *BGS Newsletter* thanking you for all you had done for older people during the crisis, which you responded to in your droves.

This time round we wanted to offer you something that might help empower you to make a small change for yourself - whether that is taking some time for self-care, being present for a colleague in need, allowing yourself a time for reflection or simply a chance to sit down and take a break to read this *Newsletter* guilt-free.

This issue also celebrates some of the creative and inspirational ways our members and their colleagues have found to find peace and calm amid the crisis. From choosing to remember acts of kindness, to being more physically active, not being afraid to ask for help, sharing experiences honestly and leading compassionately, we hope you will take something from the ideas shared.

You will also be able to find all the wellbeing content from this issue at **www.bgs.org.uk/wellbeing**, along with other links, signposting and resources which we hope will be of value.

As ever, please feel free to send us feedback, comments, submissions or ideas, we always love to hear from you. Please email editor@bgs.org.uk, or Tweet us @gerisoc.

Looking after your physical health: Do *you* practice what you preach?

Do we look after ourselves in the same way we look after those in our care? The pandemic has changed how we work, but this could be an opportunity to review and update our self-care.

The COVID-19 pandemic has affected everyone across the world and impacted all aspects of life. We have seen the impact on our patients with many emerging from lockdown with deconditioning, anxiety about returning to 'normal' life (whatever that might look like) and, in many cases, presenting with more troublesome symptoms and complex problems that otherwise might have been expected.

Whether we work in frontline health and care services, management roles or in academia, we have all had to change our working practice to embrace different ways of working. Changes may include a return to the acute setting, 12 hour shifts, wearing PPE, video and telephone appointments, working from home, as well as (what feels like) endless Teams or Zoom meetings. Many organisations have created support links for staff which focus on their mental wellbeing, but far fewer have emphasised physical health needs.

Sitting is the new smoking

While remote care can have many advantages for older people and health and care staff, there are drawbacks for staff who may find themselves spending more of their day being sedentary due to a need to be in front of a computer screen or by a telephone. Some healthcare organisations are arranging back-to-back remote clinics for staff which last for up to four hours per session with no opportunity for breaks away from the desk. This can result in issues such as joint problems or changes to eyesight, can be mentally draining, and cause muscle loss through increased sedentary behaviour – in essence, we are deconditioning ourselves. Our bodies aren't designed for long periods of sitting, we are designed to move. We promote **#MakeMovementYourMission** and **#EndPJparalysis** to encourage older people and our patients to be more active during the day, but we need to look to ourselves and **#MoveMoreSitLess**.

Top tips for being less sedentary during the working day

- **Is your work station correctly set up for you? Check the position of your workstation (monitor, keyboard, mouse, seat).**
- Try and alternate desk and non-desk based tasks where possible.
- **Discuss with your employer about the possibility of having a standing desk.**
- Get your eyes tested as you may need new or different glasses for screen working.
- **Build in breaks into your day (e.g. 5 minutes every hour; plan meetings for 25 or 50 minutes rather than 30 or 60 minutes).**
- Stand or walk during phone meetings/ consultations; walking meetings outside are another option.
- **Try and spend a few minutes throughout the day doing some exercises, such as doing some squats whilst the kettle is boiling, running on the spot or yoga stretches.**
- Move away from the desk at lunchtime and try and have a walk, ideally outdoors.
- **Some organisations offer staff activity 'bites' during the working day – short sessions (10, 15 or 30 minutes) including Yoga and Pilates.**
- Park further away from the entrance to your workplace so you increase your walking time, or get off the bus one stop earlier.
- **Encourage organisations to participate in activity motivating events, for example Step Challenges within and across teams/services, or charitable fund raising events e.g. fun runs.**

Being more active outside of work

We are all aware of how important it is to advise patients of being active, so what can we do to help ourselves practice

what we preach and challenge ourselves in order to maintain or improve our own physical and mental health? Even though many staff are physically active in doing their job, accruing >10,000 steps a day, they may also benefit from activity and exercise that focuses on their own wellbeing and physical health. We often deprioritise exercise as we are too exhausted to keep fit, strong and flexible. Identifying time to do this is a kindness to ourselves. We all know what to do to keep physically active but ring-fencing time to do this outside of work is key.

Being outdoors and engaging with the natural environment has been shown to have great benefits for our wellbeing. Whether it is walking the dog through the park, running by the river, gardening, yoga in the garden, or wild swimming – it doesn't matter. As well as the physical benefits, being mindful of your surroundings, the sights, sounds, sensations and smells, can have a calming effect and can help revitalise and refocus you, even for a short time.

