WM QRS West Midlands Quality Review Service

NHS

Care of Older People Living with Frailty

Worcestershire Health and Social Care Economy

Visit Date: 8th and 9th March 2016 Report Date: June 2016

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INTRODUCTION

This report presents the findings of the review of the Care of Older People Living with Frailty that took place on 8th and 9th March 2016. The purpose of the visit was to review compliance with the following West Midlands Quality Review Service (WMQRS) Quality Standards:

- Quality Standards for Care of Older People Living with Frailty: Assessment and Coordination of Care

The aim of the standards and the review programme is to help providers and commissioners of services to improve clinical outcomes and service users' and carers' experiences by improving the quality of services. The report also gives external assurance of the care, which can be used as part of organisations' Quality Accounts. For commissioners, the report gives assurance of the quality of services commissioned and identifies areas where developments may be needed.

The report reflects the situation at the time of the visit. The text of this report identifies the main issues raised during the course of the visit. Appendix 1 lists the visiting team which reviewed the services in Worcestershire and Appendix 2 contains the details of compliance with each of the standards and the percentage of standards met.

This report describes services provided or commissioned by the following organisations:

- Worcestershire Health & Care NHS Trust
- Worcestershire Acute Hospitals NHS Trust
- NHS South Worcestershire Clinical Commissioning Group
- NHS Redditch and Bromsgrove Clinical Commissioning Group
- NHS Wyre Forest Clinical Commissioning Group
- Worcestershire County Council

Most of the issues identified by quality reviews can be resolved by providers' and commissioners' own governance arrangements. Many can be tackled by the use of appropriate service improvement approaches; some require commissioner input. Individual organisations are responsible for taking action and monitoring this through their usual governance mechanisms. The lead commissioner for the service concerned is responsible for ensuring action plans are in place and monitoring their implementation, liaising, as appropriate, with other commissioners. The lead commissioners in relation to this report are NHS South Worcestershire, NHS Redditch and Bromsgrove and NHS Wyre Forest Clinical Commissioning Groups.

ACKNOWLEDGMENTS

West Midlands Quality Review Service would like to thank the staff and service users and carers of Worcestershire health and social care economy for their hard work in preparing for the review and for their kindness and helpfulness during the course of the visit. Thanks are also due to the visiting team and their employing organisations for the time and expertise they contributed to this review.

ABOUT WEST MIDLANDS QUALITY REVIEW SERVICE

WMQRS is a collaborative venture between NHS organisations in the West Midlands to help improve the quality of health services by developing evidence-based Quality Standards, carrying out developmental and supportive quality reviews - often through peer review visits, producing comparative information on the quality of services and providing development and learning for all involved.

Expected outcomes are better quality, safety and clinical outcomes, better patient and carer experience, organisations with better information about the quality of clinical services, and organisations with more confidence and competence in reviewing the quality of clinical services. More detail about the work of WMQRS is available on www.wmqrs.nhs.uk

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CARE OF OLDER PEOPLE LIVING WITH FRAILTY ACROSS WORCESTERSHIRE

REVIEW PROCESS

This review was the first time that the WMQRS Quality Standards for the 'Care of Older People Living with Frailty (COPLWF): Assessment and Coordination of Care' were used for a peer review visit and, for a variety of reasons, planning for the visit took place at fairly short notice and was slightly disjointed. Reviewers considered that Worcestershire should be commended for undertaking this review and being prepared to use the new Standards with relatively little preparation time.

Reviewers went out to patients' homes with staff from community-based services in both South Worcestershire and North Worcestershire (Kidderminster and Bromsgrove & Redditch). Reviewers also visited the Emergency Departments, Medical Assessment Units and wards with particular responsibility for the care of frail older people at both Worcestershire Royal Hospital, Worcester, and the Alexandra Hospital, Redditch. Reviewers visited the Minor Injuries Unit at Evesham Community Hospital, and went onto some of the community hospital wards in Evesham Community Hospital and Princess of Wales Community Hospital, Bromsgrove. A detailed review of community hospitals was not undertaken as these had been fully reviewed in 2015 as part of the 'Transfer from acute hospital care and intermediate care' review programme. Table 1 summarises the services reviewed during this review visit.

Service	Review Approach	Quality Standards (QSs) used
Primary Care	Reviewers met one South Worcestershire GP.	QSs for 'all health and social care' services. Specific QSs applicable to general practice were not specifically reviewed.
Worcestershire Health & Care NHS Trust South Worcestershire Community Care Service Delivery Unit • Pershore Proactive Care Team • Evesham District Nursing Team North Worcestershire Community Service Delivery Unit • Enhanced Care Team (Bromsgrove) • Rapid Response Team • Virtual Ward (Kidderminster) • Community Therapies Service (Kidderminster)	Reviewers met with service leads for several services. Reviewers also visited some wards at Evesham and Princess of Wales Community Hospitals.	QSs for services providing holistic frailty assessments (WMQRS COPLWF Quality Standards).
Worcestershire Health & Care NHS Trust • Evesham Community Hospital Minor Injuries Unit (MIU)	Reviewers met with staff providing the service.	QSs for services providing urgent care for older people living with frailty (WMQRS COPLWF Quality Standards).

Worcestershire Acute Hospitals Trust (WAHT)
• Worcestershire Royal Hospital
  ○ Emergency Department
  ○ Medical Assessment Unit
  ○ Wards: Avon 4 and Silver Unit
• Alexandra Hospital
  ○ Emergency Department
  ○ Medical Assessment Unit
  ○ Ward 12
	Reviewers visited all facilities and talked to staff, patients and carers.	QSs for services providing urgent care for older people living with frailty (WMQRS COPLWF Quality Standards)
		Quality Standards for services providing holistic frailty assessments are also applicable to the wards visited but were not reviewed.

Service	Review Approach	Quality Standards (QSs) used
Consultant Geriatricians (WAHT)	Reviewers met consultant geriatricians but not a Frailty Team.	Frailty Team Quality Standards (WMQRS COPLWF Quality Standards) were not reviewed as part of this visit.
Commissioning • NHS South Worcestershire CCG • NHS Wyre Forest CCG • NHS Redditch and Bromsgrove CCG	Reviewers met representatives from each CCG.	Commissioning (WMQRS COPLWF Quality Standards).

