

Ageing and frailty standards: consultation survey

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. *

- I am an older person
- I am a carer or care partner of an older person
- I am someone who works in an area related to ageing and frailty
- I am commenting on behalf of an organisation or agency
- I am submitting feedback from a session or event

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.

Job title: Policy Coordinator

Organisation: British Geriatrics Society

Please tell us about your organisation:

The British Geriatrics Society (BGS) is the membership organisation for all healthcare professionals engaged in the treatment and care of older people across the UK. Since 1947, our members have been at the forefront of transforming the quality of healthcare for older people. Our vision is for a society where all older people receive high-quality patient-centred care when and where they need it. We currently have over 5000 members, over 400 of whom are based in Scotland, including geriatricians, nurses, GPs, allied health professionals and pharmacists working across acute, primary and community care settings. BGS takes a leading role in policy debates relating to healthcare for older people, acting as a voice for our members and the speciality of geriatrics. BGS's work in Scotland is led by the Scotland Council,

which comprises healthcare professionals working with older people in Scotland. The views outlined in this consultation response represent those of the organisation and have been collated with input from the BGS Scotland Council.

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? *

- Strongly disagree
- Slightly disagree
- Neither agree nor disagree
- Slightly agree
- Strongly agree
- Don't know

Please tell us why you think this.

Prevention is, and should be, the cornerstone of geriatric medicine and the BGS welcomes the inclusion of early intervention and prevention as a key principle underpinning the standards. Importantly, the standards recognise that frailty is not an inevitable part of ageing, and it can be prevented, reversed or slowed down.

In *Joining the Dots: A blueprint for managing frailty in older people*, the BGS sets out seven system touchpoints which should be considered when planning and commissioning health and social care for older people. One of these touchpoints is “enabling independence, promoting wellbeing” and highlights that regular exercise, good quality nutrition and social contact can help people to remain healthier and more independent for longer. Therefore, we are pleased to see the inclusion of Standard 5: Keeping active; Standard 6: Nutrition and hydration; and Standard 8: Living and dying well. *Joining the Dots* also outlines that loneliness and social isolation are associated with higher mortality, increased risk of coronary heart disease, stroke, high blood pressure, depression and suicidal thoughts, and contribute to frailty risk as much as physical inactivity. We are pleased to see that loneliness is recognised in Standard 8: Living and dying well and encouraging social connections is embedded in the criteria.

Most interactions older people have in relation to their health take place in a primary or community healthcare settings, and healthcare professionals working in these areas have a key role to play in preventing the onset of frailty. For example, GPs and other healthcare professionals can intervene at an early stage through methods such as social prescribing, either to alleviate loneliness and social isolation or to find practical solutions to a patient’s worries. Action like this at an early stage can prevent associated health deterioration, keeping people healthier for longer. Due to primary and community care being a crucial preventative touchpoint, the BGS recommends the inclusion of a standard dedicated to healthcare outside of a hospital setting.

Population-based proactive care targeting older people at risk of poor health and social outcomes is key to preventing deterioration as well as improving care continuity, reducing emergency attendances, reducing health inequalities and improving system outcomes. Therefore, the BGS is pleased to see the inclusion of Standard 2: Identification and assessment.

4. 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? *

- Strongly disagree
- Slightly disagree

- Neither agree nor disagree
 Slightly agree
 Strongly agree
 Don't know

Please tell us why you think this.

The BGS advocates for a personalised approach to care, based on shared decision making heavily influenced by the individual's wishes and priorities for their care. Therefore, Standard 3: Person-led care coordination and future care planning is a vital inclusion to the standards. In *Joining the dots*, the BGS highlights the top two priorities for older people in relation to their healthcare were staying in their own home and staying independent. Therefore, the BGS recommends the inclusion of criteria in standard 3 that addresses conversations around maintaining independence and staying at home for longer, which may involve working with local communities and partner organisations.