Conclusion

Looking after our physical health has benefits to our mental health and wellbeing. However, often the reality is finding the energy and time to look after ourselves can be difficult. We have shared some of our personal experiences and curated some resources that will hopefully inspire and motivate those of you who are struggling to look after your physical health to identify some small changes that you can make. We must take care of ourselves to ensure we can effectively care for others. In principle, this means putting on your own oxygen mask first before helping others with theirs.

For more information and guidance from the authors, including resources on setting up your workstation, desk-based exercises and time management tools, as well as suggested wellbeing apps, please visit www.bgs.org.uk/wellbeing

Making time for wellbeing

"As an academic, I spend a lot of time in front of the computer and this has just increased over the past 16 months. Being at home rather than on campus means that I'm not breaking up my day walking to different meeting rooms, or popping to chat to colleagues. I'm just sitting down for up to 10 hours and barely moving. After advice from a colleague, I've started blocking out 'wellbeing' time every lunchtime in my diary. I stop and have lunch and take the dogs for a short walk. It also seems to have reduced meeting requests around that time and I don't feel bad about saying no to meetings when it means I don't get a break. I've also joined a community group in my village who look after the public green spaces. I've been involved in laying paths, weeding and planting flower beds. It's been a good motivation to get outside and be more active and the community spirit is a real boost." - Vicki Goodwin

Knowing when to ask for help

"After a relentless 18 months, many health and care staff are experiencing burnout, and it is important to recognise when you need to revaluate your coping strategies. After working in the COVID landscape, it isn't unusual for people to present with PTSD type symptoms, commonly as a result of working directly with patients with COVID, high death rates, and redeployment to unfamiliar areas. We are coming out of a battle zone and entering the next battle of restoring services. For me, my usual wellbeing activities (walking the dogs, running, being in nature) no longer had the desired effect of boosting my mood and reducing stress. I just carried on working harder, trying harder but then reached a point when the hardest part came – recognising I needed help. The second hardest part was asking for it! Some employers are better than others at providing support for staff, but there are sources of help available if you look for them. My employers have an excellent and skilled consultant psychologist focussing on staff health." - Vicky Johnston

Fiona Lindop
Specialist Physiotherapist in Parkinson's, University Hospitals of Derby & Burton NHS Foundation Trust; Clinical Therapy Lead, Excellence Network Parkinson's UK

Vicky Johnston
Highly Specialist Physiotherapist, North Cumbria Integrated Care NHS Trust

Sarah De Biase
Chair of AGILE, Professional Network for Physiotherapists working with Older People

Vicki Goodwin
Associate Professor of Ageing and Rehabilitation, University of Exeter

Happiness is home-made

With care homes particularly badly hit by COVID, and care home staff having uniquely personal relationship with residents, it is little surprise that this workforce has had an emotionally difficult time over the past 18 months. Care home owner and former NHS mental health professional, George Coxon, explains the impact he has witnessed among his colleagues and what they have been doing to help.

I spent all of my clinical NHS career as a mental health nurse, community psychiatric nurse, counsellor and therapist gaining a number deal of skills and insights that I feel have given me some useful tips for dealing with the protracted period of stress we have all endured during this pandemic.

Since migrating from a senior NHS commissioning role to the thrilling and exciting immersive life in care home land, I have learnt so much about the contrasting perceptions between health and care work. The pandemic has, I believe, helped elevate the status of care home work and given us sizable progress in the 'parity of esteem' we so desire and need. Workforce challenges across all of health and care are still severe but particularly felt in social care – with reputedly circa 120,000 vacancies at any one time.

The pandemic has illustrated the emotional cost of stress for us all. It has highlighted that the nature of the close and enduring personal relationships care home staff have with those we care for intensifies desperate feelings of fear, anxiety and grief. One of my two care homes experienced an outbreak early this year within days of celebrating being one of the first homes to have all of our residents and several staff vaccinated. The anxiety that followed after more than 10 months of hypervigilance was palpable, and this was followed by almost all of our staff testing positive and being required to isolate during a very tough period, with residents also becoming sick. The guilt and distress witnessed when staff had been able to care for our much-loved and long-lived residents, or support fellow care team members, was desperately poignant. There was a need for time to heal and express the complex emotions associated with the outbreak which included feelings of shame, blame, failure and low mood.

'There was a need for time to heal and express the complex emotions associated with the outbreak, which included feelings of shame, blame, failure and low mood.'

We had been holding team briefings on a weekly basis right from the outset of the pandemic – the agenda always included a mental health topic as the second item to share after an update on data, facts and the latest (and often changing) guidance for our work. The mental health topics ranged from how we are sleeping to dealing with frustration, isolation, the constant and gruelling mask wearing on shift and also good habits in life and coping skills. We have worked hard to embed kindness and team spirit in our everyday life – forgiving imperfections of one another and tolerance based on 'understanding before condemnation' and using words such as positivity, pride in our work, confidence and being strong. These terms forming mantras to seek to retain control and preserve the atmosphere of lively quirky, safe and fun life for our residents, even during a time when lack of contact with families and loved ones has really taken its toll on resident wellbeing.

