Ageing And Frailty – Draft Standards for The Care Of Older People

Introduction

This survey is specifically to give feedback on the ageing and frailty draft standards. A key element of developing our standards is to invite feedback. Your feedback is valuable to us.

All the comments and suggestions we receive will remain confidential and will be processed in line with the General Data Protection Regulation (GDPR). They will only be used to help edit and improve the ageing and frailty standards.

The consultation on the ageing and frailty standards closes on Tuesday 18 June 2024. We will be unable to accept any responses after this date. All comments submitted will be treated with care and made anonymous.

Responses will be considered by the ageing and frailty Standards Development Group. The final ageing and frailty standards will be published in November 2024.

If you have any questions regarding the draft standards, please contact us at his.standardsandindicators@nhs.scot.

1. **Please tell us a bit more about yourself.** *
    a. I am an older person
    b. I am a carer or care partner of an older person
    c. I am someone who works in an area related to ageing and frailty
    d. I am commenting on behalf of an organisation or agency
    e. I am submitting feedback from a session or event
    f. Other (please specify):

2. **If you work in an area related to ageing and frailty or if you're submitting feedback on behalf of an organisation or agency, please enter your job title and the name of the organisation you work for.**
    a. Job title
    b. Organisation

Please tell us about your organisation

3. **How far do you agree that these standards will support early intervention and prevention for older adults who may be at risk of frailty as they age?**
    a. Strongly disagree
    b. Slightly disagree
    c. Neither agree nor disagree
    d. Slightly agree
    e. Strongly agree

f. Don't know

Please tell us why you think this.

How far do you agree that these standards will ensure that older adults who may be at risk of frailty as they age have choice, autonomy and ownership of their life and their care?

g. Strongly disagree
h. Slightly disagree
i. Neither agree nor disagree
j. Slightly agree
k. Strongly agree
l. Don't know

Please tell us why you think this.

4. **How far do you agree that these standards will ensure older adults who may be at risk of frailty as they age experience a palliative care approach that helps them to live well with deteriorating health?**
   a. Strongly disagree
   b. Slightly disagree
   c. Neither agree nor disagree
   d. Slightly agree
   e. Strongly agree
   f. Don't know

Please tell us why you think this.

5. **Do you have any general comments on the standards?**

It is important to first contextualise our response to this consultation, Scottish Care is a membership organisation and the representative body for independent sector social care services in Scotland. We represent over 350 organisations, which totals almost 1000 individual services, delivering residential care, nursing care, day care, care at home and housing support services.

As it currently stands these standards read as a culmination of the responsibilities under multiple policies. They are well referenced across academia and supported in their creation by many key players – however, we are at a time where:

- Every local authority is financially challenged,
- Most local authorities are reducing eligibility packages for people who access Care at Home services, to exclude those deemed to have 'moderate' needs. This strategy will have an adverse effect on the principle of early prevention and intervention, allowing persons to further deteriorate until they meet the 'criteria' for community support,
- The strategic direction of many Integrated Joint Boards regarding Longer Term Care is to prevent individuals from entering care until all other options are exhausted. This undoubtedly has a negative impact on familial/unpaid care as they must continue to address

the increasing needs of their loved ones, without the appropriate support. It seems many Integrated Joint Boards have targets for the reduction of commissioned beds to meet financial targets, deprioritising the choice of the individuals and their wider support network.

Several members of our organisation, who were involved in the groups that fed into the improvement of these standards, are frustrated by what they see as duplication and tokenism in these standards. They have found that there has been a lack of meaningful engagement with the sector in the run up to this consultation. Firstly, the current standards are overly lengthy and do not provide anything new or innovative, simply reiterating existing requirements. Furthermore, the suggested improvements adopt a backward-looking approach that focuses primarily on the implications of social care needs, rather than empowering individuals to take an active role in shaping their own care and support.