Joining the dots highlights that older people have not had a sufficient voice in the planning and delivery of health services. The NHS has traditionally been organised by disease or condition and is not set up to care for the multiple or complex needs that many older people have. Involving older people and their carers in the design, delivery and evaluation of care helps to ensure responsive, flexible services that respond to their needs. Therefore, the inclusion of criteria 1.3 in Standard 1: Service design, which ensures organisations engage and involve older people as equal partners in codesign, delivery and monitoring of services, is vital in ensuring that the choice, autonomy and ownership of care for older adults is adhered to.

5. 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? *

- Strongly disagree
 Slightly disagree
 Neither agree nor disagree
 Slightly agree
 Strongly agree
 Don't know

Please tell us why you think this.

The BGS welcomes Standard 8: Living and dying well within the draft standards. However, the standards currently lack the recognition of the need to plan for multiple care scenarios for older people with frailty. End of life care for older adults living with multiple health problems and frailty is different from dying with a single disease. The range of trajectories of decline includes sudden death, slow progressive deterioration (such as in advanced dementia), catastrophic events (such as stroke or hip fracture), and periods of prolonged uncertainty associated with fluctuating episodes of acute illness associated with delirium or functional decompensation. As recovery from acute illness in the context of severe frailty is uncertain, parallel planning for recovery or deterioration is essential. Therefore, the BGS recommends an inclusion of parallel planning, involving the older individual, within Standard 8: Living and dying well.

Recognition of advanced frailty and incurable illness should trigger early, sensitive and evolving conversations related to the benefit versus burden of active treatment, the identification of realistic personalised goals of care related to current circumstances as well as a shared understanding of future goals and wishes. Therefore, the BGS supports the inclusion of standard 8.10 which ensures older individuals are supported to have early discussions about palliative care and the options available.

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

Yes

No

If yes, please give details.

The BGS very much welcomes the publication of the ageing and frailty draft standards for the care of older people. Importantly, the standards approach frailty from a whole system approach applying to all settings where older people with frailty receive health and social care. This is a welcome development from the previous standards published in 2015 which solely focused on the care for older people in hospital. Recognising a whole system approach is important as older people enter the health and social care system through different system touchpoints, as outlined in BGS's publication *Joining the dots*, and it is important that commissioners invest in all elements together to create a comprehensive 'wrap around' system of care that supports older people to age well and live well at home for longer.

Whilst we welcome the standards, BGS Scotland committee members felt that the standards were broad and non-specific in scope, which may present difficulties in implementation and evaluation. The standards are unclear in terms of evaluation processes, and members felt unclear in how to demonstrate they are meeting the criteria. The BGS recommends more specific criteria and examples to support the implementation and evaluation of the standards.

Considering the important preventative focus of the standards, the BGS recommends that the draft standards include a standard outlining what good frailty care looks like in community and primary care settings. Whilst community and primary healthcare professionals can use criteria embedded in other sections of the standards, it would be clearer to have expectations outlined for this setting, similar to Standard 9: Care in hospital. This may include the role of social prescribing, Comprehensive Geriatric Assessment (CGA) in the community, and cross-organisational setting working to prevent, manage, and reverse frailty in older people. Primary care is only mentioned once in the standards, and this should be addressed.

One of the cornerstones of geriatric medicine, with a strong evidence base, is Comprehensive Geriatric Assessment (CGA). The BGS is pleased to see the inclusion of CGA in the standards. However, more specific details of CGA would be beneficial, such as a more detailed definition, and a recognition that CGA can also be conducted in a community setting.

7. Would you like to give more detailed feedback on any of the individual standards?

All of the standards

None of the standards specifically

Standard 1: Service design

Standard 2: Identification and assessment

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

Standard 4: Support for staff and care partners

Standard 5: Keeping active

Standard 6: Nutrition and hydration

Standard 7: Medicines management

Standard 8: Living and dying well

Standard 9: Care in hospital

Standard 10: Delirium, dementia, and cognition

Standard 11: Mental health

8. Do you agree with Standard 1: Service design?

- Strongly disagree
- Slightly disagree
- Neither agree nor disagree
- Slightly agree
- Strongly agree
- Don't know

Please tell us why you think this.