There are mixed views on how we promote robustness and resilience in care home work but it's hard to argue that resisting negativity isn't an important part of mental health and wellbeing. We have kept music a constant backdrop to our work – with themed days such as marking Paul MacCartney's recent 79th birthday with a full repertoire of Beatles hits. Any excuse to give reason to look forward to better times ahead.

The essence of what matters to those that live, work and have investment in care homes life, particularly families of those living in 24/7 care is enshrined in some vitally important words. Trust, respect, value and reward are high on the list of key principles.

There remains continuing debate about reforms to social care. Many of us, as keen advocates of making positive noise to both inspire and reassure those with apprehensions of what we do as care home activists, are determined to not allow the frustrations about the virus - and even the politics - detract from creating vibrant, lively, cheerful, calm and stimulated value-adding life that keeps us all feeling upbeat as much as possible, and supported on days when this is hard.

George Coxon
Owner, Summercourt & Pottles Court Care Homes, Devon

Caring in COVID: A nurse-eye view

Pandemics come and go; they are not new and they will return. Our obligations as health professionals include preventing them, responding to them, learning from them and sadly preparing for them to arrive again, say Dawne Garrett and Jo James, professional leads for older people at the Royal College of Nursing.

As nurses we are always intimately involved - we are the largest workforce that provide clinical care for all citizens, as older people's nurses we know those we serve will often be severely affected.

The ability of nurses to manage terrible circumstances is both a tremendous strength and frequently a personal detriment. As professional leads at the Royal College of Nursing (RCN) we were uniquely placed to provide support to nursing colleagues irrespective of sector or role, producing and importantly acting as conduit for guidance across all four countries. Our COVID web pages remain (**www.rcn.org.uk/covid-19**) with individual pages receiving more than half a million hits.

Our organisation, which is both a Royal College and trade union, was faced with appalling personal details of both working conditions and personal issues. Everyone has stories to tell and we are a repository of amazing achievements and despair. It is important is that we acknowledge everyone's contribution and loss. The RCN was influential in a day of reflection and providing memorial videos and a book of remembrance, similar to our book which documented the loss of nurses during wars. Our lobbying has been influential in many political decisions and our helpline has been a source of evidence and response.

'Small acts of kindness made older people feel safe and cared for in a frightening environment... it is that experience of nursing rather than the brutality of the pandemic that I choose to remember.'

Examples of the way nurses have responded have shown the profession at its best, our older people's forum lead Jo James gives us a flavour of her experiences in the acute hospital setting.

"As resources were redirected into our critical care services and away from general geriatric and dementia care, I found myself conflicted, furious that yet again it was our patients who were disadvantaged; thrust aside with almost indecent haste to make way for younger, more 'viable' patients. Yet at the same time I felt hopeful and inspired by the nursing that I saw while redeployed in the ED. It was altogether a kinder, more elder-aware approach to patients than I remembered from my ED days some 15 years earlier.

"I had forgotten about the relentless pressure emergency nurses are subjected to; the noise; the activity and the frantic turnover of patients interspersed with the odd really tragic experience which stops everyone in their tracks for a moment. In spite of this, older patients' families were allowed to stay, skin was assessed, they were put into beds straight away and supplied with endless cups of coffee and sandwiches from a fridge in majors. These might not seem like big things, but they were small acts of kindness which made older people feel safe and cared for in a frightening environment; and it is that experience of nursing rather than the brutality of the pandemic that I choose to remember."

However, clinical guidance and acknowledgement are simply not enough, many nurses need psychological, practical and financial help. Our Lamplight team supports the nursing community with factors affecting their financial situation and work in partnership with the RCN charitable foundation to extend support to all staff working in nursing providing advice and financial assistance. This was particularly important when sick leave or agency working was problematic. Since April 2020, the RCN Foundation has helped 3,286 nursing and midwifery staff, providing just over £1.45m in grants through our COVID-19 Support Fund and the Stelios Says Thank you Awards. Our membership services provide counselling and psychological assistance.

The future requires regular scenario planning, operation cygnus warned us of so many issues prior to this pandemic Nursing must be represented and lead nursing at all levels and be properly resourced. We have done so much but acknowledge there is so much still to do.

Dawne Garrett
Professional Lead Older People and Dementia Care
Royal College of Nursing

Jo James
Older People's Forum Chair
Royal College of Nursing

Compassionate leadership and the future of health and social care

The benefits of leading with compassion go far beyond simply making people feel better - explains Professor Michael West, a Professor of Organizational Psychology at Lancaster University and speaker at the BGS Spring Meeting 2021 - it also leads to better outcomes and care.

