AGENDA

British Geriatrics Society
Improving healthcare for older people

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Mind matters

Cognitive and mental health in older adults

PLUS

- **Challenging stereotypes**
- Fighting staff burnout
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BGS AGENDA
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On the AGENDA

President's *Message*

This edition of *AGENDA* focuses on mental and cognitive health. These topics will be a source of tension and concern for many BGS members.

We - all of us, every day - see the impact of mental and cognitive health on our patients and their families. We witness dementia interfering with the ability to complete activities of daily living. We see older people with depression leading to withdrawal, change in behaviour, deconditioning and social isolation. The interaction between physical and mental wellbeing determines much of what we do.

Many of the early successes of geriatric medicine stemmed from a dismantling of arbitrary boundaries between physical and mental health. Comprehensive Geriatric Assessment (CGA) is often expressed as having five domains of assessment: physical, mental, functional, social and environmental. Some of the earliest pioneers of integrated care for older people – including Tom Arie, the inaugural Chair of Geriatric Medicine at my own university in Nottingham – were Old Age Psychiatrists. The research literature has revealed time and time again that effective dementia care underpins effective care of older people more generally. This fact is all the more salient given the rising prevalence of dementia, and predicted continued rise in prevalence for much of the next half century. In light of this, you'd expect good care for cognitive and mental health issues to be factored into all healthcare provision for older people.

The reality is, unfortunately, quite different. I was reflecting on this last week as I reviewed a patient in our Emergency Department (ED). She had been experiencing deteriorating memory and self-neglect for some time. She had been to see her GP with her son four months previously and been referred to memory clinic. She hadn't yet been seen. Three weeks of increasingly erratic behaviour resulted in attendance in the small hours to the ED. Blood tests, urine tests, and a CT head scan were conducted astonishingly quickly given the service pressures. All were normal. As I

> 'Many of the early successes of geriatric medicine stemmed from a dismantling of arbitrary boundaries between physical and mental health.'

arrived the patient was about to be admitted to the Medical Admissions Unit (MAU). She had been deemed to fall into the gaps between a panoply of care pathways by virtue of having symptoms either “too severe” or “not severe enough”. She did not qualify for an urgent care package, a mental health assessment bed, the dementia outreach team, the community mental health team or respite care. The lack of a formal diagnosis of dementia loomed large in the discussion. Her son asked why we could not just say that she had dementia. So we did just that. Meanwhile my excellent registrar, Emily, spoke to the actual human beings involved in each of the services. A few hours later she was home, care package in place, mental health follow-up in train.

I hear similar stories from around the country. If geriatric medicine has historically been a Cinderella specialty which has only in the last decade been given its tickets to the ball, there’s a distinct possibility that mental health services for older people are still labouring away in the cellar. There’s lots of reasons for this. Historical difficulties with funding have been partially ameliorated by recent governmental announcements but difficulties with recruitment remain. Meanwhile demand for services has accelerated due to population ageing and rocketed, as for all-age mental health services, post-pandemic. BGS advocates alongside the Faculty for Old Age Psychiatry and organisations like Age UK for increased focus on delivering the mental health services our older population need. But service transformation, particularly where workforce shortages are a key contributing factor, takes time.

It can be easy, when we’re all so busy, to feel overwhelmed by this. We can all describe what we’d like to do, with adequate time and resource, to dismantle silo-based working and reconfigure care pathways around truly integrated principles. Right now it’s difficult to find the hours needed, the headspace and the money to do so. Seizing small opportunities day-to-day may be all that most of us can manage. We can do this by remembering the importance of comprehensive assessment, of multidisciplinary perspectives, of listening to patients and their families. We can do it by recognising that colleagues in related disciplines, albeit allied to different Royal Colleges and working in different NHS provider organisations, usually have very similar ambitions for excellence and face similar if not worse resource constraints than the ones that hamper our own practice. Being human goes a long way in our jobs, as Emily’s ardent phoning around specialists to get our lady home from ED proved.

You’ll find some fantastic examples of clinical excellence in these pages which you may, or may not, be in a position to emulate. But even if you can’t bring yourself to realise grand ambitions at this time, I invite you to take an opportunity to reflect and to think. Consider the small things you could do to deliver good care for older people facing cognitive and mental health issues in your practice and the services you work in. BGS members often lead by example. This is another arena in which we can do so.

Adam Gordon
BGS President
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BGS responds to new research linking frailty and austerity

The BGS welcomed a study published in February in the journal *PLOS ONE* which looked at rates of frailty among older people in England between 2002 and 2018. It found that more older people developed frailty during the years of government austerity policies in the 2010s, with those from lower socioeconomic groups more likely to develop frailty.

We already know that rates of frailty are affected by inequalities. Inequalities contribute to worse health outcomes across the life course, resulting in increased levels of frailty experienced by people from lower socioeconomic groups, often at younger ages. This research further shows the impact of poverty on developing the condition.

BGS President, Professor Adam Gordon, said: "BGS members are frontline healthcare professionals and every day we see how social isolation, the inability to get out, to exercise and to eat well can impact upon the health and wellbeing of our older patients. Older people with frailty use health and social care services more than any other population group. Despite this, services are not designed around the needs of this user group. Older people are more likely than other age groups to face long waits in emergency departments and are more likely to get stuck in hospital because of a lack of care available in the community. This has a knock-on effect on the whole system; if older people cannot be discharged, new patients cannot be admitted. This contributes to overcrowding in emergency departments, longer waits for ambulances to attend emergencies and a massive backlog for elective care. In addition to the suffering experienced, these examples illustrate the longer term costs of austerity."

"Frailty is not an inevitable part of ageing – we know that it can be prevented and, if identified early enough, may be reversed with the right interventions. As we approach an election, it is essential that all major political parties have clear strategies for investing in prevention, care and support services, not just for older people who already live with frailty, but for those at risk of developing it in the future.”

You can read the study in full by following the links from www.bgs.org.uk/frailtyausterity

Despite supporting patients to improve their mental health and wellbeing, as healthcare professionals we need to make time and space to focus on our own, writes BGS Honorary Secretary Ruth Law.

The first day of February was Time to Talk Day, encouraging people to start conversations about mental health. It has caused me to pause and reflect on my own mental health and the health of the people I work with. For all the benefits of virtual communications, in the current world of perpetual Teams meetings it can be hard to find time to talk and connect with colleagues.

In the recent BGS member survey report, *The state of the older people's healthcare workforce,* more than half of respondents reported that their work negatively impacted their mental and emotional wellbeing.[1] Geriatricians were also more likely than consultants in other specialties to report that they are at risk of burnout, according to the last Royal College of Physicians (RCP) census.[2] *(For more on these reports, see the next page).*

Finding time may be difficult, but if we want to stay well, it is essential.

Last January I started the year feeling uncharacteristically low. The shifts I had worked over Christmas had left me feeling drained and depleted. During a casual scroll through social media I found myself in tears as I came across an image of a submerged healthcare worker holding a patient in a bed above the water line - it expressed everything I felt in a single picture and was a warning shot for me to stop neglecting my mental health.

It is easy to be cynical about wellbeing initiatives; especially when so many of the issues that make work through are related to systems and processes that take time to change. While BGS will continue to lobby for the structural changes that are needed to improve the working lives of healthcare professionals, there is still plenty we can do to help each other stay well. Five steps to mental wellbeing are described on the NHS website[3] and adapted for the workplace by the charity MIND.[4] These are: ***Connect***, ***Get active***, ***Take Notice***, ***Learn*** and ***Give***. They are a good starting point to generate ideas about how to stay mentally well and support the teams we work with to do the same. As I looked over them again today, I have been considering the ideas of ***Connection*** and ***Giving***.

Connect

My seven-year-old daughter's class has a worry box. At any point in the day they can confidentially write down something that is on their mind, post it in and the teacher has a chat with them at the right moment to work through their feelings. They are learning that worries shrink when you share them. We need to create environments at work where we feel able to speak openly as colleagues about the things we find difficult. In our increasingly online world it can be tricky to find time to meet in person, but I would encourage you to work hard to preserve face-to-face time with colleagues to really check in. Life is busy and we are all rushed, but unless we get to know each other we can't really look after each other.

So many of our social gatherings stopped during the pandemic, and the energy it takes to reboot them will pay back in dividends. I have experienced myself the power of a well-timed text from a colleague that has really listened and remembered, the benefit of a small cry on the shoulder of a trusted work friend, and the therapeutic effect of a team dinner with a lot of laughs. It's the people that keep the NHS going - and as people we need to connect.

Give

As workers in health and social care, we feel like we are always giving. For many of us, the desire to give and help may be what drew us into this field in the first place. When you are tired and overstretched, being asked to 'be kind' and do more does not land well. But there is a different kind of giving that replenishes rather than depletes, and links with the need for us to connect as colleagues. Giving encouragement and watching a trainee develop their confidence. Saying thank you and seeing someone stand taller with acknowledgement. Even holding the door for the person behind you and giving them a smile.

Danusha Lameris wrote the poem 'Small Kindnesses' which expresses this perfectly:

Small Kindnesses

I've been thinking about the way, when you walk down a
crowded aisle, people pull in their legs to let you by. Or how
strangers still say "bless you" when someone sneezes, a leftover
from the Bubonic plague. "Don't die," we are saying.

And sometimes, when you spill lemons from your grocery bag,
someone else will help you pick them up. Mostly, we don't want
to harm each other.

We want to be handed our cup of coffee hot, and to say thank
you to the person handing it. To smile at them and for them
to smile back. For the waitress to call us honey when she sets
down the bowl of clam chowder, and for the driver in the red
pick-up truck to let us pass.

We have so little of each other, now. So far from tribe and
fire. Only these brief moments of exchange. What if they are
the true dwelling of the holy, these fleeting temples we make
together when we say, "Here, have my seat," "Go ahead — you
first," "I like your hat."

- Danusha Lameris
(reproduced with permission)

This issue of *AGENDA* explores the issue of cognitive and mental wellbeing in our patients. We are all well-rehearsed in the steps needed to cultivate resilience and good mental health - we advise our patients on them every day.

'Wellbeing' and 'Be Kind' may need a rebrand but in my experience, personal connection and small kindnesses are essential. We would be wise to remember we have the same physiology and emotions as the people we treat and support. You cannot give from an empty cup. Every day should be a 'time to talk' day.

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Small Kindnesses from *Healing the Divide: Poems of Kindness and Connection* published by Green Writers Press, 2019.
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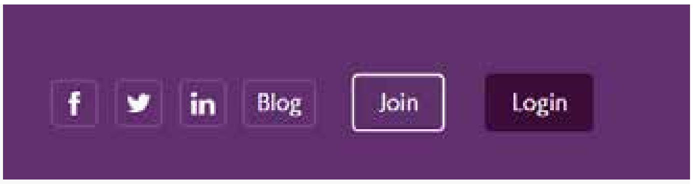

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This will take you to your account, where you can add or amend your personal details.

The email address you supply to us is how we will reach you with important updates, including links to vote in elections (the next round of President Elect elections, for example, will take place this Summer); updates from your Special Interest Groups (SIGs); information on upcoming virtual and in-person events; and our regular monthly e-bulletin, *FRONT PAGE*.

From the '**My account**' page on the website, you can also access a wealth of other information and benefits, such as downloadable copies of CPD certificates, access to free elearning modules, and direct digital access to *Age and Ageing* journal. You can also update your communication preferences if you'd like to opt in (or opt out) of various mailings.

If you have any questions about your membership options, benefits or any general queries, please do not hesitate to get in touch with our membership team at membership@bgs.org.uk

The state of the older people's healthcare workforce: A report from the BGS membership survey

www.bgs.org.uk/BGSworkforce

On 9 February, the BGS published a new report, *The state of the older people's healthcare workforce*. The findings in the report were gathered following analysis of a survey of the BGS membership. The survey was designed to understand the pressures currently being felt by multidisciplinary healthcare professionals caring for older people across the UK.

The results of this survey will not come as a surprise to BGS members, nor indeed to anyone working in the NHS. The report shows that older people's healthcare services routinely face workforce shortages with more than 80% of respondents reporting that their service is short-staffed at least weekly. Survey respondents also stated that there were difficulties recruiting to vacant roles. A majority of respondents said that they were aware of vacancies in their services being advertised but not always filled. Over 40% said that they were aware of vacancies sometimes not being advertised because there was no expectation of being able to recruit to them.

Under-staffing of older people's healthcare services is having a direct impact on the wellbeing of BGS members with more than half of respondents stating that the shortage of staff is one of the main factors having a negative impact on their mental and emotional health. Members expressed frustration at not being able to provide the high-quality care that they would wish to. When asked what changes at work would make a difference to their mental wellbeing, around a third of those who answered this question stated that having more staff available would make the biggest difference and would enable them to provide a better quality of care to their patients.


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The state of the older people's healthcare workforce: A report from the BGS membership survey

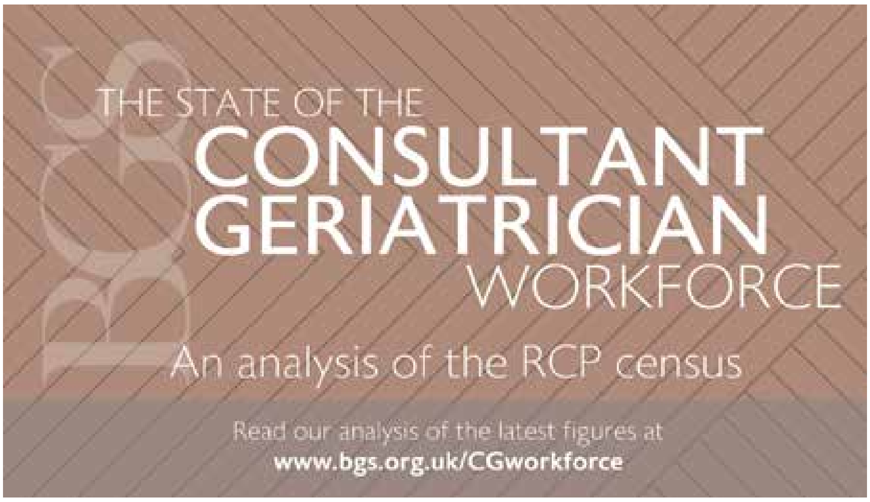
There is some cause for optimism. BGS members across the country are sharing their innovative solutions to the workforce crisis, including making the most of new roles and offering training opportunities. The BGS is encouraging members to continue to share these examples so that colleagues can implement them in their own services.

Professor Adam Gordon, President of the British Geriatrics Society, said: "It is important that we survey our membership from time to time to help us understand the situation in local services across the country. While it is heartening to hear of innovative solutions that members have implemented to address the workforce crisis, the overall message from our members is concerning, if not surprising. Older people are the biggest users of health and care systems, and it is vital that workforce capacity reflects this. There is a role for us all in ensuring that older people's healthcare is fully and sustainably resourced. We call on all political parties to ensure that this is a priority as we approach an election."

Dr Amit Arora, Vice President for Workforce, said: "BGS members have told us loud and clear that short-staffing is the biggest issue facing their services. A majority of members said that their services are short-staffed at least weekly and that their mental and emotional wellbeing would be most improved by having more staff. As part of a strategic approach, the NHS must ensure that it recruits, retains, develops and supports its workforce."

Read the report in full at
www.bgs.org.uk/BGSworkforce

Hot on the heels of *The state of the older people's healthcare workforce*, the BGS published a second workforce report, *The state of the consultant geriatrician workforce*. This report, published on 22 February, analyses data from the most recent UK census of consultant physicians conducted by the Royal College of Physicians London on behalf of the Federation of the Royal Colleges of Physicians of the UK. The BGS brings the data on consultant geriatricians up to date and explores the potential impact on healthcare for older people.



