AGENDA

British Geriatrics Society
Improving healthcare for older people

Issue 88 | March/April 2023
ISSN 2754-4532

More than care

Championing care homes

PLUS

- **Protecting the rights of older people**
- Falls prevention
- **Could you peer review?**

AGENDA
Publications information

Agenda is published every second month by:

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ISSN: 2754-4532 (print)
ISSN: 2754-4540 (online)

Printed and distributed by Brown Knight & Truscott (BKT)

Images: Cpver Photo by Dominik Lange on Unsplash
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On the
AGENDA

President's *Message*

There are three times as many care home beds in the UK as acute hospital beds, with 4% of over 65s and 15% of over 85s living in care homes. A third of care home residents will attend hospital in a year – and those who do so will attend more frequently, and for longer, than people of a similar age at home.

I often joke that when I started care home research in 2008, I could cater for an open meeting of all interested parties in my medium-sized Midlands city using a packet of Hobnobs and a handful of teabags. This is no longer the case. The pandemic taught everybody – from policy-makers to people on the street – how pivotal care homes are to effective care for older people. If care homes fall over, then so does the rest of health and social care.

Care homes were devastated by COVID-19. During the first wave, almost half of all COVID-related deaths in the UK were in care homes. Many staff still bear the scars. Many more can no longer bear to work in the sector. Meanwhile members of the public who had never contemplated life in a care home, were faced with the lived reality on the daily news. My sense is that this engendered greater sympathy for the day-to-day challenges faced by staff, and greater reticence about moving into a care home. Staff moving away from the sector, coupled to changing demand, and the cost-of-living crisis have served to destabilise many care home businesses.

Suddenly the people who should have been paying attention to care homes all along are sitting up and taking notice. It's hard to turn on a television or read a newspaper these days without an esteemed professor or policy-wonk talking about social care. Most recognise the current crisis crippling the NHS has its foundations in decades of underfunding and poor attention to domiciliary care and care homes, the sectors where the bulk of the caring is done. But simply recognising this does not move us forward.

'I often joke that when I started care home research in 2008, I could cater for an open meeting of all interested parties in my medium-sized Midlands city using a packet of Hobnobs.'

A series of announcements by the Secretary of State for Health and Social Care this year have attempted to channel money into community-based services, including care homes, to get people out of hospital. When Steve Barclay announced at the beginning of January that £200 million would be made available to spot-purchase care home beds to enable discharge, I was immediately texted by colleagues running care homes and domiciliary care services to say that they had capacity, but that neither their local NHS providers nor local authorities were able or prepared to pay the fees that they charged. They were already phoning hospitals offering places on a daily basis when the Secretary of State made his announcement.

Care homes and domiciliary care agencies have always had to operate in a slightly odd semi-regulated marketplace that distorts market forces. The mixture of private and public sector, large scale corporate and small/medium enterprise, in a market where some care recipients pay for themselves, whilst others have their ability to pay capped by local and national governmental policy, has always led to inequity and unfairness. These issues are compounded by a decade of austerity and the current cost-of-living crises. Care providers need to raise their prices to survive, and statutory purchasers can't rise to meet their new fees.

Members will see different solutions to the current situation depending on their political persuasion. For some the solution will lie with untethering the market and enabling market forces to establish more uniform rules of charging and payment. For others, it is about bringing care more "in house". The Scottish Government have already taken the brave step of announcing a National Care Service – the details of this are keenly awaited. It is encouraging, though, to see at least one UK government recognising the inadequacy of the status quo and the need for things to change. Our Westminster government needs to work similarly to put a definitive solution in place.

Whilst all this is going on, BGS members have their work cut out delivering the best possible healthcare to older people living in care homes. The BGS Ambitions for Change document, published in 2021, outlines the core principles of what "good" looks like. These are underpinned by principles of multidisciplinary, multiagency co-operation focussed around Comprehensive Geriatric Assessment. How this is delivered in the current climate is the big challenge. Through the materials in this AGENDA, our Age and Ageing Care Home series, and sessions dedicated to care homes at recent and upcoming meetings, we hope get you thinking about how to tackle this. If healthcare in care homes are pivotal to a functional health and social care system, then we need all to do our bit.

Adam Gordon
BGS President
@adamgordon1978

Included with this issue of *AGENDA*

We are excited to be sending members a four-page summary document of our new report, *Joining the Dots: A blueprint for preventing and managing frailty in older people* alongside this issue of the newsletter.

The ambitions, service interventions and enabling actions in our blueprint are relevant for all health and social care systems that aspire to enable older people to age well and live well at home for longer.

Implemented together, they will help achieve better outcomes for older people, carers, families and communities and realise greater value for health and care systems.

BGS stands ready to support health and care systems to create the conditions for change, alongside you, our members, a multidisciplinary group of over 4,600 healthcare professionals. We have extensive expertise across policy and communications, education, training and research.

We are proud that our members work across the four nations of the UK and span acute, primary, community and social care.

We urge leaders from all integrated care systems towork with us to ensure that the services they commission or provide for their older citizens, patients and carers are the best they can possibly be.

We encourage you to follow us on Twitter via @GeriSoc, share the Blueprint on social media using the hashtag #BGSBlueprint or contact our Policy Manager, Sally Greenbrook, at s.greenbrook@bgs.org.uk for more information about getting involved.

In her latest editorial, BGS Deputy Honorary Secretary, Dr Ruth Law, shares why working alongside care home colleagues brings her such joy and job satisfaction.

I first became interested in care homes medicine as a specialist trainee in geriatric medicine. I responded to an advert from the Care Quality Commission (CQC), who regulate health and social care, to attend their inspections of care homes as an 'expert by experience' and was selected to participate.

After two days of training I navigated my way out to the wilds of Essex several times over the coming months to join inspections. It was one of the most eye opening and useful things I did during my five years as a geriatrics registrar. I could not believe how ignorant I had been of the care home landscape where so many of my patients resided. The visits helped me to understand the diversity of provision - from family run homes where residents hung their own washing in the garden, to huge three-storey buildings with 90 residents.

'Care homes were fun! This was a revelation. Well run homes were a joy to visit. The care staff were the source of wonderful ideas based around their residents' needs.'

I also had so little appreciation of the challenges faced by the care home sector at that time around staffing, funding, governance and estates, many of which are unchanged today. But what struck me the most was the feeling of separation from the communities in which these buildings sat. Perched on suburban streets, surrounded by the bustle of town life and yet somehow set apart as an under-reached and under-represented population. I felt a pull to find out more- to get involved and see what happened.

Luckily for me, Sir Simon Stevens was interested in care homes too and placed them as a priority in his Five year Forward View for the NHS back in 2014. By this point I was a fledgling consultant dipping my toe into the world of community geriatrics and this mandate gave us the momentum to really get things moving locally with specialist support to our local homes. What followed was a steep but exhilarating learning curve for myself and my team as we worked alongside our care home colleagues. There are many things I loved about this work, but for me three main things stand out as I reflect on those first few years.

Multidisciplinary team (MDT) working at its most diverse

Our care home team was supported by clinical colleagues from liaison psychiatry, palliative care and general practice. speech and language therapists, dieticians, pharmacists and many more. Relatives and carers joined our discussions which were more patient-centred and holistic than any have been able to have in the hospital setting. I particularly learned from my GP colleagues with their incredible breadth of knowledge and skills in balancing risk. I grew to understand the challenges facing primary care so much better through spending time with them, and was able to translate that learning back into my management of patient pathways within the acute services. It is hard to pull hospital doctors out of their comfort zones, but I tried as often as possible to take trainees along too so they could also catch the care home bug!

Decision making at its most complex

I was struck by the complexity and frailty of so many of the residents cared for in the homes I visited. I regularly discharged patients from the wards but never found out how the story ended. Within the caring environment of the home there was time to work through the complexities of advance care planning, consider decisions around feeding with increased risk, or manage challenging polypharmacy. The complexity of ethical decision-making was counterbalanced by the continuity of care that the environment provides which facilitated a person-centred approach.

Caring at its most creative

Care homes were fun! This was a revelation. Well run homes were a joy to visit. The care staff were the source of wonderful ideas based around their residents needs - flavoured jellies to increase fluid intake, 'pimp my zimmer' to remind people to grab the correct frame, music therapy, dance sessions and viciously competitive bingo. And the care often extended to me too, with many a thoughtful cup of tea left beside the jobs list.

Those were the highs - but of course there are challenges too. Staff retention was (and remains) a huge challenge, and it is impossible to write a piece like this without reference to the terrible cost of COVID-19 experienced by care home staff and residents that is still felt keenly today.

My experience over the last decade however has been professionally challenging but personally rewarding. Though I no longer work so intensively in care homes, I remain a huge advocate for their residents and staff; for equality of access to appropriate MDT assessment and for integration into their communities and the fabric of our society.

This edition of *AGENDA* has been themed to highlight the great work that is underway and hopefully inspire more of you to dip your toe in like I did - whether in research, patient pathway design, education or clinical care- you won't regret it.

Dr Ruth Law
BGS Deputy Honorary Secretary
@Ruth_E_Law

Age and Ageing care homes collection

Curated collections of articles on specific topic themes are published periodically by *Age and Ageing*. The care homes collection, with accompanying commentary, can be accessed via www.bgs.org.uk/AAAcarehomes.

Care homes enable people with advanced physical and cognitive impairment to live well with 24-hour support from staff. They are a feature of care systems in most countries. They have proved pivotal to the COVID-19 response.

We searched *Age and Ageing* for care home articles published since 2015. From these we collated 42 into the *Age and Ageing* care home collection. This collection, published on the *Age and Ageing* website, draws together important papers that show how our journal is helping to shape and grow care home research.

The collection outlines the technical issues that researchers face, by grouping together important feasibility trials conducted in the sector. It looks at the challenges of measuring quality of life and working with routine data in care homes. It brings together observational studies considering loneliness, functional dependency, stroke outcomes, prescribing and acute deterioration. Health services research in care homes is represented by two studies that demonstrate realist evaluation as a way to make sense of service innovations.

Papers are included that consider: non-pharmacological strategies for residents with dementia, end-of-life care, sexuality and intimacy, and the care home workforce. Given the importance of the COVID-19 pandemic in care homes, all of the care home COVID-19 papers published in *Age and Ageing* to date are included.

Finally, a group of papers that present innovative approaches to research in care homes, each of which gives voice to residents and/or staff, are collated and presented as a way of moving towards a more resident- and care home-centred research agenda.

Introduction by Adam L Gordon, Chloe Bennett, Claire Goodman, Wilco P Achterberg.

Protecting the rights of older people to health and social care

In January, the BGS issued a statement outlining seven evidence-based short-term actions which should be taken to protect older people. It was supported by the Royal College of Physicians London and the Royal College of Physicians of Edinburgh, with a further 23 organisations subsequently pledging their support. This statement is set out in full below.

The current health and social care crisis affects the whole of society but has greatest impact on older people. People aged 65 and over account for over 40% of hospital admissions, occupy around two-thirds of hospital inpatient beds and are the most frequent users of health and social care services.

It is older people who are most likely to be harmed by the current unprecedented waits for ambulances, prolonged time on trolleys in emergency departments, multiple moves within hospital and lengthy delays awaiting community services and social care for discharge. The cumulative impact increases their risk of dying in hospital or of leaving hospital less mobile, more confused, and more dependent than when they arrived.

When older people leave hospital in poor health, they need rehabilitation and support to recover. Without it, their health deteriorates further – already on average 15% of older people being discharged from hospital are readmitted within 28 days. With each admission their level of frailty and care needs increase, generating even more demand for health and social care at home or in a care home.

Up to 50% of people aged over 85 live with frailty and are at increased risk of deterioration from minor illness and events. Frailty costs UK healthcare systems £5.8 billion per year but can be slowed or reversed with the right prevention and care. Investing in community services for older people can significantly reduce emergency hospital admissions but primary care is overworked, community nursing teams are understaffed, rehabilitation services are working at full capacity, and care homes and domiciliary care providers are struggling to recruit and retain sufficient staff.