Much of the evidence available to reviewers was Trust-wide evidence for Worcestershire Health & Care NHS Trust or Worcestershire Acute Hospitals NHS Trust, or related to all three Worcestershire Clinical Commissioning Groups (CCGs). A more detailed review process may have highlighted further examples of good practice or identified problems relating to specific individual services. The Worcestershire-wide themes of this report came out strongly over the two days of the review, and reviewers did not consider that these would have changed significantly had a more detailed review been undertaken.

Because the Worcestershire-wide themes emerged so clearly, this report has been written as a Worcestershire-wide report with individual examples, rather than in separate sections for each service reviewed. Compliance with Quality Standards for individual services and organisations is given in Appendix 2.

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VISIT FINDINGS

General Comments and Achievements

Reviewers met a range of staff who were highly committed to providing good care for Worcestershire's older people living with frailty. Most staff had a good understanding of the issues that needed attention, and some plans were in place for improving local services. Reviewers identified pockets of extremely good practice (see below). In general, reviewers were impressed by the range and development of community services across the county. A good range of information was available for patients and carers in both written and electronic formats and this information was easily accessible in the services visited by reviewers.

Good Practice

1 GPs in South Worcestershire had a well-organised approach to identifying patients at high risk of admission. The two per cent of patients most likely to be admitted had been identified and the top one per cent had had a frailty assessment. Since July 2015 4,000 patients from the 32 South Worcestershire practices had been identified as frail, and 2,500 had had a Comprehensive Geriatric Assessment. Links between GPs and community services seemed to work particularly well in South Worcestershire, and Emergency Care Plans had been implemented for residents of nursing homes in South Worcestershire. These initiatives were reported as having led to a reduction in both acute hospital admissions and admissions to nursing homes.

2 The Enhanced Care Teams and other community-based services across Worcestershire provided well-organised, holistic care for older people living with frailty, and supported admission avoidance, rehabilitation and ongoing care. Reviewers were particularly impressed that the South Worcestershire teams included staff with mental health-related competences and some had social workers and night sitters as part of the teams. The South Worcestershire Proactive Care Team included Advanced Nurse Practitioner support for residential and nursing homes, targeted at those with the highest rates of admission to hospital. This team had particularly good relationships with GPs and the wider multi-disciplinary team, including falls prevention and continence services. POPS (Plaster of Paris Service) was

available for patients who were unable to 'weight-bear' and needed up to four weeks of additional rehabilitation. North Worcestershire teams had very good arrangements for multi-professional working; staff had developed competences so that they could undertake a range of professional assessments, which made the work of the teams more patient-centred and more efficient. Reviewers saw excellent examples of individual clinical practice in the Redditch and Bromsgrove Rapid Response Team, where staff took a lead role in the assessment and organisation of holistic care. The North Worcestershire virtual wards operated a robust system of red / amber / green wards with clear criteria and arrangements for moving between levels. In Kidderminster, Community Matrons did weekly clinics in the eight top-referring nursing homes. The Kidderminster Enhanced Care Team was also able to evidence robust arrangements for six-weekly clinical supervision for the team. Promoting Independence Teams and a Hospital Avoidance Prevention Service were also available. These examples of good practice were those observed by reviewers. Reviewers were aware, however, that they did not see all of the teams at work and good practice may be more widespread than is reported here.

3 The wards at Evesham Community Hospital had two Advanced Nurse Practitioners for patients with mental health needs, and two Advanced Nurse Practitioners for elderly care medicine, both of whom were nurse prescribers. These posts provided a good level of support for older people living with frailty who were in the Community Hospital.

4 The model of medical cover for the 'red' virtual ward and the Community Hospital in Redditch and Bromsgrove was particularly impressive. One GP practice had been commissioned to provide medical cover for both services, and to visit the Alexandra Hospital, in order actively to support the transfer of patients out of hospital. This arrangement meant that there was good communication with community staff and good continuity of medical care for patients transferring between settings. Two GPs provided most of the service and could be contacted easily by community staff with queries or concerns.

5 The Community Hub at the Princess of Wales Community Hospital in Bromsgrove provided an excellent focus for integration and communication between different community services. The Hub was the base for the Enhanced Care Teams, the Rapid Response Team, the Virtual Ward, the District Nurses, therapy staff, social workers and the Palliative Care Team. Staff communication and advice, transfer and handover of patients were made easier because staff were all based in the same place.

6 Both acute hospitals had examples of good practice. All non-clinical staff had undertaken training in meeting the needs of people with dementia. The pharmacist in the Emergency Department at Worcestershire Royal Hospital saw patients to review their medication, and ran a falls clinic. One nurse in the same department had done additional therapy training and so was able to undertake some therapy assessments. Patients on Avon 4 Ward (Worcestershire Royal Hospital) had good support from the consultant geriatrician and Avon Ward provided a good environment for older people living with frailty, including areas for sitting and playing games, and a courtyard. At the Alexandra Hospital, the Emergency Department had a specific 'calmer area' for the care of more vulnerable patients which had both beds and chairs. Both mental health and social work support was available. Nurses had good visibility of the area, and the care provided was clearly focussed on a holistic approach to the patients' needs. Staff in both the Emergency Department and the Medical Assessment Unit at the Alexandra Hospital were concentrating on the needs of patients, even when they were aware that this was leading to pressure on waiting time targets. Ward 12 at the Alexandra Hospital had a very good 'end of life' suite, and a high dependency area with good staff presence and good visibility. Reviewers were impressed by the reduction in the number of complaints on this ward, achieved through undertaking a 'root cause analysis' of each complaint.

Immediate Risks: No immediate risks were identified.

Concerns

1 **Lack of a Frailty Team**

Worcestershire did not have a multi-disciplinary Frailty Team able to undertake Comprehensive Geriatric Assessments, as expected by national guidance and the Quality Standards (which have been derived from this guidance). Only two consultant geriatricians, plus some locum cover, were in post for a population of nearly 600,000. Two consultant geriatrician posts were vacant. Patients on Silver Unit at Worcestershire Royal Hospital had only occasional geriatrician input. Funding for two additional consultant posts had been secured but there were concerns about whether recruitment to these posts would be successful. Further consideration 1 below gives some comments and suggestions from reviewers about possible approaches to the development of a Frailty Team.