The BGS broadly agrees with the criteria set out in standard 1: service design. Importantly, the standard recognises that older people use the health and care system more than any other group and therefore systems need to be designed with their needs in mind, and in collaboration with them. Particularly, we are pleased to see the inclusion of criteria 1.1 as this aligns with recommendation 1 of BGS's *Joining the dots*: "Demonstrate strong system leadership that creates a shared vision for healthy ageing and preventing and managing frailty."

The BGS is also pleased to see the inclusion of criteria 1.2, outlining that organisations should work to a jointly-agreed multiagency delivery plan for integrated frailty services. However, detailed examples, including of the types of organisations that should be involved in this delivery plan and ways of working would be beneficial. In recommendation 11 of BGS's *Joining the dots*, the BGS recommends that public health, housing, community and voluntary sector partners should work together to build social capital, mobilise community assets and adopt place-based approaches to create inclusive, compassionate age- and dementia friendly communities.

Criteria 1.3 is also vital as it ensures older people are involved as equal partners in the design and monitoring of services. However, it would be good to see the inclusion of care partners in this criterion alongside older people. In recommendation 9 of the BGS's *Joining the dots*, the BGS recommends engaging with and involving older people, carers and communities as equal partners with health and social care professionals in co-design, delivery and monitoring the impact of these services and support. Specialised support is also needed to engage older people in the service design process, and it is important this is considered in service design and included in the standards. This aligns with recommendation 10 of the BGS's *Joining the dots*, which recommends that systems provide support to enable the lived experience of older people and carers, including those with dementia and mobility, sensory or communication needs, to inform quality improvement and assurance.

9. Do you think that there are any necessary changes to Standard 1: Service design that the Development Group should consider?

- Yes
- No

If yes, please give details.

The BGS is pleased to see that our publication *Joining the dots* is included in the reference list of the standards. This document provides a guide to the prevention and management of frailty in older people across all settings, from prevention and proactive care through to long term care in care homes and end of life care. We have heard from people working in health systems across the country who are finding the publication a useful basis for planning their services for older people. The BGS recommends that *Joining the dots* is embedded in service design across Scotland. Therefore, we recommend it is featured within the criteria of standard 1, recommending all systems to use the document as a guide to implement frailty standards alongside HIS guidance. The BGS would also recommend the following is included in the criteria of standard 1:

- Appoint a senior officer or nonexecutive Board member with a specific role to seek ongoing assurance on the quality of health and social care for older people and their carers.
- Publish baseline, then annual, State of Ageing reports on system-wide outcome indicators related to care for older people including feedback from patients and carers to reflect their experience.

We also recommend the inclusion of the following specific questions that systems should consider when designing frailty services for older people:

- How many people in your community are living with frailty?
- How will this number change in the coming years?
- Does your system understand the complexity of frailty?
- Does your system understand the impact of frailty on individuals, families and society?
- How well does your system currently manage frailty?
- What steps is your system taking to prevent and reverse frailty?

10. Do you agree with Standard 2: Identification and assessment?

- Strongly disagree
 Slightly disagree
 Neither agree nor disagree
 Slightly agree
 Strongly agree
 Don't know

Please tell us why you think this.

The BGS welcomes the inclusion of standard 2: identification and assessment, outlining how organisations should have systems in place to identify, assess and plan for the needs of older people with frailty at the earliest opportunity. This aligns with recommendation 4 in BGS's *Joining the dots* which recommends that systems should develop a system-wide strategy and costed implementation plan for a population health approach to the prevention and management of frailty, including a specific focus on dementia and falls. This is the basis of proactive care, and the BGS recommends that the term "proactive care" is referred to in the standards allowing organisations to easily refer to more literature on the topic. For example, the BGS will publish two publications this year, providing an evidence base for proactive care and outlining what good proactive care looks like in the community. NHS England have also published a framework for proactive care, and it would be good to see similar guidance in Scotland.

11. Do you think that there are any necessary changes to Standard 2: Identification and assessment that the Development Group should consider?

- Yes
 No

If yes, please give details.