The BGS has long advocated for a better staffed consultant geriatrician workforce and this new report highlights there is some way to go to meet the needs of the UK's ageing population. Based on data collected in 2022, key findings indicate that there are still not enough geriatricians to meet the target of one consultant geriatrician for every 500 people aged 85 and over, which the BGS advocates. Compounding the challenge of the workforce shortfall, it is expected that just under 50% of the current consultant geriatrician workforce will retire in the next 10 years.

Additionally, there is an uneven distribution of geriatricians across the country, with urban areas typically being better served. This is despite non-metropolitan areas being more likely to have ageing populations. The higher number of geriatricians in areas such as London has enabled the development and ongoing improvement of innovative services for older people including Front-Door Frailty, Peri-operative Care for Older Patients Undergoing Surgery (POPS) and proactive care in the community. These services could be replicated across the country with the availability of more geriatricians.

The new data highlights that most geriatricians experience a substantial level of rota gaps and vacancies in their department, echoing findings from the BGS's recently published report, 'The state of the older people's healthcare workforce'. This appears to be a bigger problem than other specialties, with an impact on the level of care provided to patients. The census data shows that most consultant geriatricians felt they did not have control of their workload and just under a quarter reported they were at risk of burnout.

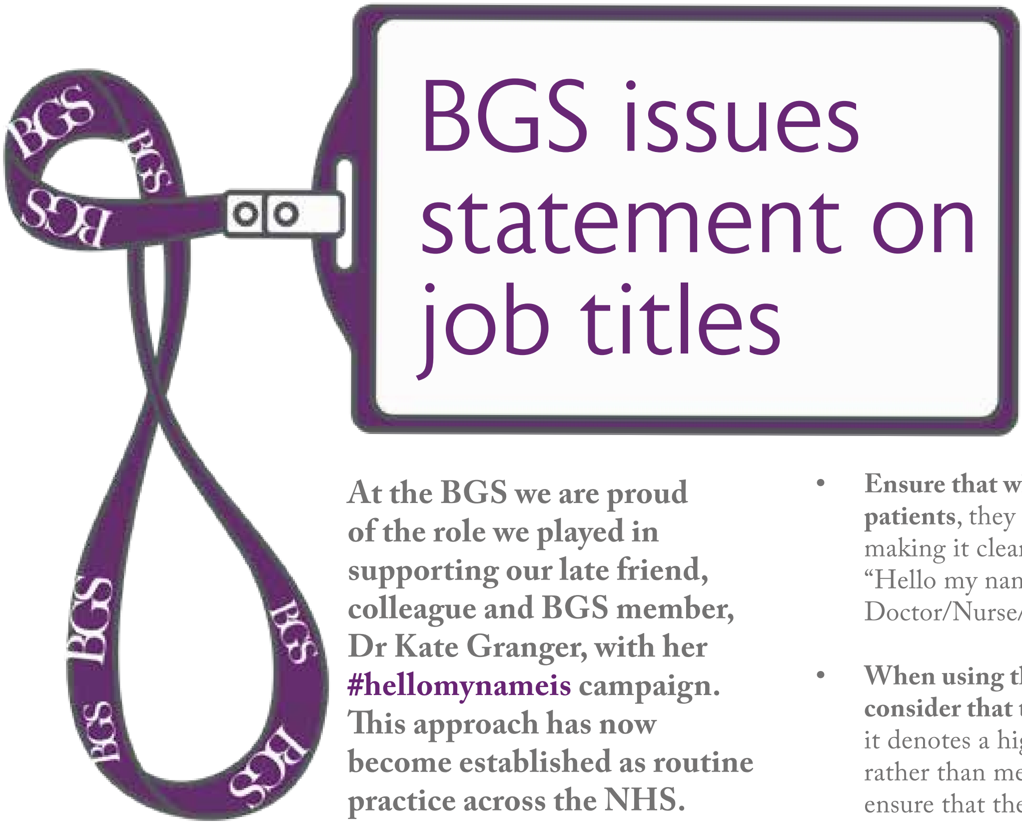
On a more positive note, for the first time since 2016, geriatric medicine is the biggest medical specialty. Despite workforce shortages and frustrations, most geriatricians are happy with their choice of specialty and feel valued by colleagues and patients. The BGS believes this sentiment needs to be captured in a recruitment drive and our upcoming #ChooseGeriatrics BGS campaign, aimed at the multidisciplinary team including doctors, nurses and allied health professionals, will make the case for the older people's healthcare workforce. More information on this campaign will be publicised soon and the BGS would value support from its members.

Consultant geriatricians are just one part of the multidisciplinary team providing healthcare to older people and more data is required on the wider team to understand current and future workforce needs. The BGS will continue its efforts to collect and analyse this. In the meantime, prompt action is needed to address the shortfall of geriatricians and to address workforce conditions. The upcoming general election is a vital opportunity to consider the needs of the UK's ageing population and the workforce supporting it. This is crucial so that older people, as the biggest users of the healthcare system, receive high-quality, personalised care when and where they need it.

Professor Andrew Elder, President of the Royal College of Physicians of Edinburgh, said: "Our ageing population deserves our best care. Geriatricians are a key part of the multiprofessional teams that serve older people and their families - without adequate numbers of adequately trained doctors, patient care will suffer. However, year on year, the physician census data demonstrate the increasing risk to the safe provision of patient care, with an alarming and rising proportion of unfilled consultant posts and consultants approaching retirement. The BGS report reflects this reality, and highlights the need for workforce planning across the UK, with a focus on recruitment and retention, addressing the reasons for early retirement including pension rules, filling rota gaps, and valuing the workforce."

Mr. Mike McKirdy, President of the Royal College of Physicians and Surgeons of Glasgow, said: "The results of the RCP's consultant physicians' census reflect the intense pressure being felt by doctors across the UK as a result of widespread rota gaps in the medical workforce. We welcome BGS's further analysis of the challenges for consultant geriatricians and their patients – the biggest users of the health and social care system. With 44% of consultant geriatricians expected to reach their intended retirement age in the next 10 years, it is vital that we continue to grow the workforce to ensure older people receive the high-quality, person-centred care they need and deserve."

Read the report in full at www.bgs.org.uk/CGworkforce



BGS issues statement on job titles

At the BGS we are proud of the role we played in supporting our late friend, colleague and BGS member, Dr Kate Granger, with her #hellomynameis campaign. This approach has now become established as routine practice across the NHS. At the heart of Kate's campaign lay an assertion, based upon her lived experience, that patients need to know who is treating them.

Effective care of older people is multidisciplinary by nature and highly specialised. Delivering it to the highest standard demands that we attract, train and retain the best colleagues across all relevant disciplines. The NHS Consultant Practitioner and Capability framework has provided a structured and robust training framework which enables colleagues, from all disciplines, the opportunity to remain patient-facing throughout their career, providing the multidisciplinary clinical leadership our service needs. The colleagues who have moved into these roles, and who are currently training to do so, are expert, experienced and highly valued.

A consequence is that the term 'Consultant' is now used by those from multiple professional backgrounds. This is part of a wider expansion of roles across the NHS which has led to a number of job titles that patients may not be fully familiar with. It is important that patients know who is treating them.

Many colleagues, both those who are medical doctors and those who are not, hold either professional or research doctorates. These are substantial achievements. Colleagues are rightly proud of their qualifications and, of course, want to use the title that they have worked so hard for. There is potential, nevertheless, for the term 'doctor' to be confusing for patients, when it is used in a clinical setting to denote research or other professional doctorates, rather than someone who is practising as a medical doctor.

The BGS supports the expansion of senior multidisciplinary leadership roles to deliver the best for our patients, but recognises the potential for new roles and titles to cause confusion for the public and the workforce. In order to avoid ambiguity, we suggest members do the following:

- **Review their job title** – is it clear to those who read written correspondence what their clinical background is? 'Consultant practitioner' is ambiguous. 'Consultant physician', 'consultant nurse', or 'consultant therapist' is not.

- **Ensure that when they introduce themselves to patients**, they explain their role in a similar way, making it clear what their clinical background is: "Hello my name is Alex, and I'm the Consultant Doctor/Nurse/Therapist here on the ward."

- **When using the term 'doctor' in a healthcare context, consider that this can be confusing to patients** where it denotes a higher professional or research degree, rather than medical training. If using the term 'doctor', ensure that they do so with reference to their wider job description: "Hello my name is Dr Smith, and I'm the Consultant Doctor/Nurse/Therapist".

- **In written correspondence, using postnominals** in addition, or in place of, the 'doctor' title may also be helpful. It is important to recognise, however, that not all patients know the difference between PhD, MD and MBBS/MBChB. Again, in written correspondence full job titles are always helpful to avoid ambiguity.

While some of these nomenclature issues have long been ambiguous in the English language, the continued expansion of professional roles within the NHS raises new challenges.

There is potential for BGS members, in particular, to find themselves in this space – because we work in multidisciplinary teams to care for older people, and because members in extended roles may find that the scope of their advanced training extends substantially beyond the traditional boundaries of the degree and discipline in which they initially trained. For example, a consultant physiotherapist working in an acute frailty service may do relatively little physiotherapy and be much more generalist in their practice.

With this in mind, the BGS will work with relevant multidisciplinary stakeholders, with the Royal Colleges and with NHS leaders to raise the issue of job title nomenclature, and the ways in which it challenges our members, and patients.

We will keep the membership updated as we do so.

For more news, policy updates and statements, please visit www.bgs.org.uk/policy-and-media

GREY matters

Editor-in-Chief of *Age and Ageing* journal, Professor Rowan Harwood, ruminates on the dualism between old age psychiatry and geriatric medicine as he reflects on recently published research evidence.

'I am a not a social worker and I'm not a psychiatrist'. I was taken aback when a frustrated colleague once announced this at a meeting (quite a long time ago). Did we not believe in the confluence of the physical, the mental and the social? For sure, geriatricians are physicians, but we are also generalists.

Almost uniquely, a geriatrician's expertise is broader than that of the parent discipline, internal medicine. We need to be good at rheumatology, neurology, palliative care, a bit of gynaecology and oncology, ethics, law and sociology. That brings tensions. Who is the primary expert in heart failure or diabetes in frailty, the cardiologist, the diabetologist or the geriatrician? We must balance confidence with a keen sense of our limits and when to consult, refer or work in partnership with others.

Arguably the most interesting, and sometimes the most problematic, interface that geriatricians encounter is with mental health. Delirium and dementia are genuinely crossover conditions - physical and neurological as much as psychiatric. Only a quarter of acute admissions of older people have no evidence of a concurrent cognitive or mental health problem. Eighty per cent of care home residents have dementia. Over half of people admitted to mental health wards under a section of the mental health act come via acute hospitals.

Older age liaison psychiatric services have developed considerably over the past decade, and their input is very much appreciated. They help with diagnosis, management and family liaison, and ensure continuity between services accessed prior to an acute admission, and follow up afterwards. However, we cannot 'outsource' all mental health expertise for patients managed under geriatric medicine. 'Confusion' is one of the geriatric giants, the non-specific presentations of acute medical illness which require medical assessment. In an acute setting, delirium and dementia are best managed where the whole ward environment can consistently deliver person-centred care. Physicians are called upon to manage episodes of distress and challenging behaviour. Sixty percent of people living with dementia fall each year, often leading to physical injury. Half of people who fracture their hips have dementia. Physical ill-health is associated with depression and anxiety, and psychotropic medications, including antidepressants, are potent falls-risk-increasing drugs. Cognitive problems and mental ill-health are unavoidable in acute hospitals. Ergo, geriatricians need to be experts in mental health.

'Delirium and dementia are genuinely crossover conditions - physical and neurological as much as psychiatric.'

Age and Ageing publishes papers on all aspects of health in older age, physical, functional, and mental. The last three months alone has seen articles on access to critical care for people living with dementia ('Too high, too low or just right?) (Yorganci *et al*, Hosie and Agar), a review of new thinking on schizophrenia-like disorders (Meesters), driving cessation following a dementia diagnosis (Cations), the mental health consequences of COVID-19 (Schaefer *et al*), a strengths-based approach to supporting family carers of people living with dementia (Yu *et al*), decision-making capacity assessments in acute hospitals (Gan *et al*), predictors of progression of mild cognitive impairment (Wu *et al*) and the impact of a geriatrician liaison service on older adult psychiatric wards (Swann *et al*). These are all issues that could impact on geriatricians and the wider multidisciplinary team.

Physicians and psychiatrists live in almost parallel universes. Our training is different, as well as our organisations, regulation and the legislation under which we work. Yet our culture has history of mind-body dualism, and a legacy of stigma against mental illness, factors that still influence practice. Geriatricians need expertise in cognitive assessment, mental state examination, dementia and delirium diagnosis, and psychopharmacology.

We have much in common with mental health practitioners, much to gain through partnership working, and much to learn from each other.

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

It's not "acopia" or *'just your age'*

Public attitudes and expectations around older people contribute to a sense that preventable mental health issues are inevitable as we age. Tom Gentry, senior lead for health and care policy at Age UK, highlights findings which suggest more needs to be done to identify and support older people struggling with their mental health.

"Older people have more worries to begin with... they're worried about 'how to live'. There's also a sense of loss - 'we used to do things'."

This brief quote from a 76-year-old woman* encapsulates the challenges we frequently come across with older people's mental health. Many older people have a lot on their plate when it comes to their health – dealing with multiple conditions and disability, including dementia. Many rely on social care to meet their essential daily needs. Many are dealing with loss, whether from bereavement or changes in their capacity and capabilities.

On top of this, we live in a society that persistently devalues or stigmatises later life, with older people as a group seemingly seen as acceptable to stereotype or dismiss. When it comes to mental health, this means a common refrain to a bout of symptomatic depression or low mood is still 'What do you expect? It's just your age.' From our experience, older people can deeply internalise this instinct.

"I have bad times but it's no good saying you're depressed. Who is going to help you?"

This can all present a challenge to the professionals supporting older people. The instinct to manage the physical health problems someone is living with – the ones that cause the chronic pain, restrict their breathing, cause confusion – is sound, and indeed necessary. That someone's mood will improve in light of this, again, is a sound instinct. As one GP put it to us:

'We're very busy with things we're trying to do to keep people alive and well from a medical perspective. Our main focus in that age group is the medical issues - we have enough on our plates with those."

Where does this leave older people's mental health? Perhaps, for some, their mood will improve with better management of their physical health conditions, though it often doesn't seem obvious that that is an explicit goal of treatment. But what about situations where the nature of 'improvement' itself is limited, because, for example, the condition in question is progressive or enduring? And what non-clinical components will be effective while health issues are being investigated, or where mental health problems themselves endure?

Answering these questions is the 'bread and butter' of good geriatric care, but they are not always properly engaged with elsewhere. At Age UK, we recently commissioned the Centre for Mental Health to examine older people's mental health in the context of what influences it, how well it is understood, and what services are offered to people. In their report, due to be published later this month, they conclude that mental health in later life has been on the margins of policy and practice in England for many decades. Opportunities to promote good mental health and wellbeing in later life are too often missed, and support to address mental health difficulties is too often lacking.

The report also observes that there is "pressing need to challenge ageism relating to mental health in our health and care system" and that at the moment there is "no national plan or blueprint for mental health support in later life". This reflects often cursory references to older people and their specific needs in national policy, such as the Community Mental Health Framework and the Mental Health Implementation Plan.

Some of the immediate affects of this can be seen in things like referral rates to NHS Talking Therapies. Writing in 2011, the Department of Health and Social Care expected that older people would represent 12% of referrals to these services, based on estimated need in the community. Currently, this rate stands at 5.6%, having peaked at just over 7% in 2017/18.