2 **Inconsistent Pathways of Care**

Although there were many examples of good practice (see above), these had been developed in individual services, and pathways of care for older people living with frailty were inconsistent across Worcestershire. Staff were often not aware of how services were organised in other parts of the county. Good infrastructure to support integrated pathways of care was also not yet in place. In particular:

a. At least three different frailty screening tools were in use across the county. It was not clear when one should be used rather than another. As a result, the identification of older people living with frailty was inconsistent and the pathway of care after identification was not clear.

b. Consistent approaches to holistic frailty assessment were not yet in place. Different assessment systems were in use in different community services and in the acute hospitals. These were not supported by agreed guidelines or clear pathways of care.

c. An Emergency Care Plan template had been developed and implemented for patients in nursing homes in South Worcestershire, but no such template had yet been implemented in other community services. Emergency Care Plans were not being agreed for patients prior to discharge from hospital.

d. Virtual Ward GPs in Redditch and Bromsgrove did 'in reach' into the acute hospital, but 'in reach' in order to identify patients suitable for discharge from acute care was less well-developed in other areas.

e. Arrangements for multi-disciplinary working between primary care, community services and acute services were different in different parts of the county. MDT meetings took place in some areas but not in others. Opportunities for integrated, holistic care may have been being missed because of the lack of clear, consistent multi-disciplinary arrangements for the care of older people living with frailty.

f. Because of the lack of clear pathways, competence frameworks for roles in the pathways were not yet in place. Some good work was taking place in individual teams, but opportunities for collaboration and economies of scale in delivering training may have been being missed.

g. IT systems to support integrated pathways of care were not yet in place, except in the Proactive Care Team in South Worcestershire who were able to use EMIS and so accessed GP records and hospital communications with GPs. Robust arrangements for electronic communication between services were not yet in place and reviewers observed a lot of faxing and photocopying of referrals and patients' records. Plans were in place for a new IT system for Worcestershire Health & Care NHS Trust which would improve this situation, although staff who met the visiting team were not clear about timescales for implementation.

3 **Worcestershire Frailty Forum**

Worcestershire did not have a strategy that brought together relevant services and focussed on the needs of older people living with frailty, although aspects of their care were covered in other strategies. In general, there was a common understanding of what needed to be done, and most staff were committed to this, although they did not always use the same vocabulary to talk about it. Staff were much less clear about how progress could be achieved.

There was no specific group that brought together relevant services and focussed on the needs of older people living with frailty. There was a Worcestershire Urgent Care/Best Practice Board, and Alliance Boards in each CCG with wide representation. Some people attended all three Alliance Boards. Consultant geriatricians were not part of any of these groups.

4 **Availability of Care Packages**

Difficulties and delays in accessing packages of care were reported by staff from across the health economy, and these were having an impact on transfers of care from acute hospitals and also on end of life care. A project was, however, taking place in Kidderminster looking at how activities of daily living could be supported with only one carer, thereby reducing the need for 'double up' carer support.

Further Consideration

Development of Frailty Team

1 Reviewers were aware of the national shortage of consultant geriatricians and the potential difficulties in recruitment to the two additional consultant posts planned. Reviewers made the following suggestions in relation to the development of a Worcestershire Frailty Team:

a. The national guidance on which the WMQRS Quality Standards for the Care of Older People Living with Frailty are built is similar to that for the care of people with long-term conditions in relation to the configuration of specialist teams, in this case the Frailty Team. The most efficient and effective arrangement is a single specialist team that cares for people with the particular long-term condition, in this case 'frailty', whether they are at home, in intermediate care or in hospital. The model for Worcestershire could be one or three Frailty Teams but, given the limited resources available, planning to develop a single county-wide Frailty Team with responsibility across hospital and community services would appear sensible in the first instance.

b. Reviewers were told that consultant geriatricians undertook out-patient clinics in community hospitals but did not meet with the community teams based in or near these community hospitals. Reviewers were also told of plans for consultant geriatricians to spend more time in the Emergency Department or other urgent care 'portals'. Given the limited consultant geriatrician time available, reviewers were not convinced that either of these represented the best use of this scarce resource.

c. Reviewers considered that an embryonic Frailty Team could be created quite quickly by bringing together the two consultants already in post with some specialist nursing (physical and mental health), therapy and social work support. Reviewers suggested that this team should focus on:

i. Working with others to develop integrated pathways of care, and then developing the guidelines and processes needed to support pathway implementation.

ii. Providing advice and guidance to other clinicians on the care of older people living with frailty, especially those with more complex needs. This should include attending multi-disciplinary meetings with community teams as well as providing support to acute consultants.

iii. Participating in multi-disciplinary Comprehensive Geriatric Assessments and care planning for patients with the most complex needs.

Innovative solutions would be needed for the team's senior decision maker staffing, including GPs with a specialist interest, Trust or staff grade doctors or Advanced Nurse Practitioners. These staff could also provide support to the Emergency Department and other urgent care 'portals' in order, whenever possible, to divert patients from hospital care or facilitate speedy investigation, treatment and discharge. The medical staffing model already functioning in Redditch and Bromsgrove virtual wards provides a good basis for this.

d. If appointment to the additional consultant posts is successful, it may be feasible to develop an acute Frailty Unit. A more suitable model for Worcestershire may, however, be for consultants to have a particular geographical / hospital interest, linking with geographically-based community teams and with the acute 'Frailty Unit' function in both the Worcestershire Royal and Alexandra Hospitals either as a 'virtual unit' or linked to a general medical ward.

e. The Frailty Team would need robust referral criteria and triage of referrals to ensure patients with less complex needs were directed to other services available, particularly the well-developed community services.

Other Issues:

2 Speech and language therapy and dietician support to patients in community hospitals was limited and delays in access to these therapies were reported. At Evesham Community Hospital the Advanced Nurse Practitioner had achieved competences in undertaking simple therapy assessments and could prescribe food supplements, but this approach had not been adopted in all the community hospitals.