This crisis has been simmering a long time. There are no quick fixes. But it is critical that the government and Integrated Care Systems across the country make the right decisions in the short term. Decisions that make best use of available funding and workforce and invest in what works to reduce harm and improve outcomes for older people. Decisions that solve rather than shift problems. Decisions that avoid simply generating further demand and cost for the health and care system.

Our seven evidence-based short-term actions to take in this current crisis:

1 All older people with frailty should receive comprehensive multidisciplinary assessment as soon as possible after they arrive in hospital. This is often best achieved by dedicated services such as acute frailty units, or frailty assessment teams. Such teams can initiate early treatment to prevent deterioration and enable timely discharge to community services at home. We outline more about how to deliver such approaches in the Silver Book II (**www.bgs.org.uk/SilverBook2**).

2 There must be a focus on preventing, identifying and managing both deconditioning and delirium in hospital. Both are avoidable and are associated with increased length of stay in hospital and increased dependency on discharge. All hospitals should have a delirium policy in place as described in our Delirium Hub (**www.bgs.org.uk/DeliriumHub**). Information on preventing deconditioning can be found in this resource from the National Falls Prevention Co-ordination Group.

3 The government, and health and social care providers, must protect and preserve the right to rehabilitation for all older people who need it. Effective care of older people with frailty requires early mobilisation in hospital, rapid establishment of rehabilitation goals, and continued therapy input until their condition has stabilised. The right to rehabilitation means that older people must be supported by rehabilitation multidisciplinary teams wherever they receive care. Where delayed transfers of care to community rehabilitation services are unavoidable, rehabilitation should commence in hospital. Older people with rehabilitation goals should not be transferred to a care home or community bed without assurance of appropriate rehabilitation being available. The principles of effective rehabilitation for older people are outlined by the Community Rehabilitation Alliance.

4 There should be continued investment in a multi-professional urgent community response that provides both intensive short-term hospital level care at home through Virtual Wards and Hospital at Home and access to goal-oriented home-based and bed-based reablement and intermediate care services. These must work closely with ambulance, ambulatory care and same day emergency care services as an integrated local network. We have written more about this in *Right Time, Right Place* (**www.bgs.org.uk/RightTimeRightPlace**) and our position statement on Virtual Wards/Hospital at Home (**www.bgs.org.uk/VirtualWards**).

5 Investment in good quality healthcare support for care homes reduces avoidable hospital admissions. There should be continued efforts to implement Enhanced Health in Care Home models where it is possible to do so. These initiatives should focus on minimising inappropriate polypharmacy and discussing resident and family preferences about what should happen in the event of an acute healthcare crisis. We discuss priorities in healthcare for care homes as part of *Ambitions for Change* (**www.bgs.org.uk/AmbitionsForChange**).

6 Services for older people living with multiple long-term conditions should take a coordinated and person-centred approach, including the involvement of geriatric medical teams as appropriate. This can reduce unnecessary investigations and medicines, and support older people to make informed decisions about their future care, treatment and place of care.

7 Experts in older people's care must be included in Government and NHS policy planning. Older people are the largest group of users of the NHS, accounting for 40% of hospital admissions. Older people are also the fastest growing age group, with the number of people aged over 85 projected to double by 2045.

Getting the right workforce in place: short and medium term

Supporting these actions will require creative and integrated workforce solutions including greater use of technology for professional-to-professional decision-making support, extended scope of practice, and some refocusing of roles. In the short term this could include, for example, asking specialists in care of older people (medical, nursing and allied health professionals) to focus exclusively on frailty-specific initiatives through winter and spring.

To move from a recurring cycle of crisis response in the longer term, it is important to recognise that there are currently not enough healthcare professionals across the multidisciplinary team to care for the complex needs of an ageing population. A workforce strategy must be published urgently, acknowledging this reality and setting out a plan to build multidisciplinary skills and capacity in caring for older people across the system. This should include proactive and personalised anticipatory care that helps older people stay independent and healthy for as long as possible. The role of nurses and therapists in leading such services must be recognised and a more integrated approach across care at home and community healthcare roles should be explored with some urgency.

Across health and social care, and around the country, colleagues tell us it is impossible to recruit the necessary expertise to deliver existing services. There are many reasons for this, but central to the solution is making sure people feel valued. We know that healthcare professionals across the country will be facing unimaginable pressure at work and experiencing moral injury as they are unable to deliver the level of care that they would wish to provide. We thank our members for their continuing service to the NHS and urge them to be kind to themselves and to each other as they continue to provide the best possible care in the worst possible circumstances.

The government must sit down with urgency to address the concerns raised by unions and professional bodies representing nurses, ambulance staff, allied health professionals and doctors to ensure that we can recruit, train and retain the people we need to deliver the best possible care for older people.

Professor Adam Gordon, President of the British Geriatrics Society, said: "While the current crisis in the NHS affects us all, it is older people who are bearing the brunt of it. It is predominantly older people who are stuck in ambulances outside emergency departments, on trolleys in hospital corridors, and waiting in hospital for care packages before they can be discharged. BGS members are working tirelessly to provide the best possible care to their patients, but they are exhausted and demoralised. We need the Government to act urgently to implement both short- and long-term changes to ensure that the NHS is there for older people when they need it most."

Dr Sarah Clarke, President of the Royal College of Physicians London, said: "The current crisis is the result of long-term neglect of funding for health and social care.... Given that older people use the NHS more than any other group, caring for them well is key, helping them stay at home as much as possible and returning there safely and quickly when they do need to go to hospital."

Professor Andrew Elder, President of the Royal College of Physicians Edinburgh, said: "The ageing of the UK population is a triumph, reflecting major improvements in socioeconomic conditions and in medical care in childhood and the middle years of life. With more of our population now living longer lives we must ensure that our NHS and social care services support those lives to be as healthy as is possible... With our older population set to increase further, the time to act is now."

Our statement supporters:

NEW REPORT OUT NOW

BGS

www.bgs.org.uk/Blueprint

#BGSBlueprint

In March, BGS launched *Joining the Dots: A blueprint for preventing and managing frailty in older people*. You will find a printed copy of the four-page Executive Summary of this document alongside this issue of *AGENDA*, and you can download the full 24-page report at www.bgs.org.uk/Blueprint. We strongly encourage members to share this blueprint widely and engage local decision-makers with its content, and we would love to hear about how it has been received.

Our blueprint document aims to show what good-quality age-attuned integrated care for older people looks like. It is intended to help commissioners in the design and delivery of health and care services for older people.

Older people are the largest group using health and social care services. But the way services are currently configured and delivered is not meeting their needs, and is creating avoidable costs for an over-stretched health and care system. This document provides commissioners across the UK with the information they need to transform older people's healthcare.

The blueprint sets out why organisations commissioning health and care services must focus on older people and on the prevention and management of frailty in particular. Frailty affects up to half of the population aged over 85 and costs UK healthcare systems £5.8billion per year. Around 47% of hospital inpatients aged over 65 are affected by frailty. But frailty is not an inevitable part of ageing, and putting in place measures to slow its onset or progression should be a priority for every commissioner across the UK. Prevention and reversal of frailty enables people to live independently for longer and helps to reduce demand for emergency care and long-term support.

The blueprint highlights seven system touchpoints and outcomes, ranging from 'Enabling independence, promoting wellbeing' through to 'Co-ordinated, compassionate end of life care', that should be considered when planning and commissioning health and social care for older people.

Twelve actions are recommended for systems to create the conditions for high-quality integrated care for older people. These are supported by evidence, illustrations and key resources to help with implementation.

Feedback from older people and the current challenges in the system demand that we look afresh at how health and care could be delivered in a more joined-up and effective way. Developed from older people's insights and the expertise of the multiprofessional BGS community, this Blueprint offers a clear and practical guide to commissioners in creating a sustainable integrated model of care for older people.

Read and download the full report at **www.bgs.org.uk/Blueprint**

Strategic Plan 2023-26

Over the course of 2022, the BGS developed its Strategic Plan for the three-year period April 2023 to March 2026. This included input from members and stakeholders, analysis of opportunities and threats in the environment and detailed work with the BGS's committees, Board and staff on how we could have most impact in improving healthcare for older people.

The 23/26 Strategic Plan was approved by the membership at the AGM in November 2022. It provides the framework to guide our activities and is supported by annual operational plans and budgets.

Members will see the continuation of the BGS's important activities in promoting clinical quality and professional practice, delivering professional development opportunities and encouraging research. Influencing the recruitment, retention, development and support of the workforce is given new prominence. Members will see the BGS taking a bolder approach to policy influencing and advocacy. We will challenge decision-makers in the NHS and government to rethink how care for older people is delivered, offering our support as an expert community to the transformational change that is needed.

The BGS is the membership association for multidisciplinary healthcare professionals working to deliver healthcare for older people in acute, primary and community care across the UK.

Our vision is of a society where all older people receive high-quality, personalised care when and where they need it. This means empowering and supporting older people to lead independent, healthy, happy lives in their communities for as long as possible.

Our mission is to improve healthcare for older people. This is the work of multidisciplinary healthcare professionals working in community, primary and acute care in the four countries of the UK.

Context

Across the world, people are living for longer in better health, which is cause for celebration. However, many develop physical and mental health needs in their later years, requiring health professionals with specialist skills in the care of older people. This is the work of BGS members. It is needed more than ever as the UK population ages. Older people were one of the groups most affected by the COVID pandemic, and as we emerge from that period, the NHS is facing major challenges of workforce shortages, backlogs to planned treatments, and blockages to flow within the health system, some of which arise from the absence of sustainable social care provision. There is a risk that the gains made in recent years will be lost and a vital need to advocate for joined-up integrated services that help older people stay healthy for as long as possible and get the care they need when and where they need it.

Overview of the Strategic Plan

The 23/26 Plan sets out how the BGS will support its members' professional practice, helping them to learn, develop and improve their knowledge and skills. It describes how BGS will use its expertise and authoritative voice, working with others, to influence those making policy, programme and resource decisions that affect outcomes for older people. It sets out the vital role of research and evidence to inform effective services and systems for older people's healthcare. Central to the delivery of all these objectives is the BGS community: the peer support and solidarity of healthcare professionals bound together by their commitment to ensuring all older people get the best care possible.

Our priorities

1. Clinical quality and professional practice

We aim to promote high standards of clinical quality in the healthcare of older people by developing knowledge and improving practice. By 2026, we will have contributed to the delivery of better healthcare for older people across all care settings by developing and sharing tools, guidance and examples which enable healthcare professionals to improve their practice.

2. Workforce

We aim to support recruitment, retention and development initiatives that increase numbers of specialists in the care of older people and help existing staff to have the appropriate skills and support to deliver good care for older people in the right place at the right time. By 2026, we will have worked with others to address the workforce crisis by helping to increase the size and skill base of the specialist workforce delivering care for older people, and by contributing to action on the workforce needed to provide healthcare to an ageing population.

3. Education and professional development

We aim to support continuing professional development of those specialising and working in healthcare of older people. By 2026, we will have enhanced the BGS educational offering for multidisciplinary professionals working in older people's healthcare across different care settings, providing a range of meetings and learning opportunities to enable their continuing professional development.

4. Policy and communications

We aim to influence the decisions, programmes and implementation of policy-makers, commissioners, system partners and health professionals relating to older people's healthcare across the UK. By 2026, we will have increased our profile and voice, and will be successfully influencing the development, design and implementation of national and regional programmes and policy for older people's healthcare.

5. Research and evidence

We aim to promote research into older people's health and healthcare, and the application of evidence-based knowledge to clinical practice across the continuum of care. By 2026, we will have strengthened research opportunities, skills and impact through our research community and through the reputation and reach of our journal, Age and Ageing.

Delivery of the Plan

The BGS is proud to be a multi-professional society which values being person-centred, inclusive, collaborative and proactive. We will deliver our Strategic Plan with and through BGS members who are the lifeblood of the Society. Our staff team support the membership, the Trustee Board and officers of the BGS who lead our work.