The BGS recommends the term "proactive care" is used in the criteria, in line with supporting literature, to allow for organisations to easily refer to further resources. Additionally, in criteria 2.5, we recommend reference to the role of comprehensive geriatric assessment undertaken by an appropriate multidisciplinary team of healthcare, social care and community or voluntary service partners working together. The CGA should result in a personalised care plan, and this should also be included in the standards. The BGS also recommends the inclusion of structured medication reviews in the list of options available to patients in criteria 2.5, due to the evidence that prescribing multiple medicines increases adverse effects and impacts on health outcomes.

We also recommend the inclusion of a population-approach to stratify the population into groups with different levels of complexity within the criteria of this standard, as this helps to target interventions and resources to where they will have the most impact. It would be beneficial to include specific examples to guide healthcare professionals, such as the electronic frailty index (eFI) which categorises the population into fit, mildly frail, moderately frail and severely frail.

12. Do you agree with Standard 3: Person-led care coordination and future care planning?

Strongly disagree

Slightly disagree

Neither agree nor disagree

Slightly agree

Strongly agree

Don't know

Please tell us why you think this.

The BGS supports standard 3: person-led care coordination and future care planning, which recommends that people should be at the centre of their care and are actively involved in decisions related to care coordination and future care planning. Importantly, this will ensure a personalised approach to care, based on shared decision-making heavily influenced by the individual's wishes and priorities for their care; and it is important that "what matters" considerations are included in the standards.

13. Do you think that there are any necessary changes to Standard 3: Person-led care coordination and future care planning that the Development Group should consider?

Yes

No

If yes, please give details

The BGS recommends that equality, diversity, and inclusion issues are included in the criteria of standard 3. Specifically, we recommend that organisations publish an older people equality and diversity impact assessment and action plan, as outlined in recommendation 4 of BGS's *Joining the dots*.

In *Joining the dots*, the BGS highlights that the top two priorities for older people in relation to their healthcare were staying in their own home and staying independent. Therefore, the BGS recommends the inclusion of criteria in standard 3 that addresses conversations around maintaining independence and staying at home for longer, which may involve working with local communities and partner organisations.

14. Do you agree with Standard 4: Support for staff and care partners?

Strongly disagree

Slightly disagree

Neither agree nor disagree

Slightly agree

Strongly agree

Don't know

Please tell us why you think this.

The BGS is pleased to see the inclusion of Standard 4 outlining that adequate support and training is required for staff and care partners to ensure that services are delivered to meet the needs of older people with frailty. Older people and their carers require timely access to a wide range of generalist and specialist care and support delivered by primary care, community services, acute care, social care, housing, community and voluntary partners as well as specialist palliative care services. Therefore, the criteria outlined in this standard, such as access and time to CPD for staff, risk enablement training for staff, frailty assessment training for staff, and importantly training on the meaning of frailty assessments and how to act on them, are vital. Specific training and education on frailty as a condition, and knowledge of caring for people with multiple long-term conditions are essential to meet the needs of an ageing population.

Considering workforce shortages, it is crucial that criteria 4.12 is included which will ensure all staff have an individual wellbeing support plan.

15. Do you think that there are any necessary changes to Standard 4: Support for staff and care partners that the Development Group should consider?

Yes

No

If yes, please give details.

Rising demand from demographic changes increases the need for more geriatricians, nurses, allied health professionals, pharmacists, GPs and social workers with specialist expertise in assessment and care for older people. At present, workforce shortages and the level of unfilled vacancies in some parts of the country are a particular problem for the delivery of healthcare for older people. Whilst all members of the multidisciplinary team face major workforce challenges, the current state of the Consultant Geriatric Medical workforce is the most well described and likely reflects similar challenges facing other disciplines. As outlined in a recent BGS publication, *The State of the Consultant Geriatrician Workforce: An analysis of the RCP census*, there are high levels of vacancies and rota gaps in geriatric medicine, which appear to worse than other specialties. There are not enough geriatricians to meet the needs of the ageing population, and this will only worsen with high retirement levels and a growing ageing population. There is an urgent need to train more specialists in older people's healthcare to provide direct clinical care and to build the capability of generalists to prevent and manage frailty across the system. Yet it takes an average of 16 years from entering medical school to complete specialist training. BGS Scotland Council members feel that the standards will be hard to implement with the current lack of geriatricians and wider multidisciplinary team to support older people with frailty. Therefore, the BGS recommends the inclusion of specific criteria that recognises the support needed for staff in the current workforce crisis, such as a review of job plans and rotas that would make a difference to wellbeing.