3 Advance Care Plans and links with end of life care appeared to be working well in Bromsgrove and Redditch but were not as clearly implemented elsewhere in the county. Reviewers saw Advance Care Plan and Emergency Care Plan templates but these had not been used for several of the patients for whom they could have been appropriate.

4 The Patient Flow Centre was coordinating the allocation of patients to community hospitals and other intermediate care facilities. Many of the clinical staff who met the visiting team were frustrated with the way the Patient Flow Centre worked, and did not consider that it improved patient care. This issue was identified in the WMQRS 2015 review of 'Transfer from acute hospital care and intermediate care' and did not appear to have progressed since that review.

5 Some other issues identified in the WMQRS 2015 review of 'Transfer from acute hospital care and intermediate care' (for example, ensuring patients waiting for discharge from Worcestershire Acute Hospitals NHS Trust had active rehabilitation while waiting for an intermediate care bed to become available) had also not yet been addressed.

6 Reviewers were told that there were often delays in the availability of patient transport at weekends. As a result, discharges were being delayed and some additional admissions to acute hospital care were taking place because patients were not moved to an appropriate intermediate care facility quickly enough.

7 Many good initiatives were being tried in different parts of the county. Reviewers did not see evidence of robust evaluation of these initiatives and arrangements for 'spread' through the county of those that were successful. 'Friends and Family' tests were being undertaken but these did not provide much information that was specific to the individual services, and initiatives or information that were specific to the care of older people living with frailty. Reviewers suggested that more robust arrangements for evaluation and cease / spread would be helpful.

8 The Kidderminster Admission Avoidance Team caring for patients in the Hospital Avoidance Prevention Service told reviewers that they were not able to refer patients directly to mental health services or to a consultant geriatrician, and that patients had to go back to the GP for onward referral. This arrangement introduced delays that were avoided in some other parts of the county.

9 Reviewers commented that it may be worth exploring whether there are more opportunities for seven-day working in community services. Some provided a seven-day service but many, including Community Matrons and the Proactive Care Team, were only available Mondays to Fridays. A pilot of enhanced GP availability from 10am to 1pm on Saturdays and Sundays was taking place in Pershore.

10 Silver Unit at Worcestershire Royal Hospital did not provide an appropriate environment for the active rehabilitation of older people living with frailty. Most patients were waiting for discharge, but limited rehabilitation appeared to be taking place. The ward was about to re-locate from the Aconbury site to the main hospital site. Reviewers suggested that the move could be an opportunity to change the model of care to one with a much more active rehabilitation focus.

11 Ward 12 at the Alexandra Hospital had no day room, no tables at which patients could eat and no mental health support as part of the ward team (referrals could be made). Further work to make the environment and culture more rehabilitation-focussed may be helpful.

12 Monitoring information about the pathway of care for older people living with frailty did not appear to be widely shared among clinical teams in either acute or community services. More openness with monitoring information may help to support a better Worcestershire-wide understanding and implementation of integrated pathways of care.

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APPENDIX 1 MEMBERSHIP OF VISITING TEAM

Visiting Team

Frances Clarke	Associate Director of Nursing	Birmingham Community Healthcare NHS Trust
Liz Colley	Community Matron	Coventry & Warwickshire Partnership NHS Trust
Karen Dawson	Service Manager – MICATS	Staffordshire and Stoke on Trent Partnership NHS Trust
Amanda Futers	Clinical Nurse Specialist Older Adults	University Hospitals of North Midlands NHS Trust
Andrew Hindle	Commissioning Manager for Integration	NHS Dudley Clinical Commissioning Group
Dr Stuart Hutchinson	Consultant, Geriatrics	The Royal Wolverhampton NHS Trust
Elizabeth Kiernan	Named Nurse for Adult Safeguarding	University Hospitals Coventry & Warwickshire NHS Trust
Marcelle Rollings	Care Group Manager & Redesign Women's and Children's Division	Walsall Healthcare NHS Trust
Dr Narinder Sahota	General Practitioner	Walsall
Julie Thompson	Head Nurse, Frail Older Person & Dementia	Burton Hospitals NHS Foundation Trust
Judith Whalley	Patient Representative	

WMQRS Team

Jane Eminson	Director	West Midlands Quality Review Service
Sarah Broomhead	Assistant Director	West Midlands Quality Review Service
Dr Anne Yardumian	Observer	West Midlands Quality Review Service

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APPENDIX 2 COMPLIANCE WITH THE QUALITY STANDARDS

Analyses of percentage compliance with the Quality Standards should be viewed with caution as they give the same weight to each of the Quality Standards. Also, the number of Quality Standards applicable to each service varies depending on the nature of the service provided. Percentage compliance also takes no account of 'working towards' a particular Quality Standard. Reviewers often comment that it is better to have a 'No, but', where there is real commitment to achieving a particular standard, than a 'Yes, but' where a 'box has been ticked' but the commitment to implementation is lacking. With these caveats, table 2 summarises the percentage compliance for each of the services reviewed.

Table 2 – Percentage of Quality Standards met

Service	Number of Applicable QS	Number of QS Met	% met
All Health and Social Care Services Caring for Older People Living with Frailty	5	1	20
Urgent Care Services – Minor Injuries Units	7	3	43
Urgent Care Services – Emergency Department (ED) and Medical Assessment Unit (MAU):	14	4	29
Worcestershire Royal Hospital ED and MAU	(7)	(1)	(14)
Alexandra Hospital ED and MAU	(7)	(3)	(43)
Services which Conduct Holistic Frailty Assessments:	32	17	53
South Worcestershire Teams	(16)	(9)	(56)
North Worcestershire Teams	(16)	(8)	(50)
Commissioning	0	0	0
Health Economy	**58**	**25**	**43**

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Ref	Quality Standards	Met? Y/N	Reviewer Comments
M*-102	**Information and Support for Older People Living with Frailty and their Families and Carers** Information and support for older people at risk of or living with frailty, and their families and carers, should be available covering at least: a. Local services available to provide help, support and care b. How to access a directory of local services c. Maintaining a healthy lifestyle and preventing harm: i. Memory loss ii. Nutrition and hydration ii. Maintaining mobility, including exercises iii. Falls prevention iv. Preventing and managing incontinence v. Skin and foot care vi. Managing medication, including reducing polypharmacy d. How to access an advocate e. How to access advice on: i. Mental capacity and Deprivation of Liberty Safeguards ii. Power of Attorney iii. Advance Care Planning iv. End of Life Care f. Support available for carers g. Availability of assistive technology h. Relevant national groups and organisations i. How to give feedback on support and care received	Y	Information and support for older people living with frailty and their families and carers, including directories of services, was available on the 'Your Life Your Choice' website hosted by Worcestershire County Council, as well as in a variety of other formats available in local services and on Trust websites. Information on health and wellbeing had been developed through a series of decision support tools used across nursing homes in Wyre Forest CCG and South Worcestershire CCG. These focussed on the prevention of falls, nutrition and hydration, skin care, and management of the deteriorating patient.