'As a society, we need to value and protect older people's mental health as much as we do at every other age.'

When we reported on this issue in 2016 in our report *Hidden in Plain Sight*, we projected that using the rate of growth at the time of writing, it would take 15 years to hit 12%. This is despite older people responding better to talking therapies when compared to other age groups, and there being proportionately many more older people compared to 2011. Given the rate has been declining, it is difficult to see when it will ever be met.

This month, Age UK and the British Association for Behavioural and Cognitive Psychotherapies (BABCP) also re-launch the older people's positive practice guide for NHS Talking Therapies, a version first developed in 2021. It sets out some of the factors that can help local services to encourage older people to think about their mental health, and some of the ways local providers can age-attune their offer. We would encourage everyone to promote the resource to their local ICS mental health leads.

This all points to a set of challenges that need addressing. As a society, we need to value and protect older people's mental health as much as we do at every other age. This is not to say we're doing that particularly well either, but if you look at any major mental health campaign or government/ NHS strategy, eyes are typically on younger people and the so-called 'working age'.

Preventing mental ill health before people reach older age, and helping people to stay in work, are indeed crucial; but what is the vision for people in retirement, or grappling with health challenges in later life? Those that are near the end of life? It shouldn't be acceptable that the vision of an isolated, depressed older person is something younger people should inevitably fear for their future. This represents a failure of society and public policy which needs to be tackled.

This attitude can leak into how older people are supported. As one clinician told us:

"As practitioners we might not consider it as much as we should. We think of it as something we offer to young people because it's a long term commitment and with older people we're looking for a quick fix to get them better that week".

Age UK's 2016 report, *Hidden in Plain Sight*

> 'If you look at any major mental health campaign or government/ NHS strategy, eyes are typically on younger people and the so-called 'working age'.'

For public services, there must be a more systematic recognition and focus on tackling poor mental health in later life. This means incorporating mental health into the assessment and planning of care, across the NHS and social care, and investing in the type of support that can improve mental wellbeing. Success of local services must be measured on the levels of mental wellbeing achieved for older people and the voluntary and community sector can play a significant role in helping to deliver this.

There is of course a nugget of truth in what one GP said to us:

"I usually recommend lifestyle changes… so exercise, socialisation and not being lonely."

Yet what can that person do if none of those things are available to them? What if their mental health is preventing them from leaving their house?

We must take older people's mental health more seriously, particularly after their experiences of the last four years. Having a mental health issue in later life is not "acopia" and it's not "just your age".

**All quotes were taken from a report in 2019 by Thinks Insight, commissioned by Age UK and funded by NHS England.*

Further reading

- **Age UK - Hidden in Plain Sight (2016)**
  www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/health--wellbeing/rb_oct16_hidden_in_plain_sight_older_peoples_mental_health.pdf
- **Age UK and Centre for Mental Health report (due out March 2024)**
  www.centreformentalhealth.org.uk/publications
- **Age UK and British Association for Behavioural and Cognitive Psychotherapies (BABCP) - updated older people's positive practice guide for NHS Talking Therapies (due out March 2024)**
  www.ageuk.org.uk/information-advice/for-professionals/mental-health-hub-for-professionals

Tom Gentry
Senior Lead for Health and Care Policy
Age UK

No *limits*

My name is Lara Mitchell. I am a Consultant Geriatrician and National Clinical Lead for Frailty at Healthcare Improvement Scotland. I am also an athlete and enjoying pushing my mind and body just to see how it responds.

This year I competed for GB at a couple of masters cycling events in Perth (Scotland) and Italy. 'Masters' events are for older competitors: you must be over 35, and competitors are grouped into five-year age bands that include 95-99 and 100-104 years old. There is even a 105+ category!

As I lined up behind all the women my age, I looked at them thinking surely these lithe, fit and strong women must be younger than me. Then, as they turned sideways, I could see the wrinkles and the grey hair slipping out of the helmet.

I first saw Alex Rotas' photographic exhibition of Masters track and field athletes in 2021 when I was attending a medical conference in Gothenburg, Sweden. It was called 'No Limits' and I was captivated by the images of very obviously older adults pushing their physical boundaries, caught in action doing long jump or pole vault, their faces a mask of determination, grit and focus.

Photo © Alex Rotas. Reproduced with kind permission.

Photo © Alex Rotas. Reproduced with kind permission.

> ‘Alex’s photographs demonstrate what’s possible... they challenge us to raise our clinical expectations regarding what we might hope for with our older patients.’

More recently I have seen her photos lining the corridors at the Forth Valley Royal Hospital in Scotland. As a Geriatrician, the value of Alex’s work for me is that she shows what the ageing human body is capable of. Not everyone can be a competitive athlete of course, but like all elite athletes, the older people that Alex photographs demonstrate what’s possible. In doing so, they challenge us to raise our clinical expectations regarding what we might hope for with our older patients following surgery or illness.

When we spoke, Alex was proud to tell me that she is 74 years old. She was a professional tennis player in her youth and played at Wimbledon. She has always loved sport and it's always been a huge part of her life; it’s fair to say that she really enjoys a challenge. After completing a visual art master’s degree in her 50s followed by a PhD, she bought a camera aged 60, and within a year was learning how to use it so she could photograph older athletes both in the UK and abroad. At 60, she had a watershed moment: all the imagery she could find around ageing depressed her and she knew there was a different, altogether more positive story. Alex said to me, “I love being a beginner, I can see ahead of me all the things I am going to learn and it’s exciting.” We could all learn from this approach.

Although I did ask Alex lots of questions, we also had an hour of excitedly talking about tackling the stereotyping of ageing and redefining it. Alex explained that since she first started this journey in 2010, the conversation has changed and she is no longer a lone voice. There is now a chorus of voices joining her call (me included). Her mission nonetheless remains to continually rethink the ageing trajectory ageing and to challenge what she describes as the ‘laziness’ of ageing stereotypes.

Tell us about yourself

Right now, I travel round the world taking photos of Master athletes. I have photographed a variety of different sports, but my main focus has been on track and field athletics.

I love having the opportunity to talk to young children in schools and show them my photographs, encouraging them to rethink their already rather entrenched and depressing views on what being ‘old’ is all about. I overheard an 8-year-old telling her mum at an open-air exhibition held in Bristol “these pictures make me think I can grow old, but not like an old person!” Even in early childhood, the stereotypes around ageing have taken hold. I have held exhibitions around the world and particularly like it when they are held in public spaces, especially outdoors. This means they are there for all to access and people can come across them by chance, as it were, without making the decision to visit a gallery.

© Alex Rotas. Reproduced with kind permission.

I have exhibited in hospitals both in the UK and Europe and I hope and believe the images may inspire and provide joy; flowers and landscapes can soothe but they don't necessarily offer the motivation that seeing obviously older people competing in sport can offer. Having these photos in hospitals corridors raises a smile and they are of course open for everyone, of every and any age, to see.
I'm a firm believer that something visual can trigger a thought in a way that words just can't and don't: it's almost an automatic response when an image moves us. The automatic response I'm hoping for involves rethinking whatever preconceived ideas we might have held about ageing.

I meet people in their 60s, 70s, 80s and 90s who bust a gut both in training and competition, yet who are full of joy. It changed my life and my attitude, and I want to get the word out that getting old can be a time of opportunity, new experiences and new friends.

My personal learning has not just been about the camera and the process of taking a photograph. I have learnt so much about other sports that were new to me, including track and field, and more latterly cycling on the velodrome track. (*Being a cyclist I was happy about this!*) I have also just collaborated with a film maker and launched a full-length documentary film following four female athletes aged between 69 and 85. This film, Younger, has three key learning points: it's never too late; belonging is winning; and purpose is a superpower.

What inspired you to portray a visually different aspect of ageing?

I want to encourage others to rethink the ageing trajectory *(music to my ears)* and move away from the stereotypical view of ageing, which is that your horizons narrow and life starts to close down. So much of the popular visual narrative about ageing is overwhelmingly depressing. The athletes I photograph show what's possible with the ageing human body and my mission is to share the uplifting message that they bring. What people see in the images is obviously not possible for everyone - but witnessing men and women in their 70s who are clearly in their relative prime, giving their all in their chosen sport, can be especially encouraging to people in their 40s and 50s. They are the ones who are often starting to feel anxious about getting older. They are the ones too who can make different life choices now with an eye on a brighter, more physically active and joyful time ahead of them than they had perhaps imagined.

'I want to encourage others to rethink the ageing trajectory and move away from the stereotypical view of ageing, which is that your horizons narrow and life starts to close down.'

‘The athletes I photograph show what’s possible with the ageing human body and my mission is to share the uplifting message that they bring.’

What have you learnt since photographing these master athletes?

I have learnt that these athletes are just like the rest of us: they go through the same traumas, relationship break-ups, bereavements, injuries, cancer diagnoses and other illnesses, not to mention the day-to-day stresses that we all do. They have taught me about the power of community, friendship, and the support you can both give and take from being in the company of people who have similar interests and outlooks to your own. Through my work, I’m proud and honoured to have made new friends myself from all round the world. I feel like I’ve been adopted as an ‘honorary member’ of the Masters Athletics community.

The athletes I photograph have a terrific sense of purpose *(we know that a sense of purpose can add on average 7 years to your life)*, they are resilient and they have a motivation that keeps them rigorously training and competing through the ups and downs of life. They find ways to get round the challenges they might be facing: if they have surgery or an issue ahead of them, they don't focus on it - the so-called ‘mountain’ ahead - they look to the other side and support each other up and around it.

What is it that drives these master athletes on to push themselves?

They love the physicality of their sport and the sense that they are in the best possible shape that they can be, at whatever stage of life – and with whatever background of injury or illness – that they find themselves. They are constantly working to improve their techniques and performances and are always looking to achieve a new PB (personal best) in their age group. Given this is continually changing as they get older, there is always a new record or personal goal to chase. Their mutual respect, their friendships and their over-arching sense of community keeps them coming back for more.

I took some photos of two great friends in the same age 60s age category who are hurdlers (below); I watched them line up for the race, give absolutely their all as they leapt over the hurdles, and then collapse over the line in each other's arms at the end of it. Everything shone through in that moment: the friendship, the mutual respect, the physicality of high-end competition and the joy!

What mantra do you think we should be saying to ourselves as we get older?

Be curious. Be curious about other people, about everything!

It's difficult not to get carried away speaking to Alex. She is generous with her time, energy, passion and work, and she is keen for any other hospital with free space that might like to show her images to get in touch. She would love her images to spark more conversations about what we should be hoping for as we age.

We both agreed that the secret to ageing is a combination of community and friendship, exercise, and nutrition. I personally have been touched by the images myself after my own experience witnessing the wrinkles and expressions of older adults in the throes of nailing a pole vault, with a wonderful face of intense concentration.

Older adults should be celebrated, and Alex’s work shows us that participation in sport as we age not only defies age related expectations but also serves as an inspiring example of the lifelong benefits of staying active and pursing one's passions.

As one of her athletes said:

“Exercise is not a luxury. It is the key to healthy ageing.”
– Olga Kotelko (1919-2014)
World record holder, masters’ athletics


Photo © Alex Rotas. Reproduced with kind permission.

If your hospital or workplace is interested in displaying Alex's work and embracing her mission to challenge stereotypes of the ageing body, she is happy to be contacted via email at alex@alexrotasphotography.co.uk. To view her other photographs, visit www.alexrotasphotography.co.uk.

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LEAVING THE DOOR AJAR

Supporting people living with dementia who identify with the LGBT community

'Oh that sounds lovely!' I said to my patient while taking his social history. Being the chatterbox that I am, we found ourselves talking about the trip to Scotland he had planned with his loved ones. I enjoyed our chat so much that I hadn't realised the time, and politely circled back to ask my final question. Given his poor mobility, I needed to check if there was someone at home able to answer the door to the carers. 'Oh I'm so jealous… think of all the shortbread you'll be able to eat! One last question from me - will your wife be able to answer the door if you're not feeling up to it?'

He went quiet. I put it down to our conversation taking it out of him. Little did I realise at the time that I had not only closed, but slammed the metaphorical door in his face. The door through which, if I had kept open, he could choose to come through and be his authentic self - a person who has a husband and identifies with the LGBT community. It was from this moment on that I made a promise to do all I can to ensure that door remains open for all my patients, friends, colleagues and everyone I meet. I've since specialised in supporting people living with dementia, and would like to share some of the ways I try to leave the door ajar for those living with dementia who identify with the LGBT community.

Dementia and the LGBT community

According to the Office for National Statistics, an estimated 3.3% of the UK population identified as lesbian, gay or bisexual (LGB) in 2022.[1] Accurate figures for trans people do not exist, however in 2021, 0.5% of people responded 'no' when asked if their gender identity was the same as that registered at birth.[2] Evidence from The Alzheimer's Society tells us that there are currently around 900,000 people living with dementia in the UK,[3] a figure set to almost double to 1.6 million by 2040. This means there are potentially around 32,400 people who are living with dementia and identify with the LGBT community.

Brief timeline of events

It is important to consider that relationships with healthcare professionals are shaped by previous experiences, and that people from the LGBT community may have had negative interactions with healthcare. This is especially important when supporting a person living with dementia who may, in their subjective experience, be living in a different timeline to ours. We know that as Alzheimer's and other certain types of dementia progress, a person is more likely to recall older memories over newer ones. With that, they bring their lived experience, whether positive or negative.

A brief timeline of events demonstrates why an LGBT person could find this particularly distressing, or feeling unable to disclose their gender identity or sexual orientation:

- Until 1967, sex between men remained illegal.
- Homosexuality was listed as a mental illness until 1973.
- 'Gender Identity Disorder' was listed as a disorder by

mental health professionals in the UK in 1980.
- The HIV/AIDS epidemic developed in the 1980s, which affected society's attitude towards people in the LGBT community.

There have been relatively recent positive changes in law and society for LGBT people, such as:

- The Gender Recognition Act in 2004, which allows transgender people to have their gender legally identified.
- Same-sex couples can have their relationships legally recognised after the Civil Partnerships Act of 2004.
- The Marriage (Same Sex) Couples Act was introduced in 2013 in England and Wales, enabling same sex couples to get married.

People living with dementia may not remember or be aware of these recent positive changes, instead remembering the mostly negative attitudes towards LGBT people, affecting how they cope today. Note that a person in their 70s today would have been in their 20s when sex between men was still illegal.

Reminiscence therapies are common for people living with dementia, but could be triggering for a person with lived experience of prejudice, discrimination or rejection in the past and should be taken into account if providing reminiscence therapy.

Distressed or misunderstood behaviour

People living with dementia may present with distressed or misunderstood behaviour. This is the result of an unmet need and may be in relation many things, including (but not limited to) physical, psychological or spiritual needs. It is our role as healthcare professionals to establish the need, and support in a person-centred approach. As a side note, this is the reason for my preferred terminology - 'distressed' or 'misunderstood' rather than 'challenging' behaviour - as this leads the person providing care to establish what is causing the distress or misunderstanding.

There are many scenarios unique to those living with dementia who identify as LGBT which may cause distress. They may not recall revealing their gender identity or sexual orientation and find it very distressing that people they have not informed are aware - especially if their subjective reality is such that they are living in the 1960s, 70s or 80s. For some with disinhibited behaviour, preventing the disclosure private information may become difficult. They may share the gender of their partner without their partners (or their own) consent, meaning they have ‘come out’ without having the capacity to do so as an informed decision.

We can support this by identifying patterns which emerge in distressed and/or misunderstood behaviour; for example, being resistant to washing and dressing, or being inappropriate with staff members while using the bathroom in a care home.

