AGENDA

British Geriatrics Society
Improving healthcare for older people

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Helping hands

The role of the charity sector in supporting older people

PLUS

Why I chose geriatrics

New BGS website

Volunteering and rural communities

AGENDA
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On the
AGENDA

President's *Message*

A lot has happened in my first couple of months as BGS President. Since taking the reins at the BGS Autumn Meeting in November, we have been busy behind the scenes (and indeed publicly!) influencing and informing, to drive home the message that older people's healthcare should be both a public and political priority. While the situations we highlight are sometimes disheartening, I do feel there is a lot to be optimistic about, as we continue to make progress on some difficult subjects.

I am pleased to have been invited to join as a commissioner Palliative and End of Life Care Commission, following lobbying from BGS. Across our membership, there are a wide range of views and opinions about the Assisted Dying Bill, but we are all aligned on the need to improve end of life care for older people. As part of this, I will work hard to develop recommendations supporting those who require end of life care, regardless of age. We need to focus on the needs of the many: older people living with multiple long-term conditions, across all care settings. Ensuring these recommendations are reflected in the forthcoming NHS 10 Year Plan is an especially important opportunity for our patients and our specialty.

We have been fortunate to meet with a range of organisations where healthcare professionals working with older people are now firmly embedded or represented. These include Getting It Right First Time, NHS England, the Royal College of Physicians London and Edinburgh, among others. We have also had productive one-to-one meetings with other Royal Colleges, including Emergency Medicine (RCEM) and General Practice (RCGP). We are especially grateful to have the support of Professor Chris Whitty in pushing for older people's care to be a national policy priority.

'We need to focus on the needs of the many: older people living with multiple long-term conditions, across all care settings.'

'With more than 5,300 voices, we have the power to speak loudly and influence decision-makers to bring about genuine change.'

Working closely with the Royal College of Emergency Medicine and Royal College of Physicians, we have been publicising the issues that older people in particular experience when care is delivered in corridors; longer waits to be seen, delays to medical admissions, and increased risk of complications. We have ensured the inclusion of triple assessment at the front door, to now include NEWS, CFS and 4AT, in recent publications from the RCP. This approach will provide data that can be used to inform appropriate pathways of care and the necessary skillsets of current and future front door teams.

We have also been working with fellow organisations to raise the profile of evidence-based hospital at home and front door frailty services. We all know examples of such services have been around for many years, but opportunities to make them visible to the public are key to getting the attention of policymakers and commissioners. Each individual success is a success for patients and our community.

The theme of partnership and collaboration is one that runs through this issue of *AGENDA*, which is focused on the role of the voluntary and third sector in the care of older people. From research, to patient advice or advocacy, to practical help and social connection, organisations in this sector frequently step in to provide wrap-around support to older people as they navigate changes in their health, independence, and place in the world. This edition highlights examples of this working well, and services that you might be able to signpost your patients to for further support.

As members of our BGS community, I call on you to join our own social movement. With more than 5,300 voices, we have the power to speak loudly and influence decision-makers to bring about genuine change. The BGS is developing series of 'key messages' documents to help you do this – the first of these, on end of life care, is available on our website now: **https://tinyurl.com/EOLCkeymessages**

There many are other areas where your voice as an expert in older people's healthcare can be a powerful tool; lobbying medical schools to increase geriatric medicine allocation using the Bristol model; writing to the RCP to advocate for increased numbers of geriatricians; or finding out who your local Integrated Care Board (ICB) lead is, in preparation for some practical materials the BGS is currently developing to help influence ICBs.

If you've had success with any of these conversations in your area, we'd love to hear more.

Professor Jugdeep Dhesi
BGS President

BGS President on **BBC Breakfast**

I had the pleasure of sitting on the red sofa on BBC Breakfast on the first (snowy) Sunday of the year.

During this interview, I was able to highlight that almost half of all adult emergency department attendees are aged over 65, many of whom are living with frailty and at risk of hospital acquired complications. The programme showcased the incredible work of the frailty unit in the Surrey and Sussex Healthcare NHS Trust, as one example of such services provided across the four nations, to support older people to get timely, effective and efficient care, ideally returning home the same day.

BGS supports **Joe Wicks** campaign

The BGS is supporting a campaign from Guy's and St Thomas' NHS Foundation Trust and the Centre for Perioperative Care to help people to prepare for surgery and recover more quickly afterwards.

Fronting the campaign is fitness coach, Joe Wicks, who has created two 10-minute online exercise routines aimed at helping to increase activity levels in people waiting for an operation. They are particularly suitable for older people.

Visit **www.bgs.org.uk/JoeWicksPOPS** to view the videos.

Prestigious **Dhole-Eddlestone Memorial Prize** awarded to study on deprescribing blood pressure treatments in older adults

The prestigious Dhole-Eddlestone Memorial Prize has been awarded to an *Age and Ageing* journal article examining the effects of discontinuing blood pressure treatments in older adults with dementia living in nursing homes.

The prise is awarded annually to the most deserving medical research relating to the needs of older people, published in *Age and Ageing,* the scientific journal of the British Geriatrics Society (BGS) in the preceding year. The award is funded by a legacy donation from late BGS member, Dr Manindra Kumar Dhole, who died in 1977. The £1,000 prise commemorates the anniversary of his marriage with Dr Margaret Eddlestone, celebrated each year on the 14 January.

The *Age and Ageing* article, 'Effects of the discontinuation of antihypertensive treatment on neuropsychiatric symptoms and quality of life in nursing home residents with dementia (DANTON): a multicentre, open-label, blinded-outcome, randomised controlled trial', was published in July 2024.

The study was led by researchers from the Leiden University Medical Centre. The randomised controlled trial assessed whether the discontinuation of blood pressure lowering medication reduced neuropsychiatric symptoms of dementia, such as agitation, depression and sleep impairment, and whether it maintained the quality of life of the resident.

The study found that discontinuing treatment for high blood pressure did not help with the neuropsychiatric dementia symptoms and suggests that discontinuing the medication might be harmful. These findings challenge the common practice of deprescribing. In this case, previous research had suggested that continuing blood pressure lowering medication may exacerbate dementia symptoms and decrease quality of life.

While the article acknowledges the need for replication in a larger trial before it could be considered definitive, there is sufficient evidence to suggest that clinical teams need to carefully consider whether to discontinue blood pressure medication proactively in people living with dementia.

Rosalinde Poortvliet, senior researcher, GP and epidemiologist at Leiden University Medical Centre, lead author on this study, said: "This year, we were lucky to have many excellent papers to consider for the Dhole-Eddleston Memorial Prise, and they were all potentially worthy of the accolade. After a lot of discussion, we selected the DANTON trial.

"This was clearly a substantial project. We recognise that conducting trials in a nursing home setting is challenging and we admired the transparency of the reporting.

"The result of the trial, that stopping blood pressure medication may be harmful, challenges usual practice in older adult care. When we select papers for the BGS *Age and Ageing* journal, we always favour those that will make clinicians stop and think about their practice, and this paper certainly does that."

Professor Roy Soiza, Editor-in-Chief of *Age and Ageing,* said: "Our journal is committed to supporting greater inclusion of older people and care home residents in clinical trials, as evidence-based medicine relies on study populations matching those seen in the real world. The DANTON trial shows such trials are feasible and lead to important discoveries that can change clinical practice, improving outcomes and efficiency."

You can read the full *Age and Ageing* paper for free at tinyurl.com/DEPrise2025

BGS condemns MRCP(UK) Part 2 results error

The BGS was dismayed to learn of a major error in the communication of results of the Membership of the Royal Colleges of Physicians (MRCP) Part 2 exam, which candidates sat in September 2023.

n announcement on 19 February from MRCP(UK), run by the Federation of Royal Colleges, admitted that of the 1451 candidates who took the MRCP Part 2 exam, 283 received incorrect information about their marks.

This significant error, which occurred nearly 18 months ago, has only now come to light. The group of 283 affected candidates includes trainees in geriatric medicine, who make up the largest medical specialty.

The personal toll and career implications for people now finding out their actual results differ from those they received at the time are considerable, and there are wider ramifications for employment and patient safety.

An independent review of what went wrong must be held, to look into the failure of quality assurance, follow-up and accountability. Every effort must be made to mitigate the impact of this on the careers of those doctors affected, including legal and psychological assistance where required. Individualised support must be provided to doctors in IMT, ST3 and ST4, who are those most likely to be affected.

The BGS urges geriatric medicine trainees to get in touch so that we can offer advice and support. Resident doctors work incredibly hard providing care for older people, bearing the brunt of much of the pressure on the health service this winter. Errors like this are highly damaging to confidence in the system of education and assessment. Our healthcare workforce deserves better.

Have you been affected by this error? Please contact us for further support.

BGS statement on the healthcare sector providing care in corridors

The British Geriatrics Society (BGS) supports colleagues in the Royal Colleges and across the healthcare sector in protesting about the pressure on emergency departments resulting in provision of care in hospital corridors.

We welcome the recent commitment from NHS England to provide data on such care provided in hospital corridors (sometimes referred to as temporary care environments or temporary escalation spaces). We are pleased to see the Royal College of Physicians (RCP) advocating for the inclusion of assessment of physiological status, frailty and cognition at the front door to identify, risk-stratify and manage patients most at risk of deterioration and poor outcomes.

Professor Jugdeep Dhesi, President of the BGS, said: "Older people currently face long waits in emergency departments, with people aged 65 and over accounting for around two thirds of those waiting over 12 hours. Older people are among the most vulnerable patient groups. Long waits and sub-optimal care provided in the inappropriate setting of a corridor are likely to be particularly harmful for them and result in protracted hospital admissions."

"Winter is a tough time in the NHS and we know that colleagues across the system are all trying to provide the best possible care in extremely challenging circumstances. No patient wants to receive treatment in a corridor and no healthcare professional wants to provide care in such environments."

"However, these challenges are not insurmountable. There are many ways in which services for older people can be better designed to reduce crisis presentation and the currently observed scenario of emergency care in hospital corridors."

"Provision of proactive care in the community helps to spot early signs of deterioration in health, and hospital at home services can provide hospital-level care in the comfort of someone's home. Front door frailty and same day emergency care services can identify older people at risk as soon as they arrive in the emergency department, ensure that they are treated quickly and, where indicated, discharged home with appropriate care, on the same day. These services relieve pressure on emergency departments and reduce the need for care in non-clinical spaces. They now need to be scaled up and rolled out to ensure all older people, regardless of geography, have access to the best care possible in the right environment for them."

BGS welcomes amendment to assisted dying bill that will safeguard older people with frailty

On 25 February, the committee examining the Terminally Ill Adults (End of Life) Bill, known as the Assisted Dying Bill, debated an amendment tabled by Danny Kruger MP to remove 'medical condition' from the definition of terminal illness.

This was prompted by the BGS's written evidence to the committee, outlining our concerns that this term implies the inclusion of frailty. After debating the amendment, we are pleased that the committee has voted to remove the term.

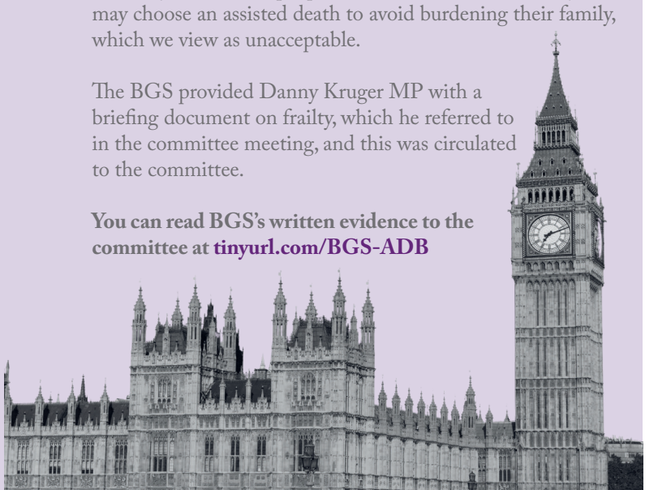
As outlined in our written evidence, the inclusion of "medical condition" within the definition of terminal illness is vague, clinically without meaning, and therefore left open to misinterpretation.