Ref	Quality Standards	Met? Y/N	Reviewer Comments
M*-104	**Reasonable Adjustments** Reasonable adjustments should be made for older people living with frailty using the service including: a. Flexible appointment times and extended appointment times, if required b. Good availability of parking bays for people with disabilities c. Easy availability of wheelchairs d. Facility for supporting communication with people with hearing deficits, such as a loop system and/or room suitable for private discussions e. Communication aids suitable for use with people with visual impairments f. Discussion and information sharing with informal carers who are acting in the best interest of the older person	N	This QS was met in some areas but no health and social care economy-wide approach to this was evident.
M*-298	**Training Programme** A rolling programme of training should be run for staff covering: **All staff:** a. Making reasonable adjustments for older people living with frailty, including those with dementia b. Use of the locally agreed 'Emergency Care Plan' c. Recognising adults with care and support needs and recognition of abuse d. Safeguarding **Staff involved in frailty screening:** e. Indications for frailty screening and use of the locally agreed frailty screening tool (QSs M*-501) including: i. Criteria for undertaking or referral for holistic frailty assessment ii. Criteria for referral for comprehensive geriatric assessment f. Main local services available for the care of older people living with frailty and referral for: i. Support and care ii. Maintaining a healthy lifestyle iii. Preventing harm iv. Support for carers	N	A programme was in place for health and social care staff covering dementia, recognising adults with care and support needs and recognition of abuse. This programme did not yet cover all the requirements of the QS; in particular, frailty screening was not yet covered.

Ref	Quality Standards	Met? Y/N	Reviewer Comments
M*-301	**Support Services** Access to the following services should be available: a. 'Single point of access' for services to manage a crisis at home or to enable those older people living with frailty to return home quickly b. Frailty Team for: i. Advice and support ii. Rapid access ambulatory clinics c. Services providing: i. Support and care ii. Support for maintaining a healthy lifestyle and preventing harm iii. Support for carers d. End of life care	N	The QS was met, with the exception of 'b'.
M*-401	**Facilities and Equipment** Facilities and equipment should be appropriate for the needs of older people living with frailty, including: a. Appropriate signage b. Noise reduction in busy areas and at night c. Access to health and social care records containing details of the care of the older person	-	Reviewers did not visit enough areas for compliance with this QS to be determined.
M*-501	**Guidelines: Frailty Screening and Care of Older People Living with Frailty (1)** Guidelines on care of older people living with frailty should be in use covering: a. Making reasonable adjustments b. Use of Emergency Care Plan, including notifying the Care Coordinator c. Recognising adults with care and support needs and recognition of abuse d. Indications for frailty screening and use of frailty screening tool e. Criteria for undertaking or referral for holistic frailty assessment f. Criteria for referral for comprehensive geriatric assessment	N	This was met in some services, but a consistent approach to frailty screening, supported by appropriate guidelines, was not yet in place.

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URGENT CARE SERVICES – MINOR INJURIES UNITS

Ref	Quality Standards	Met? Y/N	Reviewer Comments
ME-102	**Information and Support for Older People Living with Frailty and their Families and Carers** Information and support for older people at risk of or living with frailty, and their families and carers, should be available covering at least: a. Local services available to provide help, support and care b. How to access a directory of local services c. Maintaining a healthy lifestyle and preventing harm: i. Memory loss ii. Nutrition and hydration iii. Maintaining mobility, including exercises iv. Falls prevention v. Preventing and managing incontinence vi. Skin and foot care vii. Managing medication, including reducing polypharmacy d. How to access an advocate e. How to access advice on: i. Mental capacity and Deprivation of Liberty Safeguards ii. Power of Attorney iii. Advance Care Planning iv. End of Life Care f. Support available for carers g. Availability of assistive technology h. Relevant national groups and organisations i. How to give feedback on support and care received	Y	A wide range of information was available in both written and electronic formats. Staff in the MIU at Evesham were clear about how to access information, and could 'signpost' patients and carers to further advice.

Ref	Quality Standards	Met? Y/N	Reviewer Comments
ME-104	**Reasonable Adjustments** Reasonable adjustments should be made for older people living with frailty using the service including: a. Flexible appointment times and extended appointment times, if required b. Good availability of parking bays for people with disabilities c. Easy availability of wheelchairs d. Facility for supporting communication with people with hearing deficits, such as a loop system and/or room suitable for private discussions e. Communication aids suitable for use with people with visual impairments f. Discussion and information sharing with informal carers who are acting in the best interest of the older person	Y	'a' was not applicable to the Minor Injuries Units. Compliance for other aspects was based on self-assessment as some MIUs were not visited.
ME-298	**Training Programme** A rolling programme of training should be run for staff covering: **All staff:** a. Making reasonable adjustments for older people living with frailty, including those with dementia b. Use of the locally agreed 'Emergency Care Plan' c. Recognising adults with care and support needs and recognition of abuse d. Safeguarding **Staff involved in frailty screening:** a. Indications for frailty screening and use of the locally agreed frailty screening tool (QSs M*-501) including: i. Criteria for undertaking or referral for holistic frailty assessment ii. Criteria for referral for comprehensive geriatric assessment b. Main local services available for the care of older people living with frailty and referral for: i. Support and care ii. Maintaining a healthy lifestyle iii. Preventing harm iv. Support for carers	N	Mandatory training was in place, which included safeguarding. Additional training was taking place in relation to identification of older people with care and support needs, delirium and dementia. Training covering all the requirements of the QS, including training in frailty screening for appropriate staff, was not yet in place. A falls ambassador was in the department and linked well with Trust-wide processes.