Imagine for a second that, in your subjective reality, you are a young man who identifies as bisexual. A man takes you to the bathroom and unbuckles your trousers. How might you interpret this information? Your first thought probably isn’t that you are living in a care home and this carer is helping you change your incontinence pad. In this scenario, it is easy to see how a behaviour can be misunderstood. The key to avoiding distress and misunderstanding is to explain what is happening in a way that is meaningful to the person while being mindful how the task at hand may be interpreted. Above all, we remain kind, empathetic and understanding of their subjective reality.

I have met same-sex couples whereby the person living with dementia adamantly denies all knowledge of the relationship. This is an especially emotive scenario for all involved, but healthcare professionals can provide support by meeting the needs of the emotions behind the distress. We can establish if there is a ‘question behind the question’ - observe the emotion(s) behind the question, which may indicate an unmet need. In the aforementioned scenario, it is probably fear (of judgement, harm, harassment etc), but other circumstances could lend itself to loneliness, a loss of sense of self or disorientation.

Circles of support

When caring for a person living with dementia who identifies with the LGBT community, some of the following may be true:

- They may no longer communicate or be in touch with their ‘family of origin’. This is their blood or adopted family.
- They may instead have a ‘family of choice’. This is a group of people who are not your family of origin but instead people who will support you as a family would.
- They may not have disclosed their sexual orientation or gender identity to their family or friends.
- They may have experienced hostility, for example, if they are from a culture which is not supportive of the LGBT community.

It is especially important to bear this is mind when discussing information with a next of kin, family or friend, being sure to not share information of which the person would not have chosen to share themselves.

End of life care

Approaching the end of life can be overwhelming for most people, but those living with dementia who identify with the LGBT community may face unique barriers to a good death. Some may worry that their identity will be forgotten or erased after death by their community or family of origin. As a person loses their independence and function, their ability to access LGBT-safe spaces or friends is reduced, and may force a person to avoid being their authentic self. For example, people who may into a care home may worry about discrimination or whether their sexual orientation or gender identity will be supported by staff and other residents.

Leaving the door ajar

I believe that it is our role as healthcare professionals to make our patients, their loved ones and colleagues feel safe and supported to be their authentic selves. When patients feel they can be honest with us about their life, we can support them to make informed decisions which enable them to live and die in a way that is meaningful to them as valued members of their community.

We can make small, sustainable changes to our practice which go a long way towards leaving that door ajar for those we support to come through if they wish. We can do this by avoiding assumptions surrounding a person's gender identity or sexual orientation. When collating social history, I now ask open questions such as 'do you live with anybody?' instead of 'do you live with your wife/husband?'

When referring to a persons loved ones or themselves, I use they/them pronouns unless a person tells me otherwise. I share my pronouns whenever able - this gives others the opportunity to share theirs with me. When information is shared with me, I do my best to establish whether the person would like this information shared on their record, to avoid having to disclose information time and again. Equally, I establish if they do not want information to be shared, either with other healthcare professionals or with family and friends.

Finally, I have found that when supporting terminology, cultures or communities that are new to you, it is important to be as kind to yourself as you are to others. We may get it wrong when trying to get it right. When we get it wrong, we need to own it, apologise, and ask how we make it right, which can be a hard thing to do. However, I have also found that when asking genuinely curious questions with the intention of being able to provide the most compassionate, informed and kind care possible, most of the time this is met with relief and the understanding that you are an ally, who is developing their ability to ensure that those from a different community to them feel safe and welcome to be their authentic self.

Katie Faulkner
Physiotherapist and Clinical Team Lead, Specialist Dementia and Frailty Service

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Syncope in older adults: A new *Age and Ageing* themed collection

Syncope can have devastating consequences, resulting in fall-related injuries, accidents or even death. In our ageing society, the subsequent healthcare usage, such as emergency room presentations, surgeries and hospital admissions, form a significant and growing socioeconomic burden.

Causes of syncope in the older adult include orthostatic hypotension, carotid sinus syndrome, vasovagal syncope, structural cardiac abnormalities, cardiac arrhythmias and conduction abnormalities. As stated in both the ESC Guidelines on Syncope and the World Falls Guidelines published in 2022, syncope in older adults often presents as falls, which is either due to amnesia for loss of consciousness, or pre-syncope leading to a fall, especially in those prone to falls with several other risk-factors for falls present. This difference in presentation can hinder the recognition of syncope, making an adequate work-up challenging. In patients with unexplained falls, or in whom the history comprises red flags for potential syncope, special attention to (pre)syncope is therefore warranted.

When syncope is mistaken for other causes of a transient loss of consciousness (TLOC), such as epileptic seizures, or when syncope presents as falls, patients are often referred to multiple specialists, which may in turn lead to excessive and unnecessary diagnostic testing and costs. Specialist services that are able to provide a comprehensive assessment can improve diagnostic yield and minimize diagnostic testing, thus improving patient satisfaction. Comprehensive assessment also leads to reduced length of hospital stay.

Increasingly, geriatricians are involved in the assessment of syncope in the older patient, especially given the overlap with falls. Therefore, awareness of causes of syncope, as well as state-of-the-art assessment and treatment is of great importance in our field.

Age and Ageing have compiled a new collection of 15 key syncope themed papers. A commentary to accompany this collection was written by the curators of this themed collection, also published in *Age and Ageing*, titled *Syncope in older adults: challenges, approach and treatment*.

To read the new collection in full, please visit https://academic.oup.com/ageing/pages/syncope

Dementia *in* primary care

Prevention, screening, early intervention and advance care planning all play an important role in helping people live well with dementia.

With global life expectancy steadily increasing, people with dementia will appear more and more on the patient lists of general practitioners (GPs).

GPs will be commonly the first physician to recognise cogntive impairment in their ageing patients and will accompany them during their journey through the health system right up to the end of life. GPs will help improve and promote living well with dementia, prepare family members and caregivers, and co-ordinate the care process.[1,2]

Another important role of the GP is their prevantative role in the care of ageing patients. The reduction of risk factors might have an effect on the dementia rates in community. Modifiable risk factors (which account to 40% of dementia disease globally) such as lower education level, hearing loss, brain traumas, hypertension, alcoholism, obesity, smoking, depression, social isolation, sedentary life style, air pollution, and metabolic conditions like diabetes mellitus might be recognised or addressed by GPs during the care of their adult patients. And almost half of the middle-aged population have at least one modifiable risk factor of dementia.[3-5]

The GP is often the first point of care in community. An early and timely diagnosis of dementia might help the patient, their family and caregivers to prepare for the future, allowing them to navigate potential issues early and implement an advance care plan. This might also avoid or delay admittance to residential care. After diagnosis, GPs are often the preferred information and advice source for patients and their relatives.[2,4-6]

Most health systems are fragmented and the management of dementia needs a person-centred and integrated care approach. Besides the provision of pharmacological treatment, non-pharmacological interventions, caregiver support, and training need to be addressed. GPs are in a unique position to act as advocates of their patients (i.e. support for inclusion, prevent isolation, stigmatisation, marginalisation), follow up on medication adherence, continue and coordinate care, participate in the comprehensive care process with a multiprofessional team approach, address and manage comorbidities, support patients and their caregivers with behavioural symptoms and health crises, assess strain and caregivers distress, and refer to a specialist and provided community services in a timely manner.[1,2,6]

During the continuum of care, adverse effects of treatment might be increased due to specific risk factors like frailty and multimorbidity. Certain drugs used to control symptoms (such as antipsychotics or anxiolytics) might increase the risk of falls, and patients might also suffer from osteoporosis or osteosarcopenia, increasing their fracture risk. Polypharmacy needs to be addressed and only necessary drugs should be continued.[6] Despite the central role of GPs in the care of dementia, barriers to care need still to be overcome. These can include the underutilistion of diagnostic instruments; lack of skill, confidence, and experience; negative attitudes or stigma surrounding the need for a diagnosis; paternalism; belief that the patient refuses diagnosis; as well as lack of resources, support, access and incentives within the healthcare organisations and social services.[1,2,6]

GPs provide comprehensive care for a broad range of patients and health conditions. Despite their daily work mostly involving care of acute conditions and preventive services, the ratio of ageing patients with multimorbid conditions is increasing. Cognitive changes in patients might be often accepted as physiological ageing changes. These, alongside loss of independence, reports of early symptoms from patients and relatives, and loss of functionality might be the first point at which they are screened for cognitive decline. Upon diagnosis, GPs continue long-term care of their patient, considering the biological, social and psychological context of the patient and their relatives. GPs are an important stakeholder to meet the caring needs of older people with frailty and dementia in the community.

Prof Dr Hakan Yaman
GP

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HEALTH INEQUALITIES & PSYCHOSOCIAL frailty

Widening social inequalities combined with an ageing population should be a warning signal for psychosocial frailty, writes Claire Norman, an Advanced Clinical Practitioner based in West London.

Frailty is globally recognised as a state of vulnerability with limited physiological resources to recover from episodes of ill health and injury.[1] It is a condition influenced by health inequalities, which can be linked to socioeconomic position, education and gender, for example, which are widely acknowledged as contributing to earlier onset.[2] At present, there are vast and widening inequalities in life expectancy within the UK,[3] and despite improvements in healthcare and disease prevention, health disparities continue with little signs of improvement.[4]

Health inequalities

Access to healthcare services is currently inequitable, meaning those with the greatest need often also have the greatest difficulty accessing and receiving appropriate care and support. This leads to a situation often referred to as 'inverse care law,' where those that need healthcare the most access it the least.[5,6] Previous reports have highlighted how loneliness among vulnerable older adults than in other groups - including immigrant populations; lesbian, gay, bisexual, and transgender (LGBT) people; and those from lower socioeconomic classes, and ethnic minorities.[3]

Furthermore, these disadvantaged and excluded groups are often missed by efforts to identify frailty, given their hesitancy to engage with services or lack of understanding about how to access healthcare.[3] Groups that experience income poverty, for example, often find access to healthcare services impeded, as do those with gender disparities.[5] It is well documented that these groups often experience chronic exclusion, consequentially increasing their risk of experiencing frailty, reflecting the impact of the wider determinants of health as well as the psychosocial factors that influence health behaviours.[7] Given the World Health Organization's Decade of Healthy Ageing (2020-2030) is already upon us,[8] creating a society where everyone has access to support to stay healthy throughout the life course is much needed.[5] The recent Chief Medical Officer (CMO's) report[9] highlighted the need to improve healthy ageing by delaying the onset of diseases, which has the potential to improve the quality of life for older adults. In addition, acknowledging health inequalities which were described as 'largely preventable' and associated with frailty are recognised as being higher in deprived areas.[9] However, the interaction between frailty and health inequalities remains relatively unknown, warranting further exploration to help us gain a greater understanding, which in turn will improve how we support this group.[10]

Understanding frailty

Historically, frailty research focused on physiological health issues, neglecting the impact of environmental factors and influences, best described as the 'wider' or 'social determinants' of health.[2] Considered by the World Health Organization to be the main driver of health inequalities,[3] these social determinants interact across a person's life course, creating a pathway of health and social wellbeing that is recognised as being associated with increased mortality, earlier onset of comorbidities and poorer health outcomes.[4] However, it is presently unclear which of the wider determinants are the key contributory factors in frailty and which are potentially modifiable through targeted intervention.[2]

Frailty can be seen as a combination of biological, social, psychological healthcare issues, with varying degrees of dominance in any one of these characteristics.[11] Research indicates there is a strong correlation between

> 'A lack of social relationships can increase your risk of health issues, from cardiovascular disease and high blood pressure, to depression and suicidal thoughts.'

social interactions and both physical and psychological health; a lack of social relationships can increase your risk of health issues, from cardiovascular disease and high blood pressure, to depression and suicidal thoughts.[12] In addition, sociodemographic characteristics (age, sex, living alone) and the number of chronic diseases present (hypertension, stroke, heart disease, diabetes, depression) contribute collectively to disease burden,[13] while issues often associated with ageing, such as hearing loss, are more likely to increase lower social participation.[14] Furthermore, there is an association between educational levels and both frailty and cognitive impairment, with evidence suggesting that individuals with higher education have better health outcomes.[4] Social isolation is recognised as causing low self-efficiency and self-respect. Reduced emotional support and increased perceived lack of wellbeing frequently affects the mental health of older people.[16]

Social frailty

Social frailty is associated with increasing depression among older adults,[13] and evidence suggests social isolation and loneliness hinder good health, with increased risk of anxiety, depression, cognitive decline, Alzheimer's disease, and even death.[15] New research estimates that up to one in five cases of depression among older adults could be prevented by reducing loneliness,[17] while the presence of personal disorders and hoarding behaviour may indicate frailty, and have been found to be correlated with low social engagement and living alone.[11]

Psychological frailty

Psychological frailty, along with physical and cognitive frailty, is linked to an increased risk of negative health outcomes among older adults, however the definition of psychological frailty has received limited attention.[18] Previous research suggests it is physical frailty that leads to psychosocial frailty, yet some refute this hypothesis, suggesting it is the other way round.[19] However, given the dynamic and often chaotic nature of complex health issues such as frailty, it is difficult to accurately establish which came first.[20] Nonetheless, psychological wellbeing impaired by frailty may play an important role in defining subjective health in older adults.[21]

> 'The presence of mental health disorders in older adults should alert those involved in supporting them to the increased risk of frailty.'

Psychosocial frailty

Psychosocial frailty, a combination of social complexities and psychological health issues, remains a relatively unexplored aspect of frailty, with a clear definition yet to be determined.[10] However, it is recognised that frailty can pertain to behavioural or lifestyle disorders such as hoarding and poor social engagement patterns.[11] The presence of mental health disorders in older adults should alert those involved with supporting them to the increased risk of frailty, given these issues are commonly associated with higher levels of isolation, low mood, anxiety and depression.[16] There has been increasing acknowledgment around ageing and mental health issues, which may present themselves in a different manner to those in younger populations, although recent reports highlight the need for renewed focus.[9]

Improving outcomes for people with frailty

The links between psychological and social frailty show the importance of health and well-being outcomes[1], highlighting the need to understand the dynamics of different health determinants in order to protect those vulnerable within an ageing population.[22] It would be reasonable to suggest that there is need to develop a greater understanding of psychosocial frailty, coupled with an improved awareness of the socioeconomic factors that can lead to the onset of frailty earlier in life,[5] which would allow greater support for vulnerable patient groups in a rapidly ageing population.[4]

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How are you sleeping?

Age-related physiological change is well understood, but do we know what the consequences are for sleep? Advanced Frailty Pharmacist Louise Organista explains how better sleep can have a positive impact on older people's mental and cognitive health.

At times certain times in our lives, it's inevitable we will struggle with sleep. Whether it's due to a major life change, the side effect of a stressor or (perhaps more relatable) as an outcome of shiftwork, sleep will suffer.