The BGS's main sources of income are from membership fees, our journal and events. We plan to diversify our income and make our money work harder in pursuit of our mission. We will upgrade our website over the next year, so that the digital experience for those joining our meetings online or accessing information via the website is user-friendly and joined-up. The operational environment in which our members work is changing constantly. Our Strategic plan will be adaptive, taking advantage of opportunities to influence and improve care for older people and responding to challenges that threaten the quality or availability of that care. We will monitor progress and be accountable for the direction we have set ourselves. We will work with our members and with wider stakeholders to improve healthcare for older people.

Read the full BGS Strategic Plan 2023-26 at www.bgs.org.uk/strategy

Who cares

Former NHS manager Andrew Hindle reflects on some of the challenges facing the care home sector, from underfunding to workforce to the cost of living, and highlights why social care should be a bigger political priority.

Rishi Sunak has continued the trend of Conservative prime ministers of delaying a promise to fix the 'social care crisis' and deferring the manifesto policy to cap care costs until at least 2025. This continues to leave the care sector in a perilous situation with up to 170,000 vacancies in adult social care providers in England alone. This is critical as funding levels for social care remain woefully inadequate and parity of pay for care workers shamefully remains a far-flung pipedream.

There is sympathy for striking NHS staff and colleagues, and there is no taking away the fact that they are well-organised and receiving wide-spread publicity with one recent Observer poll showing 60% of the public back the strikes.

This sympathy hits home even more when the public hear of stories such as nurses using foodbanks. Yet the structured and systemised NHS strike action is not available to care work home workers living on even lower (poverty-inducing) wages than most NHS workers, and who remain a disparate group with thousands of different employers and many in non-unionised organisations.

Care home staff perversely had their hopes raised during the dreadfulness of COVID when the nation's consciousness was heightened to the conditions and suffering, they faced. However, in the same vein as other key workers, while the national Thursday evening clap was valued, it was a change in their pay, staffing levels and working conditions that would have been the greater reward.

Care homes, be they nursing or residential, are unfortunately not always ideal places to spend the rest of our days on earth. Yet for the vast majority they are a form of hospice without the generous staffing ratios and hands on support from highly skilled clinical palliative staff. Indeed, millions of us will enter through the doors of care homes and remain there until the end of our days. Staff do their best but under very testing circumstances. It is well recognised that the carers work is difficult and underpaid; and a recurring perception from care workers is that 'society doesn't value the work being done in social care.' Yet can any government win an election on a manifesto commitment to increase taxes to improve care of residents and better pay for the staff?

Carers pay has improved via the National Living Wage, however, at £9.50 an hour a full-time carer salary is around £18k which is not keeping up with the cost-of-living crisis and remains insufficient for the daunting physical and mental tasks they face each day, as Ed Balls found out for himself when he experienced working in a care home in Scarborough in the insightful and poignant BBC documentary Inside The Care Crisis.

Most of the population would find the workload utterly daunting. Duties and tasks that care workers must perform include the process of washing and dressing an older person who is often in discomfort due to physical disablement, or they have some element of cognitive decline that may include confusion and resistance towards being cleaned.

In all circumstances the task requires delicate and careful handling of the individual with frailty. Often it will entail washing genital areas due to incontinence. Sadly, and wrongly, the connotation 'wiping arses' has become associated with the whole caring profession.

The comedian Pope Lonergan (in his vivid memoirs as a care home worker, *I'll Die After Bingo: the Unlikely Story of my Decade as a Care Assistant*) considers that this leads to the gross 'misconception that carers are unskilled, uncaring and unprofessional'. In turn this contributes to the incredibly high numbers of staff that leave care home employment each year. Indeed, it is all too easy to leave the caring profession and earn more money such as Amazon's warehouse in Nottinghamshire that was luring staff with

'Sadly, and wrongly, the connotation *'wiping arses'* has become associated with the whole caring profession.'

'It all leads to a familiar route to care home admission, which in many cases, with the right resources, could have been delayed or avoided.'

30% more pay. The stress of two people trying to care for 15 or more residents who all require considerable help can be overwhelming and stressful. No surprise then that 47% of care workers who took part in a Unison survey last year said staffing shortages are having a negative impact on the care provided and 31% stated that staffing levels are dangerously low, getting worse and having a negative impact on the care provided.

Recruitment is another worryingly and disturbing issue with staff vacancy rates in care homes in 2021 as high as 10.2% and this was exacerbated further by the COVID pandemic and mandatory vaccinations. Attracting good quality staff into the profession of caring for vulnerable and frail older adults is difficult. Some care homes whose attempts at recruitment have failed are now having to cancel their registration to provide nursing care, with devastating consequences.

As well as distraught staff it also leaves residents on a palliative care pathway and their families in the distressing situation of having to look for new homes in local areas that are already at, or close to, capacity. This scenario is also repeated via the dozens of homes that are forcibly closed each year by the Care Quality Commission (CQC) for poor standards of service and care. Between 2015 and 2020, 1,578 care homes closed, forcing the relocation of around 48,600 vulnerable people, according to a CSI Market Intelligence report published in 2020.

The five largest care home companies are seeing increasing profits which is not transferring to the frontline staff, with Citizens UK chief executive Matthew Bolton stating they "should step up and show leadership and make sure that every care worker they employee gets the real Living Wage" There are smaller private providers that go the extra mile to support their residents but struggle with keeping the businesses up and running, forcing closures because the home is no longer profitable or sustainable.

Both Age UK and the Nuffield Trust have warned that the fall in social care provision for home-based care result in a substantial amount of unmet need in the community. These are not small numbers and Age UK report that over 1.2 million people aged 65 and over don't receive all the care and support they need with essential daily living activities.

Tightening of the eligibility criteria has led to an estimated 25% reduction in the number of older people accessing publicly funded care since 2009/10. NHS staff and Social Care frequently comment that a person must be in dire straits to be fortunate enough to be allotted a care visit. It all leads to a familiar route to a care home admission which, in many cases, with the right resources, could have been delayed or avoided.

With the demand for community care provision so high, it is the primary reason for delayed discharges in hospitals and contributes to the queue of ambulances at A&E as the transfer and movement of patients within the hospital is blocked. An invariable outcome is that it becomes an easier solution to admit a patient to a care home for assessment, which can so easily become a permanent admission; either because there is no capacity for a care agency to visit, or because rehabilitation and reablement is restricted due to insufficient numbers of community physiotherapists and occupational therapists.

Social care remains an almighty mess of underfunding and successive governments have skirted around the edges to tackle the enormous challenges. The 2021 government policy paper *People at the Heart of Care- Adult Social Care Reform* acknowledged the challenges and emphasised that "those working in social care feel recognised, rewarded and are equipped with the right skills and knowledge with a £500 million investment over three years to improve social care as a long-term career choice."

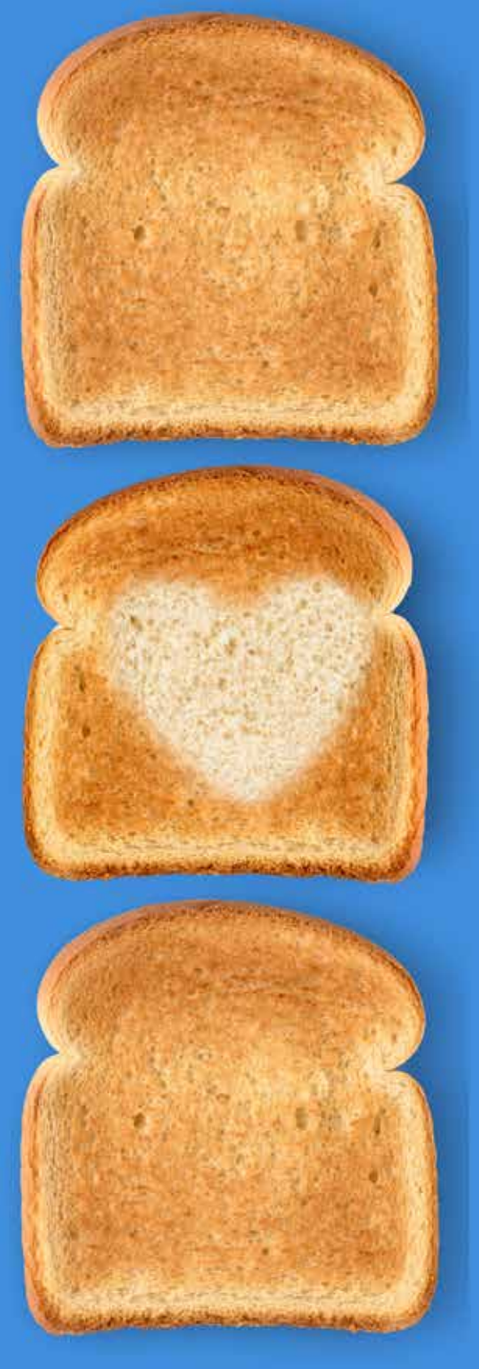
All the new support and development for the workforce is correct and encouraging, but as the CQC emphasise if the funding for social care is to have any impact, there must be consistent investment, higher overall levels of pay to increase the competitiveness of the market, and good terms and conditions to ensure employers can attract and retain the right people.

The policy paper refers to getting on track to reach the Government's target of two-thirds of median earnings by 2024, but this is not enough to stop the flow of care assistants who often out of financial necessity opt for less rewarding but better paid jobs in the service and retail industries. An alternative workforce comparison are NHS nursing auxiliaries, who generally have superior pay and conditions, including pensions to their equivalents working in care homes. Given that care assistants work is on a par or indeed often more arduous and can require more skills to care for residents approaching the end of life, there is a strong case for an integration within the NHS terms and conditions of employment as well as pay scales. If care home assistants were directly employed by the NHS it would facilitate improved career and pay progression, wider training access, increased consistency and continuity of care of residents, improvements in management and nursing leadership, oversight of rotas and shifts, seamless transfers of residents from secondary care to care homes with a halt to delays, fewer closures of care homes by the CQC and increased occupancy of beds.

Many of us will become elderly and frail and require care home support services and with an aging population are only likely to increase which, should make this a political priority. Yet for these institutions to operate effectively with quality care it requires brave and compassionate politicians to promote a fairer funding and more equitable system of health and social care that is inclusive of care homes.

Andrew Hindle
MA Gerontology; Retired NHS Manager

Walk with *me*



Care home nurse and Associate Lecturer at Oxford Brookes School of Nursing and Midwifery, Dr Helen Cowan, ruminates on how care can't simply be something that simply happens *to* a resident; it must be something that happens *with* them.

With around 160,000 vacancies in the social care workforce, Professor Deborah Sturdy, chief nurse for adult social care, says that the social care workforce needs a boost, and that the solution lies in talking up the praises of the work done by nurses in social care.[1]

"One of the things I talk a lot about," says Professor Sturdy, "is how we have got to change the narrative. If you look at nurses just within the four walls of a care home, what they are actually doing is running a nurse-led service."

"If you start to use a different narrative around this, it brings a different kind of thinking and a different kind of recognition for what the career is. The sector itself needs to talk up the phenomenal skills that nurses in social care have."

The '*cum panis*' of care home nursing

Before my career in care home nursing, I worked in a hospice for terminally ill young people. The nurse and religious sister in charge explained, during my induction, the philosophy behind the care. "Cum panis," she said, are two Latin words meaning "bread with", used in Roman times when workers would share, quite literally, the bread of their labours.

Derived from "cum panis" is the English word "companion", a fellow journeyer who walks beside us, sharing not bread but life's way, and this idea, she explained, would underpin our work in the hospice.

In any type of palliative nursing, be it in the care home, hospice or family home, the nurse 'walks with' the patient at the end of life, a journey lasting days, months or years.

Needs can be acute, chronic, physical, emotional or spiritual, and the nurse knows the patient and family well enough to decide when to walk in front (when they take the lead in clinical decision making) and when to walk behind (when they enable residents, and promote independence). In the final hours, the care home nurse is often found simply at the bedside, walking now 'beside.'