BGS members have raised concerns that this term may include frailty, a condition which affects up to half of the population over 85, and which can be noted on a death certificate. In the early stages, many of its impacts are potentially reversible and even in the advanced stages there is often clinical uncertainty about whether it can truly be considered a terminal illness, denoting people eligible in this bill, or a disability, making people ineligible.

Data shows that frailty is cited as the main reason for Assisted Dying in 5.7% of cases in Canada. There is also an established link between frailty and feeling a burden to others. This may mean older people with treatable clinical frailty may choose an assisted death to avoid burdening their family, which we view as unacceptable.

The BGS provided Danny Kruger MP with a briefing document on frailty, which he referred to in the committee meeting, and this was circulated to the committee.

You can read BGS's written evidence to the committee at tinyurl.com/BGS-ADB



Getting to know the **new BGS website**

Visit

www.bgs.org.uk

to get started

The new BGS website is finally live! We're so excited to show you around our new home and help you discover how to get the most out of its new and improved features.

What's new?

In response to your feedback, we've improved and added some exciting features to enhance your experience of using our website. Here are a few new things you can try out:

- **Bookmarking** – Look for the bookmark icon to save any page to revisit later. Once logged into the website, you can view all your bookmarked pages by clicking the 'Reading List' icon on the top right of every page.
- **Search** – We've improved our search function to help guide users to the content they actually want. You can now also search from any page using the search bar underneath the main navigation menu, and suggested results will pop up as you type. Our search function is continually learning and developing, so give it a try and let us know what you think.
- **Your account** – We've simplified and improved the information displayed on your main account page, and made it easier to complete or change your details and preferences. Letting us know more about your role and interests helps us to highlight content that's relevant to you.
- **Rewards** – The more you interact with the BGS (which might include completing your profile or getting involved with our other activities) the stronger your profile becomes. Earn badges for participating, strengthen your profile, and get the most out of your membership.
- **Portals** – We know you love and use our comprehensive topic Hubs, which signpost to excellent quality content from mainly external sources. Our new Portals are designed to be a BGS-specific version of these on other topics, bringing together highlights from our own materials. Let us know if there's a Portal topic you'd like to see added.

www.bgs.org.uk

What's different?

While we've tried to keep things as simple as possible, we've moved some things around and made a few changes to some key pages and functions. We're confident that you'll get used to these changes quickly and find them easier to use in future. Don't forget, you can now bookmark and search for your favourite pages, as detailed above.

- **Navigation** – Our website is home to a huge amount of information (there were more than 3,500 pages on the old website!) We've adjusted the navigation structure to help you make more sense of this wealth of content and assist you in finding information relevant to your needs.
- **Viewing live and on-demand events** – The live event experience should feel even more seamless, through our Vimeo-integrated streaming pages. We'll place a large and obvious button on the home page when a live event is in progress, so you can quickly join in on the virtual action. You can join or rewatch events from the event page, as well as from your account under CPD and Certificates. Those watching on demand will now also receive CPD certificates.
- **Accessing resources** – You can still find these under 'Resources' in the main menu, but you will also find them filtered by topic in the 'Libraries' section, and curated in our Portals. If you're not sure where to find something, try out the new search function.
- **Joining and leaving SIGs** – You can join or leave a SIG directly from the SIG page (under 'Groups') or via the 'My account' page. You can join – or leave – as many SIGs as you want, whenever you want.
- **Blogs** – Instead of a button at the top of the site, we've integrated the blog into the 'Our voice' section. We hope you'll continue to use this as your space to highlight important issues via our highly-regarded blog.
- **Reports** – Our key reports were previously hidden under 'Resources', so we've popped some of our more recent and well-used ones under 'Our voice' and then 'Reports'.
- **Submitting abstracts and posters** – You can now submit an abstract via your 'My account' page, the 'Abstract submission' page, or on the page of any event that is currently open for abstract submission. The poster platform, which enables electronic posters to be displayed at our hybrid events, is now integrated into our main website, and you can access this via the main navigation menu under 'Events and CPD'.

What's still the same?

For the time being at least, the following features and benefits are still the same – so you can keep using them the way you're used to:

- **Your login (username and password)** – Your account details are exactly the same - your username, password, preferences, membership, etc will all have been carried over from the previous website. If you can't login, please email editor@bgs.org.uk.
- **Events** – Your bookings for any upcoming events, plus any on-demand access to past event recordings and CPD, have all been recorded and retained. If you're looking to register for a new event, please do so by visiting the events page and following the links to register. The process for applying for a fully-funded place remains the same. As always, if you have any queries about your registration, please email registrations@bgs.org.uk
- **Elearning** – All access to elearning, including registrations, progress and certificates will be exactly as you left them. Elearning modules can now be found in the navigation menu under 'Events and CPD'.
- **Age and Ageing** – Members with access to Age and Ageing included as part of their membership will still have digital access via their account page.
- **AGENDA** – Members can still access back issues via the website, and update their address and contact details to receive future issues (including opting out of all mailings) via 'My account.'
- **URLs** – Any URLs you've got saved in your bookmarks will all still work, unless the page has been removed entirely due to being out of date. If you can't find something you're looking for, try the search function or email editor@bgs.org.uk.
- **Our Hubs (Frailty, Delirium, QI and Research)** – You'll find these under 'Resources' and then 'Hubs', and littered across other relevant pages.

Communities in crisis?

'It will be no surprise that the older age group and those with dementia are at an increased risk from adverse weather events, including cold, heat, flooding and resulting loss of power.'

Charity begins at home, as the old saying says. When people pull together they can collectively improve the lives of older adults, both now and in the future, writes BGS Deputy Honorary Secretary, Deb Gompertz.

Early in the summer of 2023, a critical incident was announced in the national news. Over a short period of 1-2 hours between 8-10cm of rain fell where I live and the surrounding villages. Up to 150 properties were recorded to have been flooded.

Boats were used to evacuate people; there was a car literally floating along the road. The community rallied – there was soup in the village hall and a 'knock' on all doors, and teams to help bail out were assembled. This wasn't a case of a river that had burst its banks, it was just an unpredictable, chance occurrence. We are extremely lucky to live in a community where people come together to support those that need help in a crisis. The impact on the different ages was striking - ranging from excited children in wellies, to people helping move furniture and using saucepans to bail out the flood water from people's homes. There was also an evacuation of the older population by whatever means possible, which was not without risk itself. Homes and lives were destroyed, and the rebuild is still ongoing.

The government has put together its *Adverse Weather Plan and Equity Review and Impact Assessment*[1] recognising that individual, community and population response to adverse weather will be affected by multiple different factors. The report looks to reduce health inequalities and increase inclusion and equity. Part of the review was also to look at which populations would be most at risk, done through the CORE20PLUS framework, considering increased risks or barriers related to not being able to access or interpret information, or potentially take action as needed.

Research is limited and everyone can be affected, but it will be no surprise that the older age group and those with dementia are at an increased risk from adverse weather events, including cold, heat, flooding and resulting loss of power. Power cuts can affect those who may need oxygen or to use stair lifts, lack of lighting can increase the risk of falls and cause anxiety. People living on their own may find it difficult to call for help and those trying to get to them may also be affected by the adverse weather. Recently one of our district nurses got a puncture in one of her car tyres during storm Darragh due to debris on the roads. Fortunately for her, a local garage helped her change her tyre and get her back on the road.

How the population is affected by these adverse events will also be affected by the community, voluntary sector, social services and health services around a population. Thankfully there is more emphasis now on looking after our local communities with our voluntary sectors playing a key part. We must never forget though the impact of a local community, and that ingrained knowledge of who may need support in a crisis.

Wes Streeting talks about three major changes, of which prevention is one - *prevent illness rather than treat sickness*. For me this goes beyond proactive care and prevention of illness, like stopping smoking, reducing alcohol and exercising more. It also goes beyond the community and voluntary services there to support people in their homes and neighbourhoods. We need to think about proactively looking after and caring for our environment. This can happen at every level and there is plenty we can be doing ourselves.

Recycling is extremely important and not to be forgotten, but there are steps to take even before we get to recycling which can get upstream to reduce the need for recycling by reducing the waste in the first case. Simply taking our own water bottles and coffee mugs when going out could significantly reduce waste. Costa committed to recycling 500 million coffee cups a year by 2020 – yet as a nation we get through 2.5 billion takeaway coffee cups annually. Different figures are quoted, but rail travel may produce one tenth of the amount of carbon per passenger and a thirteenth of that produced travelling by plane.

Every year £110 million of medicines is returned to pharmacies unused. Stopping waste to prevent recycling is the first step. Opening your bag of medicines in the chemist before leaving the building to make sure you only have what is needed can prevent medicines waste. 'Check your bag before you leave'. Encouraging people to take all their medicines into hospital to be reused rather than the hospital ordering more. Our local hospital is getting the word out for people to take their medication with them when they go into hospital after auditing the number that do, therefore reducing medicines waste.

We can all start to do something no matter how small, the climate crisis really is a health crisis.

Deb Gompertz
BGS Deputy Honorary Secretary

1. Adverse weather and health plan equity review and impact assessment (2024). Available at: www.gov.uk/government/publications/adverse-weather-health-plan-equity-review-and-impact-assessment/adverse-weather-and-health-plan-equity-review-and-impact-assessment-2024

What *is* the voluntary sector?

This issue of *AGENDA* focuses on the voluntary sector, but what does this actually mean and where does the BGS fit in? Our Chief Executive, Sarah Mistry, explains some of the history and background of such organisations, their value, and what they say about society more widely.

If you're a healthcare professional working with older people, you will probably be familiar with voluntary sector organisations. You'll know the household names like AgeUK, Oxfam and Alzheimer's UK. You may have encountered voluntary sector organisations helping older people to settle back home after a hospital stay. You may be a volunteer or a trustee or perhaps you donate or fundraise for a good cause you care about.

The voluntary and community sector (VCS) goes by many names: third sector; not-for-profit sector; non-governmental organisation (NGO) sector; civil society; voluntary, community and social enterprise (VCSE) sector. Academics have whiled away many hours puzzling over definitions and boundaries. This brief piece aims to give an introduction to some of the key characteristics of the sector to help readers as they explore the theme of this issue of *AGENDA*.

Over the last 500 years, nation states have grown with governments exercising power over the people to enact the business of state in the public realm, and markets growing ever stronger as part of the global economy.

Alongside these two big forces of the public and private sectors sits something much more fluid, often described as 'the glue' of society. People have been coming together to sort out a problem, to campaign against an injustice, or to help each other for millennia. They have built associations, formal or informal, and given their time voluntarily to strengthening their communities or trying to make things fairer.

In some parts of the world, such as the UK, this third sector is substantial, well-defined and regulated. In more authoritarian countries, it operates under the radar, and may be perceived as a threat to the state. It generally starts at the grassroots, but can include highly-developed institutions with a substantial financial turnover. In the UK in 2021/22, there were over 166,000 voluntary sector organisations; 85% of these had an income of under £10,000 and rely entirely on volunteers, but there were 85 organisations with a turnover of over £100m a year with significant numbers of paid staff. Data from the Charity Commission revealed the sector's income to be around £69 billion in 2021/22.

Voluntary sector organisations share some characteristics:

1. **Formality:** They are formalised and institutionalised to some extent, with a recognisable structure and a constitution or a formal set of rules.
2. **Independence:** They are separate from the state and private sector.
3. **Non-profit distributing:** They do not distribute profits to owners or directors, but reinvest them in the organisation or use them for the benefit of the community.
4. **Self-governance:** They are truly independent in determining their own course.
5. **Voluntarism:** They involve a meaningful degree of voluntary participation through having, for example, a trustee board, volunteers, and donations.
6. **Public benefit:** They have social objectives and work to benefit the community.

A wider definition of the sector may include organisations that advocate and campaign for social change, that promote civic engagement or that act as a watchdog. Social enterprises are businesses with a social purpose. They make a profit which they plough back into the business.

The diversity and breadth of the UK voluntary sector is an indicator of a dynamic civil society. It has an important role to play in supporting older people in their communities. Sometimes it steps in to fill a gap where public sector systems are lacking or where there is unequal access or support. Over the last decades, many VCS organisations have evolved from doing benevolent philanthropy to being led by their users, with the agency and legitimacy that comes from lived experience.