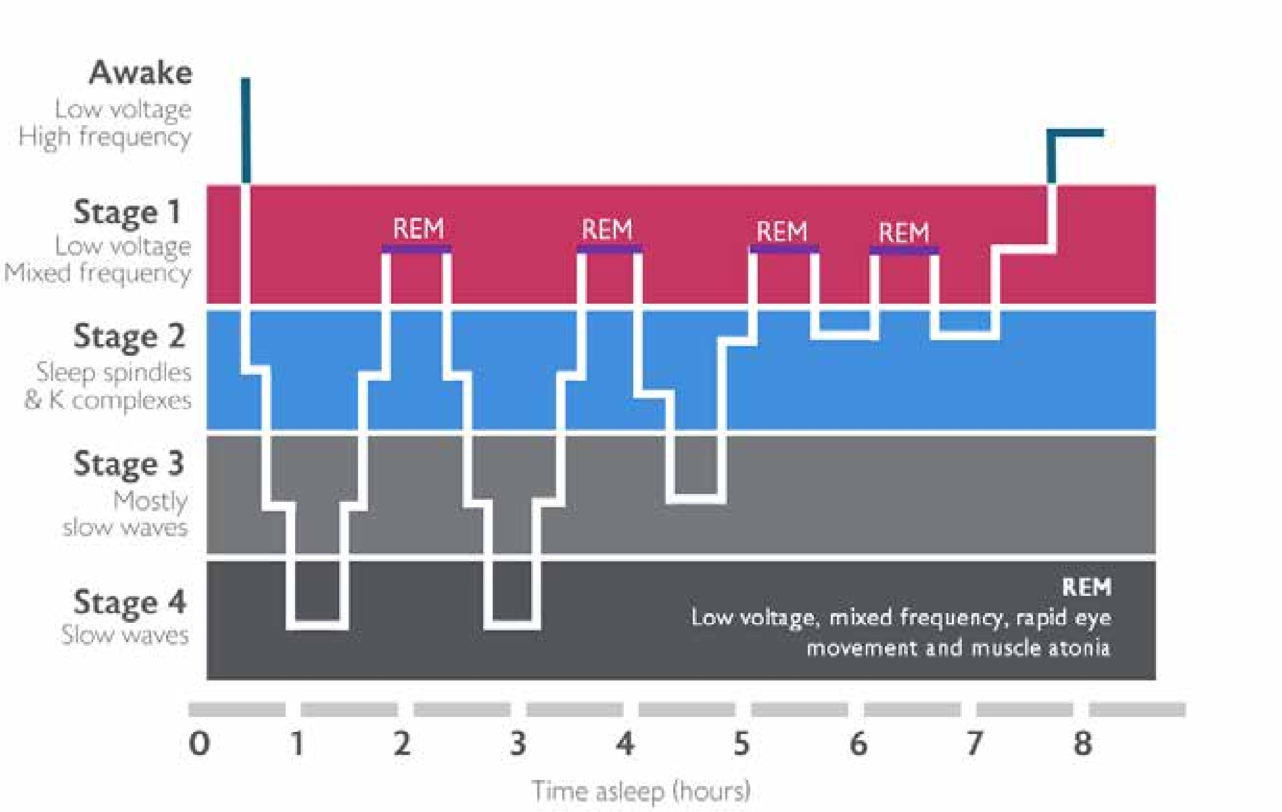
Having difficulty getting to or maintaining sleep, despite adequate opportunity and circumstances to sleep, resulting in daytime consequences is known as insomnia.[1] It's a sleep disorder which affects an increasing number of the population, and our older patients are not exempt. Like almost all bodily processes, sleep quality is another which declines with advancing age, and yet we assume this is just 'part of getting old' without acknowledging it.

It's often thought that as we age, we need less sleep, rather than understanding the reduction is a consequence of ageing. Older patients still need the same amount of sleep - it's just more difficult to attain. As a result, an older person's wellbeing, psychological, physical and cognitive health can be adversely affected.

Before considering the age-related changes to sleep physiology, it's important to consider sleep architecture.

The hypnogram in Figure 1 shows that both REM (rapid eye movement) and NREM (non-rapid eye movement) sleep - also known as deep or slow wave sleep - occur in 4-5 cycles across the night. In REM states, dreaming and emotional processing occur; whereas NREM sleep is important for memory consolidation, immune functioning, regulation of glucose metabolism and removal of waste metabolites from the brain.[2] The drive to sleep, known as sleep pressure, is caused by a build-up of adenosine. It's this sleep pressure that makes us feel sleepy, along with the neurohormone, melatonin, which is released from the pineal gland in response to low

Figure 1: A hypnogram showing sleep cycles across a typical night



light. Caffeine is an adenosine receptor antagonist, which explains why tiredness can be temporarily offset, but also why a wave of fatigue occurs once it's cleared from the body.

Sleep truly deserves its title as a pillar of health: when we don't get enough of it, it's inevitable that consequences will ensue, from increased pain sensitivity, impaired immune response, diabetes, reduced ability to cope with everyday stressors and even delirium.

Age-related changes affecting sleep

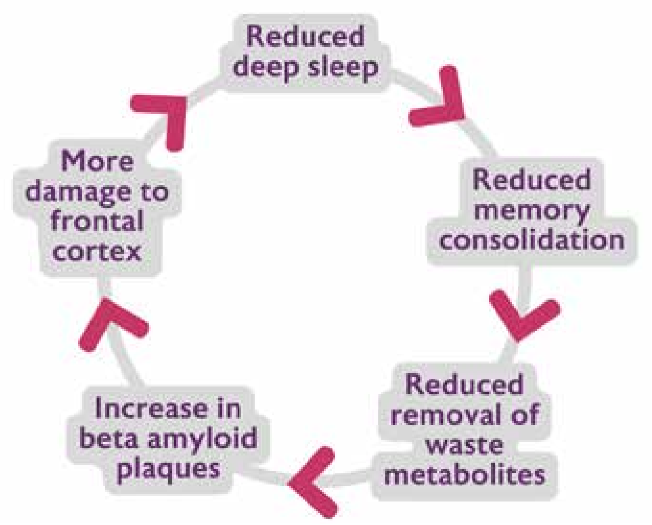
There are various ways that age affects the ability to sleep, which include:

- An increased number of nocturnal awakenings and time spent awake during night (i.e. reduced sleep maintenance), therefore reduced sleep efficiency (the time spent in bed actually asleep).
- Less NREM (slow wave) sleep due to age-related atrophy of the frontal cortex (the area of the brain in which slow waves originate).
- Increased daytime naps and excessive daytime sleepiness (a consequence of poor sleep or sedative medications, which off-sets sleep pressure and makes it more difficult to sleep again at night).
- Advanced circadian timing and reduction in melatonin release. This phase advance is seen not only in the sleep-wake cycle, but also in body temperature rhythm, and in the timing of secretion of melatonin and cortisol. Patients feel sleepy earlier in the evening, may have a nap or fall asleep, less sleepy for bed, wake up early and feel unrefreshed.
- Medications (e.g. causing daytime sedation, nightmares, nocturia) and co-morbidities (e.g. pain, anxiety, incontinence, restless legs).
- Reduced social stimulation, emotional grief or loneliness.

Poor sleep and dementia risk

One of the most devastating outcomes of poor-quality sleep is the increased risk of developing Alzheimer's disease. Historically, needing to sleep less and work hard was a trait about which some very successful individuals boasted: both Ronald Reagan and Margaret Thatcher claimed to only need 4-5 hours per night, yet both also went on to be diagnosed with (and eventually die with) this condition.

By having poor or little sleep each night, there are less NREM sleep cycles for memory consolidation (therefore overnight forgetting ensues). NREM sleep is also the stage in which the glymphatic system removes waste metabolites from the brain, such as neurotoxic beta amyloid protein. With reduced NREM sleep, the efficacy of the glymphatic system to remove waste metabolites (such as beta amyloid) decreases by 10-20 fold. Beta amyloid plaques can therefore become established, causing further damage to the frontal cortex and further reducing the ability of the brain to produce NREM sleep waves. It's a perpetual cycle which shows why patients with Alzheimer's disease are more likely to have insomnia, and why insomnia is a risk factor for the disease itself. Current research is underway to investigate the effect of neurostimulation to enhance slow wave sleep and improve cognition in ageing.[3]



Poor sleep and depression risk

Insomnia may also induce or exacerbate depression, whereas historically, sleeping problems were seen as a consequence of depression. It's not uncommon for a patient with insomnia to be prescribed an antidepressant, since many GPs are taught to look at poor sleep as a symptom of this illness. This is not to lay the blame with anyone - medical schools across UK only spend about 1.5 hours teaching about sleep,[4] something we spend a third of our lives doing!

Management

Good sleep hygiene advice should always be provided in the first instance, and it's value should never be overlooked. If unsure where to start, ask "how are you sleeping?" as part of history taking. Find out about the patient's routine, their sleeping and waking times, if they nap, how much caffeine or alcohol they consume, what medication they're taking and if their co-morbidities are being managed. This will allow for a real insight into the patient's life and enable you as a clinician to provide tailored advice that may really make a difference. It may be as simple as suggesting switching to decaffeinated drinks, writing down worries in a notebook before bed, or getting some daylight first thing in the morning to re-establish a healthy sleep-wake cycle. Even managing the patient's sleep expectations can make a difference - many are still trying to achieve the golden 'eight hours a night' and are frustrated about not being able to attain it.

Take the opportunity to ensure patients have the practical support they need to reduce the risk of nocturnal falls (which are all too common) by highlighting these patients to our therapy colleagues. Advice on procuring motion-sensor lights, pendant alarms and ensuring night lights are in easy reach can be provided.

> 'It's often thought that as we age, we need less sleep, rather than understanding the reduction is a consequence of ageing.'

CBT-I

Cognitive behavioural therapy for insomnia (CBT-I) is recommended for treatment of both short and long-term insomnia in adults of all ages - unlike medication, benefits associated with CBT-I persist on completion of treatment.[5]

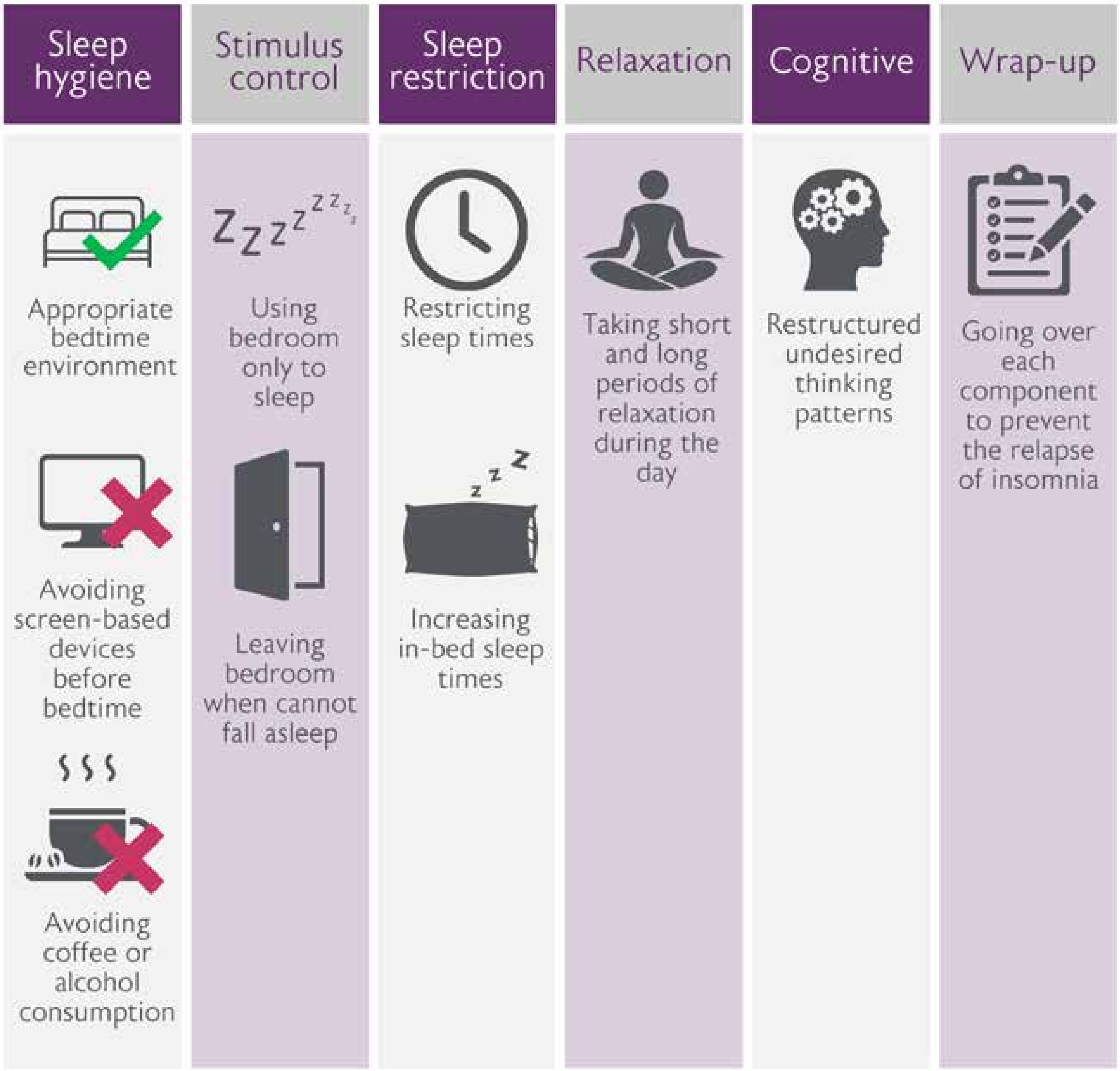
CBT-I (see Figure 2) builds on the provision of sleep hygiene advice by focusing on additional methods to increase sleep quality. This includes stimulus control, which strengthens the bed as a cue for sleep rather than wakefulness; sleep restriction, which encourages the patient to only go to bed for restricted hours to increase sleep efficiency; relaxation techniques which address stressful lifestyles; and finally, the CBT which challenges unhelpful thinking patterns around sleep. Access to this highly effective tool in the NHS is extremely variable, however - I hope this is something that will change in the future.

Hypnotics

The pharmacological options (hypnotics) for insomnia are not recommended for prescribing in older patients, causing dependence, tolerance and reduced cognition (sedation, drowsiness, mental slowing) which increases falls risk. None of the drugs truly match the sleep architecture of natural sleep, therefore patients may not receive the restorative benefits of a good night's rest. They are however, utilised in our patient cohort all too often, and for some, in the short term (up to four weeks), may improve quality of life for the patient.

Writing a prescription is all too easy - the challenge for us as clinicians can be stopping these drugs, which needs to be a slow process, taken at the patient's pace. Shared decision-making here is paramount. The patient's fears about insomnia and reducing their medication must be

Figure 2: The basic principles of CBT-I[6]



listened to; monitoring during the weaning process should be arranged. Do challenge the use of any sedative medication that has been prescribed for this purpose e.g. sedating antihistamines, benzodiazepines and antidepressants (when only used for sedation). For that reason, always ensure to ask about over-the-counter items the patient may be buying (diphenhydramine is in many cough and cold products).

A new drug to be aware of is daridorexant, an orexin (hypocretin) inhibitor, indicated for 'the treatment of adult patients with insomnia characterised by symptoms present for at least three months and considerable impact on daytime functioning'.[7] Orexin is a neuropeptide which regulates various physiological phenomena such as wakefulness, feeding, reward, and thermogenesis - its name derives from the Greek 'orexis', meaning 'appetite.' However effective it may be for supressing wakefulness, it will not be without adverse effects, especially if our patients already have reduced appetite and stimulation.

In summary, sleep and its importance to both physical and psychological health at all stages in life should not be underestimated - its value is more than a pill could ever provide. Sleep quality deteriorates with age, and older patients should be supported with non-pharmacological measures as best as possible.

Don't be afraid to talk to your patient.

"How are you sleeping?" may become one of the most important questions they hope you will ask.

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Shared decision-making:

Power & disempowerment

Person-centred care and shared decision-making have started to be used interchangeably within healthcare, but what is a truly *shared* decision, and how do we ensure that it is the person's decision and not ours? Dr Pippa Collins explores how power dynamics effect the process of shared decision-making, and why professional instincts can sometimes interfere with the ability to truly listen to a person's own wishes.