Demographic change means that most of the health and care workforce will care primarily for older people and therefore need the knowledge and skills to be able to deliver care and support for older people, regardless of their specialty. Therefore, we would recommend that the criteria specifically outline the range of healthcare professionals that would benefit from frailty training, such as geriatricians, nurses, allied health professionals, pharmacists, GPs and social workers.

The BGS also recommends specific examples of educational and training resources aimed at healthcare professionals are referenced in the standards, including:

- The Skills for Health Frailty Core Capabilities Framework
- BGS's Frailty E-Learning module
- Diploma in Geriatric Medicine

It would also be beneficial to see the inclusion of support to build effective interdisciplinary teams within the criteria. High-performing teams are characterised by people who respect and trust each other and enhance each other's contributions. Each member has the professional agency to operate at the upper end of what their skills and licences permit, rather than be constrained by overly hierarchical, siloed structures that limit their contributions. Development opportunities to enhance skills and scope of practice can strengthen the contribution of professionals to the MDT, improve their experience and enhance care outcomes. Teamwork and individual judgement are particularly important in care for older people with multiple health and social care needs, where benefits of interventions and potential harms have to be balanced carefully.

16. Do you agree with Standard 5: Keeping active?

- Strongly disagree
- Slightly disagree
- Neither agree nor disagree
- Slightly agree
- Strongly agree
- Don't know

Please tell us why you think this.

The inclusion of Standard 5: keeping active and the criteria incorporated will allow people to live independently for longer whilst helping to reduce demand for emergency care and long-term support. It also aligns with recommendation 7 of BGS's *Joining the dots* outlining that systems should protect and preserve the right to rehabilitation for all older people who need it, in line with the principles outlined by the Community Rehabilitation Alliance. The BGS has recently published a document highlighting why rehabilitation in older people matters and outlines examples of best practice called *Reablement, Rehabilitation, Recovery: Everyone's Business*, which we recommend the Development Group considers.

The aims of rehabilitation will vary depending on the individual, often supporting somebody to recover from ill health. Therefore, it is important that the criteria in the standard focus on goal-focussed, person-led rehabilitation and people with frailty undertake rehabilitation based on their own values and priorities. Rehabilitation is everyone's business, and it is important that it is implemented across all care settings.

17. Do you think that there are any necessary changes to Standard 5: Keeping active that the Development Group should consider?

- Yes
- No

If yes, please give details.

The BGS recommends that BGS's new publication, *Reablement, rehabilitation, recovery: Everyone's business*, is included in the criteria as an example of a key resource to help systems deliver effective and integrated rehabilitation as a right for all older people, wherever and whenever they need it. The BGS urges the Development Group to read the publication and ensure all 12 recommendations are referred to in the criteria.

Many older people are currently excluded from rehabilitation services because of restrictive access criteria, limited capacity or postcode lottery of provision. Systems must act now to address this inequity, and the BGS recommends that this is recognised in the criteria. This is important as every older person can benefit from rehabilitation in some way and chronological age alone should never bar access. Whilst the criteria broadly acknowledges 'keeping active' to be incorporated into all settings, the BGS recommends that rehabilitation is included as an essential component to all care plans in

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all setting, including long-term care. The criteria should recognise that rehabilitation should start as soon as possible after the onset of illness and has a role in preventing further decline.

Senior leadership is critical for a strategic and sustainable approach to planning and delivering rehabilitation for older people. The criteria should recommend systems identify a senior officer or nonexecutive Board member with a specific role in assuring equitable access to rehabilitation attuned to the needs of older people and continually improving the quality of services delivered.