Ref	Quality Standards	Met? Y/N	Reviewer Comments
ME-301	**Support Services** Access to the following services should be available: a. 'Single point of access' for services to manage a crisis at home or to enable those older people living with frailty to return home quickly b. Frailty Team for: i. Advice and support ii. Rapid access ambulatory clinics c. Services providing: i. Support and care ii. Support for maintaining a healthy lifestyle and preventing harm iii. Support for carers d. End of life care	N	The QS was met, with the exception of 'b'.
ME-401	**Facilities and Equipment** Facilities and equipment should be appropriate for the needs of older people living with frailty, including: a. Appropriate signage b. Noise reduction in busy areas and at night c. Access to health and social care records containing details of the care of the older person	Y	
ME-501	**Guidelines: Frailty Screening and Care of Older People Living with Frailty (1)** Guidelines on care of older people living with frailty should be in use covering: a. Making reasonable adjustments b. Use of Emergency Care Plan, including notifying the Care Coordinator c. Recognising adults with care and support needs and recognition of abuse d. Indications for frailty screening and use of frailty screening tool e. Criteria for undertaking or referral for holistic frailty assessment f. Criteria for referral for comprehensive geriatric assessment	N	Specific guidelines were not yet in place although staff were clear how to seek advice, if required, and Trust-wide guidelines on the care of vulnerable adults, safeguarding, and recognising and reporting abuse were in place. Health-economy wide formats for frailty screening had not yet been agreed.

Ref	Quality Standards	Met? Y/N	Reviewer Comments
ME-502	**Clinical Guidelines: Care of Older People Living with Frailty (2)** Clinical guidelines for the care of older people living with frailty should be in use in each urgent care service, covering at least: a. Initial assessment and management of older people living with frailty, covering at least: i. Assessment of their clinical condition ii. Assessment of function iii. Consideration of capacity to make informed decisions iv. Obtaining relevant information from their GP and/or care home b. Medication review c. Recognising adults with care and support needs and recognition of abuse d. Management of frailty syndromes, covering at least: i. Intellectual impairment ii. Falls iii. Immobility iv. Incontinence v. Skin care vi. Nutrition and hydration	N	As QS ME-501. Several other relevant guidelines were in place but were not specific about the care of older people living with frailty.

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URGENT CARE SERVICES – EMERGENCY DEPARTMENT (ED) AND MEDICAL ASSESSMENT UNIT (MAU)

Ref	Quality Standards	Met? Y/N	Worcestershire Royal Hospital ED and MAU Reviewer Comments	Met? Y/N	Alexandra Hospital ED and MAU Reviewer Comments
ME-102	**Information and Support for Older People Living with Frailty and their Families and Carers** Information and support for older people at risk of or living with frailty, and their families and carers, should be available covering at least: a. Local services available to provide help, support and care b. How to access a directory of local services c. Maintaining a healthy lifestyle and preventing harm: i. Memory loss ii. Nutrition and hydration iii. Maintaining mobility, including exercises iv. Falls prevention v. Preventing and managing incontinence vi. Skin and foot care vii. Managing medication, including reducing polypharmacy d. How to access an advocate e. How to access advice on: i. Mental capacity and Deprivation of Liberty Safeguards ii. Power of Attorney iii. Advance Care Planning iv. End of Life Care f. Support available for carers g. Availability of assistive technology h. Relevant national groups and organisations i. How to give feedback on support and care received	Y	Information was available in the clinical areas and via the intranet.	Y	Information was available in the clinical areas and via the intranet.

Ref	Quality Standards	Met? Y/N	Worcestershire Royal Hospital ED and MAU Reviewer Comments	Met? Y/N	Alexandra Hospital ED and MAU Reviewer Comments
ME-104	**Reasonable Adjustments** Reasonable adjustments should be made for older people living with frailty using the service including: a. Flexible appointment times and extended appointment times, if required b. Good availability of parking bays for people with disabilities c. Easy availability of wheelchairs d. Facility for supporting communication with people with hearing deficits, such as a loop system and/or room suitable for private discussions e. Communication aids suitable for use with people with visual impairments f. Discussion and information sharing with informal carers who are acting in the best interest of the older person	N	The signage and environment in the ED and MAU was not conducive for people with dementia. 'Flagging' of older people living with frailty had just been implemented through the Trust IT system.	Y	Systems in place in the ED and MAU were working well and staff were clearly aware of the needs of older people living with frailty and were making reasonable adjustments (see main report: good practice section). There was less evidence of reasonable adjustments on Ward 12 and further work with this team may be helpful.

Ref	Quality Standards	Met? Y/N	Worcestershire Royal Hospital ED and MAU Reviewer Comments	Met? Y/N	Alexandra Hospital ED and MAU Reviewer Comments
ME-298	**Training Programme** A rolling programme of training should be run for staff covering: **All staff:** a. Making reasonable adjustments for older people living with frailty, including those with dementia b. Use of the locally agreed 'Emergency Care Plan' c. Recognising adults with care and support needs and recognition of abuse d. Safeguarding **Staff involved in frailty screening:** e. Indications for frailty screening and use of the locally agreed frailty screening tool (QSs M*-501) including: i. Criteria for undertaking or referral for holistic frailty assessment ii. Criteria for referral for comprehensive geriatric assessment f. Main local services available for the care of older people living with frailty and referral for: i. Support and care ii. Maintaining a healthy lifestyle iii. Preventing harm iv. Support for carers	N	Mandatory training was in place, which included safeguarding. Additional training was taking place in relation to identification of older people with care and support needs and dementia. The nurse training did not cover delirium. All non-clinical staff had completed dementia training. Training covering all the requirements of the QS, including training in frailty screening for appropriate staff, was not yet in place.	N	Mandatory training was in place, which included safeguarding. Additional training was taking place in relation to identification of older people with care and support needs, delirium and dementia. Training covering all the requirements of the QS, including training in frailty screening for appropriate staff, was not yet in place.