Person-centred care is premised on the concept of personhood which is "a standing or status that is bestowed upon one human being, by others."[1] Thus personhood is not, within the concept of person-centred care, a right which is expected, but is a status that might (or might not) be bestowed upon a recipient by another person. Power dynamics are clearly demarcated; one person has the ability to bestow; the other awaits passively for largess to fall. The act of moving through the doors of a hospital changes one person into a patient dependent for their care on the healthcare staff around them; another person crosses the threshold of the hospital and becomes an empowered professional.

Why is this important? To me this dichotomy of power is the underpinning, yet rarely acknowledged, foundation of healthcare in our society, and is why real shared decision-making can be so difficult. My first real reflection on this power imbalance came during my PhD when I was data collecting with people living with dementia on an acute ward. I split the consent process into two parts, firstly to

> 'The act of moving through the doors of a hospital changes one person into a patient dependent for their care on the healthcare staff around them; another person crosses the threshold of the hospital and becomes an empowered professional.'

give consent to take part in a conversation that was videoed; secondly to consent for the data to be used in research and education. Using the tablet for context I discussed my research with each participant and if they took part, I assessed during our time together if the participant understood the abstract concept of the use of data.

All the participants who could consent for themselves signed, or marked, a consent form; alternatively I consulted with a proxy. What I noticed in myself was the deep discomfort that I felt when I empowered a participant with dementia to consent for themselves, even within the structure of the Mental Capacity Act (2005). What if they changed their minds? What if they came across the videos at a later date and were upset? What if the family objected?

Yet this surely is the process of decision-making. Discussing this at length with different clinicians and researchers, it was an Admiral Nurse who said to me that we can all change our minds at a later date, or regret taking part. To prevent a person with dementia from consenting is to infantilise and negate their capacity for decision-making. It also works to exclude their lived experiences from research.

This discomfort when supporting another person's decision,is also present in my clinical role. Our algorithms and guidelines are there to be followed. But what happens when the person at the centre of the treatment decision does not wish to follow them? It is uncomfortable, and at times it is frightening.

The lady who declines admission for a DVT even though she fully understands that it might kill her if she is only treated at the community level (and she does in fact die); the man with heart failure who develops severe central chest pain who says to me "I know that my heart is packing up, and I am at peace," and requests pain relief and supportive care at home. And the man with a dementia diagnosis who wants no treatments that could prolong his life, dreading the prospect of reaching the final stages, and declines to take anti hypertensives, statins and blood thinners. To empower one person, the other must by definition be disempowered; their advice must take second place to another's wishes.

> 'To truly make shared decisions requires that we are brave and let go of our professional certainty and power.'

A dementia diagnosis plus a decision that goes against recommended advice is often a cue to question a person's capacity. Clinically I notice a tendency for a capacity assessment to be used as a reason to prove that a person does not have the capacity to make a treatment decision that is in conflict with that of the professional; rarely do I see this assessment done in order to support and facilitate a decision that concurs with healthcare advice.

I have heard colleagues in both acute and community settings override a patient's decision because they believed that it put their professional integrity at state, because there was a fear of litigation, or because they believe that their decision is the correct one. To truly make shared decisions requires that we are brave and let go of our professional certainty and power. To remember that healthcare is only one aspect of a many-faceted life story. We need to listen unconditionally to the other's narrative and understand where healthcare decisions are positioned within this.

A well documented account of the decision to be made, how it was made and why it was made, is the essence of a shared decision. In the event of questions around capacity to make a specific decision, the Mental Capacity Act gives direction to practitioners in how to establish capacity, clearly stating that people have the right not to be treated as lacking capacity merely because they make a decision that others deem 'unwise'.

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Dementia:

a global perspective

We are all aware that dementia is a huge issue in the UK. We see people with dementia every day in our clinical practice and observe the challenges that it can create for individuals and their caregivers. Yet dementia is an issue that reaches across the world. Its prevalence is increasing everywhere, but this is happening particularly quickly in low- and middle-income countries, where the rate of population ageing is faster than we have ever seen in Europe.

In France, it took 150 years for the proportion of the population aged 60 years or more to increase from 10% to 20%. This is happening in just over 20 years in Brazil, China and India. By the year 2050, it is predicted that more than two thirds of people living with dementia will be in low- and middle-income countries.

In addition to demographic changes increasing the number of older people at risk of dementia, countries have serious challenges to face in addressing modifiable risk factors for dementia. These include vascular risk factors like smoking, uncontrolled hypertension and diabetes, and excessive alcohol consumption, as well as managing sensory impairments such as hearing loss in midlife. Managing these issues is never easy, but this is particularly the case in countries where access to health services is limited.

Regardless of the context, living with dementia can exert a real toll on individuals and their carers, with research from all around the world describing carer strain, burnout, stigma related to dementia, and even, sadly, elder abuse. Regarding treatment options, acetylcholinesterase inhibitors and Memantine can provide symptomatic benefit in Alzheimer's disease and dementia with Lewy bodies. Unfortunately, these medications are not widely available in many low-income settings, as they are not on the World Health Organization Essential Medicines list, which provides guidance to Ministries of Health across the world on which medications to prioritise for their populations.

Globally, a vast amount of the care provided to people with dementia comes from family members, either by choice or because of a lack of alternative. It was estimated in 2015 that every year, around 82 billion hours of informal care was provided to people living with dementia at home, equating to more than 40 million full-time workers, and this is predicted to rise to the equivalent of 65 million full-time workers by 2030. In clinical practice we see first-hand the relentless dedication and energy that family members put into caring for their loved ones with dementia, and this story is played out in every country in the world. It is deeply inspiring and meaningful work. And so surely, one of the most important things that we can do as a society, is to create and deliver effective methods to support these caregivers, in a way that is tailored to their specific context.

In the UK, NICE recommends offering carers support through training on both providing care to people with dementia and looking after themselves. This is based on evidence that these programmes can reduce carer burden, depression and anxiety, and may even delay placement into residential care. The majority of this evidence comes from trials in high-income settings, but studies done in middle-income contexts have also shown promising results. For example, an intervention in Alexandria, Egypt, included education about dementia, six sessions of group Cognitive Behavioural Therapy (CBT), and group support sessions. This led to reduced depression and anxiety among carers that was persistent three months after completion. However, while interventions such as this may be beneficial, the use of skilled practitioners trained in CBT to deliver sessions would not be feasible at scale in many low-income settings.

In recognition of this, the 10/66 Dementia Research Group (a collective of researchers carrying out population-based research into dementia in low and middle income countries) trialled an approach called *Helping Carers to Care* in Russia, India, Venezuela, Peru, Dominican Republic and China starting from around 2010. Their approach focused on using low-cost interventions grounded within existing health and social care structures. Based on this approach, in a study in Goa, India, Home Care Advisors (non-clinically trained high-school graduates) were given intensive training for a week, then did home visits to families caring for someone with dementia at least every two weeks for six months. These visits aimed to improve understanding of dementia and caring skills, as well as signposting to existing government schemes or psychiatric services if indicated. After six months the researchers found a small improvement in carer mental health.

More recently, the World Health Organisation has developed a standardised tool for caregivers of people with dementia, called iSupport, aiming to train and support caregivers globally.
It includes five modules:

- Introduction to dementia.
- Being a carer.
- Caring for me.
- Providing everyday care.
- Dealing with behaviour changes.

It is a tool that can be used either for self-directed learning or as a resource for a training programme. Just the creation of this programme is an important step in the global recognition of the caring work that is ongoing, unsupported, in so many global contexts.

Whether it effectively improves the lives of carers around the world is yet to be determined. While some of the challenges of living with dementia may be universal, others are bound to be context-specific, and may vary with factors such as whether a person is in a rural or urban environment, how dementia-friendly the community is, and assumed caring roles within a family. So there is a balance to be struck between finding a simple programme that can easily be scaled up across multiple settings, and designing a programme that is specifically tailored to a specific context.

There are trials ongoing currently in Brazil, Australia, China, the UK, the Netherlands, India, Japan, and Portugal to look at the impact of using iSupport on carer experiences, and we eagerly await the results. It will also be important to see similar studies in lower-resources settings, where we currently have even less evidence on how to effectively support carers of people with dementia.

It is predicted that in 2030, 78 million people worldwide will have dementia, rising to 139 million in 2050. With no effective treatment widely available globally, understanding how best to support people with dementia and their caregivers should be one of the highest priorities within global dementia research. While simple, scalable tools such as iSupport are highly promising, understanding the lived experiences and unmet needs of individual populations is crucial to the delivery of effective and supportive programmes.

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Josie Prynn
Clinical PhD Fellow Researching dementia epidemiology in Uganda; Geriatric Medicine SpR

BGS Delirium Hub: A comprehensive delirium resource

The BGS Delirium Hub links users to useful, practical and high-quality information on all aspects of delirium in older people.

Frequently misdiagnosed or under-diagnosed, delirium is a state of acute confusion. Characteristic features include difficulty concentrating, disorientation, difficulty with understanding or memory and personality changes, which can be immensely upsetting to both patients and their loved ones.

The causes of delirium are multifactorial and can often be a sign of an underlying physical illness. Raising awareness of the risk factors, signs and management of delirium among the wider multidisciplinary healthcare team is vital to help ensure that older people can access the support and care they need, reducing unnecessary distress for those affected.

The hub guides users through the topic of delirium, focusing on four key interlinked areas; an introduction to delirium; presentation, screening and treatment of delirium in specific settings; education and training; and current research evidence.

The BGS Dementia and Related Disorders Special Interest Group (SIG) led on the curation of the resource, which provides useful context and signposting to material from organisations such as BGS, Health Education England, Health Improvement Scotland, National Institute of Health and Care Excellence (NICE) and the Scottish Intercollegiate Guidelines Network (SIGN), as well as free-to-access papers from Age and Ageing and other globally-recognised peer-reviewed journals.

Visit the Delirium Hub on the BGS website at www.bgs.org.uk/DeliriumHub

Recognising BURNOUT

Burnout has only recently been recognised as a syndrome and occupational phenomenon, mentioned in the International Classification of Diseases 11th Revision (ICD-11) published in 2019.[1] It is, however, still not recognised as a medical condition; it is a syndrome, described as being caused by chronic workplace stress that is not successfully managed.

Burnout is defined with a triad of signs: [1] feeling depleted in energy (or exhaustion); increasing mental distance from your job, including overly negative feelings or cynicism; and reduction in professional efficacy.

Over the past few years, especially since the COVID-19 pandemic and the rise of working from home, there has been increased awareness of, and media attention on, the idea of burnout. NHS workers working in a busy and overstretched system are recognised as being a key group of workers at risk from burnout. With staffing pressures, industrial tensions and high workload likely to increase further, we look at how to identify and manage burnout at an early stage, hopefully arming people with helpful tools to stay healthy, and reminding people of the importance of taking care of themselves.

How to identify burnout

Although burnout has officially been described and recognised, it can be difficult to see the symptoms and signs in yourself. Often, it is colleagues, friends and family who notice the signs and may intervene to help you. Burnout is not something that will go away on its own, but rather, it will likely worsen until the underlying problems are addressed and managed.[2] The longer burnout goes on without addressing the core problems, the more likely it is to start having knock-on effects to other areas of your life. As it is a state of physical and emotional exhaustion it is important to be able to recognise the symptoms and signs of burnout in yourself in order to intervene early.

The most common signs of burnout include:[2]

- Feeling tired, drained or exhausted most of the time.
- Feeling helpless, trapped and/or defeated.
- Feeling lonely or detached in the world.
- Having an overly cynical/negative outlook.
- Self-doubt.
- Procrastinating and taking longer to get things done.
- Feeling overwhelmed.

There are several factors which have been identified which can increase the likelihood of developing burnout. Not all of these factors are solely work-related, but combined with work pressures, they have a large impact on wellbeing:

- **Money worries:** Whether this is feeling like you are not adequately compensated for the work you do, or struggling with budgeting or debt, money worries are a huge stress for a large number of workers, and are particularly prevalent at a time of high cost of living and widespread strike action.
- **Working from home:** The pandemic shifted the culture of working life, making working from home a lot more common. When working from home, boundaries between work and home life become blurred, with decreased face-to-face interaction with colleagues. This has been identified as a key factor contributing towards burnout.
- **Worries about job security:** Whether this is because you have interviews for new posts looming, are unsure of which career path to follow, or something else, worrying about your job and your next pay cheque can have a huge negative impact.
- **Isolation:** Feeling lonely can negatively affect your mental health, and reduces the ability to talk about how you are feeling with others. The importance of interpersonal relationships and interactions was highlighted by repeated COVID lockdowns.
- **Physical health:** Staying healthy with a healthy balanced diet, plenty of water intake, reducing alcohol, and ensuring you get up, move and exercise, all have a large positive effect on our mental health. Any intercurrent illnesses or chronic ill-health, as well as an unhealthy lifestyle, can have a negative effect on our ability to cope with other stressors in the workplace.
- **Sleep:** Sleep is often a vicious cycle and one of the first things to become disrupted. How you feel can affect your ability to have a good night's sleep, and a poor night's sleep can also affect how you feel.
- **Relationships:** Your relationships with both yourself and others can affect how you are able to deal with other stress and problems in your life and at work. If you struggle to get support from the relationships around you this can contribute towards you feeling lonely and reduce your ability to deal with stress.
- **Caring for others:** Being a long-term carer for another person has long been recognised as a source of chronic stress. Whether this is a child, a friend or family member with disability or elderly parents, having caring responsibilities can contribute towards the likelihood of you developing burnout.

Tips for recognising burnout

- **Identify and be aware of risk factors in your life for developing burnout**
- **Check-in with yourself. Ask yourself why you're feeling exhausted, why did you snap at that colleague, why are you finding it hard to concentrate?**
- **Be aware of changes in your personality. If you have always enjoyed an activity or hobby, question why you suddenly do not have the time, energy or interest in it.**
- **Listen to your friends, family and colleagues. This can sometimes be hard to hear, but try to remember these people care about you and your wellbeing.**

Recovering from burnout

Coping with and managing burnout can be difficult as we often do not have control over a lot of workplace factors which contribute towards it. If burnout is recognised at an early stage, some simple interventions (such as ensuring daily time and space for you and something you enjoy out of work, may be enough. But if burnout is left unaddressed, it may be that time out of and away from the work environment is needed, in order to reset, rest and re-energise.

As a personal example, I experienced emotional fatigue 2.5 years ago when I lost my beloved father to COVID, and work pressure was getting on top of me. I experienced problems within our team and it felt like everything was disintegrating. When I was at home with my kids I found I was not mentally present 'in the moment'. They would talk to me but it would just not register. It felt as if I was on autopilot with no insight into my mental wellbeing. As often happens with burnout, it was my family who pointed out that I was not quite myself, and emotionally distant. I realised that I had to take control of my mental health. Here are some important steps that helped me regain control:

- **Say no:** It's okay to say no to extra work or commitments, even if you feel like you should say yes. You need to focus on your own recovery and well-being and realise that it doesn't make you a bad clinician. The key to remaining well is to continue to strike a better balance between work and 'self'. You are not responsible for every single event that occurs in your department, and others will be able to help and fix things if you aren't there.
- **Set boundaries:** This means leaving work on time, taking lunch breaks, and also recognising how important it is to set boundaries with friends and family, so that you have time to yourself to relax and recharge.
- **Inspire and motivate yourself:** Listen to something you can relate to or you find inspiring, such as music, audiobooks or podcasts.
- **Procrastination is a marker of emotional fatigue:** Make small regular achievable tasks for the day or the week, ensuring to take regular breaks.
- **Take time out to refocus:** Pray/meditate/practice mindfulness, or any healthy activity that helps you to remain in a 'zen' frame of mind.
- **Exercise:** Exercise has long been shown to have a positive effect on our mental health, and just getting outdoors in the fresh air and daylight will help enormously. Whether this is walking or running, or something else, you don't have to go far, but moving will help you to feel so much better.
- **Get enough sleep:** Shift work takes its toll on all of us, making it even more important to ensure we have adequate sleep. When you're well-rested, you're better able to cope with stress and manage your emotions. If sleep is something you struggle with, perhaps apps like Calm & Headspace can help.
- **Remind yourself:** "Be kind to yourself" as many times as you can, every single day.
- **Stop multitasking:** Share and delegate. Multitasking is the biggest cause of forgetfulness in working mothers, in my opinion. I call it 'mumnesia.' But everyone, parent or not, is guilty of multi-tasking. Eisenhower's decision matrix (see Figure 1 on the next page) can help you to prioritise jobs, or to get rid of ones which really do not need to be done. I have this stuck on my kitchen door. It helps me to differentiate between tasks that are important/urgent vs tasks that can wait.
- **Seek help and support:** Be aware of where to go if you need help and support, and ask for help if you're struggling. These might be Occupational Health; staff support (most hospitals now have a staff support service to which you can self-refer for counselling, psychology or other well-being support); the Deanery (if you are a trainee); your GP; or the Practitioner Health Programme.