The BGS is registered with the Charity Commission. Like many other charities, it is also registered with Companies House. So our Board members are both charity trustees and company directors. They oversee the strategic direction of the BGS, making sure we comply with Charity Commission good practice, stewarding our resources prudently in line with our charitable mission.

The BGS works closely with Age UK in the four countries of the UK and with other charities that serve older people. In the mixed economy of care for older people, there will be many VCS organisations in your area that can help to bridge or support NHS care and can help older people to be more active and involved in their local company. Please share your stories with us so that we can profile great examples of cross-sector collaboration.

Sarah Mistry
BGS Chief Executive

RESEARCH *and the* charity sector

The voluntary and charity sector plays an essential role in supporting older people across the UK and internationally. From funding and undertaking research on age-related conditions to providing hands-on care and social support networks, charities and voluntary organisations complement statutory services and fill critical gaps in care.

This is particularly important given the increasing number of older adults living with multiple long-term conditions and the rise of ageing in place as a preferred model of care. As research highlights the importance of social inclusion, community support, and holistic care,[1] the voluntary sector remains at the forefront of ensuring older people receive not only medical attention but also the social and emotional support needed for a good quality of life.

The voluntary sector and research into ageing

Charities and non-profit organisations significantly contribute to research on ageing-related conditions, including dementia, stroke, and frailty. Studies such as a recent one by Parker SG *et al*[1] who engaged with the James Lind Alliance Priority Setting Partnership have emphasised that older people and their carers prioritise research into psychosocial aspects of ageing, including social isolation prevention, emotional wellbeing, and promotion of independence. These findings align with the work of many charities, such as the Alzheimer's Society[2] and Age UK,[3] which fund and conduct research while also delivering interventions that address these needs.

Research funded by charities has also shed light on care quality within institutional settings. For example, recent studies on private equity investment in care homes indicate that for-profit care homes, especially those owned by private equity firms, tend to deliver lower-quality care compared to charitable or non-profit providers.[4] These findings reinforce the role of the voluntary sector in advocating for transparency and higher standards in care provision, ensuring that financial incentives do not override the well-being of residents.

Lessons from the Netherlands: A comparative perspective

The Netherlands provides an interesting comparison, where the voluntary sector is deeply integrated into the healthcare system.[5,6] Dutch care models emphasise strong community-based support and public-private partnerships that allow charities and local organisations to play a formalised role in service provision. Compared to the UK, the Netherlands has a more structured approach to incorporating volunteer-led initiatives into healthcare, with community-based services often seen as an extension of statutory health and social care.

'From funding crucial research to providing hands-on care and social support, charities help fill gaps in service provision and advocate for higher care standards.'

This contrasts with the UK, where voluntary organisations often act as a safety net, stepping in where formal services fall short. Understanding these differences could help inform UK policies to better integrate voluntary organisations into mainstream care pathways.

The role of community support and volunteering

Recent research highlights the significant role of informal caregiving and community support, particularly in rural and remote areas. A study by Mogan C *et al* on family carers supporting older people at the end of life in rural UK found that while formal healthcare services were often difficult to access due to workforce shortages, the wider community played a crucial role in providing practical assistance and emotional support.[7]

Initiatives such as Compassionate Communities - which take a strengths-based approach to engaging local networks - are gaining attention as an effective way to supplement formal palliative and end-of-life care. These approaches align with ongoing efforts in public health to harness community assets for better health outcomes.

Charity shops, another cornerstone of the voluntary sector, also serve as vital social spaces for older adults. However, research into ageism in the charity retail sector suggests that older volunteers sometimes face pressures to conform to increased professionalisation and productivity expectations, which can undermine their sense of belonging.[8] This highlights the need for charities to ensure their volunteer models remain inclusive and age-friendly.

Future directions: The need for further research and support

Despite the critical role of voluntary organisations, more research is needed to optimise their integration into formal health and social care systems.

Key priorities include:

- Understanding how voluntary sector initiatives can be better supported to ensure sustainable, high-quality services.
- Evaluating the effectiveness of community-driven models that address care pathways and care provisions using outcomes measures prioritised by older adults, eg. PROMS.
- Investigating how volunteering opportunities can be designed to maximise benefits for both older volunteers and the organisations they support as well as vice versa.

The voluntary and charity sector is an indispensable part of both the UK and international health and social care landscape for older people. From funding crucial research to providing hands-on care and social support, charities help fill gaps in service provision and advocate for higher care standards. As the population ages and the demand for integrated, community-based care grows, it is essential that the contributions of the voluntary sector are recognised, supported, and researched further to ensure the best outcomes for older adults and their carers.

'It is essential that the contributions of the voluntary sector are recognised, supported, and researched further to ensure the best outcomes for older adults and their carers.'

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Nathalie van der Velde
Deputy Editor-in-Chief, Age and Ageing

Imagine a city where older adults are not just surviving but thriving - staying connected, engaged, and healthy. In Leeds, that vision is becoming a reality thanks to the city's vibrant voluntary sector.

Among its many initiatives are the Neighbourhood Networks, a unique support system catering specifically to older residents. These networks offer a kaleidoscope of activities designed to foster social connections and bolster health and wellbeing as people age, wherever they live in the city. Although many services couldn't run without volunteers, all Neighbourhood Networks, and the majority of medium to large scale projects, are led by paid staff. As in the health sector, the voluntary sector is full of passionate, professional, caring people with expertise in their field.

Working to support older people, there is always more that the voluntary sector wants to do, but funding can be short-term and precarious. As in the health sector, resources in the voluntary sector are often stretched to the limit; identifying new ways of working in partnership can be mutually beneficial. Recognising these parallels, a groundbreaking partnership emerged in 2022 - the Enhance programme - a model of collaboration aimed at leveraging the strengths of both sectors.

Overview of Enhance

Enhance, a partnership between Leeds Older People's Forum and Leeds Community Healthcare NHS Trust (LCH), enables voluntary sector organisations to provide non-clinical, community-based, person-centred support to older patients, many of whom have no family support. Ten of the 13 delivery partners are Neighbourhood Networks. Enhance is more than just a partnership; it's a lifeline for older adults navigating complex health and social challenges. This collaborative model aids recovery, prevents deterioration and enables LCH staff to focus on their clinical work.

‘As in the health sector, resources in the voluntary sector are often stretched to the limit; identifying new ways of working in partnership can be mutually beneficial.’

Enhance leverages the strengths of Leeds' vibrant voluntary sector to provide personalised, non-clinical support for up to 12 weeks, using a strengths-based approach. This not only lifts the burden on LCH clinicians but also transforms lives in ways clinical data alone can't capture. Local organisations have deep connections in the community and understand the complex challenges older people face, but before Enhance, they lacked the capacity to offer one-on-one, tailored support. The programme was built on the understanding that these unmet non-clinical needs contributed to pressure on LCH resources and increased demand on health and social care services, including hospital admissions and readmissions.

The list below doesn't do justice to the variety and complexity of non-clinical support provided by Enhance delivery partners over the last three years, but support could include:

- Supporting access to health services, including transport
- Prompts and support for physiotherapy exercises
- Arranging deep cleaning/decluttering
- Applying for clothing and fuel grants, providing bedding, clothes, slippers
- Encouragement and support to attend social activities
- Regular wellbeing calls
- Providing food hampers, shopping
- Completing benefit applications
- Arranging Dossett boxes.

The benefit of this collaborative approach is that voluntary sector staff can take time to build relationships with patients, and find out what is important to them and help with a wide range of things, including onward referrals. By focusing on what matters most to each individual, Enhance support fosters a sense of dignity, independence, and connection. At the same time, it allows LCH staff to focus on their clinical expertise, ensuring that patients receive comprehensive, well-rounded care.

Key learning points

- **The need is there**
  Many older people with health issues, particularly those without family close by, really need additional support to benefit their health, wellbeing and quality of life and prevent health deterioration.

- **Trust takes time**
  Building trust between sectors is essential but requires sustained effort and long-term funding. Short-term investments rarely allow partnerships to flourish.

- **Align priorities**
  Successful collaborations must balance immediate patient benefits with broader cost-saving goals. Prioritising one over the other can dilute the partnership's impact.

- **Flexibility matters**
  Programmes like Enhance must adapt to meet the diverse needs of patients while maintaining their core mission.

- **Empower health staff**
  By reducing non-clinical demands on clinicians, partnerships like Enhance free up valuable time for medical care and help to improve wellbeing and job satisfaction.

Faith's story

Faith lives with COPD and multiple other health challenges, and Neighbourhood Team staff were very concerned that the effect of her cold, draughty home may cause a deterioration in her health. With Enhance support, Faith's needs for financial assistance were met through benefits checks, 'heating on prescription' from the Green Doctor service, and arranging repairs. Faith also received practical items to keep her warm while she awaited repairs and insulation upgrades on her council property.

Evaluation

From the outset, monitoring and evaluation were integral to Enhance's success. Dr Sarah Alden, a freelance evaluation partner,[1] Prof Anne-Marie Bagnall et al. at Leeds Beckett University,[2] and Gemma Howorth at the Health and Care Evaluation Service,[3] worked closely with LCH and Leeds Older People's Forum to measure the programme's impact in Years 1, 2 and 3.

Success was defined in terms of outcomes for patients, clinicians, and the wider healthcare system. For patients, this meant improved independence, reduced social isolation, and a better quality of life. For clinicians, success was measured by reduced clinical demand, time saved, and earlier discharge of patients from caseloads. At a system level, success included a decreased demand on urgent care services.

'I am now going to activities [offered by the Neighbourhood Network] twice a week, they do a friendship group and then I have a dinner, we play bingo, and I have joined a craft class and make cards. I really enjoy it and have met lots of new friends. I feel better health wise now… before I didn't go out and was really struggling with my mental health - now I am in a much better place… I honestly can say I wouldn't be here [without Enhance support]. I have a more positive outlook – I wouldn't have come out of my house without it. It changed my life."
- Enhance participant

Dr Sarah Alden's qualitative evaluation report in Year 3 focused specifically on Enhance's reported outcomes and impact on LCH staff. It is based on group and one-to-one interviews with 36 staff members and questionnaires completed by 33 LCH staff referrers.
Based on applicable survey responses:

- Enhance had saved time for 82% of referrers
- For 76% it saved an average of 1.8 to 3.9 visits per person
- For 60% it enabled shorter visits/appointments
- It saved time carrying out other non-clinical tasks for 76% who provided a positive response (an average of 1.4-2.4 hours per person)
- For 27% it enabled fewer and/or lower band staff to provide clinical support
- 12% reported reduced non-attendance/cancellations.

This report also contains quotes from LCH referrers, including:

"We have patients who say they don't need to socialise, but they're lonely and need someone to talk to… so I end up spending longer with these patients during visits. When Enhance steps in and helps them get out into the community, it reduces that need for us to check in so often."
- Occupational Therapist

The Leeds Beckett University quantitative evaluation report included the following points:

- There was a statistically significant reduction in calls to 111 in the Enhance group, compared to the matched comparison subgroup, following referral to Enhance.
- Relative reductions in service use in the Enhance group compared to the matched comparison subgroup, although not statistically significant, were also seen for 999 calls, elective hospital stays and contacts with community healthcare.
- The data suggest that referral to Enhance is associated with a reduction in visits to A&E and unplanned hospital stays, in the three months after referral compared to the three months before referral.
- The data suggest that the number of outpatient visits and use of the patient transport service increased slightly in the Enhance group following referral, compared to the matched comparison subgroup, which may indicate that Enhance clients are supported to access appropriate healthcare appointments.

Steve's story

Steve was referred to Enhance for support with getting services in place, such as cleaning and shopping due to physical impairments, and also difficulties navigating services independently. He wanted to maintain his independence but struggled with where to find the right services to assist. Steve said he felt his visits from his Neighbourhood Team didn't allow enough time to help him resolve his non-clinical issues. After an Enhance worker spent some time with Steve to discuss his priorities, he said he already felt relieved that he had more time to chat.

During subsequent visits we were able to help Steve get some structure around his energy bills, prescription deliveries and help him maintain his independence with light help around the house. He said he found it 'so helpful and kind' to have an Enhance worker who was able to provide more time with him during his recovery. Building rapport with Steve also allowed us to encourage him to attend medical appointments and engage with healthcare staff better, as we were able to explain their roles and importance of these appointments in a way which worked for him.