Even before the COVID-19 pandemic, the health and social care sector was facing the biggest crisis in staffing since the introduction of the welfare state in 1948.[1] There was a crisis related to vacancies, sickness absence, staff turnover and stress levels. This has damaging consequences for staff health, performance and patient/service user safety. The causes of these difficulties include inadequate staffing levels; work overload and inflexible work schedules; moral distress; bullying, harassment and violence; discrimination and poor pay. Collectively these problems reveal a crisis of leadership.

We can find hope and inspiration from the evidence which shows that compassionate leadership results in profoundly better staff wellbeing and commitment, improved care quality, and fairer, more transparent and kinder workplaces. Compassion is a universal value because of two truths – the first is that we have all experienced compassion, no matter what our cultural background, upbringing, or the different paths that our lives take. And second, compassion is universal because it is care that flows naturally from a deep part of ourselves, to those who need it, ideally regardless of status, wealth, ethnicity, age or gender. Compassion binds us together and creates a sense of safety and interconnectedness (as we have seen during the pandemic). It nurtures a feeling of belonging to others beyond our immediate circles.

The role of leadership in modelling and embodying compassion to develop compassionate cultures in health and social care is fundamental. Compassionate leadership may be mistaken for a soft and ineffective approach to leading in health and social care, but far more courage and authenticity is required to lead compassionately than to lead using command and control.

Compassion is fundamental in health and social care, but it is far more important even than is often imagined. Much research evidence now describes the importance of compassion as protective of health and life; the impact of clinician compassion on patient outcomes; the link between compassion and patient experience; how being compassionate also protects those providing care; and the effectiveness of compassionate leadership.

Leaders can put into practice the four elements of compassionate leadership – attending, understanding, empathising and helping those they lead – by developing compassion in interactions with colleagues, nurturing and sustaining compassionate climates in teams and departments, and developing compassionate organisational and institutional cultures. If leadership is not inclusive, it is not compassionate.

Inclusion was a founding value of the welfare state in the United Kingdom but organisational cultures in health and social care continue to reflect the widespread and pathological discrimination within wider society. The pandemic shone a spotlight on the effects of discrimination on health in society with far higher proportions of those with disabilities or those from minority ethnic groups dying from COVID-19. Inclusive leadership promotes equity, cultures that value diversity in all its forms, and ensures inclusion in practice. Compassionate leadership offers a means by which inclusive leadership can be achieved, including the compassionate management of conflict and developing strategies to ensure all individuals, teams and leaders take responsibility for sustaining inclusive cultures.

Traditional approaches to leadership have important limitations with their emphasis on developing individual capability while neglecting the need for developing collective leadership capability. They are also limited in that they can hamper the dialogue, debate and discussion that enable shared understanding about quality problems and solutions. Compassionate leadership in contrast enables all to feel they have leadership responsibility, rights and accountability, effectively ensuring the skills of all are harnessed in the delivery of high-quality care. Compassionate leadership offers a practical means for ensuring that the resources of the largest, most skilled and motivated workforce in the whole of industry (healthcare staff) are effectively utilised.

This is being implemented in practice in many places, including Health Education and Improvement Wales' ten-year strategy for developing compassionate leadership across the whole of health and social care in Wales (see **https://nhswalesleadershipportal.heiw.wales**).

Central to this is leadership self-compassion. Self-compassion enables us to deepen the wisdom, humanity and presence that sustain compassionate leadership and a life of authenticity and flourishing. Compassion is rooted in the relationships shared between people. Often overlooked though in explorations of compassion, is the relationship we have with ourselves. Our relationship with ourselves is the basis for our relationships with others. How we relate to ourselves, determines how we relate to others.

'Compassionate leadership may be mistaken for a soft and ineffective approach to leading in health and social care, but far more courage and authenticity is required to lead compassionately than to lead using command and control.'

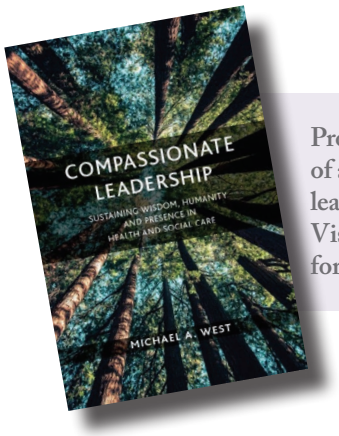
'Compassionate leadership enables all to feel they have leadership responsibility, rights and accountability, effectively ensuring the skills of all are harnessed in the delivery of high-quality care.'