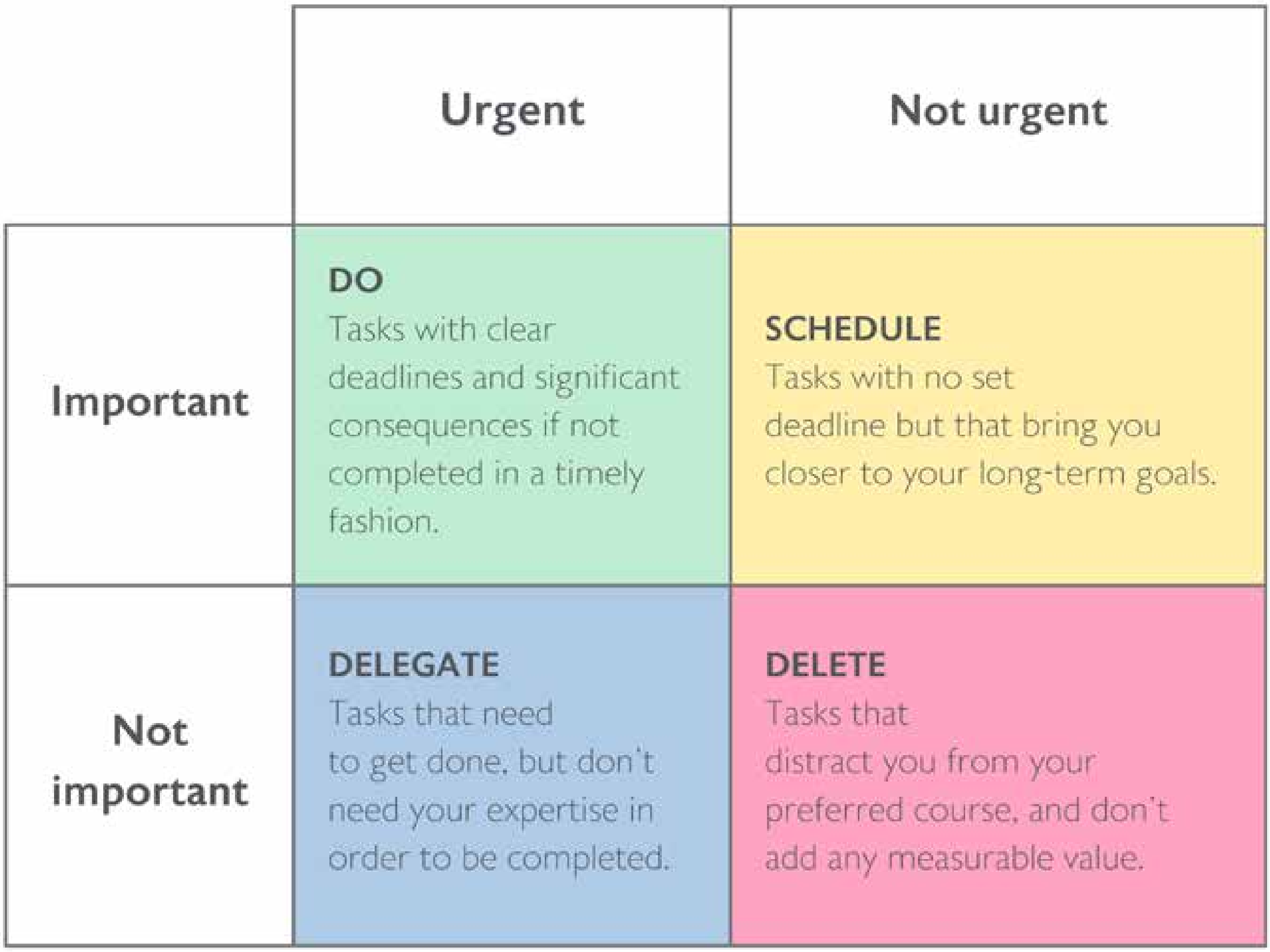
> 'Often, it is colleagues, friends and family who notice the signs and may intervene to help you.'

Sometimes adjusting and changing things yourself is not quite enough. If you are still struggling, talk to your supervisor or manager. Do you need to reduce your hours temporarily, or even permanently? Do you need other changes in the workplace? Do you need time out of work completely followed by a phased return?

There are a multitude of avenues of support out there, and others may be in a better position to advise, or be aware of options which you are not aware of.

Managing burnout does not stop the moment you start to feel better. The reality of post-burnout recovery is that it's not always obvious and it can be hard to see how far we have come.

Figure 1: Eisenhower's decision matrix



	Urgent	Not urgent
Important	**DO** Tasks with clear deadlines and significant consequences if not completed in a timely fashion.	**SCHEDULE** Tasks with no set deadline but that bring you closer to your long-term goals.
Not important	**DELEGATE** Tasks that need to get done, but don't need your expertise in order to be completed.	**DELETE** Tasks that distract you from your preferred course, and don't add any measurable value.

"My first sign that I wasn't burnt out came from enjoying a work day after several months. It came from the realisation that I hadn't cried that whole week and that I no longer felt so angry towards medicine, the career I gave so much to and gave so much up for."

Remember, recovery from burnout takes time and is an ongoing process. Be patient with yourself and don't be afraid to ask for help. Continue to find that balance between work and 'self' ongoing in order to ensure you remain healthy and well.

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'Be aware of where to go if you need help and support, and ask for help if you're struggling.'

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Dr Victoria O'Brien
BGS Trainees' Council Co-Chair; Registrar (StR) in Geriatric Medicine

Introducing…

The Scottish Brain Health ARC!

Dementia, and the other cognitive issues associated with ageing, represent one of the most pressing public health challenges of the 21st century. In Scotland, there are 90,000 people living with dementia, with an estimated annual incidence of 20,000.

Research has an important role to play in dementia and brain health. However, traditional ways of working have resulted in us missing opportunities to collaborate, create research synergy, and truly realise the potential of our various research communities. For example, in Scotland we have centres of research excellence in fields such as delirium, vascular cognitive impairment, and traumatic brain injury – all important to brain health, but these groups have tended to not work together. This fragmentation can be seen at many other levels. Fundamental science, social science and clinical science all have a role to play in brain health research but have tended to work in silos. The same argument could be applied to Universities, Industry, and the NHS.

Greater collaboration between groups already working in the brain health space is much needed, but may not be a sufficiently radical change for the problems we face. To bring new ideas and to really tackle an issue as complex as brain health, there would be a strong argument for including other disciplines such as mathematics, engineering, the arts and humanities and many others.

With increasing public awareness of brain health, new funding available for brain health research, and new therapies coming online, we have a unique and time-limited opportunity to work together and improve our nation's brain health.

The Scottish Funding Council (SFC) clearly agreed with these sentiments, and through its Alliance for Research Challenges (ARCs) funding call agreed to support a new research facilitating initiative - the Brain Health ARC.

So what's the Brain Health ARC all about?

The ultimate aim of the ARC is to make Scotland the 'go-to' destination for brain health research. To make this happen, we have set ourselves some ambitious goals. We want to create and support new cross-institute, cross-sectoral, and cross-disciplinary collaborations. We see the ARC as a platform that supports and encourages new collaborations, especially from research teams that may be working in areas and centres outwith the traditional neurosciences.

We are not limiting ourselves to the delivery of research - we also want to educate the public, develop the workforce, and influence policy, but most importantly, we want to find solutions to the societal challenges associated with poor brain health.

For a topic like brain health, there is no shortage of areas that could benefit from greater support. Based on feedback from the research community we have chosen to focus our energies on seven themes (illustrated below):

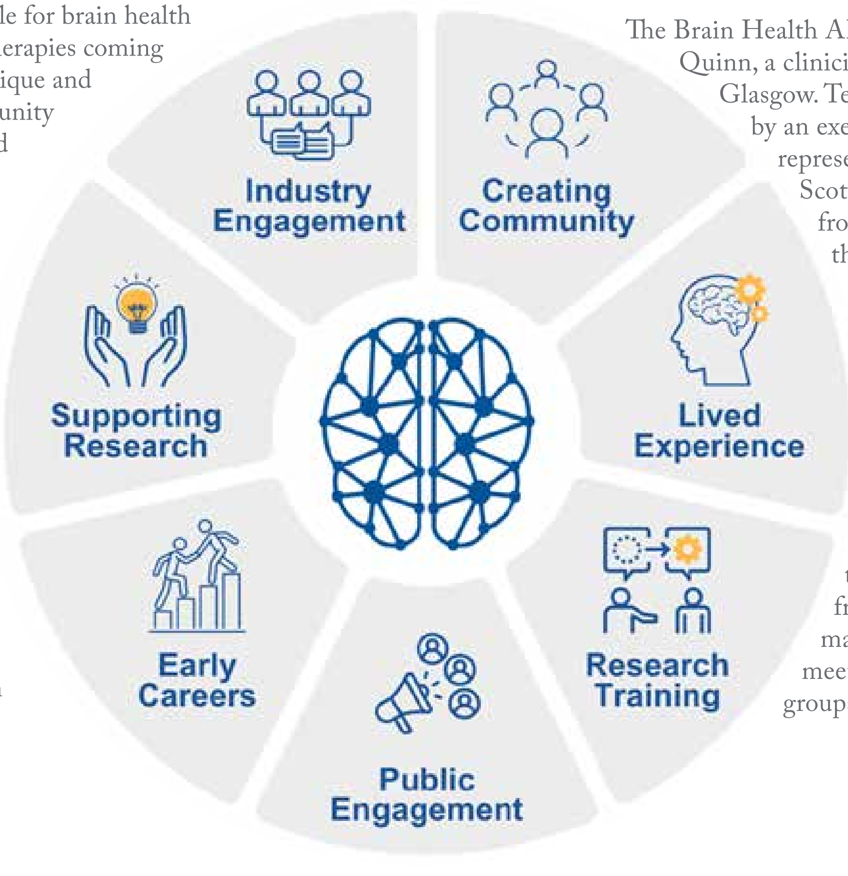
- Supporting Research.
- Industry Engagement.
- Creating Community.
- Lived Experience.
- Public Engagement.
- Early Careers.
- Research Training.

Who's involved in the Brain Health ARC?

The Brain Health ARC team is led by Terry Quinn, a clinician and researcher from Glasgow. Terry will be ably assisted by an executive team with representatives from the major Scottish Universities as well as from the NHS, industry, and the third sector.

Through the ARC we want to create a diverse brain health community, and we want to hear from fellow brain health enthusiasts.

People can engage with the ARC in many ways from simply being on our mailing list, to attending meetings, joining working groups or applying for funding.



Do we need another dementia research consortium?

Compared to a decade ago, there are now a multitude of collective organisations working in dementia, brain health and other areas pertinent to older adults. With ARUK, DPUK, DRI, SDRC and many others, it is possible to feel overwhelmed by the abbreviations. The Brain Health ARC is working with all these organisations, but we will ensure we retain our own remit and identity. A key differentiating feature of the ARC is that we are considering brain health research in the broadest sense, including but not limiting our activity to supporting laboratory neurosciences and clinical trials.

What will the Brain Health ARC offer?

You may think that the ARC's ambition is laudable, but what will we actually do in practice?

Training and supporting people who are new to research is an important goal of the ARC. The next activity on our training agenda is a webinar series with a focus on practical topics such as getting research funding, getting publications and working in partnership with people living with dementia.

To create new collaborations, we are running a series of meetings. These meetings are themed around anticipated UK and international research funding calls. Through participation in the meetings, research teams will be fully prepared to submit the very best applications when the major funding is announced. If teams need support to develop their ideas, we will have a rolling series of calls for seed funding and pilot work. Our last meeting in February 2024 focused on Dementia Biomarkers. However, we are already starting to plan other meetings themed around working with the arts and physical activity and lifestyle.

Below we have listed some of our other activities, but these are only some examples of what we are doing and have planned:

- Scotland-wide mapping exercise to identify all teams active in the brain health space
- Creating a national resource for patient and public participation in research
- Research priority setting exercises
- Pilot and seed funding of research
- Early career mentoring
- Supporting named prizes and guest lectures at meetings

Hot off the press - announcing the Biomarker Data Challenge

The Brain Health ARC, in a collaboration between University of Glasgow, University of St Andrews and the Global Alzheimer's Platform have been given exclusive access to the data from the Bio-Hermes study. Bio-Hermes is a cohort study of 1,200 participants that assessed various imaging, CSF, neuropsychological and other biomarkers, including 15 digital tests and 25 blood-based biomarkers. For more information, visit: **https://globalalzplatform.org/biohermesstudy.**

> 'We have a unique and time-limited opportunity to work together and improve our nation's brain health.'

In the spirit of collaboration and community, we are going to make data open to research teams across the UK. We know that many people may have interesting ideas but lack the analytical skills to work with a big dataset. To ensure that everyone has a chance to work with the data, we are offering the support of experienced data scientists who will work with teams to design, conduct and interpret their analyses. Bringing these data scientists into the ARC team has only been possible through working with the Race Against Dementia charity and we are very grateful for their support.

We know that big datasets can be intimidating to people who have not used them before. Through the ARC we are offering an end-to-end solution, we are handling all the ethical and data governance aspects, our data scientists will assist with analyses, and we have a dissemination event planned where researchers can present their work. Applications to the access the data will open in early 2024.

Watch this space…

How do I find out more?

If you are interested in keeping up to date with our activities and upcoming events & opportunities, get in touch on brainhealthARC@glasgow.ac.uk to be added to our mailing list

Or join us online:
Twitter/X: @brainhealtharc
LinkedIn: brain-health-arc
Website: www.sdrc.scot/brainhealtharc

If you have any other questions on comments contact us via email: BrainhealthARC@glasgow.ac.uk

Prof Terry Quinn
Professor in Cardiovascular Ageing
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Bridging Healthcare Globally: The Medical Training Initiative (MTI) in the UK

In an era of interconnected healthcare systems, the exchange of medical knowledge and expertise has become paramount for elevating global healthcare standards. The Medical Training Initiative (MTI) stands as a beacon of collaborative learning between international medical graduates (IMGs), their home countries, and the NHS.