The Health and Care Evaluation service report in Year 2 indicate that Enhance provides significant amount of support to older residents of Leeds with frailty. Overall Enhance supports people in areas with higher levels of deprivation. The service supports large populations in the frailty, cancer, and long-term condition population cohorts, with many of those supported having multiple long-term conditions such as hypertension, osteoarthritis and chronic depression. In addition to this many have risk factors on their records and mild to moderate frailty with flags around anaemia, hypertension, being housebound, arthritis, and falls being most common across the populations. All the Enhance evaluation reports for years 1 to 3 are available on the resources page of the Leeds Older People's Forum website: **www.opforum.org.uk/resources**.

Next steps

Going into year 4, LCH will be focusing on two strands of Enhance work. Firstly, increasing patients' access to self-management health hubs and integrated clinics in the most deprived areas. Secondly, continuing Enhance provision for patients living in the most deprived areas who are referred by Specialist Business Unit teams, most notably cardiac, respiratory and neurology. While this targeted approach is promising, it raises concerns about excluding other vulnerable populations who may not fit the new criteria.

We have two calls for action for readers, wherever you may live:

- Firstly, please familiarise yourselves with the range of voluntary sector activities and providers in your local area, if you're not already aware of everything that's on offer. Hearing about the opportunities from a trusted healthcare professional may tip the scales in favour of a patient making contact with a local voluntary sector group and taking steps to improve their health, wellbeing and/or social connections. Proactively seek out voluntary sector colleagues to talk to - identify the opportunities, and take steps to understand the limitations of what the voluntary sector can and can't do for your patients.
- Secondly, talk to peers and leaders to try to find new ways to create innovative opportunities to provide longer-term, funded partnership work with local voluntary sector organisations. Enhance grew from a seed planted in 2021 during a quick conversation between LCH and a member or staff at Leeds Older People's Forum about the pressures faced by the Community Health Neighbourhood Teams.

Conclusion

When done well, collaboration between the health and voluntary sectors has significant benefits to people, prevention and partnerships and can help deliver the NHS Long Term Plan. In Year 3, the Return on Investment for the wider health service as a result of Enhance was calculated to be between +38.7% and +49.1% but the impact on people's lives is immeasurable. By embracing and investing in similar partnerships, we can collectively work toward a future where older adults everywhere can age with dignity, health, and connection.

References and further information available at www.opforum.org.uk/resources:

1. To read Enhance evaluation reports and short thematic reports for Years 1-3 by Dr Sarah Alden type 'Alden Enhance' into the search box of the Resources section of the Leeds Older People's Forum website.
2. To read the Enhance quantitative evaluation report for Year 3 by Prof Anne-Marie Bagnall, Mr Ruben Muhayiteto and Dr Joanne Trigwell at Leeds Beckett University type 'University Enhance' into the search box.
3. To read the Enhance evaluation report for Year 2 from Gemma Howorth at the Health and Care Evaluation Service type 'Evaluation Service Enhance' into the

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Geriatrician *on a* mission

'I've laid paths in local parks, collected Christmas trees in cold, wet January and painted local community centres. I even bought some gardening gloves and a head torch!'

In 2019, as a core medical trainee at the Whittington Hospital, I was sat in an MDT discussing planned discharges. One patient's discharge was dependent on a hospital bed being delivered, but to make space for it, their old bed would need to be moved.

This patient did not have anyone who would be able to do this, a scenario not uncommon to many of the older people we look after in hospital. Worry not, said one of the Occupational Therapists (OTs) - we can ask GoodGym to do it as one of their 'missions.' I liked the sound of these missions, and immediately wanted to find out more.

GoodGym is a charity that aims to get people fitter by doing good. It is a community of runners, walkers and cyclists - in characteristic red tops - who combine exercise with volunteering, in particular supporting local community projects with physical tasks and providing support to isolated, lonely and older individuals in their community. There are several ways GoodGymers can 'do good': Group Runs where GoodGymers take on physical tasks in local community projects; Mission Runs where GoodGymers support isolated people in their community with a one off practical task such as moving furniture, changing a lightbulb or collecting a prescription; and Coach Runs where GoodGymers are paired with an isolated, older person who motivates them to keep fit by making a weekly visit to see them part of their work out.

I joined GoodGym soon after that MDT. I began by joining Group Runs, which, as a Brummie in London, have been a great way of exploring my local area and giving back to the community. I've laid paths in local parks, collected Christmas trees in cold, wet January and painted local community centres. I even bought some gardening gloves and a head torch! I also started the process of being paired with a GoodGym coach, and in January 2020 I was paired with Norman, and he has been my coach - and friend - ever since.

Norman and I like to talk to each other once a week, usually for an hour or so. Initially our visits were face-to-face but moved to being over the phone during the pandemic. Although I didn't quite master the art of a running-phone-call, the pandemic didn't stop Norman motivating me when it came to running, and he would suggest parks or routes that I might like to try, such as the London Greenways. We can cover quite a lot of ground during our chats, be it our shared love of athletics (and our unofficial Dina, Daryl and Laura Fan Club), what we've had for our tea (I've been impressed by the variety of deliverable frozen foods that are on offer!) and what's been happening in his sheltered accommodation (let me tell you there was uproar the year there were no hats in the crackers at Christmas!)

Group Runs have been harder to fit in after work, but I do still occasionally join GoodGym Tower Hamlets, and this has been a brilliant opportunity to find out more about

'I liked the sound of these missions, and immediately wanted to find out more.'

some amazing projects in my local area, such as the Felix Project and GET OUT.

One of the biggest things that has stuck with me about getting to know Norman over the last few years is his experience being an LQBTQ+ Older Person. As an older person identifying as LGBTQ+, Norman has taught me a lot about some of challenges faced by this community when it comes to ageing, and the reasons why this group may be more susceptible to loneliness and isolation. For example, they may not have been able to have children or legally recognised partners, they may have lost close ones to HIV/ AIDS, and they may have become estranged from family at a time when identifying as LQBTQ+ was much less socially acceptable. I attended a talk, LGBTQ+ Older People, at the BGS Autumn Meeting in 2021 and recall talking to Norman about it afterwards, particularly the case study from Opening Doors. This prompted Norman to tell me more about the impact Opening Doors had had on his life, and about the time he spent volunteering with London Friend and Switchboard.

Being able to not only connect but form a companionship with someone from a different generation has been incredibly rewarding. On paper, Norman and I might seem very different and, in addition to hearing more about his life including the year he spent in Japan and his experience of homelessness, it has been wonderful to discover unexpected connections. My good friend Dave sings with the Pink Singers, an LGBTQ+ choir that Norman sang with in its infancy. During an anniversary concert at Cadogan Hall, a photo of Norman from 40 years ago appeared on the screen and it was great to share this with him! Norman has become a part of my life, and my family, friends and colleagues often ask after him.

While (predictably!) my rota has occasionally presented challenges in terms of fitting in visits, I think the biggest challenges we experienced were during the COVID pandemic. At the time, I worried that moving to phone calls would lead to Norman feeling even more isolated than he already was. However, the phone calls were not a problem at all, and after a day on the CPAP ward, I looked forward to catching up with Norman on my walk home.

What was more challenging was hearing first-hand how frightening pandemics can be for those who are house-bound and socially isolated. The anxiety surrounding getting everyday essentials such as food and prescriptions is not to be underestimated. Nor is the impact of losing what little social connectedness you had beforehand - Norman's communal lounge was closed - and how it feels to hear through the grapevine that your neighbours have become unwell and that sadly, some have died. Norman was understandably very afraid of catching COVID and managed to avoid it until Spring 2024. We use the word 'triggering' a lot these days but for someone who had lost friends to the HIV/AIDS pandemic in the 80s, I think the COVID pandemic brought back a lot of sad memories for Norman, and it was incredibly moving and a privilege to be able to talk to him about this.

'Being able to not only connect but form a companionship with someone from a different generation has been incredibly rewarding.'

Joining GoodGym as a doctor (and later a geriatrician), I had worried about there being a potential conflict of interest. However, this has not been a problem at all – what I do for a living has been irrelevant, I talk to Norman about my work as I would any of my other friends.

I joined GoodGym 18 months before starting my speciality training in geriatric medicine, and while I had been interested in a career in geriatrics prior to joining, this was not the reason I joined or wanted to befriend an older person. It has, however, undeniably had a positive impact on my approach to working with older people. On a practical level, I have been able to learn more about what services, particularly social prescribing, are available locally for the older people I look after.

As a geriatrician, Norman has also given me invaluable insight into the impact of some of the decisions we make in Health and Social Care. For example, I don't think I'd appreciated how distressing the concept of a blitz clean might be for someone who does not have someone to be there to advocate for them and safeguard their precious belongings.

Perhaps most importantly, I've learned a great deal firsthand about social isolation and loneliness, and the significant impact these can have on someone's day to day life, health and wellbeing. The World Health Organization declared loneliness a global public health concern, with the National Institute on Ageing stating that prolonged social isolation and loneliness have the equivalent health risks to smoking 15 cigarettes/day. The NHS does fantastic work when it comes to smoking cessation and while I can prescribe a nicotine patch in hospital, I can't do the same for loneliness.

This is why organisations like GoodGym are so vital. Whilst I know we can't all join GoodGym, as people working with Older People perhaps we should make it one of our 'missions' to recognise/ identify loneliness in those we look after.

GoodGym has certainly been the longest gym membership I've managed to keep up and, like my OT colleague did five years ago, if I can do my bit to spread the word about GoodGym, well that's mission accomplished for me!

You can find out out more about GoodGym and missions happening in your area at www.goodgym.org

Esme Ingham
Registrar in Geriatric Medicine and General Internal Medicine (ST7), University College London Hospital

With special thanks to Norman for his kind agreement to be photographed, interviewed and written about for this article, and to GoodGym for their support in navigating this process.

Norman's story

To find out more about his life experiences and his luck in having befriended a geriatrician, BGS Publications and Website Editor, Amy Brewerton, spent an enjoyable half an hour speaking to Norman, passing some time while he was staying in a rehabilitation unit following a recent hospital stay.

Hi Norman! Tell us a little bit about you and your life at the moment…
I'm 88 and have a bad back so I live in sheltered housing – there's an attendant in case I fall over or something, which has happened a few times. I live on my own and the only relative I have is my nephew who now lives in Portugal. In the past he would be over to help me if I had any problems, he's more like a son than a nephew, he's absolutely wonderful.

The flat I'm in now is probably the nicest place I've ever lived. At one point I was virtually homeless – my business venture folded and I ran out of money, so I was fed and clothed by charities that help the homeless, and queued up every day for my soup and my cheese sandwich. For about 12 years I lived most of my time on the streets, until my health declined and I was moved to sheltered housing. Being on the streets was a very interesting experience and I don't regret it at all. It taught me so much.

How did you find out about GoodGym?
I think I was put in touch by Age UK. I was originally paired with someone called Adam, and he was very nice. I really got to know him and his boyfriend, and when they got married I went to their wedding reception. I've been housebound for the last five or six years now though so I can't do things like that any more.

What do you enjoy most about Esme's visits?
Esme's terrific, she's a lovely person, so nice and so kind. We'd only actually met twice before COVID came around, and then we decided it was better, due to my vulnerability, to speak on the phone. She's lovely, we've got a lot in common and she's a terrific person. I'm very happy to know her.

How did you feel when you found out that Esme was a doctor working particularly with older people in hospital? Does she give you advice or do you prefer to talk about more fun topics?
I had a few people before Esme, and actually one of them was a Trainee doctor working at King's, but Esme and I talk about all kinds of things! We have lots of things in common, like music (I trained as a concert pianist for three years) and she knows the Pink Singers who I used to sing with years ago. We talk about all sorts of topics all the time, and we even like the same sort of crisps! Esme is so exceptionally nice, and deeply caring, and we really get on, it's lovely.

What kind of things matter most to you at the moment?
I'm housebound but I've got so many hobbies, I'm perfectly happy actually in my own flat. It's my walking and mobility that's affected really, but I enjoy chess and music and reading, so I just keep on going. I've got plenty of things in my flat to keep me occupied.