If we are honest with ourselves, open to our experiences (thoughts, desires, fears), not distorted by arrogance or pumped-up pride; if we are realistically positive in our view of ourselves; and quietly appreciative of our privileges, qualities and talents, we can also be compassionate towards ourselves.

Compassion is a sensitivity to suffering in self and others with a commitment to try to alleviate and prevent it. These basic human orientations underpin our motivation to help. The commitment to alleviate and prevent suffering requires wisdom, humanity and presence that enables us to take wise and caring action. Compassionate leadership is leadership that embodies these fundamental human orientations in wise ways.

Such leadership is not hidden behind a mask of organisational titles, hierarchical positions or formulaic phrases that inhibit authentic connection. It is a courageous leadership that embodies presence – being present with ourselves and others. Present with their challenges and suffering; present with our own challenges and suffering; present with joy at work and present with the core values of compassion, inclusion, kindness and caring that must be woven into the genetic structure of our health and social care workplaces.

It is the responsibility of all of us to practice compassion, self-compassion and compassionate leadership in our health and social care services and more widely. Our imperative for our future and those of our children and our planet: to lead compassionately to sustain wisdom, humanity and presence for all our futures.



Professor Michael West is the author of a new book on compassionate leadership in health and social care. Visit https://tinyurl.com/vh55mker for more information.

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Professor Michael West CBE
Senior Visiting Fellow, The King's Fund; Professor of Organizational Psychology, Lancaster University; Emeritus Professor, Aston University.

WELLBEING
Special Issue

PTSD in the MDT: What, when and how?

Healthcare workers caring for older people have been enormously challenged over the last 18 months – with over 90% of COVID-19 deaths occurring in the over 65's, significant resource and equipment constraints, and overwhelming moral distress,* the pandemic has had a huge impact on the mental health of staff, and the scale of this is only just beginning to come to light. Post-traumatic stress disorder (PTSD) is one such condition that is on the rise in healthcare workers for older people, as a result of COVID-19.

What is PTSD and how is it caused?

PTSD is caused by experiencing a traumatic event which causes fear, helplessness, or horror in response to the threat of injury or death to yourself or another person. It's no surprise then that the British Medical Association[2] have recently reported that the issues that many healthcare workers have come up against - staff shortages, having to deliver difficult news over the phone, mental and physical fatigue, witnessing the huge scale of patient death, lack of time to give emotional support, lack of PPE, and having to deny family members access to dying patients – is enough to cause PTSD and other severe mental health conditions.

What are the symptoms of PTSD?

With PTSD, your brain physically changes as a result of trauma – it's not a sign of weakness or something you can just 'get over'. Your brain is activated by the stressful stimuli of a trauma; the disruption that occurs with PTSD can be conceptualised as a kind of 'false alarm.' This 'dysfunction' of the systems is thought to produce hippocampal damage manifested as impaired memory. Additionally, exposure to trauma can activate the amygdala (responsible for fear responses), resulting in hypervigilance and inappropriate fear responses. Some other common PTSD symptoms include:

- Flashbacks - reliving the traumatic event, and feeling like it happening right now including physical symptoms such as a racing heart or sweating.
- Recurring memories or nightmares.
- Physical sensations like sweating, trembling, pain or feeling sick.
- Feeling emotionally numb or cut off from your feelings
- Feeling tense, on guard, or 'on edge.'
- Having difficulty concentrating on simple everyday tasks.
- Having difficulty falling asleep or staying asleep.
- Feeling irritable and having angry or aggressive outbursts.
- Distorted thoughts about the trauma that cause feelings of blame and guilt.
- Overwhelming negative emotions, such as fear, sadness, anger, guilt, or shame.
- Loss of interest in previous activities.
- Feeling like nowhere is safe.
- Difficulty feeling positive emotions, such as happiness or satisfaction.

PTSD can manifest itself in a variety of ways and is likely to have a significant impact on your daily life – but as a healthcare worker, this can cause huge amounts of guilt, which can almost re-traumatise you over and over again.

Treatment options for PTSD

It's important that if you feel that you've been feeling any of these symptoms, that you reach out to your GP, or a friend or colleague. For some, the first step may be watchful waiting, then exploring therapeutic options such as individual or group therapy. NICE guidance (updated in 2018) recommends trauma-focused psychological treatments such as EMDR (eye movement desensitisation reprocessing), and trauma-focused cognitive behavioural therapy (CBT). You may also want to explore holistic non-pharmacological therapies such as yoga, running, or even crafting, to help manage your symptoms.

Traumatic events can be very difficult to come to terms with, but confronting and understanding your feelings and seeking professional help is often the only way of effectively treating PTSD.