The MTI is a UK government initiative that enables non-EU doctors to work in the UK's NHS, experiencing specialty training for up to 24 months before returning home to implement their new skills and experience. The Academy of Medical Royal Colleges facilitates MTI (two year) visas as the umbrella organisation for a number of MTI sponsors – principally the specialty Royal Colleges, who operate separate MTI programmes. These Colleges also sponsor GMC registration, ensuring that the IMGs meet GMC criteria. For example, the Royal College of Physicians of Edinburgh requires applicants to have full MRCP(UK) or an acceptable alternative, for its MTI programme (see **www.rcpe.ac.uk/MTI** for further detail). RCPE has worked with almost 70 NHS Trusts and Boards since 2012 to place IMGs in posts around the UK in most medical specialties including geriatrics.

Contextually, the MTI operates against a backdrop of global health disparities, where developing nations often grapple with insufficient healthcare resources and limited training opportunities. Meanwhile, the NHS, while renowned for its excellence, faces challenges in staffing and training, especially in filling rota gaps and reducing costs for locum cover.

The MTI therefore caters to the needs of all three primary stakeholders: the international doctors, their home countries, and the NHS.

For the international doctors, the MTI offers a unique platform for professional growth and development. It provides exposure to advanced medical techniques, diverse patient populations, and a high-standard healthcare system. This immersion in the NHS environment equips these doctors with invaluable skills and experiences that they carry back to their home countries, thereby enhancing healthcare practices and augmenting the quality of care in their regions. Simultaneously, the initiative benefits the home countries by nurturing a cadre of medical professionals enriched with global best practices. These returning doctors become agents of change, infusing their local healthcare systems with newfound knowledge, skills, and perspectives.

Moreover, the NHS gains from the MTI by leveraging spare training capacity with highly competent graduate doctors. These individuals fill critical rota gaps, mitigating staffing shortages and contributing to the functioning of healthcare services. The initiative not only addresses immediate staffing needs but also fosters a diverse and inclusive environment within NHS facilities, promoting cultural exchange and mutual learning among healthcare professionals.

However, despite its evident benefits, the MTI is not without its challenges. Potential threats include the risk of brain drain from developing nations, where highly skilled professionals might choose to settle abroad permanently, exacerbating healthcare workforce shortages in their home countries (though the limited duration of the Tier 5 visa is intended to mitigate this). Furthermore, ensuring a balanced exchange of knowledge and expertise without compromising the NHS's primary responsibilities towards its local workforce remains a perpetual challenge.

Nevertheless, the MTI remains a cornerstone of collaborative healthcare initiatives, embodying the spirit of global solidarity in healthcare. It stands as a testament to the power of partnerships, demonstrating how international cooperation can bridge healthcare disparities and elevate standards worldwide: a testament to the collective commitment towards building a healthier, more equitable world.

If you have any vacant (salaried) posts RCPE may be able to help you fill them through MTI. Posts must include some higher specialty training but do not require a NTN. Please contact the team at mti@rcpe.ac.uk or for further details see www.rcpe.ac.uk/international/how-fill-vacant- posts.

Ninete Premdas
RCPE Fellowships and International Manager

Talking to the psychiatrist: Q&A with Dr Rashi Negi

Dr Rashi Negi is a Consultant Old Age Psychiatrist and sits on the committee of the Royal College of Psychiatrists' Faculty of Old Age Psychiatry, where part of her role is strengthen links between the Faculty and the BGS. We spoke to her about some of the key developments in her field, and how geriatric medicine and old age psychiatry share many of the same challenges and goals.

Could you tell us a little bit about the Royal College of Psychiatrists (RCPsych) Faculty of Old Age Psychiatry?

The Faculty's main purpose is to increase awareness and engagement of large scale service developments in old age psychiatry, and we see ourselves as advocates for older adults who are suffering with mental health conditions. With new advances, developments and treatments, we aim to provide some quality assurance and a voice to this population. We also try to recruit and retain cutting-edge, excellent psychiatrists for the future, because psychiatry, as any speciality, keeps evolving. We have a training arm within the Old Age Faculty.

What do you think the biggest challenge is for your members at the moment?

The first challenge is around retention of the best doctors and ensuring the future of old age psychiatry. People are living longer, so we have to think about how the speciality can cope with demand, which is only going to increase. Sometimes trainees think of the specialty as being just about dementia, but old age psychiatry is about all mental health illnesses which are prevalent in the older adult population. This includes depression, anxiety, schizophrenia and bipolar, and dementia obviously brings another dimension to it. We also see a lot of patients with delirium. I say to trainees that old age psychiatry is particularly about the '3 Ds' - dementia, depression and delirium. Our challenge is to inspire and motivate this new pool of excellent doctors or trainees to understand and consider old age psychiatry as future speciality option.

The other challenge is around new drug treatments. It's a really exciting time, and there's a lot of research happening behind the scenes at the moment. The challenge is to achieve a balance between being excited about the new treatments, but equally being careful and cautious about the potential benefits, harm or issues that these drugs could have. The research is still in early stages, so I'd say we should be cautiously optimistic.

> 'The challenge is to balance being excited about the new treatments, and being careful and cautious about the potential benefits, harm or issues that that these drugs could have.'

Can you tell us about any new medications for dementia on the horizon?

There's a lot of interest in disease-modifying treatments. These are mainly targeting amyloid plaques at the moment, but there's also a role for the tau. And in fact, there's been a lot of research that tauopathy is actually more closely linked to Alzheimer's disease. There's a lot further to go in terms of combination therapy in the future, where they'll be targeting both amyloid and tau. But for the time being, we have got two at least on the horizon.

The first is called Lecanemab, which is quite likely to be approved in the UK. It's going through MHRA currently and if everything goes well this could be approved by 2025. Again this is an amyloid-related medication, but it binds to protofibril so it has a different mode of action. Lecanemab is already being used in the US, it's been approved by the FDA and it appears to slow down cognitive decline by 27% and slow down decline in activities of daily living by 56%. So the figures are quite promising, but it's a balancing act between effects and side effects - and also its important to remember that this is only for early Alzheimer's.

There's another one which is on the horizon called Donanemab which slows cognitive decline by 35%, with 40% less decline in the ability to perform activities of daily living - so again very promising, and something to look forward to, but at the moment it's slightly delayed. I think we're looking at a year or two after Lecanemab, that I should be available in the UK market.

Additionally, instead of relying on PET scanning and the CSF to check the amyloid burden before we can prescribe treatments, in the future, we are hoping plasma biomarkers could be used, so a blood test could actually tell if you have a high quantity of P-tau181 and P-tau217. Whatever the treatment, its important to note that infrastructure should improve to support these treatments, improving better quality of service as a result.

How important is it that Old Age Psychiatrists are included as part of the MDT caring for older people?

Extremely important in my view because mental health and physical health are not only connected, but interlinked as 'one' - many psychological illnesses have physical manifestation and vice versa, as we know. Old age psychiatry and geriatrics both take a multidisciplinary approach, where you look at the whole biopsychosocial aspect of an illness rather than just fixing what is in front of your eyes. It's about understanding the patient and taking a holistic approach and having a longitudinal view of treatment plans. Pain is a good example – it's a very dynamic thing and it's all about perception and threshold. What works for one person might not work for another person, and one person might not experience as much pain as another person, despite suffering with the same condition.

As an example, in my area we set up a Frailty Hub with the help of our local GP and geriatrician from the hospital as well as myself. Patients who were deemed to be falling short of the cut off for the frailty index were sent to this clinic (it's actually called Staying Well Clinic now because it sounds more positive!) Here, what we do is go through a range of interventions, holistically, including reviewing their medications, reviewing falls, physical health conditions, mental health, and cognitive impairment (if there is any). Patients have been coming earlier to these services, whereas otherwise they would have been missed. So I think this is an example of where collaboration can work really well.

Can you tell us about the app you've developed to help detect delirium in care homes?

I was part of a West Midland frailty collaborative initiative, and we were asked to look into why so many patients are being admitted into hospital with delirium. We found that in one of the acute hospitals in the West Midlands, 60% of older patients were presenting with delirium or delirium-like confusion and that they were referred from care homes. We were then asked to develop a delirium training package and delirium pathways for care homes. With the help of another GP working within my catchment area and another Old Age Psychiatrist, we came up with a delirium app called 'Delirium Wheel' which is designed for care home support workers. We wanted to empower them, educate them and give them an interactive tool, so they can feel confident in diagnosing the condition and providing basic management rather than reaching out for help from the GP or an ambulance, as first port of call.

What do you think is the biggest misconception about psychiatry in older age?

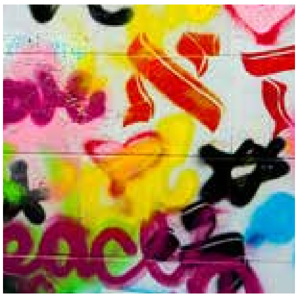
There is a stigma and lack of awareness, knowledge and understanding of mental illness, particularly among the current generation of older adults. People think 'Oh this is all part of growing old, it doesn't matter' and that kind of attitude doesn't really encourage them to seek help when things do happen, whether it be dementia or depression or anything else. Sometimes they're not sure what these professions can offer, and they don't want tablets. What people sometimes don't understand is that old age psychiatry is not only medication, we can offer a whole range of psychosocial interventions. So I think a lack of understanding of what we do, our role and how we can make a difference to their lives, perhaps stops them from reaching out to us.

What single most important thing you think BGS members could do to help support the mental health of the older people they see?

I think it's just about working together, because we are seeing the same group of patients. Speaking to my GP and geriatrics colleagues, I also think it's important to screen for mental health issues or cognitive impairment. Just asking one question can actually help so much. Ask the patient if they've been struggling with their memory in any shape form, or if there's been any concern that's been raised by a family member or that they've noticed themselves. They don't need a detailed assessment - a quick screening question would be good enough to refer them to the right specialist. We can then do the cognitive test - we'd always rather see someone who is well than miss someone who is not.

Often a condition like frailty will affect a person psychologically, so depression and anxiety is quite high in that population. So it's all about just having that conversation – 'How are you been feeling? How you how's your mood been? Has something been troubling you?' Simple questions but they can reveal a lot, and enables them to be sent to the right people who can help.

I think the future is all about working together - a multispeciality, multidisciplinary team - to provide holistic care to our older population.



BGS Northern Ireland and Royal College of Psychiatrists Old Age Faculty Joint Meeting 2024:

Stream now on demand

Catch up with all the content from the one-day hybrid meeting held in Belfast and online on 1 March by visiting www.bgs.org.uk/24NISpring.

Programme highlights include PTSD and The Troubles, substance abuse in older people, dementia, delirium, inpatient care, research... and much more.

Obituary:

Dr Louise Finch 1985-2023

Dr Louise Finch was a Consultant Geriatrician at Addenbrookes Hospital. She died in the summer of 2023, decades too young, and is much missed by her family and all her colleagues.

Louise qualified from Nottingham Medical School in 2008, having met her future husband, Dr Dave Leverton as a student. She completed her foundation posts in Nottingham City Hospital and Lincoln County Hospital. Ever adventurous, Louise then moved to Darwin, Australia for a year, before returning to Nottingham to complete her core medical training.

Louise considered Oncology and Palliative Care as possible career options, but by the end of CMT had realised Geriatric Medicine was the right choice and so was delighted to accept a training post in East Anglia. She worked as a Geriatrics and General Medical Registrar in Addenbrookes, West Suffolk and Ipswich Hospitals, before accepting a Consultant Geriatrician position in Addenbrookes Hospital in 2018.

Louise's subspecialty interest was movement disorders, and as a new consultant, she joined the Parkinson's service. Louise took on running the diagnostic clinic alongside satellite clinics in Saffron Walden. She worked as part of a wider MDT supporting both the community specialist Parkinson's nurses and inpatient specialist nurses with regular mentoring sessions. During her time in the service she worked with colleagues setting foundations for the ongoing development of the Parkinson's service. She was committed to improving the lives of people living with Parkinson's and is greatly missed by her patients.
Louise was ambitious and determined. She completed a postgraduate certificate in Medical Education, was an ALS instructor and was working towards an MSc in Medical Education before she became unwell. She was always keen to teach medical students and junior doctors, and her enthusiasm for medicine was infectious.

Outside of Medicine, Louise had a passion for life and was always busy. She was a fantastic jazz singer and was part of a 10 part piece called 'Dr Jazz and the Rhythm Method' in her younger days! Louise also enjoyed amateur dramatics and contributed as a performer and a stage manager, raising funds from charity performances for her local hospital. Dave and Louise were keen travellers and managed to visit many continents together throughout their training: they took 6 months off to backpack around Asia and Australasia as junior doctors, and even before taking up consultant posts, managed another 6 week backpacking around France. Before Louise became unwell, Dave and Lou enjoyed a magical winter trip to Finland, and despite her illness, they continued to travel around the UK visiting friends as much as possible.

Louise was a beautiful person, both inside and out: she will always be remembered as the best dressed consultant in the department - but mostly, she will be remembered for being a wonderful wife to Dave, and a wonderful mother to her twin boys Archie and Noah, who were born in November 2019. Tragically, Archie passed away 3 years before Louise's untimely death, and our thoughts remain with Dave and Noah when we remember Louise.

BGS joins the UK Health Alliance on Climate Change

As part of its ongoing commitment to sustainability the BGS has now joined this important Alliance of UK-based health organisations representing about one million health professionals. The Alliance brings together health professionals to advocate for just responses to the climate and ecological crisis, promote the health benefits that flow from those responses, and empower members and health professionals to make changes in their professional and personal lives to respond to the crisis. Fellow members of the Alliance include the RCP, the RCN, the BMA, the RCPSG, and the RCGP. We look forward to working with the Alliance in finding ways to help mitigate the adverse impacts of climate change. If you are interested in helping to lead and champion our work in this field by becoming the BGS Green Lead, please contact Mark Stewart to discuss what's involved at **M.Stewart@bgs.org.uk** or on 0207 608 8575.

BGS vacancies and notices View all current BGS opportunities online at **www.bgs.org.uk/BGSvacancies**

THEN THINK AGAIN!
Many BGS members are now eligible to apply for a FREE in-person place at our upcoming meetings - lunch included! Find out more at:

www.bgs.org.uk/grants

Vacancy: BGS Vice President for Clinical Quality

Applications are now open for the position of BGS Vice President for Clinical Quality.

The VP Clinical Quality plays a crucial role within the BGS, leading work on clinical quality.

This is a wide-ranging and senior role with scope to influence the provision and quality of care provided to older people in the NHS. The position has become vacant due to the previous postholder being appointed to a clinical leadership role with NHS England.

The VP Clinical Quality chairs the Clinical Quality Committee (CQC), setting a clear workplan, working with the committee on specific projects, such as the development of new practical resources or publications, and planning BGS conference sessions on quality improvement and inputs to NHS or other organisational consultations or documents.

For a full description of the role, and details of how to apply, please visit www.bgs.org.uk/VPCQ24. The deadline for applications is 9am on 25 March.

Upcoming BGS Meetings

Visit www.bgs.org.uk/events for more

- **BGS Wales Spring Meeting**
  19 April, Wrexham & online
- **BGS Scotland Spring Meeting**
  26 April, Edinburgh & online
- **BGS Spring Meeting 2024**
  22-24 May, Birmingham & online
- **25th International Conference on Falls and Postural Stability**
  6 September, Nottingham & online
- **Cardiovascular Health in Older People SIG Meeting**
  20 September, Hybrid, Newcastle & online.
- **POPS Meeting (Perioperative Care of Older People Undergoing Surgery)**
  27 September, Liverpool & online
- **BGS Autumn Meeting 2024**
  20-22 November, London & online

BGS

Spring Meeting

2024

22-24 May 2024

Birmingham & Online

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Programme highlights:

- Dementia and nutrition
- Continence
- Prescribing at end of life
- Respiratory diseases and the ageing lung
- Syncope and falls
- Tissue viability
- Education and training

View programme and register at www.bgs.org.uk/Spring24