Ref	Quality Standards	Met? Y/N	Worcestershire Royal Hospital ED and MAU Reviewer Comments	Met? Y/N	Alexandra Hospital ED and MAU Reviewer Comments
ME-301	**Support Services** Access to the following services should be available: a. 'Single point of access' for services to manage a crisis at home or to enable those older people living with frailty to return home quickly b. Frailty Team for: i. Advice and support ii. Rapid access ambulatory clinics c. Services providing: i. Support and care ii. Support for maintaining a healthy lifestyle and preventing harm iii. Support for carers d. End of life care	N	The QS was met, with the exception of 'b'.	N	The QS was met, with the exception of 'b'.
ME-401	**Facilities and Equipment** Facilities and equipment should be appropriate for the needs of older people living with frailty, including: a. Appropriate signage b. Noise reduction in busy areas and at night c. Access to health and social care records containing details of the care of the older person	N	Appropriate signage was not yet in place in all areas.	Y	

Ref	Quality Standards	Met? Y/N	Worcestershire Royal Hospital ED and MAU Reviewer Comments	Met? Y/N	Alexandra Hospital ED and MAU Reviewer Comments
ME-501	**Guidelines: Frailty Screening and Care of Older People Living with Frailty (1)** Guidelines on care of older people living with frailty should be in use covering: d. Making reasonable adjustments e. Use of Emergency Care Plan, including notifying the Care Coordinator f. Recognising adults with care and support needs and recognition of abuse g. Indications for frailty screening and use of frailty screening tool h. Criteria for undertaking or referral for holistic frailty assessment i. Criteria for referral for comprehensive geriatric assessment	N	Frailty-specific guidelines were not yet in place, although Trust-wide guidelines on care of vulnerable adults, safeguarding, and recognising and reporting abuse were in place. Health-economy wide formats for frailty screening had not yet been agreed.	N	Frailty-specific guidelines were not yet in place although Trust-wide guidelines on care of vulnerable adults, safeguarding and recognising and reporting abuse were in place. Health-economy wide formats for frailty screening had not yet been agreed.

Ref	Quality Standards	Met? Y/N	Worcestershire Royal Hospital ED and MAU Reviewer Comments	Met? Y/N	Alexandra Hospital ED and MAU Reviewer Comments
ME-502	**Clinical Guidelines: Care of Older People Living with Frailty (2)** Clinical guidelines for the care of older people living with frailty should be in use in each urgent care service, covering at least: a. Initial assessment and management of older people living with frailty, covering at least: i. Assessment of their clinical condition ii. Assessment of function iii. Consideration of capacity to make informed decisions iv. Obtaining relevant information from their GP and/or care home b. Medication review c. Recognising adults with care and support needs and recognition of abuse d. Management of frailty syndromes, covering at least: i. Intellectual impairment ii. Falls iii. Immobility iv. Incontinence v. Skin care vi. Nutrition and hydration	N	As QS ME-501. Several other relevant guidelines were in place but were not specific about the care of older people living with frailty.	N	As QS ME-501. Several other relevant guidelines were in place but were not specific about the care of older people living with frailty.

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SERVICES WHICH CONDUCT HOLISTIC FRAILTY ASSESSMENTS

Ref	Quality Standards	South Worcestershire Teams		North Worcestershire Teams	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
MN-102	**Information and Support for Older People Living with Frailty and their Families and Carers** Information and support for older people at risk of or living with frailty, and their families and carers, should be available covering at least: a. Local services available to provide help, support and care b. How to access a directory of local services c. Maintaining a healthy lifestyle and preventing harm: i. Memory loss ii. Nutrition and hydration iii. Maintaining mobility, including exercises iv. Falls prevention v. Preventing and managing incontinence vi. Skin and foot care vii. Managing medication, including reducing polypharmacy d. How to access an advocate e. How to access advice on: i. Mental capacity and Deprivation of Liberty Safeguards ii. Power of Attorney iii. Advance Care Planning iv. End of Life Care f. Support available for carers g. Availability of assistive technology h. Relevant national groups and organisations i. How to give feedback on support and care received	Y	A wide range of information was available in a range of formats. Work was also taking place on an improved service directory.	Y	A wide range of information was available in a range of formats. Work was also taking place on an improved service directory.

Ref	Quality Standards	South Worcestershire Teams		North Worcestershire Teams	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
MN-103	**Frailty-Specific Information** Information for older people and their family and carers should be available covering, at least: a. Assessment process b. Care and Support Planning, including: i. Advice available to help them identify choices and evaluate options ii. Access to an advocate for people with substantial difficulty in being actively involved with planning their care c. Emergency Care Plan and its use d. Maintaining a healthy lifestyle, preventing harm and managing problems with: i. Memory loss ii. Nutrition and hydration iii. Maintaining mobility, including exercises iv. Falls prevention v. Preventing and managing incontinence vi. Skin and foot care vii. Managing medication, including reducing polypharmacy e. DVLA regulations and driving advice (if applicable) f. Personal health and care budgets g. Advance Care Planning h. Sources of further advice and information	Y		Y	

Ref	Quality Standards	South Worcestershire Teams		North Worcestershire Teams	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
MN-104	**Reasonable Adjustments** Reasonable adjustments should be made for older people living with frailty using the service including: a. Flexible appointment times and extended appointment times, if required b. Good availability of parking bays for people with disabilities c. Easy availability of wheelchairs d. Facility for supporting communication with people with hearing deficits, such as a loop system and/or room suitable for private discussions e. Communication aids suitable for use with people with visual impairments f. Discussion and information sharing with informal carers who are acting in the best interest of the older person	Y	The Enhanced Care Teams had flexibility in time 'slots', depending on need.	Y	Reviewers saw some excellent examples of reasonable adjustments being made by staff who they accompanied on home visits.
MN-105	**Advice and Advocacy** Older people living with frailty and their families and carers should be offered: a. Advice to help them identify choices and evaluate options b. If requested, an opinion or recommendation on appropriate care and support c. If the older person has substantial difficulty in being actively involved with planning their care, access to an advocate	Y	See main report in relation to the impact of the Patient Flow Centre on patient choice.	Y	See main report in relation to the impact of the Patient Flow Centre on patient choice.