Further reading and resources

For more information about the causes, symptoms and treatments available for PTSD, please visit the PTSD UK website at www.PTSDuk.org

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2. BMA. Moral Distress. 2021. Available at: www.bma.org.uk/moraldistress

PSTD UK
www.PTSDuk.org

** where professionals identify an ethically correct action to take but are constrained in their ability to take that action.*

You okay? Caring for those who care for older people during the pandemic

Caring for older people and maintaining wellbeing among healthcare professionals (HCPs) is often difficult. The COVID-19 pandemic has presented additional challenges and exacerbated existing ones, meaning optimal care provision and maintaining NHS staff morale is more essential than ever, explains Charles Carey, an F1 doctor and ambassador for medic support charity 'You Okay, Doc?'

The early stages of the pandemic saw COVID-19 rip through care homes and lead to the death and suffering of many older patients. Negative COVID-19 PCR tests were therefore mandatory for all patients on my complex care ward before admission and before patients could be discharged back to care homes and places with other vulnerable people. This led to many patients having delayed discharges and others having to wait for long periods for beds, an issue that was highlighted in an earlier BGS survey.[1]

Sadly, these precautions were not always able to prevent COVID-19 outbreaks on our ward and many patients developed the disease having initially been COVID negative during their stay. As a result, patients had to be moved to COVID wards and many subsequently deteriorated. Furthermore, our ward had to be closed to new admissions during outbreaks, preventing others from accessing care from geriatric specialists. The risk of nosocomial COVID infection also had an impact on patients outside of hospital. Many were too afraid to present to hospital or to their GP, preventing them from managing their care needs at an early stage. In addition, the need to shield has led to large numbers of elderly people feeling isolated and to stop exercising regularly. As a result, patients in hospital were commonly less mobile than before the numerous lockdowns and cited that they would have sought care sooner than they eventually did. Consequently patients needed more intense medical care and had heightened needs for care packages before discharge.

> 'HCPs were commonly exposed to older patients deteriorating despite full medical management, with little that they could do to improve their condition.'

Family members play a key role in caring for complex medical patients. The inability to have family members with patients made acquiring collateral histories and insights into patients' physical and cognitive baselines much more challenging.

In addition, patients were prevented from having someone there who they know, can feel safe around and who can help orientate and provide care during hospital stays. The pandemic also prevented staff from attending hospital if they were required to self-isolate after developing COVID-19 symptoms or following a positive COVID test from themselves or their contacts. Rota gaps were therefore commonplace during the many COVID peaks and since geriatric wards are frequently poorly staffed, high demands were placed on those who were able to work. This meant that leaving after contracted working hours was almost the norm.

Although medical methods and supplemental oxygen is often effective in treating COVID-19, the virus can have horrific consequences for older people. Geriatric patients are commonly inappropriate for intensive care admission, meaning that their ceiling of care is on the ward. HCPs were commonly exposed to older patients deteriorating despite full medical management, with little that they could do to improve their condition. Along

with the rest of the nation, HCPs were also largely unable to enjoy outlets such as seeing friends and family when not working as a result of necessary lockdown restrictions. The toll of the pandemic on the wellbeing of HCPs has been well documented.[1,2] The British Medical Association has stated 80% of doctors are at high risk of burnout and identified a correlation between working long hours (51 hours or more/week) and suffering from psychological or emotional conditions.[3]

Resilience is an obvious necessary characteristic for HCPs but an emphasis on this alone is not sustainable for anyone long-term. It is also necessary to acknowledge that it is 'OK not to be OK' and that periods of low mood are not signs of weakness but are part of being human and can indicate that changes are necessary. Furthermore, the need for HCPs to practice methods of self-care and self-awareness has been highlighted as keys to avoid burnout, compassion fatigue, and impaired clinical decision making.[4]

The BMA has recognised that the impact of pandemic is likely to lead more people to require professional mental health support and that mental health services prior to COVID-19 were frequently unable to supply patients with adequate care.[2] You Okay, Doc? (YOD) is a UK registered charity that seeks to provide a space where doctors can seek psychological support, speak about their own wellbeing and general topics around mental health. The charity develops strategies to help manage personal and systemic mental health challenges. YOD also aims to develop a culture among doctors in which mental health struggles are not stigmatised and instead are met with openness, guidance and support. YOD provides a free 24-hour mental health service for doctors and runs a weekly Huddle in which doctors can talk about their mental health and support each other. In addition, the charity produces regular podcast episodes, webinars and social media posts aimed at discussing the key challenges to doctors' mental health and ways to overcome them, an example of which is shown on the opposite page.