I like watching travel programmes where they go around on a train or a boat, and old movies, but I find a lot of modern comedies are for people much younger than me, I just don't understand the references! I just like living a calm, peaceful existence, and quietly cooking with the help of the carers that come and see me.

Living every day and enjoying every day is important. I find something rewarding and interesting, and possibly even educational, every single day.

I'm still progressing, and improving my chess technique, playing the piano, and hopefully reading again, but I'm waiting for an operation on my cataracts. I'm looking forward to getting home and to try and get as fit as I can again, try and keep improving my walking (I walk with a zimmer) and keep on going until I drop!

I've had a good life. I'm happy, I'm not in pain, I just need to improve my walking. I've been very fortunate. Having friends like Esme only adds to my happiness.

A voice for older people:

The importance of voluntary organisations in rural communities

Rural life can have a huge appeal and, in recent years, the UK has seen a growing trend of migration from cities to the countryside. People moving to the countryside tend to be older and seeking an improved quality of life.

East Sussex is no stranger to internal migration especially for older people who are seeking a slower pace of life, access to nature and attractive rural landscapes. As a result, the older age population of East Sussex is growing faster than that of younger age groups. In the Rother District of East Sussex, the total population is 94,200 and of that number, 51,000 are aged 50 years and above. It is anticipated that there will be a 4% increase in the population of Rother by 2026 with the largest population increase projected for people aged 65-84 years of age.

However, rural living can pose challenges for older people including digital divide, limited access to some services and a poor transport infrastructure compared with urban areas. With this in mind, and coupled with the fact that older people are at higher risk for chronic health conditions, there has never been a more important time for support and advice organisations for older people. Involvement in such groups can have positive effects on social interaction, creating a sense of community involvement, reducing loneliness and improving mental health. One such organisation is that of older peoples' forums which enable older people to have 'a voice' and put forward a positive view of older people living in society. Fortunately for older people living in Rother District, such a forum exists i.e. Rother Seniors Forum (RSF). RSF was established as an independent organisation in 2005 and now has over 400 members. The current chair, Terry Steeples is supported by a team of dedicated volunteers including John Schultz, Membership Secretary and Tony Moore, Treasurer. Since its inception, other Seniors Forums have formed and currently there are seven in total across East Sussex.

'Rural living can pose challenges for older people, including digital divide, limited access to some services and a poor transport infrastructure compared with urban areas.'

RSF is run by volunteers and is strictly non-party political. The Forum works collaboratively with a number of other organisations to the benefit of members and furthers the aims and objectives of the Forum. For those wishing to join the Forum, it is free to anyone aged 50 years of age and above regardless of ethnicity, disability, religion, sexuality, cultural or political beliefs.

Rother Seniors' Forum decides its own agenda and takes up issues at local level as well as working with other seniors' forums in East Sussex, promoting an 'older voice' at regional and national levels. Its aim is to encourage older people to share their views and raise concerns so that their voice will be heard in the planning and provision of services locally, regionally and nationally. Members regularly attend meetings with East Sussex County Council, NHS Trusts, Rother District Council and Rother Voluntary Association share useful information with RSF members.

Having fun

The Forum celebrates 'Older Peoples' Day' on or around 1 October each year. Past celebrations have included tea parties and Healthy Ageing health promotion events. Throughout the year, the Forum arranges afternoon teas, theatre trips and outings to National Trust or English Heritage properties to name but a few. The Forums also run coffee mornings with the location varied at each event to enable members from all geographical areas across Rother District to attend. Members are encouraged to use their own or public transport but the Forum can provide transport at a minimal cost and subsidised by grant funding.

Impact on members

Members are involved in other projects locally with one member attending meetings with Healthwatch, the health and social care champion. Feedback is given on people's experiences of using health and social care services ensuring issues that really matter to local communities are communicated and heard. This role also includes carrying

Miranda Steeples, past President of the British Society of Dental Hygiene and Therapy (BSDHT) speaking at a RSF event

out 'inspections' in the local hospitals and care homes in the area, positively influencing standards of care.

During COVID it was impossible to meet up, so several members including the Forum Chair, Mr Terry Steeples, were in contact with other members to ensure that they were safe, that they were able to access food and could obtain prescription medications. In some cases, members exchanged telephone numbers with people/members living nearby.

One example is of two ladies, both of whom lived alone in Bexhill, and who agreed to share telephone numbers and maintain contact; both as it turned out were keen gardeners and were pleased to find someone with a shared interest. After COVID restrictions eased, they met up in each other's gardens and a lasting friendship was formed.

Working collaboratively

Professionally, I signpost patients that I see living in the Rother District to RSF. These patients often live in rural towns and villages and can experience loneliness and isolation. Becoming a member of RSF enables connection to not just the organisation but to other members and often who face similar issues. Membership includes a newsletter (paper or electronic copies available) informing members of forthcoming events in the area, important information such as the Priority Services Register and a list of useful telephone numbers including Age UK, Citzen's Advice and much more. Very often, I visit patients who have the newsletter positioned on their fridge or noticeboard at home and feedback how useful it is to have telephone numbers 'all together and easy to access on paper' rather than electronically.


Dr Mucci, Consultant Geriatrician and Sue Lyne, Staplecross Community Open Space Project Lead/Community Frailty Practitioner


Attendees at the Healthy Ageing event in October 2024

'Voluntary organisations play a crucial part in helping with social isolation and loneliness, and can help older people feel more connected and valued.'

On a personal level, over two years ago, I set up a Community Open Space (COS) Project in our village, running fortnightly 'Open Space' events. The aim was to 'connect people' living locally, reduce social isolation and provide a warm and welcoming space where people could come for a free lunch and meet other residents living locally. Guest speakers including RSF are invited and are always very well received. Last year, RSF, COS and Rother Voluntary Action (RVA) worked collaboratively to hold a Healthy Ageing Event attended by 80 people, with guest speakers including a Consultant Geriatrician, Pilates instructor and dental hygienist and therapist. This event showcased the benefits of collaborative working with the voluntary sector and the impact on improving the health and wellbeing of older people living in rural towns and communities. Rother Seniors Forum is testament to the vital importance of voluntary organisations for older people. They play a crucial part in helping with social isolation and loneliness and can help older people feel more connected and valued. Ultimately, enabling older people living in Rother District to have their voices heard.

Sue Lyne
Community Frailty Practitioner, East Sussex Healthcare NHS Trust

Terry Steeples
Chair of Rother Seniors Forum

John Shultz
Membership Secretary, Rother Seniors Forum

Age UK *sevices in action*

At Age UK, we are fortunate to have around 120 local partners across England, providing essential support and services to older people in their communities. This article highlights some of the vital services they offer and their role in supporting the local health and care sector.

Age UK Hertfordshire: Waiting Well

Age UK Hertfordshire has been commissioned by its local ICS to support patients aged 65+ who have been waiting 52-64 weeks for treatment in trauma and orthopaedics, pain management, or ophthalmology. This service forms part of the ICS' Planned Care Recovery Group which oversees the transformation work in outpatients, priority elective recovery programmes and diagnostic transformation work.

Waiting Well provides holistic wellbeing support, linking individuals to social prescribing and the voluntary sector to ensure that:

- Their financial and overall wellbeing are supported.
- They remain mobile and active, with pre-habilitation offered to improve treatment outcomes.
- They can afford and access essentials like heating and food.
- They are informed about the status of their treatment.

Service in action
Linda (name changed) is awaiting spinal injections for her pain management. She was very depressed and upset on the phone and stressed how she had been waiting over a year. She lives with her son, who is her full-time carer, with minimal family support. She was feeling very low and felt talking to someone about her emotional issues and mental battles would help her. Age UK Hertfordshire connected her to mental wellbeing coaches, providing the emotional support she needed.

Age UK Lancashire: Living Well Support Service

This service offers practical and emotional support to help people remain independent and avoid hospital readmission. The service is for those aged 18+ who need care and support following a hospital stay, illness or significant life event, with 77% of users aged 65+. Referrals come from a range of healthcare professionals or through self-referral.

The service has two tiers:

- Tier 1: A "take home and settle" service usually provided within an hour of hospital discharge.
- Tier 2: Ongoing support for up to six weeks, including practical help (e.g., shopping, collecting prescriptions) and connecting individuals to community services.

Funded by the county council, this service works closely with other intermediate care services. From April 2023 to March 2024, the service received over 13,000 referrals, an 8% increase from the previous year. The team responded quickly, with an average time of 30 minutes from referral to contact, enabled by the team being located at hospitals all over Lancashire. The team liaised with other professionals on behalf of service users in more than 7600 cases, an increase of 44% from last year, reflecting the complexity of needs and level of integration of the service within a wide range of health and social care settings. They were also able to identify over 650 unpaid carers and provide support for them.

Service in action
James (name changed) was referred for help with meal preparation after the death of his wife, James was unsteady on his feet and not eating and drinking well and it soon became clear that more support was needed. The team helped clean his house, supported him to prepare his own meals, and arranged transport for GP appointments. James was also unable to access any of his finances, as his wife had previously managed this. The team were able to solve this and encouraged James to re-connect with his previously estranged son who was also able to provide support. At the time there was a pending referral for a care assessment but after support and signposting, James was taking better care of himself and his mental and physical health had improved, to the point that no care package was required at that time.

James stated that he didn't know what he would have done without this service. He said that he would never have been able to attend the GP appointments that had been arranged without them taking him and he would still be constantly worrying about what would happen next and not feeling he was going to be able to deal with it.

Age UK Berkshire: Keeping in Touch

This service supports people aged 60+ with complex needs who are at high risk of crisis, have a high dependency on health services and need broader holistic support. It works with other professionals within the system to identify a cohort of residents who are at high risk of requiring an emergency health or social care intervention.

It seeks to provide the following:

- Pre-emptive/anticipatory support, information, tools and networks to mitigate needs and improve resilience to reduce re-admissions/ impact of crisis events
- Information and signposts to VCSE
- Support for their clients' and carers' wellbeing
- Identification and intervention around issues related to wider determinants of health: social isolation, housing transport, physical activities etc.

Referrals come from GPs, care navigators, social prescribers, and the Urgent Community Response team. The team initially call referred clients and work through a welfare script to assess their need. This guided conversation gives them a real insight into the individual and their current situation and likely risk factors. A relationship is built, a combination of home visits and regular calls mean that there is ongoing support available for the client. Visits and calls are made for as long as the client needs them, areas of support are worked through and onward referrals and signposts often to VSCE organisations are made.

Service in action:
Alice (name changed) has been supported with the service for about a year: *'I've been helped an awful lot with visits, calls and information and support. My family have moved away and I have outlived my friends. I was feeling alone and isolated, with regular trips to my GP to discuss how I was feeling. Then Age UK Berkshire contacted me. M [the Age UK worker] has helped hugely, visiting and calls. She has helped me with lots of things over the last year, I know that she is always there if I need someone to talk to, I've hardly been to my local surgery. She has increased the contact since my husband has been in hospital and I've been alone. I've started to make plans for the future, I'm moving to a care home in Yorkshire, closer to family and M has been helping me get organised for transition. I've not been worrying about the change as I thought I would and this is due to the support I've had.'*

The impact of these services

These examples demonstrate how Age UK services provide holistic, personalised support, reducing the need for additional health and social care. These services have a lasting positive impact. These are just a fraction of the incredible work that local Age UK partners and other voluntary sector organisations provide. Their contributions to older people and the broader health and care sector are invaluable and should not be overlooked.

We would encourage anyone, if they have not already, to contact their local Age UK and understand what support is available in their area. You can find out more at: **www.ageuk.org.uk/services/in-your-area**

Jenny Lippiatt
Health Strategic Programme Manager, Age UK

Tom Gentry
Joint Head of Health Influencing, Age UK

Parkinson's UK Excellence Network

Working with health professionals to drive better care for older people with Parkinson's and their carers

Parkinson's is the fastest growing neurological condition in the world. As there is currently no cure, accessing the right care from health professionals following a diagnosis is essential to ensure symptoms are managed well, right from the start.

Parkinson's is a complex neurological condition with over 40 different symptoms. People's symptoms can change over time, meaning everyone's experience of the condition is different. The Parkinson's UK Excellence Network drives improved patient outcomes and productivity in the care of everyone living with the condition, including 75% of the Parkinson's community who are over 70 years old.