"Don't walk behind me; I may not lead. Don't walk in front of me; I may not follow. Just walk beside me and be my friend." †

Walking in front

Care home nurses are used to making best interest decisions for residents who lack capacity. The resident is at the heart of the decision-making process and involved as far as possible. This means "finding out about the person's past and present wishes, feelings, values and beliefs, using information included in care plans and advance care plans, consulting with the person's family, carers and advocates and seeking to establish the person's wishes, preferences and values."[2]

Clinical decisions are made in the context of frailty, possible futility, and objectives of treatment which may differ from those for younger people, with an increased emphasis on comfort rather than cure. Prescribing needs to take into account the perspectives of patient, pharmacology, and prescriber. Alongside overall appropriateness of the prescription, its acceptability to a resident with dementia is another part of the prescribing puzzle. Will the resident be able and willing to swallow the medication? Will they tolerate monitoring, even blood pressure measurement? Non-adherence to prescribed treatment[3] remains a significant feature of care home nursing.

Professor Deborah Sturdy, England's first-ever chief nurse for adult social care, describes the "incredible tenacity, management skills and advanced clinical decision-making skills" required by nurses in care homes (which she prefers to call 'nurse-led units'), "because often you are the only registered practitioner in there making complex decisions."[4]

The care home nurse needs a grasp of everything from neurology to urology, cardiology, pharmacology, endocrinology, and psychology; to inform wound care, palliative care and symptom control, continence care, and management of diabetes and advanced Parkinson's, when symptoms are more complex.

Deciding whether or not to call for emergency assistance from an already-overstretched ambulance service can be difficult; acute emergencies such as stroke, sepsis, diabetic ketoacidosis, and 'cardiac asthm' can present, as well as more subtle signs such as those associated with delirium or infection, against a background of dementia-associated confusion.

Acting as advocate if expert opinion is needed, the care home nurse helps modify the prescribed plan of care to reflect the individual's specific routines and behaviours - sometimes affected by dementia - and finds ways to aid communication, understanding and acceptance. Before collaborating with the care home nurse, one tissue viability nurse was kicked by the resident as she started to assess a leg ulcer; integration and strong relationships between nursing colleagues in the NHS and social care are essential, as we "work together to deliver the best for some of the most vulnerable in society."[5]

Walking behind

Seen and unseen, the care home team enables and empowers the resident, restoring ability and dignity, or reconsidering what remains realistic, and helping those important 'little victories' to happen. Sometimes walking quite literally behind the resident with a wheelchair in case they tire and need to sit, staff (including carers and visiting occupational therapists and physiotherapists) skilfully assist mobility and reduce falls risk through a variety of methods, starting with a comprehensive falls risk assessment - which covers cognitive impairment; continence problems; falls history; footwear that is unsuitable or missing; health problems that may increase the risk of falling; medication, postural instability, mobility problems and/or balance problems; syncope syndrome; and visual impairment.[6]

'"*Cum panis*," she said, are two Latin words meaning "*bread with*," used in Roman times when workers would share, quite literally, the bread of their labours.'

Buildings designed with colours, textures and layouts that take dementia into account enable and empower residents to explore and exercise without obvious intervention (though a close eye is kept, and sensor mats provide added safety). When food is made soft and bite-sized, minced and moist, pureed or liquidised, and fluids thickened, and both are in continual supply, residents claim back some control over their swallow, their intake, and their choice of when they eat (frequently little and often).

Sometimes staff are not needed – and, for residents with dementia, a doll can be an important 'travelling companion', 'walking behind' the resident, restoring them to a place and time when they felt in control.[7] Doll therapy has the potential to preserve dignity by de-escalating agitation or engagement in physical or verbal abuse. A sense of dignity also comes from the person now being able to give care rather than receive it.

Much is written on music – it too can restore a sense of self, and reawaken souls. Neurologist Oliver Sacks showed how music could 'call back the self' in dementia, awakening moods, memories and thoughts – and sometimes even spoken words - that had seemingly been lost. Music can enliven, calm, focus and engage patients long after they have forgotten the music itself.[8]

Walking beside

Some residents will reach out to hold the hand of a staff member, or accept one that is offered, expressing, non-verbally, a desire for another to truly 'walk beside' and 'be their friend'. During dying, the being 'beside' happens at the bedside. Subtle signs that the end is near include reduced or absent oral intake, a change in breathing patterns and blotchy-red purplish marbling of the skin, especially on the legs. Diagnosing dying is though a combination of science and art, and nobody has mastered it.

Advance care planning, focusing on individual wishes for resuscitation and hospital admission, is essential. Far from being a tick-box exercise, it gives families the chance to share what matters most to their loved one with dementia. Having the time to listen and co-create a shared narrative helps form a truly person-centred plan.[9]

In the final hours, or days, anticipatory medicines are available, in small doses, to reduce pain or agitation. Mostly though, care home nurses are trained to simply be at the bedside, 'walking beside.' Perhaps feeling as though they are doing nothing, they need to remember, as other trained professionals do, that sometimes, doing nothing is the bravest decision of all[10] – and that the act of stepping back from invasive intervention, when all involved are in

agreement, allows attention to turn to the small things, the details of daily living, which are so easily overlooked when the focus is fixed on fighting for life at all costs.

Walking beside the resident, and behind the family (as appropriate), allows the 'fundamentals of nursing care' such as oral hygiene, pressure relief and continence care to take centre-stage.[11] Comfort and compassion are key, as well as connection to those who really matter, and at moments like these Kitwood's emphasis[12] on love as the "one all-encompassing need" is entirely right – and actually underpins all that we do in care homes, where, in the misting of memory, feelings become very much more important than facts.

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†A saying attributed to French writer and philosopher Albert Camus, though there is no accurate reference.
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Embracing & *enhancing*

NHS England's Enhanced Health in Care Homes (EHCH) model was a commitment in the NHS Long Term Plan. This article summarises some of the recent changes and highlights ways in which teams across England have implemented the model to date.

The Enhanced Health in Care Homes (EHCH) model was first conceived and developed through the EHCH Vanguards, of which there were six across England:[1]

- **Wakefield** aimed to improve the health and experience of people living in care homes and supported housing by bringing together primary (GP) care, a mixed team of health and social care professionals, and specialist voluntary workers along with care home managers.
- **Gateshead** aimed to support the health and wellbeing of older people by speeding up improvements in care for residents in Newcastle and Gateshead.
- **East and North Hertfordshire** aimed to support health and social care providers to work together to provide enhanced levels of care for vulnerable patients in care homes and avoid unnecessary trips to hospital.
- **Nottingham** aimed to enable residents living in a care home to be healthier, have a better quality of life and to be treated with dignity and respect, focusing on their capabilities rather than their dependencies.
- **Sutton** saw partners from across health and care working together with care homes and local communities to provide high quality, value for money services that enhanced the health and wellbeing of care home residents
- **Airedale** aimed to harness the full potential of modern technology called 'telehealth' or 'telemedicine' to improve the quality of life and end of life care for nursing and care home residents across Yorkshire and Lancashire.

This culmination of their work led to the publication of the first EHCH framework in 2016,[2] identifying best practice in new ways of working to deliver the three principle aims:

1. Deliver high-quality personalised care within care homes.
2. Provide, wherever possible, for people who (temporarily or permanently), live in a care home proactive access to the right care and the right health services in the place of their choosing in order to prevent or delay deterioration in their health and wellbeing.
3. Enable effective use of resources through efficient collaboration across health and social care to improve outcomes for people living in a care home, and in turn reducing unnecessary conveyances to hospitals, hospital admissions, and bed days whilst ensuring the best care.

The NHS Long Term Plan (2019) made a commitment to full implementation of the EHCH framework and signalled a new direction away from reactive models of care delivery towards proactive care centred on the needs of a person, their loved ones, and care home staff. The 2020 EHCH framework refresh (version 2.0) set out how Primary Care Networks (PCNs), General Practice (GP), community services providers and commissioners should work with care homes to deliver high quality, cost-effective care for people.

The COVID-19 pandemic has had a significant impact on care homes, the people living and working in them,[3] and those close to them and changed how health services and care homes interact. In particular, the pandemic demonstrated how collaborative working, commitment to teamwork between professionals in health and care, and innovation, such as that demonstrated by the use of digital advances to improve integrated working and information sharing, is essential to improve the quality and experience of care for people in care homes. This resulted in the EHCH framework being implemented much quicker and ahead of the NHS Long Term Plan schedule.

The revised EHCH Framework Implementation Guide has gone through +6 months of engagement with >500 individuals and a range of key stakeholders.

The updated framework includes:

- Best practice from the pandemic and changes to the digital infrastructure that enables implementation
- A focus on personalised care to support holistic needs of those living in care homes
- A subset of health and wellbeing elements to focus on as these impact all people in care home and are key for commissioners to consider to aid proactive and prevention commissioning. These are: learning disability and autism; nutrition and hydration; falls, strength, and balance; mental health; dementia; deterioration; and palliative and end of life care.

There are no changes the contractual requirements for Primary Care Networks. These requirements were agreed as part of GP contract for 2020/21 – 2023/24 and the NHS Standard Contract requirements for community services providers.

To find out more about the enhanced health in care home model visit NHS England Enhanced health in care homes at www.england.nhs.uk/community-health-services/ehch.

Are you involved in delivering enhanced health in care homes? The NHS England team would love to hear from you and share best practice from across the country – please contact them at england.communityservices1@nhs.net

Case studies

Southwark

Southwark has prioritised delivery of EHCH in older people care homes over the last few years as one of four key areas for transformation through the local care plan. Developing relationships between organisations and staff has meant that teams have been better able to provide the care needed by residents. Staff have also reported feeling more connected to leadership, being supported to adopt a 'can-do' attitude and having stronger relationships with colleagues.

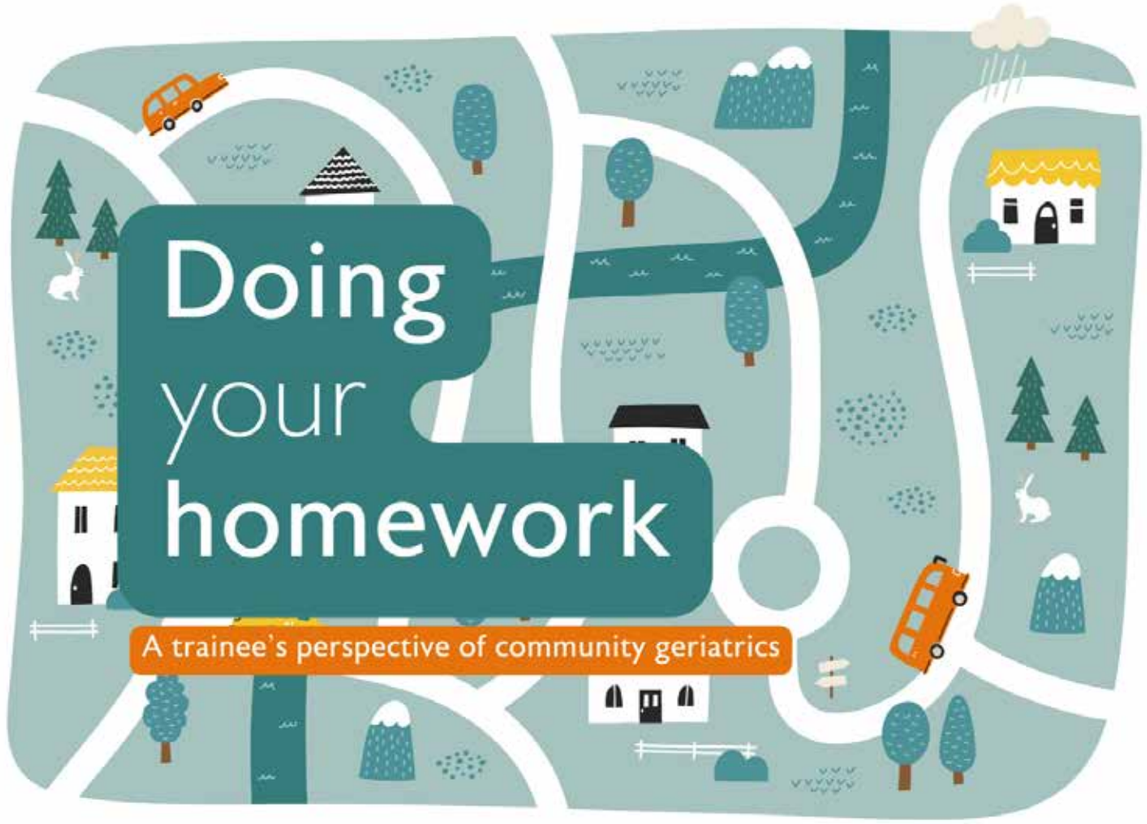
Older people care homes in Southwark are mostly medium-large and residents are registered with a single GP practice that only supports care homes. The GP practice provides proactive and routine care with twice weekly visits to nursing homes and weekly visits to residential homes. A broader multidisciplinary team support the delivery of EHCH including geriatricians, dieticians, social workers, speech and language, mental health, tissue viability as well as wider community services and the Hospital@Home service. To help co-ordinate activity, the team hold regular multidisciplinary meetings that enable the delivery of high-quality personalised care plans. The whole team has developed operational frameworks to support this work that enable flexibility to meet individual care home needs.