Conclusion

COVID-19 has exacerbated feelings of stress, fatigue and mental health difficulties that were already widespread among HCPs. The pandemic provided an additional and severe disease that needed urgent care, especially amongst elderly patients. This indirectly created issues that made managing complex patients difficult. Currently mental health support services for doctors at work and more generally are insufficient to meet current demands and ensure all HCPs are cared for in the future. You Okay, Doc? is a charity that seeks to provide mental health support for doctors and encourages openness around their wellbeing and self-care.

Please contact You Okay, Doc? if you support what the charity is doing and/or feel that you would benefit from our services via our website, email address or social media accounts, or text message support service.

- **Website: youokaydoc.org.uk**
- **Email: info@youokaydoc.org.uk**
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- **LinkedIn: www.linkedin.com/company/you-okay-doc**
- **Text Message Support Service Number: 85258**

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Charles Carey
F1 doctor and You OK Doc? Ambassador

Self-harm: A growing issue for older adults

Self-harm is often portrayed as a health concern among young people. Although the incidence and rates of self-harm among older adults are low, research shows these are increasing.

The risks associated with self-harm are also high in this group. Those who self-harm are approximately 150 times more likely to die by suicide, and the risk is three times higher compared to young people who self-harm. This makes timely and effective management of self-harm central to suicide prevention and adverse mental health outcomes.

Risks associated with the COVID-19 pandemic

The COVID-19 pandemic and subsequent restrictions over the last year or so has had a detrimental impact on the mental health of the population. Increases in anxiety and depression have already been reported. Although there have been no COVID-related increases in suicide and self-harm so far, including in older adults, important risk factors for suicide and self-harm in older adults may have worsened. We need to remain vigilant and respond to any future increases as the longer-term mental health effects of the pandemic unfold.

In the pre-pandemic world, social isolation and loneliness were common among older adults. These are often associated with increased risk for self-harm and poor physical and mental health outcomes. In a bid to protect the most vulnerable, measures such as shielding due to pre-existing health conditions, visitation restrictions in care homes, and reduced face-to-face contact with family and loved ones may have exacerbated feelings of entrapment, isolation, and loneliness in this group.

Research on covid-related factors people reported for self-harm during the lockdown period in 2020 found some of the most common reasons were:

- Isolation and loneliness.
- Entrapment.
- Reduced contact with family and friends.

Other factors related to healthcare provision were:

- Delays in treatment.
- A loss or reduction in support for mental health problems.
- Cessation of face-to-face contact with services.

Physical and mental health problems are commonly reported as problems precipitating self-harm in older adults. Any changes to routine care during the pandemic may have harmful impacts.

There is also concern about the economic impacts of the pandemic on working older adults. Those aged over 65 are more likely to be furloughed and may face challenges finding work after government furlough schemes end.

It is vital we continue to monitor and respond to the impacts of these changes promptly to reduce risks. Interdisciplinary care from GPs, specialist mental health services and third sector voluntary organisations needs to be in place to support patients during the pandemic.

While the longer-term impacts of the pandemic on mental health continue to unfold, we also need to ensure effective preventive measures are in place.

Management and support

Below is a summary of some key areas for prevention and intervention:

Broaching sensitive subjects

Asking and talking about self-harm and suicide does increase risk of self-harm and suicide. Broaching the subject of self-harm with kindness and compassion and active listening is

important in gaining trust. There is a lot of stigma associated with self-harm and older adults are less likely to seek help for their mental health. Adopting a non-judgemental approach is especially important in these circumstances. Self-harm is often a symptom of distress, understanding reasons for self-harm will help better support patients.

Early intervention

Older adults have higher rates of primary care contacts, therefore primary care is well-placed to provide early mental health support. Self-harm in older adults is often a symptom of underlying mental health problems – particularly depression. Treatments should include talking therapies or pharmacological treatments. Identification and diagnoses of mental health problems by GPs and prompt referral to Improving Access to Psychological Therapies (IAPT) services should be considered as preventive measures.

Chronic long-term physical health problems are more common among this group and may cause feelings of hopelessness. Services such as IAPT may be useful for providing mental health support for long-term conditions. Effective healthcare management by those involved in the routine care of the patient should also be ensured.
There is an increased risk of self-harm repetition in those that have a history of self-harm and are receiving (or have in the past) care from psychiatric services. Therefore, we need to ensure provision of routine care. Where face-to-face contact is not possible the option of telephone or video consultations should be considered. Men aged 75 and over have the greatest risk for suicide, careful monitoring and support in the community as preventive measures should be in place.

Social isolation and loneliness in the context of the pandemic may exacerbate any mental health issues. The ability to communicate with family and friends is vital. Referral to third sector organisations (such as MIND) can also be considered. Timely assessment and care by a GP in the first instance and further follow-care by mental health services may be warranted. Those that have any caring responsibilities for family members should also be supported during the pandemic. Support following bereavement should be prompt.