Parkinson's UK Excellence Network

The Parkinson's UK Excellence Network brings together, and supports, health and care professionals to provide better care for people with Parkinson's. Experts from across the Parkinson's community are involved in the Network, including Parkinson's nurses, neurologists, geriatricians, care professionals, plus people with Parkinson's and their families and carers.

Working directly with health and care professionals to assess and improve Parkinson's services across the UK, the Parkinson's UK Excellence Network educates its members, drives collaboration and shares resources including guidelines, clinical tools and information. There are a number of ways that it works with, and support healthcare professionals, including:

1. Excellence Network Hubs

The Parkinson's UK Excellence Network offers a range of Excellence Hubs. These groups are focused in areas of special interest and are led by experts in that area to provide information, support and guidance. These range from an Exercise Hub to a Speech and Language Therapy Clinical Excellence Network. Access the Excellence Hubs at **www.parkinsons.org.uk/professionals/local-parkinsons-excellence-networks-and-excellence-hubs**

2. Online collaboration

The Parkinson's UK Excellence Network uses Basecamp, an online collaboration tool, to facilitate virtual networking and information sharing between its regional networks and Excellence Hubs. To join the Excellence Network, email **excellence@parkinsons.org.uk**.

3. Professional learning and resources

Created in collaboration with subject matter experts, the Learning Hub and online resource directory are designed to equip health and care professionals with the knowledge and skills they need to deliver high-quality care to people with Parkinson's. Since the Hub's launch in 2015, over 200,000 professionals have accessed its training. Access the learning hub and online resource directory at **www.parkinsons.org.uk/professionals/learning-hub**

Find out more about the Parkinson's UK Excellence Network at www.parkinsons.org.uk/professionals/parkinsons-uk-excellence-network

Ensuring quality care: Training care home staff in administering time-critical medication

Patients with Parkinson's are at risk of significant harm if they don't get their medication within 30 minutes of the patient's prescribed time in the hospital and care setting, so this a key area of work for Parkinson's UK and its Excellence Network. In 2023, as part of the wider charity campaign to ensure people with Parkinson's receive their medication punctually, the Parkinson's UK Excellence Network partnered with the Royal College of Emergency Medicine to improve the administration of time critical medication in hospitals.

Following the campaign, the NHS committed to a three year Medicines Safety Improvement programme, but the Excellence Network's focus on educating health professionals on the importance of time critical medication still continues, including through the training of care home staff.

Speaking of their experience undertaking the training, Hiral Vyas, Director of Care & Medicines at TLC Care, said: *"Delays in administering medication can significantly impact residents' quality of life and require considerable time for recovery. As a result of receiving 'Introduction to Parkinson's' education, we now ensure residents with Parkinson's receive their medications on time to manage symptoms and minimise anxiety, which is reducing additional care needs."*

Connecting patients with vital resources

As a charity, Parkinson's UK also offers a wealth of resources for those living or caring for someone with Parkinson's.

Parkinson's UK has a team of 90 local advisers, who can provide in-depth support both over the phone and in person. This service is open to partners, friends or family members of someone with Parkinson's. Advisers include Parkinson's nurses as well as experts on employment and benefits, emotional support and local activities. Call the charity's free and confidential helpline on **0808 800 0303** or email **hello@parkinsons.org.uk**.

Parkinson's UK has recently developed an information booklet to assist people with Parkinson's and their carers which details the roles and responsibilities of various healthcare professionals, as well as how to access care and keep track of appointments. It is available to download from **www.parkinsons.org.uk/information-and-support/your-healthcare-team** or can be ordered along with other printed resources online or over the phone.

For more information visit the Parkinson's UK website: www.parkinsons.org.uk

Age of INDEPENDENCE?

Independent Age is the only national UK charity solely dedicated to tackling poverty in later life. This is a huge issue blighting the country where misconceptions exist that all older people are financially secure, luxuriating on regular cruises and living in mortgage-free homes.

This couldn't be further from the truth for the almost 2 million older people living in poverty, which is defined as households with an income below 60% of median income, after housing costs.

Living in poverty can be an extremely isolating experience and also damaging to both a person's physical and mental health. Callers to our helpline tell us they have to cut back on heating and eating, go to bed in hats and coats and wash less to save on water. It's not right that so many people in later life are forced to live like this.

Independent Age supports older people living in financial hardship in a variety of ways. We have a free helpline where our advisers provide vital information on how to claim welfare benefits and other ways to maxmise income, care arrangements and housing options to help older people stay independent at home.

In 2024 we identified almost £7 million in unclaimed life changing benefits for people who called our helpline. These includes Pension Credit, Attendance Allowance and Housing Benefit. One of our advisers helped a caller apply for Attendance Allowance as his health condition entitled him to this benefit. After supporting him with his application, he was awarded the higher rate of Attendance Allowance of £108.55 per week plus a backdated amount of over £1,000. We also helped the caller increase the amount of income he gets from Pension Credit, because receiving Attendance Allowance can, in certain circumstances, entitle you to a higher rate of Pension Credit.

We also provide a voice to older people in financial hardship, by highlighting the issues to decision-makers, and influencing politicians to introduce polices that tackle later life poverty. Recent examples include the changes to the Winter Fuel Payment, a policy that the charity is firmly against as it means millions of older people on low incomes will miss out on vital support.

We are also making the case for the UK and Scottish Governments to introduce a Commissioner for Older People and Ageing in England and an Older Person's Commisioner in Scotland. This would be an independent champion that raises awareness of the issues people face in later life and would bring together decision-makers to make change happen. Wales has already introduced a similar role with great success.

At Independent Age, we also use our resources to help small local charities sitting at the heart of their communities. In July 2024, we awarded a total of £3.1 million of funding to support advice-focused organisations which are on the frontline helping older people apply for financial support entitlements and reducing household bills that might be stretching their budgets to breaking point. Examples of charities we have funded include Coatbridge Citizens Advice Bureau and the Roma Support Group in London.

> 'Callers to our helpline tell us they have to cut back on heating and eating, go to bed in hats and coats and wash less to save on water.'

If you are healthcare provider that supports older people that could be struggling financially, you can point them towards our helpline at 0800 319 6789. We can run a free welfare benefits check to see if there is any financial support they might be entitled to. You can also direct them to our website at www.independentage.org. Here we have a huge array of advice ranging from home adaptations and maintenance to protecting yourself from scams.

Independent Age
www.independentage.org

Care *for* carers

Carers UK is the biggest membership organisation for unpaid carers in the UK, and was initially founded in 1965 by Mary Webster – making this year our 60th Anniversary! We currently have over 45,000 members, with many of the carers we represent being older carers.

Our work as a charity comprises our campaigns and policy work as well as direct advice and support for unpaid carers. We have spent many years advocating for better support for unpaid family carers from the Government, whether that is with their finances and ability to work, better access to breaks or better support from the NHS and social care system. We work with employers to improve support for carers in the workplace. We also work with professionals within different settings to help support them to know how to better identify, support and involve unpaid carers when accessing services for themselves or the person they care for.

It is crucial that unpaid carers are identified at the earliest opportunity when interacting with services – whether that is supporting someone they care for (eg, arranging a GP appointment), or when they themselves have to use a service. More people than ever are providing care, especially as the population ages and older people provide the most hours of care each week, according to the most recent Census in England and Wales. There are just over 1.3 million unpaid carers above the age of 65 in the UK – making up 23% of all unpaid carers in the UK.

- Women aged between 75 and 79 were the most likely to provide 50 hours or more of care per week.
- Men aged between 85 and 89 were the most likely to be providing 50 hours or more of care per week.

Older carers often find themselves facing age-related health issues, which can be exacerbated by the pressures of spending much of their time caring for someone else. This adds to the importance of identifying older carers at the earliest opportunity – not only to support them with their caring role, but also to ensure that they have the space and time to also take care of their own health.

A recent campaign of ours has been around the changes to the Winter Fuel Payment. With the Government's decision to means-test the Winter Fuel Payment in the summer of 2024, we have used different channels to inform as many older carers as possible on how to check whether they are eligible to receive Pension Credit, which is now linked to the eligibility criteria for Winter Fuel Payments. Many carers are not aware that they are actually more likely to be eligible for Pension Credit due to the Carer Addition and, if so, can receive a higher amount of Pension Credit. Having Pension Credit could open the door to extra financial support throughout the year and entitlement to several different benefits. However, the application process is both complicated and confusing for older carers. If you work with any older carers, we'd encourage you to direct them to our information page (**www.carersuk.org/help-and-advice/financial-support/benefits-for-carers-who-are-pension-age/what-is-pension-credit**) where we have provided a guide to navigating the application process and also a video from a webinar we ran to explain the process in more detail.

We provide lots of advice on our website for carers on how they can access financial and practical support with their caring role. However, we also recognise that in some cases, older carers are less likely to use the internet to search for information. This means that they could face significant barriers in accessing support – in a survey we ran with organisations who support unpaid carers, such as local carer centres, NHS bodies, and local authorities, found that 82% said that they were supporting older carers who were digitally excluded. Our audio resource is available over the phone – **0800 888 6999** – and older carers can use to listen to audio segments that contain information on:

- Help with finances
- Information on specific health conditions
- Support with getting a break from caring
- Tips to improve wellbeing

To support professionals who may work with digitally excluded carers, we have also produced a good practice guide,

‘Older carers often find themselves facing age-related health issues, which can be exacerbated by the pressures of spending much of their time caring for someone else.’

‘A survey we ran with organisations who support unpaid carers, such as local carer centres, NHS bodies, and local authorities, found that 82% said that they were supporting older carers who were digitally excluded.’

which you can find here. We offer a wide range of guides including printed copies of the *Looking after someone* guide, which can be ordered from our website: **www.carersuk.org/help-and-advice/guides-and-tools**.

Among the most popular regular services we provide to all carers, are our weekly ‘Care for a Cuppa’ sessions (**www.carersuk.org/help-and-advice/your-health-and-wellbeing/online-meetups/care-for-a-cuppa**), which many older carers join. They are designed to offer carers a space to meet up weekly and share their experiences with one another. This helps to create a space for sharing useful tips and information as well as combatting loneliness and isolation. Carers UK staff facilitate these sessions, but it is also helpful for carers to be able to speak to one another, allowing many who may not be able to socialise as much to connect with one another on a weekly basis.

We also run ‘Share and Learn’ sessions (**www.carersuk.org/help-and-advice/your-health-and-wellbeing/online-meetups/share-and-learn**), also weekly, in which professionals will lead a session designed to support carers with their caring role – one such session we ran in January focused on falls prevention.

Our Carers UK Helpline offers carers direct support about many different aspects of caring from issues with finances and benefits, to support with navigating or challenging the social care system.

For information and signposting, our telephone helpline is available on **0808 808 7777** from Monday to Friday, 9am – 6pm (including Bank Holidays).

If carers have a more complex query or would like more detailed guidance, we encourage them to use our email Helpline (**advice@carersuk.org**).

If you are a professional working with older carers, and you think that they may need further support or signposting, you can direct them to our helpline and website pages. Additionally, our website has a directory of local carers organisations who may be able to support unpaid carers locally (**www.carersuk.org/help-and-advice/support-where-you-live**).

Carers UK
www.carersuk.org

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Happier *endings*

Sue Ryder Chief Medical Director and Consultant in Palliative Medicine, Dr Paul Perkins, discusses the work of palliative care and bereavement charity, Sue Ryder, and how the charity operates in the healthcare landscape for older people.

For over 70 years, the national palliative care and bereavement charity, Sue Ryder, has supported people through the most difficult times of their lives. Whether that's a terminal illness or the death of a loved one, the charity aims to make sure that everyone approaching the end of life or living with grief can access the support they need.

Our expert palliative care supports people to have the best possible quality of life, when faced with an illness that could shorten their life. Our hospices and palliative care hubs offer inpatient care in calm surroundings, with healthcare professionals who are highly skilled in dealing with the physical aspects of life limiting conditions, such as pain and other distressing symptoms, as well as the emotional effects.

Who is palliative care for?