Somerset

North Somerset is part of the BNSSG (Bristol, North Somerset, and South Gloucestershire) Integrated Care System. Within North Somerset the care home hub is supporting several care homes, echoing the recommendations set out in the EHCH framework.

Initially set up to ease the burden on the town's acute Trust, the care home hub began to support the management of resident's healthcare in care homes. The care home hub began working with the care homes who had the highest conveyances to hospital and significant safeguarding concerns. The care home hub is based in a GP surgery at 168 medical group and are part of a larger PCN Primary care network.

The care home hub staff are a combination of different professions including GPs, Advanced Nurse Practitioners, nurses, care home lead providers, pharmacists a paramedic and a mental health nurse. A unique aspect of the hub is the cross over working between community and primary care, coming together as one to work as a collaborative, integrated team to meet the needs of the care home residents.



The recent changes to the geriatric medicine curriculum have placed a much greater emphasis on community geriatrics. This has resulted in trainees re-organising their working weeks, spending less time on in-patient wards, and opening up a very different way of working. This is one trainee's account of how the curriculum change has brought enormous benefits.

"Half a day a week in the community? But how on earth will I get all my learning...?"

As I took my first steps into community medicine back in September, I had no idea how much I would enjoy my placement, nor how much I would gain from it. My first impressions were of a very small and very friendly team, who were keen to do the best for their patients. I am fortunate to be working at The Rotherham NHS Foundation Trust, with community services being headed up by Dr Rod Kersh – a Community Physician.

Rod and his team (made up of Advanced Healthcare Practitioners specialising in Frailty, and a GP trainee - pictured smiling, opposite), take referrals from other community services, GPs and the hospital. A member of the team visits the patient at their home, be that a care home, or own home, and forms a management plan.

Referrals are unpredictable and hugely varied, which is part of the appeal.

Examples of some of the referrals include:

- Advance Care Planning
- Possible new diagnosis of Parkinson's disease
- Heart failure
- Recurrent falls
- Postural hypotension
- Mental health problems

During my placement I have had the opportunity to shadow Rod and his team or visits, and undertake my own. It is during these visits that the benefit and value of community geriatrics became clear.

Case studies

The team received an urgent referral for a care home resident with advanced heart failure. On review, she was felt to be approaching end of life. On review, she was felt to be very comfortable and her family felt she was happy in the care home environment. She was therefore managed without a hospital admission.

A referral was sent for a patient recently discharged from hospital. The patient had advanced dementia and did not have an advanced care plan, nor a DNACPR. We visited the patient at home, and found a very dedicated family who were in need of additional support for them. Having the time to spend with the family allowed us to make an advance care plan, put in a DNACPR, and also arrange for the family to have input from the Admiral nurses, which they were very grateful for.

We reviewed a patient at home with multiple medical problems. He was suffering from leg oedema, breathlessness, and a possible diagnosis of lung cancer. He was frustrated by having so many hospital visits, which were having an impact both on his quality of life and his mental health. We undertook a comprehensive geriatric review in his own home, reviewed his medications, rationalised his appointments and reassured him. He reported feeling much better in himself after our visit.

When seeing patients in their own environment, the comprehensive geriatric assessment almost writes itself. You are able to see at a glance how well people are doing or, conversely, how much they are struggling. Questions regarding mobility, mobility aids and stairs are not needed. A subtle glance around might reveal much about nutrition, hobbies, and levels of activity.

People are so much more relaxed in their own homes – I think the balance shifts and allows people to be really honest. 'We' (the healthcare professional) are in 'their' (the patient's) world, not the other way around. Hospitals can be very frightening places, in which things happen to the health professional's schedule. In Community Geriatrics 'we' have to fit around 'theirs' – it is patient centred care in its truest sense.

I have found the people that I have visited to be incredibly grateful. They feel very pleased that the healthcare professional has come to them. I personally feel very privileged to be allowed in to someone's home. Having the time to spend with them (and ideally their family) has been incredible. Seeing people in their own environment has allowed me to see patients differently when they are in hospital, and reinforced the need to work with someone's family to ensure the right treatment for them.

Having a base in the community has also allowed me to work more closely with other professionals. So far, I have spent time with District Nurses, Community Matrons, Occupational Therapists, Heart Failure Specialist Nurses, Respiratory Specialist Nurses, Speech and Language Therapists and Admiral Nurses.

'When seeing patients in their own environment, the comprehensive geriatric assessment almost writes itself. You are able to see at a glance how well people are doing.'

Having spent some time practising community geriatrics, I personally feel that doing so is an absolutely essential part of training. If we want to be hospital physicians with a pro-active approach to discharge, it is imperative that we have a good understanding not just of the community services in our area, but of how these services work together, and how well (or unwell) patients need to be to be supported in their own homes. If we want to be community physicians, then all the better, as we can keep more people out of hospital and help them manage well at home.

Rod's pesepctive

I moved from inpatient work four years ago, deciding that I would be better able to influence patient care and outcomes through admission avoidance and maintaining wellbeing than the hospitalist perspective of supporting when things have gone-wrong. In that time, I have forged new relationships and gained a better understanding of the whole health and social care system, I speak the language of primary and secondary care (including separate computer systems) which has improved my effectiveness.

Now, having a geriatric trainee on the team has allowed me to pass on much of this learning and envisage a future where more and more colleagues realise hospital medicine and eternal ward rounds are less effective and efficient ways of supporting the health and wellbeing of older people than the community approach. In the past month we have started a Virtual Ward which has further expanded the remit of what we can do and who we can support.

Pictured: Rod (left) and the team

Joan's (patient) perspective

I enjoyed it. I thought it was lovely that Dr Laura came to see me at home. I find it really hard to get to hospital appointments and my family always have to bring me, which is difficult for them because they work. I really appreciated someone coming to see me in my home.

Laura Kendal
Geriatric and General Internal Medicine Registrar. Rotherham NHS Foundation Trust

Wessex Academic Health Science Network (AHSN) explain how they are looking differently across the patient journey when it comes to addressing the issue of falls.

Falling is a cause of distress, pain, injury, loss of confidence, loss of independence and mortality. The Office for Health Improvement and Disparities (OHID) updated guidance, *Falls: applying All Our Health* (February 2022), highlights the annual activity and costs related to those aged 65+ falling:

- The Public Health Outcomes Framework (PHOF) reported that in 2017 to 2018 there were around 220,160 emergency hospital admissions related to falls among patients aged 65 and over, with around 146,665 (66.6%) of these patients aged 80 and over. The statistics are staggering:
- Falls were the ninth highest cause of disability-adjusted life years (DALYs) in England in 2013 and the leading cause of injury
- Unaddressed fall hazards in the home are estimated to cost the NHS in England £435 million
- The total annual cost of fragility fractures to the UK has been estimated at £4.4 billion which includes £1.1 billion for social care; hip fractures account for around £2 billion of this sum
- Short and long-term outlooks for patients are poor following a hip fracture, with an increased one-year mortality of between 18% and 33% and negative effects on daily living activities such as shopping and walking
- A review of long-term disability found that around 20% of hip fracture patients entered long-term care in the first year after fracture
- Falls in hospitals are the most reported patient safety incident with more than 240,000 reported in acute hospitals and mental health trusts in England and Wales.

Bringing together colleagues working within services that touch the lives of older adults aged 65+ across Wessex who wanted to learn more about falls prevention digital innovations within the marketplace, the Wessex Academic Health Science Network (AHSN), Healthy Ageing and Industry and Innovation Programmes held an interactive event on 23 February 2023 to provide insights into thinking differently along the patient journey by:

- Showcasing innovations in the marketplace – presentation of current innovative solutions to nudge you to 'think differently' about falls prevention.
- Understanding what organisations would want from a falls prevention innovation- Hearing from a variety of partner organisations on what matters most to them about falls prevention innovations.
- Horizon scanning for falls prevention technologies – Attendees learnt from Wessex Industry and Innovation team about the horizon scanning process through which we identify suitable technologies to meet the needs of NHS health and care providers. This builds on a 2022 horizon scan of falls prevention technologies carried out by Wessex AHSN with the Hampshire and Isle of Wight Integrated Care Board Falls Prevention Team to identify potential technologies for adoption in this area
- Capturing the energy within the virtual forum to enact a change in thinking through the completion of an attitudes to innovation survey pre- and post-event
- Overcoming common implementation barriers – attendees heard from a Integrated Care System Lead as they share an innovation story in a care home setting from concept to real world delivery.

Responding to the Department of Health and Social Care and NHS England plan for digital health and social care to support the roll-out of sensor-based falls prevention and detection technologies for those most at risk of falls, the session provided an opportunity for the AHSN and event attendees to hear directly from falls prevention innovators via a fast-paced marketplace forum. There was the chance to listen to the voice of experts from health and care, community voices and innovators on what falls innovation means to them and best ways to overcome obstacles when implementing new ideas. This led to the creation of a Wessex-wide resource that shares learning within Wessex on the topic of digital innovation in preventing falls in adults 65+ and how to overcome common implementation barriers.

To access outputs and resources from the session please visit https://wessexahsn.org.uk/projects/303/healthy-ageing-recent-events

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Take 5

tips for *falls prevention* in care homes

BGS Care Home Fellow, Leah Bressington, shares some of her top tips for helping to prevent falls in care homes.

I would like to share my top five falls recommendations plus a bonus recommendation. Together I think these make the biggest difference to care home residents.

1 Recognising that falls management is just as important as falls prevention

With a growing population of over 400, 000 people living in UK care homes, and with residents three times as likely to fall as older people living at home, for the foreseeable future falls are likely to continue to be a daily dilemma for care home staff, despite prevention interventions. A balanced response to all falls is key. Of course it is important for care homes to focus on avoiding long term reduced quality of life and reduced mobility from serious injury, but this must be balanced with reducing unnecessary ambulance trips and A&E waits during what for most are their final precious years.

2. Making use of Comprehensive Geriatric Assessment (CGA).

This holistic and continuous assessment identifies functional limitations in older people with frailty to allow individualised care planning. The CGA includes a set of specific presentations including mobility and balance, bone health and falls. It is therefore effective in identifying a resident who has a history of falls, and helping the clinician identify and addresses contributing factors that have led to the falls. It is ideally initiated in the first week of admission to a care home. In my experience it is most effective when the care home nurses contribute and are aware of the individualised care plans. They are best placed to supports the goals set, for example, by encouraging the resident to mobilise around the care home.

3. Include a falls plan in the ReSPECT form and ensure it's accessible

The ReSPECT form aims to record a shared understanding between health care professionals and the patient regarding the patient's most valued and most feared outcomes. Often, the forms are completed in A&E with little time for in-depth conversations about advance planning. They often lack a detailed action plan for responding to a fall, so that the first response of the care home staff member is to call for an ambulance even following a minor fall. I would encourage the care home nurse to be involved in writing the ReSPECT form with the rest of the multi-disciplinary team. They often have an established professional relationship and so are the right person to have that difficult conversation with a resident and their loved ones and be involved in advance planning. It is important that the ReSPECT form is accessible, that the content is understood, and that the agreed actions are followed by the care home nurse to prevent unnecessary hospital attendances.