BGS's *Joining the Dots* highlights that there is strong evidence that regular exercise, particularly strength and balance training, can partially reverse or slow the progression of frailty. It would be good to see specific mention of the benefits of strength and balance training in preventing frailty either in the criteria or examples.

18. Do you agree with Standard 6: Nutrition and hydration?

- Strongly disagree
- Slightly disagree
- Neither agree nor disagree
- Slightly agree
- Strongly agree
- Don't know

Please tell us why you think this.

The BGS welcomes the inclusion of standard 6: nutrition and hydration due to its integral role in ensuring good health in later life. Importantly, the criteria includes recommendations of a personalised approach to nutrition encompassing a whole system approach, including signposting to relevant community and social care organisations and consideration of religious and philosophical beliefs. It is important that older individuals with frailty have access to an assessment that results in relevant personalised interventions and support.

19. Do you think that there are any necessary changes to Standard 6: Nutrition and hydration that the Development Group should consider?

- Yes
- No

If yes, please give details.

One of the cornerstones of older people's healthcare is the assessment and management process known as Comprehensive Geriatric Assessment (CGA), and this encompasses tailored interventions regarding nutrition if appropriate. The BGS recommends the criteria includes the role of nutrition assessments in CGA.

20. Do you agree with Standard 7: Medicines management?

- Strongly disagree
- Slightly disagree
- Neither agree nor disagree
- Slightly agree
- Strongly agree
- Don't know

Please tell us why you think this.

The BGS supports the inclusion of medicine management within the draft standards. Effective medicine management is a core component of population-based proactive

anticipatory care, offering older individuals tailored support to stay well for longer. An important inclusion in the standards is annual person-centred medication review for those on high-risk medicines or those taking more than five medications. This is a key intervention, alongside other criteria, to reduce adverse effects of medication which can impact significantly on health outcomes.

21. Do you think that there are any necessary changes to Standard 7: Medicines management that the Development Group should consider?

- Yes
 No

If yes, please give details.

22. Do you agree with Standard 8: Living and dying well?

- Strongly disagree
 Slightly disagree
 Neither agree nor disagree
 Slightly agree
 Strongly agree
 Don't know

Please tell us why you think this.

Ensuring that older people with frailty live and die well should be at the heart of healthcare provision. The principles of 'what matters to me' and the 'Realistic Medicine' movements ensure a personalised approach to care, based on shared decision-making heavily influenced by the individual's wishes and priorities for their care. Older individuals should be supported to live the life they want to live and the criteria featured in this standard ensures that is a priority.

It is important that the standards include criteria around honest, compassionate and early discussions around palliative care. Recognition of advanced frailty and incurable illness should trigger early sensitive and evolving conversations related to the benefit versus burden of active treatment, the identification of realistic personalised goals of care related to current circumstances as well as a shared understanding of future goals and wishes. Therefore, the BGS supports the inclusion of standard 8.10 which ensures older individuals are supported to have early discussions about palliative care and the options available.

23. Do you think that there are any necessary changes to Standard 8: Living and dying well that the Development Group should consider?

- Yes
 No

If yes, please give details

As mentioned in question 5, end of life care for older adults living with multiple health problems and frailty is different from dying with a single disease. The range of trajectories of decline includes sudden death, slow progressive deterioration (such as in advanced dementia), catastrophic events (such as stroke or hip fracture), and periods of prolonged uncertainty associated with fluctuating episodes of acute illness associated with delirium or functional decompensation. As recovery from acute illness in the context of severe frailty is uncertain, parallel planning for recovery or deterioration is essential. Therefore, the BGS recommends that the standard includes parallel planning within the criteria.

BGS members felt that the advice around managing incontinence in older people is minimal within the standards, and therefore the BGS recommends more detailed criteria within this standard regarding continence. More advice around managing personal hygiene, oral health, pressure ulcers, and health and sight loss should also be addressed.

24. Do you agree with Standard 9: Care in hospital?

- Strongly disagree
- Slightly disagree
- Neither agree nor disagree
- Slightly agree
- Strongly agree
- Don't know

Please tell us why you think this.