Reducing access to means

One of the most effective methods of self-harm and suicide prevention are reducing access to means. Self-poisoning is the most common method of self-harm seen in hospital presentations for self-harm. Prescription of less toxic medication to manage physical and mental health problems, and regular medication reviews to reduce risks of stockpiling, are some methods that reduce risk. Those with existing mental and physical health problems may be prescribed antidepressants or pain management medication, some of which can be toxic in overdose. Alternative medications should be considered where possible.

Management of self-harm in primary care should include:

- If urgent referral to an emergency department is not considered necessary for those who have self-harmed, a comprehensive psychosocial assessment of risk and needs should be arranged in the community. People aged over 65 years who have self-harmed should be assessed by mental healthcare practitioners experienced in the assessment of older people.

- A comprehensive psychosocial assessment of needs should include evaluation of the social, psychological and motivational factors behind act of self-harm, current intent and hopelessness, as well as a full mental health and social needs assessment. Further follow-care should be arranged based on needs identified during the assessment.

Long-term management should consider:

- Repetition of self-harm: occurs quickly after an initial episode of self-harm and there is an increased risk for suicide during this period –particularly in the first month. Follow-up care should be prompt.
- Every repeat self-harm act should be taken seriously, reasons may be different each time.
- Safer prescribing of medication and regular reviews to reduce risks of overdose.
- Routine monitoring and effective management of chronic physical and mental health problems.
- Promotion of good mental health.

References and further reading

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Bushra Farooq
Research Assistant, Manchester Self-Harm Project (MaSH), Division of Psychology & Mental Health, University of Manchester

British Geriatrics Society
Improving healthcare for older people

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British Geriatrics Society Falls and Bone Health Section

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Clinical quality: Be the change you want to see

Where do you start when you want to make a difference? This is the question Sangam Malani, BGS Clinical Quality Trainee Representative, often finds herself asking. She explains how being part of the Clinical Quality Committee has helped her achieve her goals.

In a world where it often feels like that there are more issues than people itself, you often wonder where to start when trying to make a difference. When there are issues ranging from climate crisis to inequality, I question - where and what is my role in all of this? It feels overwhelming, but I realise I can make a difference in the one area I understand - healthcare.

My time with the BGS Clinical Quality Committee has been a stepping stone in the journey towards improving global health through quality improvement and, dare I say, self-improvement. I have had a chance to be a part of a multi-disciplinary committee who share the same vision of improving the quality of health and services being delivered in the elderly population.

My role on the committee has ranged from being a fly on the wall on benchmarking conversations to being an active member of the team at national conferences. I've had the opportunity to co-chair sessions at BGS's Spring and Autumn meetings, and on both occasions, the people I've had the honour to chair alongside have been just as inspirational and accomplished as the ones presenting.

'The most important thing I learned was that the failed projects teach you just as much as the good ones, maybe even more.'

These conferences have been an opportunity to share best practice and at a time where we feel more distant than ever, the virtual world of BGS has somehow helped bridge that distance as I've connected with clinicians from Dorset to Singapore.

As a trainee, I've only ever been on the other side of the conference presenting my poster but over the last two years, I've had the chance to adjudicate hundreds of abstracts - and what a humbling, as well as inspiring, experience that has been. A project that stands out is one looking at reducing the carbon footprint of the NHS, and it's truly amazing to see junior doctors out there who believe in making the world a better place and have gone about doing it in truly innovative ways.

Having done 10 different quality improvement projects in my time as a junior doctor, I'd be lying if I said, it was all smooth sailing. But the most important thing I learned was that the failed projects teach you just as much as the good ones, maybe even more.

So, through it all I have remembered why I joined BGS in the first place – to share past successes and mistakes like mine so that healthcare professionals may use each other's experience to improve and enable change. And I am doing just this by helping the team set up Quality Improvement (QI) Hub.

As passionate as I feel about improving the quality of care at an individual level, I hope that by helping set up a QI hub I can initiate gradual systemic change, because I truly believe that great things are done by a series of small things brought together.

Sangam Malani
Specialty Registrar in Elderly Medicine, Imperial College Healthcare Trust; BGS Clinical Quality Trainee Representative

Notices

Upcoming BGS Elections

The BGS will shortly be holding elections for the following posts:

- **Chair, Nurses and AHPs Council**
- **Deputy Chair, Nurses and AHPs Council**
- **Chair, Trainees Council**

Those eligible to vote (i.e. members of the above mentioned Councils) will be notified via email as soon as the elections open. Please ensure your contact details are up-to-date to avoid missing out.

Candidate profiles and supporting information will be made available via the BGS website.

Visit www.bgs.org.uk/vacancies for more information.

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