4. Address the 2 Ps: polypharmacy and postural hypotension - they are closely related!

Medications are amongst the most common causes of increased falls in care homes but are a fixable problem needing only a structured medication review. A structured medication review should be carried out by a healthcare professional who has appropriate clinical and therapeutic knowledge and the skills to communicate with the residents and MDT. More information on this can be found in the BGS resource End of Life Care in Frailty: Medicines management. This guidance examines the issue of polypharmacy at the end of life. Please click here to view the other chapters in this series.

Postural hypotension can result from a multitude of factors, but I would always advise the same starting point, which is to perform a lying and standing blood pressure. In my experience, this is often performed incorrectly or not done

at all. The BP should be taken 1 minute after standing from a lying position, and again at 3 minutes. Care home nurses should be trained and encouraged to do this after a resident's fall and discuss the results with the multi-disciplinary team.

5. Encourage activity

The simplest and most effective recommendation for both falls prevention and falls management is to encourage care home residents to be active. Note I mention activity as opposed to mobility. Activity can include any form of movement and should be incorporated into everyday life for care home residents. The care home nurse is best suited to identify activities the resident enjoys, and to support them to do them as part of their care delivery. Activity not only encourages movement and prevents deconditioning but improves overall quality and enjoyment of life for all residents.

The care home nurse is key!

What struck me about my recommendations is they all have a shared commonality. The care home nurse! An often underused, overlooked, and undervalued healthcare professional. I encourage everyone to recognise and utilise the care home nurse as the centre point in falls prevention and falls management. This principle also underpins one of the largest studies about falls in care homes. The Falls in Care Home (FinCH) study led by Pip Logan in Nottingham University examined a new Guide to Action in Care Homes (GtACH) programme. which was designed by a collaboration group including care home staff and families to prevent resident falls in care homes. The study involved 84 care homes across the UK with 1600 residents over a three-year period by training care home staff to carry out a personal assessment and suggest changes that may prevent residents falling in the future. One of the main contributing factors to the project's success in reducing falls was the inclusion of care home staff in the design stage of the programme, and in its implementation.

Ultimately, I believe the care home nurse is indispensable in the prevention and management of falls in care homes. Often, they are the first person at the scene after a fall, the first responder to the next action that follows and the source of information for the multi-disciplinary team. By working as a collaborative multi-disciplinary team, we can get it right when a resident falls.

One final thought: there is always something that can be implemented to reduce falls in care homes. If you're stuck for ideas, the BGS has a number of resources on falls prevention on its website, including the recent World Falls Guidlines (**www.bgs.org.uk/wfg**), the Falls and Bone Health Special Interest Group (**www.bgs.org.uk/falls-and-bone-health**) and the annual International Conference on Falls and Postural Stability, which you can catch on demand at **www.bgs.org.uk/events,** or register for the 2023 event being held in Newcastle and online in September.

Leah Bressington
BGS Care Home Fellow
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The Global Council on Brain Health (GCBH) is an independent collaborative, created to provide trusted information on how you can maintain and improve your brain health. Over the past seven years, it has issued 12 reports on a broad range of topics examining whether adults' behaviors and lifestyle habits impact their brain health as they age.

The GCBH Council recently brought together an interdisciplinary group of experts from around the world to review the current state of science on behavior change with the goal of reaching consensus. This body of work aims to provide information on what people should do to achieve better brain health as they age. The report entitled *How to Sustain Brain Healthy Behaviors: Applying Lessons of Public Health and Science to Drive Change* explains how we can influence people to act in ways that can benefit brain health over the lifespan.

The latest Global Council report makes recommendations for how people can be influenced to act in ways that can benefit their brain health. The recommendations below highlight the ways in which people can modify their daily behaviors to benefit brain health.

The report also recognises the important role that communities play in helping to support individuals by making these healthy habits sustainable. In this way, community-wide initiatives as well as employers, healthcare systems, and governments can offer support at an individual level while simultaneously bolstering the economy and promoting healthy living more broadly.

'The term 'brain health' may encourage more positive action than 'cognitive decline.' Communication should try to eliminate fear and stigma.'

Individuals can consider the following tips for successful behavior change:

1. Set a goal, identify a specific action you want to take. Think about the behavior you would like to change and why it is important to you.
2. Be thoughtful and realistic about the goals you choose. Think about the various options and choose one that fits in well and regularly with your daily routines.
3. Take a step-by-step, gradual approach. Starting with something easier for you to do may help you sustain the behavior.
4. Find something that is fun; choose what is enjoyable for you. Incorporating some element of pleasure in what you choose provides positive reinforcement to keep it going. If you don't like running, but enjoy dancing, take a dance class.
5. Re-purpose some of your free time. Try substituting healthier habits for less desirable ones; switch 30 minutes of walking for some of the time you would normally spend on social media or watching television.
6. Rethink your environment to reduce temptations and encourage better choices.
7. The more you put healthy choices in easy reach, the more likely you are to make them.
8. Celebrate the wins. Recognising small achievements can have a real impact on adherence, especially at the beginning of pursuing a goal.
9. Learn from the setbacks. Setbacks show you what works and what doesn't work for you, and help you recall your commitment.
10. Involve friends or family with common goals to reinforce healthy choices. Involving a friend or family member in your new behavior can be a win-win. Not only can this help make the process more enjoyable and encouraging, but you may also help someone else.
11. Pick a good start time. Plan to introduce new routines and behaviors at a time that offers a perception of a "fresh start."

Selected recommendations for community-based organisations:

- Set a goal identifying behavior change targets focused on brain health. Use your platforms to promote brain-healthy behaviors such as increasing cognitively stimulating activities, increased physical activity, or improved heart health.
- Create opportunities for peer-to-peer health coaching. Well-trained peers understand how to communicate effectively and may have insight into cultural influences that impact a person's actions.
- Take an inclusive, multi-faceted approach collaborating across sectors to create a culture of health. Aim for public-private partnerships.
- Keep track of the response. Monitor progress and keep participants up to date on progress.

Selected recommendations for policymakers

- Set a goal to improve the public's brain health with a focus on building equity. Measure progress along the way. Having a goal is a good way to focus attention on the things that are important.
- Raise public awareness that people can take steps to promote their brain health. Provide information to people that their behavior choices and lifestyles can foster or damage brain health and that cognitive decline is not inevitable.
- Deliver culturally-appropriate messages for designated audiences. You can't raise awareness unless people listen. Communications should be tailored to fit your chosen audiences reflect their cultural perspectives. The message, the messenger, and the platform all make a difference.
- Recognise that social determinants of health can shape cognitive well-being. People are influenced by their social environment and opportunities in life. Remember that many policy areas, including education, influence brain health throughout the life course.
- Fight the stigma of dementia. The term 'brain health' may encourage more positive action than 'cognitive decline.' Communications should try to eliminate fear and stigma, as these can result in people avoiding treatment and feeling helpless.
- Think globally. Collaborate. Emulate best practices and spread your insights through your networks. Researchers and advocates around the world are exploring how to best apply scientific findings on behavior change and brain health.
- Use the tools of policy to make brain health a top priority. Legislation, regulations, taxes and other fiscal measures, creation of guidelines, modeling desired behaviors, urban design, fostering cross-sector collaborations and environmental restructuring are among the levers to create incentives to encourage healthy habits and discourage bad ones.

For the complete GCBH report, including practical tips and recommendations, visit: www.globalcouncilonbrainhealth.org. The infographic accompanying this report can be downloaded at https://tinyurl.com/brainbgs.

Lindsay R Chura PhD
Chief Scientific Officer, Global Council on Brain Health

Could **YOU** peer review?

Ever wondered what peer review really means, how decisions are reached about publishing manuscripts, or whether you would make a good reviewer yourself? Editorial Fellows for *Age and Ageing* journal explain what is involved and why this role is so valuable in advancing research in geriatric medicine.

Age and Ageing is the journal of the British Geriatrics Society and is currently the highest-ranked Geriatrics and Gerontology journal, with a with a Journal Impact Factor™ of 12.782 in 2022 (Journal Citation Reports, Clarivate, 2022). *Age and Ageing* is constantly seeking new clinicians and academics from a wide range of backgrounds to peer-review for the journal, in order to ensure the publication of rigorous scientific research of clinical relevance to the practice of geriatric medicine. While peer-reviewing may initially appear daunting or intimidating, it can be a truly rewarding experience, both on a personal level, and for the wider discipline of geriatrics. Involvement of Early-Career Researchers (ECRs) and practicing clinicians is vital to ensure that published research is as relevant as possible to the needs of older people and to the clinicians who work with them.

What is peer review?

Broadly defined, peer review is the evaluation of scientific research by one or more experts in the field with similar competencies as the producers of the work. Peer review can foster trust in published scientific and clinical research, ensuring that only articles meeting the required methodological standards are published in academic journals.[1] The method of peer review is as old as publishing itself, with scientific journals employing the practice since the 17th Century.[2] Even in its embryonic form – as used by the Royal Society of Edinburgh – peer review was meant as a means of validating and authenticating scientific findings. Many years on, peer review is standard practice for academic journals and serves to both prioritise research for publication and ensuring the quality and authenticity of published research.

At an academic journal such as *Age and Ageing,* manuscripts containing original research findings (or a systematic review of findings in the literature) are submitted by authors to the journal for consideration for publication. Following routine technical checks, manuscripts are then screened by the editorial board, which comprises members with expertise in different areas of geriatric medicine. Papers falling within the scope of the journal with important and novel findings are then usually assigned by an Editor-in-Chief to an Associate (or handling) Editor for further assessment. If papers are deemed to be of interest to the broad readership of the journal in question and have clinically relevant findings, they will then be sent out for peer review.

How does peer review work?

Peer review involves selecting experts in a given field for detailed scrutiny and comment on scientific publications. Peer reviewers can be anyone with competence and expertise in the field, as well as those with a more general relevant knowledge-base. The identity of reviewers is known only to the editor, so that feedback is as honest and robust as possible. Typically, at least two reviewers are required. In practice, more than two reviewers may be required where there is disagreement on the merit or quality of the work, or if specific input on a particular component of the paper is needed, such as statistical analysis. Peer reviewers are invited to submit detailed comments on the manuscript and to justify a recommendation to the handling editor – such as acceptance, major or minor revision, or rejection. This feedback is invaluable to the handling editor who can synthesise this detailed information from clinical and academic experts with their own expertise to make an informed decision on the merit of a particular paper.[3]

For journals with a clinical focus such as *Age and Ageing*, insights from practising clinicians are invaluable. Journals typically have a bank of reviewers, including those who have previously reviewed for the journal but they are constantly seeking new peer-reviewers. In 2022 we were supported by more than 700 people who performed a peer review of a submitted article – for which we are hugely grateful! We tend to not invite a reviewer more than twice a year and prefer to spread the load over a wider pool of people.

‘In 2022 we were supported by more than 700 people who performed a peer review of a submitted article – for which we are hugely grateful!’

Why become a peer reviewer?

It should be noted that peer review is not usually remunerated. However, there are a number of other benefits for anyone interested in ageing-related research. These include:

- The opportunity to keep up-to-date with the latest developments in the field, including to read pre-published research with implications for clinical practice.
- Learning from others’ clinical practice and improving understanding of a wide range of research topics and methodologies, and develop critical appraisal skills.
- For clinical professions, peer review is recognised for Continuous Professional Development (CPD) activity; generally considered to equate to one CPD credit per review. Recently developed platforms such as Web of Science (previously known as Publons) and ORCID enable researchers to showcase peer review and editorial contributions.
- We send an annual letter of thanks and recognition from the BGS and *Age and Ageing* so that peer review can be noted on the CV and be considered by academic institutions when assessing performance or promotions.
- Rewards for the most active reviewers. This year we were pleased to offer a Charity Voucher to the people who reviewed four or more times in 2022.
- And remember – the papers that you have submitted or will submit as a researcher are reviewed by peer review experts such as yourself. This is an opportunity to give back to the field of academic geriatric medicine and make a small, but important, contribution of your own to clinical research.