Without investment in early prevention, we risk service provision which is reactive only. To truly move forward, we need to shift the focus to a person-led approach that prioritizes the opportunities and possibilities presented by acuity. This requires a more dynamic and forward-thinking approach that acknowledges the unique experiences and strengths of each individual, rather than simply focusing on their limitations.

6. **Would you like to give more detailed feedback on any of the individual standards? {For these questions each box you tick will come up with an additional two a.) Do you agree with Standard X? B.) Do you think that there are any necessary changes to Standard x that the Development Group should consider?}**
    a. All of the standards
    b. None of the standards specifically
    c. Standard 1: Service design

The Service design standard can be improved through innovation and the use of artificial technologies. An efficient application of a new design will require investment and a stable workforce who can be trained and become skilled, this is not the current reality of the social care workforce.

The approach to this standard should create a repository of evidence-based practice, therefore working with relevant organisations and stakeholders such as Scottish Care and Enhancing Research in Care Homes are necessary to share good practice. However, this standard should not just mimic current data sharing tools but should instead strive for a more effective method. While My Health My Care My Home frameworks recommends data sharing, the systems which hold the data between the NHS and Social Care providers do not always work in harmony. We have found that Clinical Mailboxes which are set up for the benefit of the user's care remain unused by General Practitioners and services alike. Therefore, future care plans created within care homes remain unutilised by outside agencies who have their own methods. Furthermore, the ReSPECT tool does not offer enough detail to hold what is important to an individual's life. Its heavy clinical focus suggests that it is designed for Healthcare Professionals, disregarding the importance of the social aspect in people's lives.

Another improvement that can be made towards this standard is increasing the support and communication for care partners. This support must include training and education on a variety of necessary topics such as building resilience and dementia awareness. Additionally, the role of

Service Champions must be co-produced and led by the input of people who access care and support, their voices should be heard the loudest in all plans.

Lastly, those receiving care also give care. The needs of people who access care and support, must be assessed both separately and together with the workforce that provides such essential care.

d. Standard 2: Identification and assessment

Under this standard it is unclear how those who are included in the group of 'frailty' are being identified. According to the 2022 British Geriatric Society Report, there is currently a national shortage of geriatricians in Scotland. With this shortage, there is concern amongst care providers that there will not be sufficient capacity to carry out the necessary assessments, ensuring respect and communication is purposeful and that each person is celebrated for their uniqueness. Additionally, once the needs of an individual are assessed it is unclear who will be responsible for ensuring the recommendations are followed. For example, when an Adult Carers Assessment is carried out and x, y, z is agreed as required, who ensures x, y z of Comprehensive Geriatric Assessment are met?

Furthermore, when it comes to the assessments of an individual's care needs in relation to their care setting, there is still much debate and confusion over the supply of specialist equipment. Such equipment that encourages and assists with independence are not publicly funded and the waiting list for said equipment is great. Lastly, the assessment used to identify underlying causes in older adults, 'investigation and diagnostics', is not always realistic medicine.

Please see above

e. Standard 3: Person-led care coordination and future care planning

To make improvements towards this standard, it is necessary for staff to have access to information they need to provide effective care. However, care staff are often not provided with the medical assessment information of the people accessing their care and support. We have had reports from our members, that sometimes when a person moves into their care home, the information shared to make the move seamless and comfortable for the individual is not detailed. Ideally a comprehensive Geriatric Assessment should be done within the community before a move to a residential/nursing care takes place.

As in the previous standard, there is also the issue of a unified care plan, as the one held by care settings may not match one used by the GP/ Community services. It is important that care plans are comprehensively collected and monitored to ensure that all appropriate providers are operating from one plan which the individual accessing care and support as agreed to. Also with accessible documentation, it is unclear how those with dementia are supported to understand and take part in the conversations around their plans; it currently seems they have limited involvement.