The BGS fully supports the inclusion of standard 9: care in hospital as older people with frailty account for a significant amount of hospital admissions and often have poor experiences and outcomes from urgent care. Many older people with frailty admitted to hospital as an emergency could be fit to return home on the same day if they were assessed, diagnosed and treated swiftly on arrival at hospital. Therefore, the BGS is pleased to see the inclusion of criteria 9.9 and 9.10, focused on proactive and early discharge planning, and planned discharge dates which the multidisciplinary team should work towards.

There is much that hospital staff can do to improve the quality and safety of care and contribute to holistic and proactive care for older people with frailty. This includes the proactive identification of frailty within older patients, and it is good to see the inclusion of criteria 9.2 within standard 9, which highlights patients should be screened for frailty and have prompt access to multidisciplinary support.

25. Do you think that there are any necessary changes to Standard 9: Care in hospital that the Development Group should consider?

- Yes
- No

If yes, please give details.

Whilst we welcome the inclusion of criteria 9.2, highlighting patients should be screened for frailty, the BGS recommends that the standards include the specific mention of the need to complete early comprehensive geriatric assessment alongside interventions to reduce harm and improve outcomes. A definition of CGA, and examples of how it can be implemented would be useful here. Despite evidence that CGA can improve care outcomes and experience, implementation in hospitals remains patchy outside geriatric medical units. This contributes to considerable variation between hospitals for many quality metrics. Other contributing factors to this unwarranted variation are systematic differences in recognition and management of frailty and delirium, prevention of deconditioning and in discharge practice. Solutions require pathways attuned to the needs of older people with frailty across the whole hospital. Whilst criteria 9.1 recognises the need for appropriate risk assessed frailty pathways, this criterion needs to be more specific regarding the integrated pathways that should be included. As outlined in BGS's *Joining the dots*, the BGS recommends the following elements are included in the criteria as elements to integrated pathways:

- Acute care at the front door
- Acute frailty services
- Same day emergency care

- Orthogeriatric services and Perioperative medicine for Older People undergoing Surgery (POPS)
- Dementia management
- Delirium management
- Reducing deconditioning
- Hospital discharge and Discharge to Assess (D2A) pathways

In BGS's *Front door frailty: Advice on setting up services*, the BGS highlights five principles that should underpin front door frailty services and provides tips on establishing services from those who have been through the process. We recommend the Development Group consider the recommendations in this publication, and references it within the draft standards.

The BGS also recommends the inclusion of criteria to support better coordinated transfers of care to the community.

The need to adjust the traditional outpatient model for older people is increasingly pressing. There may be a need to shift from traditional outpatient models in order to embrace technology, improve patient experience and reduce the carbon impact. Innovations such as one-stop frailty clinics and community-based ambulatory care hubs and clinics can help to improve patient experience and ensure that already stretched services operate more efficiently. Outpatient telemedicine for older people may be beneficial, cost effective and well received by patients. Whilst due consideration must be given to the risk of digital exclusion, there are many advantages to embracing technology to enable new models of ambulatory and outpatient care for older people. Therefore, the BGS recommends the inclusion of criteria that supports staff to implement innovative ideas in their areas, such as one-stop frailty clinics and new use of technology to improve patient experience.

The BGS recommends that the list of services that older people can access whilst in hospital outlined in criteria 9.6 is expanded to include access to rehabilitation services, stroke services, and surgical specialities. We also recommend that criteria 9.4 is also expanded to include the encouragement of physical activity whilst in hospital.

Older patients are at risk of deconditioning in hospital from long periods of immobility resulting in loss of muscle mass, functional decline and increased risk of death or long-term care. Effective care requires early mobilisation, rapid establishment of rehabilitation goals and continued rehabilitation input until their condition has stabilised. Therefore, as outline in BGS's *Reablement, rehabilitation, recovery: Everyone's business*, the BGS recommends the following is included in the criteria: older people with acute illness decondition rapidly so need rehabilitation to start as soon as possible – healthcare professionals should not wait for a crisis to pass before providing rehabilitation at hospital. All hospital staff should prevent older people deconditioning by encouraging mobility and offering early active rehabilitation.