The benefits of peer review are even more apparent for research related to the needs of older people. Geriatric medicine is different to other medical specialties for several reasons – its multi-disciplinary nature, the inherent intra and inter-individual variability in the ageing process and the lack of evidence base for many important clinical decisions and interventions.[4] Peer reviewing for journals such as *Age and Ageing* enables reviewers to ensure that published research is specific and relevant to the needs of older people and to raise awareness and standards of research for a patient population typically underrepresented.

Are there any downsides for peer reviewers?

In a word, no. Most experienced peer-reviewers will take about an hour to read and comment on a manuscript, although it can take longer depending on your level of familiarity with the topic and the manuscript itself. In any case, time can be counted for CPD, so need not be ‘additional’ to your busy schedule. Moreover, there is no commitment to review a manuscript you are invited to review, and you can decline if you are too busy or do not feel confident enough on the topic. However, once you agree to review a specific manuscript, you would be expected to return the review within about two weeks.

Peer-reviewing for the first time may seem a little daunting but there are excellent help and training resources available online. Like anything else, it gets much easier with practice!

Our experience of peer-reviewing

As Editorial Fellows for *Age and Ageing,* we have had the benefit of becoming involved in the peer review process, both as peer reviewers for the journal and in handling manuscripts through the editorial process under the supervision of senior editors. This has been an incredibly rewarding opportunity to observe the processes from submission to publication first-hand. From influencing editorial decisions, to ensuring the relevance and quality of manuscripts and further shaping the dialogue around ageing-related research, peer review affords a unique opportunity for both early career researchers and experienced clinicians.

This is not to say that the current system of peer review for academic journals isn’t without its flaws; indeed, peer review may not enhance the quality of scientific research[5] or comprehensively detect all inaccuracies present in published research.[6] Debate continues about how best to recognise peer reviewers for their time and effort. However, it is only through engagement with the current processes that we can effect change. Peer review remains the cornerstone of how leading academic journals select and publish the best scientific research with relevance to clinical practice. We have found the experience incredibly rewarding - and are happy to speak to anyone interested in our experiences.

We would be delighted to hear from BGS members who are interested in joining the team of *Age and Ageing* peer reviewers. Please contact the editorial team at aa@bgs.org.uk for more information on how to get involved.

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How I die:

Normalising advance care planning in Northern Ireland

***'I'm not afraid of dying, I'm only afraid about how I die.'* That was Colin's response to my probing about his smoking intentions before we discharged him home.**

It switched me out of autopilot mode. He was a 77 year old man, independent around the home, with no serious life limiting illness and a short hospitalisation with delirium associated with his chronic lung disease exacerbation. I was working on persuading him to pack in his smoking habit for good when he said, smiling and non-confrontationally,: 'I'm not afraid of dying. I'm only afraid about how I die'.

One month earlier I had shared a stage with BGS colleagues from across the UK at the BGS Autumn Meeting 2022, describing how Northern Ireland's recent landmark policy launch by our Health Minister on Advance Care Planning (ACP) had many features to be proud of, with the intention of sharing these together with some cautionary notes.

The ambition is that ACP is in Northern Ireland is normalised for all adults aged 18 and over, not simply focusing on the important clinical, psychological and social aspects of end of life care when the need is clearly in view. It is about creating the opportunity for adults to express their wishes and intentions, and to have these reflected in the care and treatment they receive in the future.While clinical staff will naturally gravitate to the clinical aspects of the process, it is important to stress it is much more holistic by also including legal, personal and financial elements (see Figure 1). It is a voluntary, continual process - more on that later.

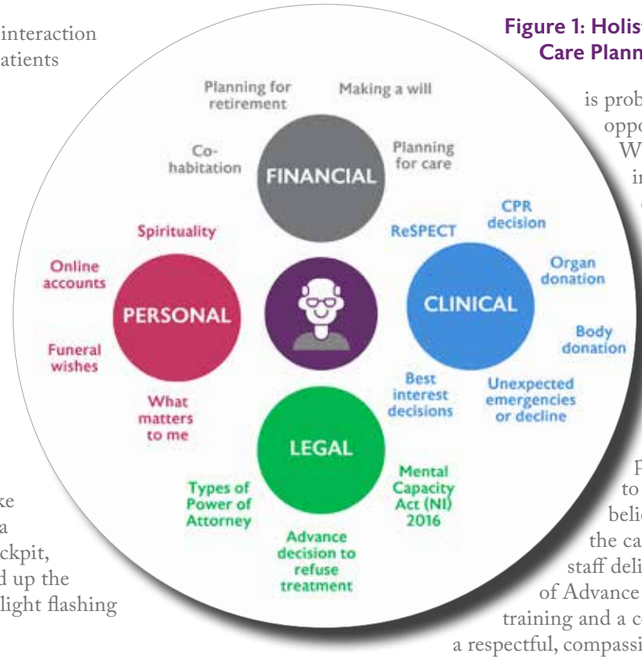
Back to Colin. My internal monologue in response to his comment challenged me mischievously with both 'great opportunity to discuss important matters' and 'do you walk the walk Mark, or just talk the talk'.The least time-consuming thing to do would be smile, and make some platitudes along the lines of 'well you really should stop smoking' and move on. I could then return to my oak-panelled Consultant office sooner, overlooking Romanesque fountains and sweeping valleys (!) Thankfully, on this occasion I decided to pause, pull up a nearby chair so we were at eye level, take my mask off (with social distancing that afforded this) and say 'OK, let's talk about that then'.

What followed was no more than a 5-6 minute conversation on the ward round, where it was abundantly clear he had no intention of stopping smoking, and that if he ever got ill enough to need hospital for his chest again that he would consider non-invasive ventilation whilst declining intubation and intensive care. Given his limited mobility and cardiorespiratory reserve I thought these were reasonable decisions to make. Cardiopulmonary resuscitation was briefly touched on – 'I don't want that'.

He was made aware of the principles of anticipatory medications to keep him comfortable if and when the time came, and how these could be delivered at his home.We agreed I would summarise the main discussion in a letter to his GP, and send a copy in the post to his home for his records. I also stressed if he wanted to revisit and potentially change any elements of this that could be done with his GP, myself or attending doctors in the future.

Reflecting on this interaction reminds me that patients often give signals that they want to consider changing lanes in clinical conversations, and in pressured working environments it is easy to not pick up on them or elect to focus on the lane healthcare professionals might consider the most pressing. At times we are like pilots monitoring a multi-indicator cockpit, but have we picked up the important quieter light flashing away?

Figure 1: Holistic elements of Advance Care Planning



Sometimes these quieter signals speak to matters of great depth and importance to patients. His desire to want to talk about treatment and management options at the end of his life, even though it was not imminent, meant he was already well in the 'Thinking – Understanding' phases (see Figure 2). Our interaction felt more productive, impactful and tailored in part because I wasn't having to drop him into these discussions when he was in the 'Not knowing' phase. In terms of efficiency, one can also argue the extra 5-6 minutes and the few minutes to dictate the letter were well spent it if means Colin in the future receives more patient-centred and appropriate care that respects his wishes and is within the envelope of what can reasonably be offered. This latter point is important for the public, patients and clinical staff alike to understand – this is not about shopping for options and acquiescing to undeliverable or inappropriate demands.

I suspect many BGS colleagues will already be involved in elements of ACP work in their daily working life but it is probably discretionary and applied opportunistically and inconsistently. While I am confident it is an investment valued by patient and clinician it is probably invisible, and therefore terribly, perhaps catastrophically, undervalued by the broader health and social care system.

Having a policy and launching it is only the first but vital step to systemising the opportunities for all adult citizens (and future patients) of Northern Ireland to consider their wishes and beliefs and have these reflected in the care that can be offered.Clinical staff delivering the clinical components of Advance Care Planning need time, training and a commitment that we engage in a respectful, compassionate and accessible way. Some standalone components, such as the ReSPECT process (Recommended Summary Plan for Emergency Care and Treatment) will involve targeted training to those helping to complete these forms including trained Consultants, General Practitioners and Staff and Associate Specialist Doctors, those Doctors in senior training grades and Specialist Nurses.

There will be practical challenges including ensuring any mental capacity and communication challenges are sufficiently addressed.But the birth of a formed, considered ACP policy at a small country level represents a significant ambition to shift away from a reactive, clumsier model of healthcare provision towards one that is more proactive, calmer, tailored and patient-centred.

Dr Mark Roberts
Consultant Geriatrician, Western Health and Social Care Trust, Northern Ireland

Figure 2: Moving through the phases relevant to advance care planning

Trainees' palliative care experiences

With palliative care now a component of the geriatric medicine curriculum, members of the BGS Trainees' Council reflect on their experiences and learning, and how things can be improved for participants moving forward.

The new geriatric medicine curriculum recognises that specialists who manage frail older people with long-term conditions requires a training programme and curriculum which equips doctors with the capabilities to manage older patients with acute illness, chronic conditions, rehabilitation, end of life and palliative care needs. The new curriculum stresses that trainees should have significant experience of palliative care. It seeks to increase confidence in developing appropriate advance care plans, including DNA/CPR decisions.

The objectives include recognising patients with limited reversibility and the dying patient and knowing interventions available to them. It also focuses on increasing the confidence of physicians in managing physical symptoms of patients and the psychosocial distress of patients and families. As a result, the new curriculum recommends that trainees in Geriatric Medicine undertake a specific palliative medicine attachment.

In view of this, the BGS Trainees' Council sought to compare palliative care experiences across the different deaneries and their experiences are as below. The shared commentaries show the varied approaches taken by registrars across the country to achieve a common objective. However, the discrepancies are striking and raise some important questions regarding the need for standardisation of palliative care experience across the nations.

Dr Helen Sims: ST7 Registrar, Severn Deanery

Palliative care has been a key part of my training since day one of ST3. Almost every day on a geriatrics ward there are escalation decisions and advanced care planning discussions which need to take place. I have taken the opportunity to sit in with palliative care nurses when they are having difficult discussions with families and patients on the ward. On the majority of our regional geriatric training days there is at least one talk on an aspect of palliative care, from medications used to community management of patients in the last stages of life.

When I was ST5 working in Severn (Gloucestershire) I was able to do a lot of palliative care while on a community geriatrics rotation. This was in 2020 during the pandemic. I was able to arrange several visits to a local hospice for consultant-led ward rounds. I also attended palliative care clinics and spent time with the hospital palliative care liaison service (Consultant and nurses). I attended several palliative care multidisciplinary teams (MDTs) where complex patients, both in hospital and in the community, were discussed and management strategies were agreed upon. A lot of clinics were cancelled during this time due to the pandemic and so my aim will be to continue to gain palliative care experience now that things are returning to some form of normality.

Anonymous Speciality Registrar, West Scotland

I did my palliative care block in Lanarkshire whieattached to Monklands last year. It was difficult to organise in terms of getting released from the GIM rota initially, but once a suitable four-week slot was found, I had a good experience. Lanarkshire is unusual in that there are two hospices, and because there are a lot of trainees needing to do palliative care attachments now, I spent time in both, rather than all four weeks in one place. I spent two weeks at St Andrew's Hospice in Airdrie and two weeks in Kilbryde Hospice. I was able to do a couple of sessions doing in-reach in Hairmyres and Monklands, and also got a day with the community palliative care team.

I had a consultant supervisor for the purposes of portfolio, and they made an effort to ensure I got the required number of Consultant-signed-off supervised learning events (SLEs) for the block. Also got some really good teaching from one of the Specialty Doctors at St Andrew's. They really did value having a medical registrar around - I contributed a lot more to ward rounds and gave a lot more advice than I thought I would.