Lastly, social care staff can connect with those being supported, they can play a key role in 'frailty assessments' where they are afforded the time via funding and training.

f. Standard 4: Support for staff and care partners

Polypharmacy review is not available everywhere. There is not an automatic trigger for this review therefore many people who access care and support, remain on medications (paracetamol for example) longer than is required. There should be trigger points for this review, for example when a

person has a comprehensive Geriatric Assessment, is beginning a care service, is being discharged from hospital etc. We have seen that some medications are stockpiled but not used, this is leading to a lot of unnecessary wastage. There is also a knock-on effect, as some individuals then require further medication such as laxatives when pain relief is inappropriately consumed.

Within this standard, it is also unclear who is assessing 'frailty', for while these assessments are necessary, there isn't enough appropriate resource and capacity within the sector. For example, AHPs are in short supply within the NHS and some care home professional support teams are struggling to recruit AHPs into this work. Is the home assessment triggered at a certain point?

Additionally, care homes can be supported by the provision of exercise equipment that can be used for strength and train or carry out progressive exercise programmes. The provision needs to include universal equipment that can be used by all residents.

g. Standard 5: Keeping active

Currently, Vitamin D is not funded by the NHS, therefore service users are reliant on care homes purchasing this supplement. However, as the consumption of this vitamin is encouraged and yet is not mandated, not all care homes are able to provide the supplement which leads to inconsistent access. A review of this vitamin can be given on an individual basis, and if found to be beneficial in the prevention of malnutrition, the GP could prescribe this as part of the medication review.

Additionally, in the sector recruitment into dietetics and speech and language therapist roles are currently quite challenging. Also, there is no face-to-face training provided, for dysphagia, safe swallowing etc, and in the community instead this education comes from online modules. Private training on this is expensive and not all care homes are able to afford this training. This leads to inconsistencies in the care available across different regions. There needs to be a programme of delivery which reaches all care staff.

h. Standard 6: Nutrition and hydration
i. Standard 7: Medicines management
j. Standard 8: Living and dying well

Future care planning should not be limited to just when a person's health is or is likely to decline. It should be encouraged at all points in life, to change the cultural narrative that currently fears death and end of life conversations to one which is normal. Also, realistic medicine, social prescribing and non-pharmaceutical advice should be broadcast to the public, to enable them to fully inform and understand their options.

k. Standard 9: Care in hospital

We have heard from our care providers that often some of the older adults who access their care and support do not feel that they receive equitable compassionate care in the hospital setting. We have an ageing demographic, yet older adults are left feeling unwelcome in hospitals and the care staff assisting older adults to hospitals are frequently demonised as responsible for failures in care. There also seems to be a skewed vision provided by statistics around care in hospital, categories such as 'bed blocking', (a horrible terminology), and falls, all of which might suggest a lack of care for older adults. There is such a heavy focus on discharging an individual into the community that holistic care is often missed – there are no frailty assessments done, multi-disciplinary tam working or conversations between care providers and NHS are lacking. The focus must be on doing the right thing for the individual and not just 'clearing a bed'.

l. Standard 10: Delirium, dementia, and cognition
m. Standard 11: Mental health

These are the last two questions, once you have commented on the standards you would like.

7. Do you feel that anything is missing from the standards? *

a. Yes
b. No

If yes, please give details.

In line with the Dementia Strategy for Scottish Government, it is remiss to not include within these standards

- elements in relation to the sharing of information across health and social care;
- how the workforce qualifications/skills and aptitudes are going to be monitored and assured regarding supporting those with cognitive impairments;
- standards for timescales in addressing concerns regarding cognition in a timely manner (which are currently 12-48 months for diagnosis);
- how meaningful engagement and activity for those in hospital will be used to support individuals (as it is within care homes)
- clear definitions of capacity and consent, particularly how capacity can fluctuate and that only when Adults with Incapacity legislation is used is it legal for proxies to make 'best interest' decisions for individuals in particular regard to treatment, withdrawal of treatment and realistic medicine.

8. Would you like to be sent the final standards when they are published?
If yes, please include your email address. *

a. Yes x
b. No
c. Email (if applicable)- Ifeoluwa.Asefon@scottishcare.org