26. Do you agree with Standard 10: Delirium, dementia, and cognition?

- Strongly disagree
- Slightly disagree
- Neither agree nor disagree
- Slightly agree
- Strongly agree
- Don't know

Please tell us why you think this

The BGS supports the inclusion of standard 10: delirium, dementia, and cognition in the draft standards. Poorly identified, assessed and managed delirium not only extends

length of stay but can cause significant distress for patients, carers and staff. Older people with dementia are at higher risk of poor health outcomes when they present at urgent care settings and may spend longer in emergency departments. Patients with dementia may have vague symptoms or be unable to report their symptoms, resulting in higher rates of burdensome or invasive testing. Therefore, it is important that the criteria include identification, assessment and personalised management plans for cognitive impairment with a focus on patients feeling safe, involved and well cared in their care environments.

27. Do you think that there are any necessary changes to Standard 10: Delirium, dementia, and cognition that the Development Group should consider?

- Yes
 No

The BGS recommends that hospitals should have specific delirium and dementia pathways available to patients experiencing these conditions, and this should be included in the criteria of the standard. For example, a specific delirium pathway that runs for up to 12 weeks, involves a CGA, a management plan and regularly reviewing the patient's symptoms.

28. Do you agree with Standard 11: Mental health?

- Strongly disagree
 Slightly disagree
 Neither agree nor disagree
 Slightly agree
 Strongly agree
 Don't know

Please tell us why you think this.

There is a high prevalence of mental health issues in older people, making standard 11: mental health a vital inclusion in the draft standards. Alongside often experiencing multiple conditions and disabilities, many deal with loss and bereavement, all within a society that stigmatises later life. This results in mental health problems, such as depression and anxiety, often being ignored by older people who often associate it with an unavoidable symptom of getting older. Therefore, it is important that medical professionals proactively screen for mental health conditions in older people and it is included in comprehensive geriatric assessment. Those with mental health conditions are at more risk of having frailty in later life. The BGS welcomes the inclusion of criteria that promotes mental health assessment, proactive regular screening, identification those at high risk of frailty due to mental health conditions, access to appropriate treatment and medication and barriers addressed.

29. Do you think that there are any necessary changes to Standard 11: Mental health that the Development Group should consider?

- Yes
 No

If yes, please give details.

Whilst the BGS very much welcomes the inclusion of mental health review within the draft standards, more specifics are needed regarding what constitutes a mental health review. A definition and examples of how to implement a mental health review within healthcare settings would be beneficial.

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

Yes

No

If yes, please give details.

Considering the standards will apply in all settings where older people with frailty receive health and social care, alongside the focus on prevention and early intervention, the current draft standards exclude a standard focussed on healthcare provision for older people in primary and community care settings. The BGS recommends the inclusion of a standard focussed on care outside of hospital settings, outlining how healthcare professionals based in the community can implement good care for older people with frailty. Most interactions that older individuals have with a health care professional will be in the primary and community care setting and it acts as a key intervention point for preventative measures to ensure older people continue to live well and avoid hospital admission. The BGS is happy to provide further feedback on what should be included in the criteria of this standard. Broadly, we recommend the inclusion of proactive care in the community, social prescribing, identification of social isolation and loneliness, CGAs in the community, healthcare for care residents to be organised around the care home and rehabilitation in the community.

Older people with frailty often experience five common syndromes: falls, immobility, delirium, incontinence and medication-related harms. Falls and immobility are covered sufficiently within standard 5, delirium in standard 10 and medication-related harms in standard 7. BGS members felt that there were not enough criteria within the standards relating to incontinence, and we recommend the development group considers a standard focused on incontinence.

Finally, we recommend that *BGS's Joining the dots: A blueprint for preventing and managing frailty in older people*, is referenced in the standards as a resource for healthcare professionals working with older people with frailty. We encourage the Development Group to read the document's 12 recommendations, and ensure they are included within the standards.

31. Would you like to be sent the final standards when they are published?

If yes, please include your email address. *

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