Hospices can provide care for people in their final days of life and that's how people think of them but that's not their only function. People can also get help with difficult symptoms with a short stay in the hospice, and there are wider support services such as weekly group meetings which help patients socialise with others who are also living with a life-limiting disease. We also support carers by providing respite care at some of our hospices, offering a break from routine and responsibilities.

And, outside of the walls of a hospice, we support people in the community. People may be surprised to hear that support in the community – people's homes, care homes and nursing homes – accounts for around 80% of the care we provide.

This leads on to one of the most common misconceptions of palliative care - that you need to be actively dying to need it or access it. Palliative care is for people with life-limiting conditions like cancer, heart failure and lung disease. It aims to give people the best quality of life possible, and it can start early in the illness, alongside treatments that can help someone live longer.

There is also a role for palliative care for people living with frailty. The message from us to healthcare professionals of all specialties is to think about how timely and early access to palliative care could benefit their patients and to remember that we have some people who receive our support for months or years.

'Research shows that older adults grieving a spouse's death have an increased risk of dying, and this group often struggle with feelings of isolation and loneliness.'

Person-centred care

Aside from the very practical support and hands-on care, people need to spend the time they have left in the way they choose. Palliative care also seeks to address the emotional, social, and spiritual wishes of patients, which can often remain unexpressed and unfulfilled. At Sue Ryder, we put our patients at the heart of everything we do. We tailor our care to suit the individual needs of each person we care for and their families, going the extra mile to find out what's important to each person and support them to make their own choices and give them agency.

This holistic approach extends beyond the person receiving care to the people who are important to them, who may be struggling to cope with their role as a carer, or experiencing anticipatory grief and trying to prepare for life after the death of their loved one. Research shows that older adults grieving a spouse's death have an increased risk of dying, and this group often struggle with feelings of isolation and loneliness, whilst they process their grief and navigate this new chapter. We know that there is an unmet need with regards to bereavement.

Our online bereavement support services are there for people living with grief at a time when they need it most. We want everyone who is grieving to be able to be able to reach out and access our services and advice when they need it. Whether it's our online bereavement community, online counselling service, text message support service or local in-person support groups, we strive to connect people with the right support for them. But if people in your care struggle with online support, there are both national and local providers that can support people either on the phone or face-to-face. A person's GP can advise or signpost to a national charity such as Cruse.

Inequity at the end of life

Palliative care doesn't lead to people dying sooner. Death is as natural a process as birth and is something that we will all need to face. It's part of being a human being and our job is to help it be as good as it can be for the dying person and those they leave behind.

Research shows us that 90% of people would benefit from palliative care. And yet one in four people do not get the care they need toward the end of their lives. Research shows that people over 85 years old experience greater inequity when it comes to timely access to palliative care. This is a huge number of people not having their distressing symptoms controlled and dying with avoidable pain. Demand for palliative care is set to rise by 42% in the next 15 years, yet the sector's government funding is static, and services struggle to meet demand.

'There is also a role for palliative care for people living with frailty... healthcare professionals of all specialties should think about how timely and early access to palliative care could benefit their patients.'

Greater integration with the NHS

The hospice sector is needed to relieve pressure on the NHS and there is so much potential for us to help transform the palliative and end-of-life care that is available. Around 9 million hospital bed days a year result from an emergency admission of someone in the last year of life. And 43% of deaths happen in hospital, despite people saying they would prefer to die at home. People are often admitted into hospitals because they have not been able to access the care they need from elsewhere - adding further strain to the NHS.

We have called on the Government to work with us to create innovative Sue Ryder hospice wards on hospital grounds. These would be built on existing hospital estates and could form part of newly built hospitals. They would combat issues like delayed discharge and corridor care and offer the compassionate care dying people need in hospitals.

It is our vision that terminally ill patients could be swiftly discharged from hospital to the community, or ensure people have a calm, compassionate, good death in our 'home-from-home' hospice wards if they are at the end-of-life.

This model of care directly supports the Government's plans for hospitals and community healthcare and our aim is to transform the experience of everyone facing dying and grief in the UK. We are proud to be spearheading this movement for vital change, providing dying people with the care and dignity they deserve.

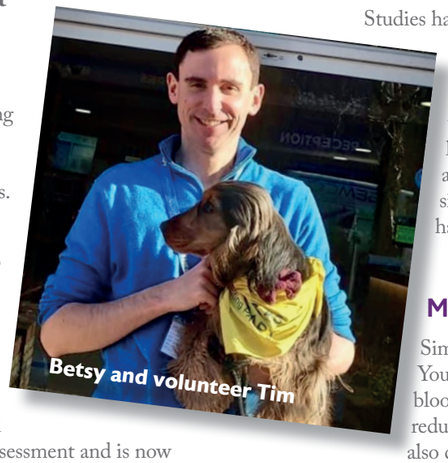
For more information and resources for healthcare professionals please visit sueryder.org/for-healthcare-professionals. To signpost people to Sue Ryder's bereavement support please ask them to search 'Grief Deserves Better' or visit sueryder.org/grief-support

Sue Ryder
www.sueryder.org

Pets as therapy

Pets As Therapy is a charity that spreads love and happiness to those who need it most.

Cute cockapoos, big-eyed bassets, loving Labradors, gentle Great Danes— dogs come in all different shapes and sises, and have unique personalities and traits. However, regardless of the breed, the four-legged friends who volunteer with the charity Pets As Therapy (PAT for short) all have the same amazing power. They can mend hearts, lift spirits and bring hope to people facing life's tough challenges.



Betsy and volunteer Tim

One such dog is Betsy, a cocker spaniel who has passed PAT's temperament assessment and is now a therapy pet who regularly visits a care home in Sydenham, south-east London. Along with her owner, PAT Volunteer Tim, the dynamic duo spend time with older residents, who just love interacting with a four-legged friend.

"Betsy is curious but gentle and a lover of all things and people," says Tim. "She can be cheeky at times, but she's non-judgemental and takes everyone as she finds them. If just one resident smiles or their eyes light up on seeing Betsy, or they have a moment of connection with her, that visit has made a difference and hopefully we have brightened someone's day. Many of the residents share stories of being dog owners themselves and it is nice knowing they still have the opportunity to have a dog in their lives through Betsy's visits."

Serving local communities

Pets As Therapy has over 4,000 volunteering teams who visit hospitals, hospices, care homes, schools, universities and prisons. All the dogs (and cats) are family pets with no formal training. They are simply good-natured, healthy animals who have passed PAT's temperament assessment and love being around people. As for the volunteers, they're amazing pet owners who give up their spare time to help others.

In 2024, PAT made 168,500 visits in local communities across the UK, and around 30,000 people every week had the pleasure of meeting a PAT Pet.

Residents in care homes who suffer from ill health, as well as older patients in hospitals, can sometimes experience loneliness, depression and anxiety-related conditions. Feeling isolated from family members and having a lack of motivation or sense of purpose, a friendly PAT visit is a chance for people to chat and reminisce about past experiences or much-loved pets.

Studies have shown that spending time with a PAT Dog or PAT Cat can improve a person's mental health and wellbeing. There's often an increased connection with carers and family too, and those living with dementia can feel energised and elated. It all comes down to a very simple truth — pets just make us feel happier.

Meg magic

Simply stroking a pet has a calming effect. Your heart beats more slowly and your blood pressure reduces, which in turn can reduce stress or tension. PAT Dogs can also distract anyone who may be anxious about an operation or medical procedure, and they can even aid a person's recovery.

Meg and volunteer Pat

PAT Dog Meg, owned by volunteer Jo, works alongside physiotherapists and occupational therapists at a hospital in Haywards Heath, West Sussex. "Stroking Meg has proved to be an excellent way for patients to exercise paralysed limbs," Jo explains. "This therapy is now referred to as 'Meg's magic'. We also occasionally go for a walk around the grounds with any patient who is soon to be discharged. We're accompanied by physios and it's a way for people who have a dog at home to practice taking it for a stroll under supervision."

Staff benefit too, who get a brief respite from what is often a hectic shift. Jo continues, "Meg has a great fuss made of her by members of staff before we even start on the wards."

Want to volunteer with PAT?

PAT is always looking to recruit more volunteers. To find out more about volunteering with your pet cat or dog – or to make a donation – visit **petsastherapy.org**.

Pets as Therapy
www.petsastherapy.org

WHY i CHOSE GERIATRICS

www.bgs.org.uk/choose

The BGS #ChooseGeriatrics campaign celebrates the variety and rewards of a career in older people's healthcare. Our team of #ChooseGeriatrics ambassadors have been busy sharing their own career journeys and what they love about their jobs. To find out more about becoming an ambassador or getting involved in our campaign another way, please visit www.bgs.org.uk/ambassador

Dr Laura Pugh is a Consultant in Geriatric Medicine and General Internal Medicine in the East Midlands. Laura is also the East Midlands Representative on the RCP New Consultant Committee.

I never imagined I was going to be a doctor, never mind a Geriatrician, but I can honestly say there's no other job I would rather have.

I was only interested in the arts at school, and my first degree was in English Literature. However, after several bends in the road, at the age of 30, I was working as a Diabetic Eye Screener part-time while my children were young. The 'big' birthday got me thinking, and I applied for Graduate Entry Medicine and never looked back.

During the four years of medical school, I had one three-week placement in geriatrics. I wish I could say that's when it hit me, but it didn't! My overriding memory is how difficult I found it to cannulate such fragile veins. I finished the placement, and graduated from medical school with the firm belief that I was destined to be a paediatrician.

A few weeks later I started my first FY1 job – in geriatrics! Within a fortnight I was sold. I was going to #ChooseGeriatrics and nothing would stop me. The difference? It was one good geriatrician.

My consultant on that first rotation was everything I wanted to be as a doctor: proactive and professionally curious, holistic but efficient, and always patient-centred. They made geriatric medicine seem like wizardry on one hand, and yet broke it down in such a way that it also appeared to be achievable and something I could be good at. Since then, many things have kept me committed to the specialty I love, but that mentor started me on this path.

So, if you work within geriatrics, show people why you chose it – you could be inspiring the next person to love our specialty.

It's easy to focus on the hardest parts of the job, or the bits we have less control over, but I try to remind myself that there could always be someone watching or listening that I could inspire to #ChooseGeriatrics, just like my mentor did for me.

Beth Carey is an Advanced Physiotherapy Practitioner in Healthcare of Older People at Nottingham University Hospitals NHS Trust. She is supporting the BGS #ChooseGeriatrics campaign.

I currently work at Nottingham University Hospitals NHS Trust as a Physiotherapy Advanced Practitioner in Healthcare of Older People - or a 'Highly Specialist Physiotherapist'; a new name that I haven't got used to yet!

My journey into physiotherapy began as a 15-year-old. Boringly, it's often the way people become physiotherapists, but it wasn't the treatment I received by physiotherapists that made me choose my career.

Rather, it was the effect the injury had on my whole life - even as a young woman. I went from exercising several times a week, walking at least 50 minutes each day, and not having to worry about how I got around, to struggling to walk 10 metres. Of course, it was painful, physically challenging and I relied a lot on those around me to help me, but the largest impact it had was on my mental health.

My mood suffered greatly from the isolation that my lack of physical ability caused. Social interaction with my peers lessened, my freedom was decreased, and I could no longer spend time doing the things I loved. Just being able to walk 'kept me going' in ways I didn't realise.

My realisation led me to appreciate the power of physiotherapy. I set my sights on becoming a physiotherapist to help improve lives through understanding the effect being immobile has on people, to help motivate them to move and spend time living their best lives.

My love of working with older people stemmed from a patient that I saw in my musculoskeletal placement at university. She was a lady in her 80s who had experienced an acromio-clavicular joint excision operation and was attending our clinic for post-operative management and rehabilitation. She was disappointed that her shoulder pain had not been fixed post-operatively and that her function was less than it was before.

I think her expectations had not been managed well with regards to post-operative recovery and return to normal function. Through exercises and motivational education, her pain and function improved. I saw first-hand how important remaining independent is to people, and specifically older people who are losing function in other ways. Being able to impact older people in this way motivated me greatly in developing my career within frailty and healthcare of older people. And I even got a kiss from her on my final day of placement!

'Being able to impact older people in this way motivated me greatly in developing my career within frailty and healthcare of older people.'