Dr Ayesha Sheikh: Specialty Doctor Frailty/ Orthogeriatrics, KSS Deanery

My experience in palliative medicine began from the first wave of COVID-19 in the UK. I was covering front door frailty and a COVID older patients' unit. The Palliative Medicine team worked with us and provided support in all domains of patient care. Patients would come in very sick and died within a few hours, mostly due to acute respiratory distress syndrome (ARDS) on the background of co-morbidities. They would commonly present with symptoms of dyspnoea and delirium. Their clinical frailty scale (CFS) score would range from 5-8. Non-invasive ventilation (NIV) vs ITU admission proved to be a challenge. We worked as an MDT and it was decided that CFS 6 and below, due to guarded prognosis, would not be for invasive ventilation and should be treated symptomatically. Provision of oxygen, steroids, devising syringe drivers, opioids and providing adequate symptom relief/pain control was a challenge well-handled by the palliative and medical teams.

There was a fear of the unknown and anxiety among the staff and family members. Dying alone in hospital had put many families at risk of complicated grief. We had arranged for virtual Face Time facilities for patients and their loved ones. Our local community hospital was dealing with many deaths and running out of body bags. Uncertain prognosis, DNR, symptom control, limitation to family visits and handling of body after death to minimise risk of transmission and in accordance with patient/families' religious belief remained challenging areas. Palliative clinical nurse specialists supported us in these mentally and physically exhausting times.

Anonymous Speciality Registrar, West Scotland

I've not had particularly a positive experience trying to arrange this time (both pre and during covid and in the two large teaching hospitals). There seems to be an issue centrally applying the guidance of a total of four weeks of experience, whereas those in District General Hospitals (DGHs) seem to be better supported to take the time and have an immersive experience. I don't think the advocates of several weeks' worth of half-day sessions realise how difficult this is to timetable, as 40 sessions are extremely difficult to accommodate (and a lot to ask another service to take on). While I know that death and dying are seen as core geriatrics, leading to some assuming we already have this experience and thus not prioritising the time for us to leave day to day ward-based service, I think there needs to be stricter demarcation around this aspect and that of old age psychiatry, especially in early phase of higher speciality training, to ensure people are supported to make room for the specialist aspects of practice. I think clearer guidance on the split between community, hospice and in-hospital experience would be useful to help make the case more strongly. Similarly, guidelines on assessments by those in the specialty, as these can be more difficult particularly with the randomness of sessional working.

Dr Rachel Melrose: ST7 Registrar, South Yorkshire Deanery

In Yorkshire it can be very variable. Pre-pandemic the hospices were very accommodating and allowing us to spend a week or two with them but this has been more difficult through the pandemic. Most of the hospitals have an inpatient team and a hospice attached. This seems to be felt to be sufficient alongside the general palliative care experienced through general geriatrics wards.

I completed my palliative care experience during my ST3 year (pre-COVID) whilst working at a small DGH. I found it relatively easy to arrange a week in the hospice as there was only two geriatrics registrars and one palliative care doctor to co-ordinate this with. In larger hospitals I imagine this may have been more difficult to ensure the hospice is not overwhelmed with trainees.

Similarly, within the hospital there were daily palliative care nurse ward round which I could attend as long as I was not needed on the wards. There was a coordinated palliative care MDT which was attended by both the primary care teams and secondary care palliative care teams (nursing and medical staff) which I could attend. The teams were very accommodating. While I think post-COVID era brings a lot more logistical difficulties, I believe this along with general ward work was sufficient experience for our curriculum.

Dr Fariha Naeem: ST4 Registrar, West Scotland

I did my palliative care block at the Royal Alexandra Hospital (RAH). It was based between Accord Hospice, hospital liaison work at RAH, and home visits. It was an excellent placement, I was well supported with plenty of time for discussion and feedback. I felt the timetable was varied enough and the seniors were really helpful with portfolio work.

Dr Sangam Malani: ST5 Registrar, NW London Deanery

I was at Northwick Park Hospital for my ST4 year and as part of our rotations, we have two months allocated towards a sub-speciality block. During this block you are not on the on-call rota, and you have the chance to organise a bespoke placement to fulfil your training needs. I used this time to garner experience in orthogeriatrics, urogynaecology, old age psychiatry and palliative care. I spent one week with the palliative care team in the inpatient, community as well as hospice setting. I went on ward rounds on their inpatient unit and participated as an active member of the team in their community MDT. I spent time with the CNS who was on the 24/7 palliative helpline and learnt that this was a service available to all patients and clinicians in the area. This knowledge came handy when a patient approaching end of life presented to ED and I was able to access their advance care plan and ring the palliative care CNS who knew them to organise care at home. I learnt about the various therapies offered to patients and families, got 1:1 teaching on medications from the palliative care consultant and did joint reviews in nursing homes as well as hospitals with the Clinical Nurse Specialists.

For me the biggest take away was the shared learning and inter-disciplinary learning that week. At the end of my placement, I received an email from them extending their offer to visit again and I am happy to report that I 100% plan to!

What have your experiences been? Are there any objectives in the new curriculum objectives you feel you are struggling to achieve? How can the BGS help? We would love to hear from you - please email us at trainees@bgs.org.uk

Examine for the

Diploma in Geriatric Medicine

British Geriatrics Society
Improving healthcare for older people

Royal College of Physicians

The Diploma in Geriatric Medicine (DGM) is an examination developed collaboratively by the Royal College of Physicians and the British Geriatrics Society. It is designed for healthcare professionals who want to demonstrate their advanced knowledge and expertise in the healthcare of older people. The RCP and BGS are recruiting new examiners for the DGM.

What does being an examiner involve?

Clinical examiners for the Diploma in Geriatric Medicine (DGM) are involved in assessment of the practical aspect of the exam (DGM part 2) which takes place at The Spine in Liverpool twice a year (around June and November). This is in the form of an observed clinical examination, with the examiners for each station selected on the basis of their relevant specific skills and expertise. You will receive full training and the support of experienced examiners. Examiners typically serve a term of three years, but this can be renewed following review by the DGM Clinical Examination Lead.

'I like listening to the candidates and knowing that the future is in good hands. As a physiotherapist and advanced clinical practitioner I've been welcomed, and my specific knowledge, skills and experience have been really valued."

- Jo Jennings, Advanced Clinical Practitioner

Who is eligible to apply?

Any experienced healthcare professional involved in the care of older people, registered with the applicable professional body, is eligible to apply to become a DGM examiner. You do not need to have previously taken the DGM yourself. You will also need to be actively engaged with the training of junior practitioners and be up-to-date with the necessary CPD. For more details about the minimum experience levels required, please click here.

Members of the wider multidisciplinary team are welcomed and encouraged to apply. This includes

- Advanced Clinical Practitioners
- AHPs
- Physician Associates
- Consultant Physicians in Geriatrics or related specialties
- SAS grade doctors
- GPs
- Old Age Pyschiatrists

'It's been so encouraging lately to see the calibre of candidates who are coming through from the exam, both nationally and internationally. We have GPs, psychiatrists, SAS doctors, advanced nurse practitioners and our MDT colleague professionals, as well as physician associates."

- Bella Richards, Consultant Stroke Physician

What will I gain in return?

This is an unpaid, voluntary position, however all expenses related to travel and accomodation will be covered. Examining for the DGM is a recognised professional activity and you will be able to claim CPD points from the relevant provider for your involvement. You can find out more about why our current examiners love this role by viewing the short videos on this page.

'It's really an enjoyable day out. It's usually held at the Spine in Liverpool, and I'd really encourage my geriatrics colleagues to get involved."

- Bella Richards, Consultant Stroke Physician

How do I apply?

If you are interested in becoming a DGM examiner, please visit **www.bgs.org.uk/DGM-examiner** for further information, including further details of eligibility criteria and how to apply. If you have any questions regarding the application process, please contact the RCP Assessment Unit via **DGM@rcp.ac.uk**.

Obituary: Stuart Parker, a geriatrician's geriatrician

We were sad to learn of the death of Professor Stuart Parker in early February 2023. Stuart was a much admired and respected geriatrician, and for me personally a great mentor and friend.

Stuart trained in Geriatric Medicine in Newcastle upon Tyne (1980-93) and worked in Experimental Gerontology in the Netherlands (1990-91). He was also an intellectual powerhouse who held senior academic positions in Leicester and Sheffield before returning as professor of geriatric medicine in Newcastle in 2013, in his beloved Northumberland.

Stuart led research in many areas, but perhaps his greatest achievement was in acute care, including highly cited work on the Hospital Frailty Risk Score published in the Lancet in 2018. Ever humble and understated, but quietly effective, Stuart has undertaken much to improve the lives of older people across the UK and globally.

I was privileged to work with Stuart on acute care, and learned much from his leadership on the Hospital Wide Comprehensive Geriatric Assessment study. His pseudo-shambolic style bellied a razor sharp intellect and his understated manner spoke volumes.

Outside of work Stuart enjoyed photography and sailing. I recall his photos from a Caribbean beach whilst we were battling with winter pressures on the back-end of his Atlantic and Indian Ocean sailing trip in 2017. With his wife Sue, he was also a keen cyclist, often just following the weather to enjoy the British scenery on their cycling holidays.

Stuart was diagnosed with renal cell cancer in 2020 but following a range of treatments was able to return to swimming a mile a week in Spring 2022. But the cancer recurred in December 2022, with Stuart dying peacefully in a hospice in February 2023. Our thoughts are with his wife Sue and their family – he will be much missed.

John Gladman. Professor of Medicine for Older People at the University of Nottingham added 'Stuart had a kind sense of humour and was a great person to have a drink with - we liked him as a man and not just as the geriatrician's geriatrician.

Professor Simon Conroy
Professor of Geriatric Medicine, University of Leicester

Call for examples of rehabilitation services for older people

Do you provide rehabilitation for older people? The BGS would like to ask for your help in showcasing examples.

Yours might be a community service helping older people to recover when they have been discharged from hospital. It might be a 'pre-hab' service developed with voluntary sector partners, encouraging older people to be active in order to slow down the progression of frailty. It might be an in-hospital programme to help older people build their strength and balance, and avoid deconditioning.

Wherever rehab is undertaken, we'd like to hear how it is helping older people. Feel free to focus on patient outcomes and share the challenges you face as well as achievements.

We are particularly keen to hear from members of the multidisciplinary team across the four countries of the UK, with rehab case studies from community, primary and acute care and from care homes.

We invite you to self-record a video of up to 10 minutes describing your service and how it is helping older people. You can make the video yourself.

We plan to show a selection of the case study videos at the BGS Autumn Meeting, which takes place in Birmingham and online from 22 to 24 November 2023. We will also host the videos on our website. You might also like to consider submitting your project as an abstract.

Please send your videos to g.collingridge@bgs.org.uk by 31 May. For more detailed information on how to get involved and technical advice about self-recording, please visit www.bgs.org.uk/rehab-reels

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

Abstract submission deadlines

We are currently accepting abstract submissions for the following BGS conferences:

- **2023 Improving Continence in Older People**
  Closes: 16 June 2023
- **24th International Conference on Falls and Postural Stability**
  Closes: 16 June 2023

For all current abstract submission dates, including links to submission guidelines and our abstract submission portal, please visit: **www.bgs.org.uk/abstracts.**

Medical Student Rep: Trainees Council

The BGS is seeking to recruit a medical student representative to participate in its Trainees Council, to be an ambassador for Geriatric Medicine and to raise the profile of the BGS across medical schools.

For full role details visit **www.bgs.org.uk/vacancy-medical-student-representative-trainees-council** Expressions of interest should be sent to **trainees@bgs.org.uk**.

Junior regional representative vacancies

Would you like a chance to help promote local talent and research, facilitate networking within the region, and influence decisions taken at a regional level in relation to the specialty? Junior regional representative roles provide a great entry level opportunity for BGS members to create a supportive and collaborative local environment for fellow healthcare professionals specialising in the care of older people.

Regions currently with vacancies for junior epresentatives:

- Northern
- North Thames
- Oxford
- South East
- South West Thames
- Trent
- Wessex
- West Midlands

Trainees of all grades may apply to this position. For full role details visit **www.bgs.org.uk/vacancy-junior-regional-representatives** Expressions of interest should be sent to **trainees@bgs.org.uk**.