Once I qualified, my rotations included working in front door frailty and healthcare of older people wards, and later I became the Trust's 'Falls Lead' at the brilliant Kings Mill Hospital in Sutton-in-Ashfield. This solidified my love for the specialty; being able to dedicate time, patience and care to this group of people inspires me daily.

It allows me to develop and strengthen a plethora of skills: gait re-education, working with those with dementia, working within acute medical management, collateral history taking, postural stability exercises, motivational interviewing, complex multidisciplinary working and compassionate communication with patients and carers.

My move to Nottingham University Hospitals means that I can do this every day in a large Geriatric Medicine department and also help inject my passion for older people's care into other members of the multidisciplinary team.

I believe older people are often a marginalised group in society. There is an expectation from all of society that as we age, we lose function and become more dependent. I feel this leads to older people often being 'written off'. Working with older people allows a fantastic opportunity to advocate for a part of our community that is particularly vulnerable. Older people in society are a precious commodity. Their wealth of experience and knowledge is not only a delight to engage with, but also invaluable to our society today. We owe it to our older people to look after them well and it is a privilege to do this every day.

#CHOOSEGERIATRICS

Multipurpose medicines

Polypharmacy is a particular problem among older people - but what if we knew more about the potential of medicines to do more than one job, asks Helen Cowan.

"Most older people in care homes are taking several medications and errors may arise at the point of prescribing, dispensing, administering or monitoring that medication. Recent research has highlighted the unacceptably high levels of medication error," writes the Centre for Policy on Ageing.[1] For the administering nurse, chance of error can be reduced by avoiding interruptions (perhaps by wearing a labelled jacket asking that they are not disturbed), and by requesting printed, rather than hand-written drug charts, with a photograph of the resident attached.

The report also suggests that staff training in medication is vital. Knowledge of individual drugs, their indication and side effects can reduce administration error, but it can be difficult for nurses to keep up to date with drug developments and discoveries. Even common drugs can confuse when prescribed for new conditions, with some medicines being truly multipurpose. Viagra, for example, started out as an anti-angina pill, but is perhaps a "little blue pill to treat all ills", prescribed for erectile dysfunction and pulmonary arterial hypertension, and showing promise in the treatment of cancer, heart disease[2] and Alzheimer's. When old drugs are taught new tricks, staff need training too.

Old wine in new bottles...

...is the title of a scientific paper written in Poland for the *European Journal of Pharmacology*, and refers to so-called 'drug repurposing' (rather than rebottling), where everything from aspirin to thalidomide, antibiotics to anti-diabetic drugs, are being tested for their potential to treat cancer. Just because a drug is designed for one condition, doesn't mean it can't treat another – thalidomide was identified originally as an anti-sickness drug (and did a lot of damage to unborn babies) but is now prescribed to treat a type of blood cancer, and has been tested against breast, lung and prostate cancer.

It works the other way too: clabridine and haematopoietic stem cell transplantation (HSCT) were originally treatments for cancer, and are now licensed as a treatment for relapsing multiple sclerosis. The MS Society[3] are investigating, in the "Octopus" trial, whether other drugs might also be more multipurpose than first imagined. Sometimes it's the side effects of a drug which hint at how it might be helpful for a completely different condition.

The painkillers

Amitriptyline is taken to treat nerve pain and prevent migraine. It started out as an antidepressant yet has gained more popularity as a painkiller. Around ten million prescriptions were given to patients in England at the dose recommended for pain in 2022-2023, with five million issued at the higher dose for depression. With its widespread use, doctors are calling for clinical trials[4] to evaluate its effectiveness as a painkiller, and to study safety when taken long-term.

Amitriptyline can also reduce bed-wetting at night in some children, when other treatments haven't worked. It's also prescribed to treat insomnia, though not licensed for this purpose, and the 'ATLANTIS' trial suggests it can relieve symptoms of irritable bowel syndrome in adults (mean age 48). Acting on the brain, bladder and bowel, amitriptyline could have untapped potential. A word of caution though - in older adults, amitriptyline is a drug which it is recommended to target in deprescribing discussions. We know there is limited evidence of its benefit in managing chronic pain in this patient group,[5] and there is some evidence that is causes harm in older patients.[6]

Other pleiotropic painkillers (meaning they have many effects) include morphine and codeine. Both are prescribed for pain – and can suppress cough. Morphine can also relieve breathlessness in cancer, whilst codeine constipates, relieving diarrhoea. Pregabalin, meanwhile, is a painkiller and an anti-epileptic and anti-anxiety drug.

The anaesthetic and antiviral drugs

For 50 years, ketamine[7] has been used as an important anaesthetic in human and animal medicine. "More recently, ketamine has been studied and used for several new indications, ranging from chronic pain to drug addiction and post-traumatic stress disorder," writes Dr Samuel Kohtala from the University of Helsinki. It also has potential in the treatment of depression, though it's early days. "The ability of ketamine to provide a rapid relief of depressive symptoms, often within hours, has brought it to the forefront of treating severe treatment-resistant depression," he writes.

Could anaesthetics help the heart as well as the head? It's long been pondered whether some inhaled anaesthetics protect the heart[8] from injury during a heart attack or heart surgery, perhaps by triggering release of antioxidants within. I studied this for my PhD back in 2000, but it's proving difficult to translate from the laboratory bench to the bedside.

The antiviral drug amantadine made a surprise announcement as a treatment for Parkinson's in the 1960's when a patient with the movement disorder noticed relief of her symptoms whilst taking amantadine to treat a bout of flu; side effects here signalling a surprising new use for an existing medicine. Today amantadine can be used for involuntary movements in Parkinson's,[9] for complications of shingles and, sometimes, for relieving fatigue in multiple sclerosis.[10]

The healthy heart medicines

Type 2 diabetes and raised cholesterol both increase your risk of heart disease and stroke: metformin and statin drugs lower sugar and cholesterol levels respectively and perhaps treat a whole host of other conditions in the body too. Metformin might actually turn out to be something of a wonder drug.[11] Dr Robert H. Shmerling, writing for Harvard Health Publishing, notes that, beyond diabetes, metformin is prescribed for polycystic ovary syndrome, to help with fertility and menstrual regulation; it might also minimise the weight gain sometimes seen with antipsychotic drugs used in schizophrenia. "Researchers are also investigating the potential of metformin to lower the risk of cancer in people with type 2 diabetes, lower risks for dementia and stroke….and slow ageing and increase lifespan," he writes. "If that's true, 'wonder drug' might be an understatement."

It may be too soon to celebrate, however, particularly for older people with frailty - the MET-PREVENT trial found that metformin did not improve physical performance and was poorly tolerated in older people with sarcopenia, with high rates of adverse events.[12]

Statins meanwhile are one of the most prescribed drugs in the UK, with an estimated 7-8 million adults taking them for heart health. They work to lower cholesterol and protect the inside of artery walls. They are also attracting attention as possible anti-cancer agents,[13] and as drugs which might slow or stop disability progression for people with secondary progressive multiple sclerosis.[14]

Teaching old drugs new tricks

Is a phrase commonly used in scientific circles as clinicians consider new uses for existing drugs. NHS England established a 'Medicines Repurposing Programme' in 2021 to do just this, and gives an example of tocilizumab, an arthritis drug, repurposed to support recovery from COVID-19 pneumonia. Writing for the American Association for Cancer Research, Dr Srivani Ravoori wonders whether "good old aspirin might be a saviour for cancer patients". [15]

That, globally, we have not yet exhausted the uses of existing medicines gives hope that much needed cures for some of our most difficult to treat diseases could be closer than we think. For clinical staff, the challenge will be to keep up to date with the rapid rate of drug discovery, especially in an age of artificial intelligence, where complex biological and chemical languages are decoded at speed and cures may be conceived more quickly. Medication training really matters.

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This article is for intended for discussion purposes only and information should not be taken as prescribing advice.

Learning from the **Netherlands**

Maya Kessler and Harry Keevil are trainees in Geriatric Medicine currently working in the East Midlands. They had the opportunity to undertake an exchange to the University of Leiden Medical Centre (LUMC) in the Netherlands.

Open any newspaper or listen to a current affairs podcast, and it won't be long until someone mentions the challenges posed by the ageing Western populations. Although alluded to for years, these challenges are beginning to manifest as pressures on health and social care systems; with hospital bed pressure and access to social care notably under strain in the past 12 months. But what should we do about it? Should we rip up our current system and design a new one which is better suited to the challenges of the day? Is the problem simply one of resource, where the only outcome of system overhaul will be to divert time and resource from where it is most needed? Training and working within a single system can limit our conception of how to deliver healthcare. We spent one week in Leiden, Netherlands, exploring how we can use boundary crossing to increase our understanding of different healthcare systems and better equip future geriatricians to shape healthcare to meet the needs of our population.

We both have different areas of special interest. Maya has an interest in community geriatrics and completed a year out of programme working as a community geriatrician in Derbyshire. Harry is currently completing a PhD focused on non-pharmacological interventions to improve vascular health in older adults. The exchange provided both with an opportunity to experience how physicians approach practice in these areas in a different healthcare setting. During the weeklong exchange, we were given the opportunity to experience delivery of healthcare to older people in the Netherlands in their own homes, in Nursing Home, in rehabilitation facilities and in acute hospitals. We also had the opportunity to participate in a research meeting of the older people's research group at LUMC. Reflecting on these experiences enabled us to map the differences and similarities between the Netherlands and the UK, providing a platform from which to explore how establishing a permanent collaboration between the two groups could enhance the training of physicians in both countries.

The most notable difference between the Netherlands and the UK is the allocation of resource between the community and the acute hospital. In the Netherlands, the role of Elderly Care Physician exists and is distinct from a Geriatrician. Elderly Care Physicians work in community settings (including nursing homes and rehabilitation units), whereas Geriatricians work in the acute hospital only. Elderly Care Physicians significantly outnumber Geriatricians, in contrast to the UK where most Geriatricians are hospital based. This allows for every community rehabilitation unit and nursing home to have an Elderly Care Physician whose sole working responsibility is to care for the patients in that institution, as well as far greater access to home visits from specialists in elderly care medicine for those who live in the Netherlands. The resulting continuity of care, particularly for those living in nursing homes, can only be of benefit when caring for complex older patients who are living with multimorbidity.

However, allocation of this amount of resource to the community necessarily means that fewer resources are allocated to the acute hospital in the Dutch system. Hospital geriatricians largely provide a liaison service, with other specialties taking primary responsibility for the care of frail older people admitted to hospital. This contrasts with the UK system where Geriatric Medicine departments are well established in almost every hospital, providing continuous comprehensive geriatric assessment of frail older patients admitted to hospital.

Noting the differences between systems allows us to see similarities in what practitioners in both countries are trying to achieve. Ultimately, we are all trying to provide the best care possible for an increasing number of patients with increasingly complex needs. As discussed, the two countries have different approaches to this, each with strengths and weaknesses. Working out which system is better is potentially impossible, not least because it is up for debate what outcome measure you would use to measure quality: life expectancy? Reduced institutionalisation? Measures of functional ability? Quality of Life indices? Indeed, trying to do so would miss the point of the opportunities that this exchange gave us. Simply experiencing different practices initiates reflective learning that helps clarify our thoughts about how our own practices and systems can be improved.

We plan to establish a series of online shared educational events between Elderly Care Medicine Trainees in the Netherlands and Geriatric Medicine Trainees in the East Midlands. Our aim is to replicate the learning experience of our exchange as far as possible, with the sessions explaining the structure of the two healthcare systems and then plotting patient journeys for a particular presentation or condition. Our hope is that this learning will enable current and future cohorts of trainees to conceive of better ways of delivering healthcare to older populations.

Healthcare systems are large and complex, when working in them it can be difficult to see the woods from the trees. We often wonder, 'am I doing this because the system demands that I do it or am I doing it because it will lead to a tangible benefit for my patient?' Experiencing another system, however briefly, allowed us to step outside our boundaries and appreciate that different solutions to the same problem exist throughout the world. Now, our focus is to share this thought-provoking experience with others, enabling reflection, learning and ultimately to support more trainees to step outside their system. Watch this space!

Harry Keevil
Clinical Research Fellow University of Nottingham
Maya Kessler
ST7 Trainee, East Midlands

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