Ref	Quality Standards	South Worcestershire Teams		North Worcestershire Teams	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
MN-106	**Care and Support Plan** Each frail older person and, where appropriate, their family or carers should discuss and agree their Care and Support Plan, and should be offered a written record covering at least: a. Older person's wishes and goals, including life-style goals b. Summary of holistic frailty assessment (QS MN-503) c. Self-management d. Planned care and support e. Care Coordinator, including contact details f. Review date and review arrangements g. Advocate details (if applicable) h. 'Do not attempt resuscitation' documentation (if applicable) i. Advance Directives (if applicable) The Care and Support Plan should be communicated to the older person's GP and to relevant other services involved in their care.	Y	Care home Nurse Practitioners undertook holistic frailty assessments that were then uploaded onto EMIS, which meant that the information was accessible to GPs and other community staff. A joint holistic assessment document was in use in the community teams. Different documentation was in place on the wards. Community teams could access primary care records. A single Care and Support Plan for older people living with frailty across Worcestershire was not yet in place.	Y	This QS was met for each of the individual services, although a single Care and Support Plan for older people living with frailty across Worcestershire was not yet in place.
MN-107	**Review of Care and Support Plan** The Care Coordinator should ensure that a formal review of the older person's Care and Support Plan should take place as planned, after each change in their condition or circumstances, after each emergency hospital admission and, at least, six monthly. This review should involve the older person, where appropriate, their family or carer, and appropriate members of the multi-disciplinary team. The outcome of the review should be communicated in writing to the older person, their GP and to relevant other services involved in their care.	Y	Reviewers suggested that arrangements for Advanced Nurse Practitioners' review of care and support plans may benefit from audit.	Y	

Ref	Quality Standards	South Worcestershire Teams		North Worcestershire Teams	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
MN-108	**Emergency Care Plan** All older people living with frailty should have the opportunity to develop an 'Emergency Care Plan', covering at least: a. Summary of their wishes and goals b. Preferred care in an emergency c. Contact details of main family or carers d. Contact details of the Care Coordinator e. Main services already involved with the person's care f. If 'do not attempt resuscitation' or other Advance Directives are in place g. Date agreed and review date Guidance on keeping the Emergency Care Plan in an accessible place should be available.	Y	The format of the Emergency Care Plan may benefit from review to include more about the older person's wishes. The version in use defined 'ceilings of care' from a service perspective.	N	Reviewers saw an Emergency Care Plan template but did not see examples in use in any of the homes visited. Emergency Care Plans would have been helpful for some of the older people visited.

Ref	Quality Standards	South Worcestershire Teams		North Worcestershire Teams	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
MN-203	**Staff Competences** All staff should have competences appropriate to their role in: a. Conducting Holistic Frailty Assessments / Comprehensive Geriatric Assessments (as applicable) b. Safeguarding adults with care and support needs c. Recognising and meeting the needs of adults with care and support needs d. Dealing with challenging behaviour, violence and aggression e. Mental Capacity Act and Deprivation of Liberty Safeguards	N	In Droitwich and Worcester City work was in progress to look at competences for the services. Some aspects were already covered by mandatory training and additional training in relation to delirium and dementia but these did not cover all aspects of the QS. The Enhanced Care Team had mapped a competence framework with the view to implementation. Reviewers were told that there were some differences between health and social care staff in terms of competences. Care home practitioners did have competences appropriate to their roles. Wards had Advanced Nurse Practitioners for mental health and two Advanced Nurse Practitioners for elderly medicine covered the wards and were nurse prescribers.	N	Work was in progress looking at competences needed for the services. Some aspects were already covered by mandatory training and additional training in relation to delirium and dementia, but these did not cover all aspects of the QS.

Ref	Quality Standards	South Worcestershire Teams		North Worcestershire Teams	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
MN-298	**Training Programme** A rolling programme of training should be run for staff covering: **All staff:** a. Making reasonable adjustments for older people living with frailty, including those with dementia b. Use of the locally agreed 'Emergency Care Plan' c. Recognising adults with care and support needs and recognition of abuse d. Safeguarding **Staff involved in frailty screening:** e. Indications for frailty screening and use of the locally agreed frailty screening tool (QSs M*-501) including: i. Criteria for undertaking or referral for holistic frailty assessment ii. Criteria for referral for comprehensive geriatric assessment f. Main local services available for the care of older people living with frailty and referral for: i. Support and care ii. Maintaining a healthy lifestyle iii. Preventing harm iv. Support for carers	N	Mandatory training was in place, which included safeguarding. Additional training was taking place in relation to the identification of older people with care and support needs, delirium and dementia. Training covering all the requirements of the QS, including training in frailty screening for appropriate staff, was not yet in place.	N	Mandatory training was in place, which included safeguarding. Additional training was taking place in relation to identification of older people with care and support needs, delirium and dementia. Training covering all the requirements of the QS, including training in frailty screening for appropriate staff, was not yet in place.

Ref	Quality Standards	South Worcestershire Teams		North Worcestershire Teams	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
MN-301	**Support Services** Access to the following services should be available: a. 'Single point of access' for services to manage a crisis at home or to enable those older people living with frailty to return home quickly b. Frailty Team for: i. Advice and support ii. Rapid access ambulatory clinics i. Services providing: ii. Support and care iii. Support for maintaining a healthy lifestyle and preventing harm iv. Support for carers c. End of life care	N	The QS was met, with the exception of 'b'. Integration with mental health services was particularly good.	N	The QS was met, with the exception of 'b'.
MN-401	**Facilities and Equipment** Facilities and equipment should be appropriate for the needs of older people living with frailty, including: a. Appropriate signage b. Noise reduction in busy areas and at night c. Access to health and social care records containing details of the care of the older person	Y	The equipment provider 'Able 2' was able to undertake assessments, and provided a wide range of equipment. Staff who met the reviewing team commented that this service often reduced the level of input by care staff that was required.	Y	Good access to large equipment was available. Reviewers were told of some problems with access to small items of equipment in Bromsgrove and Redditch although other staff said this was not difficult. Supply of equipment in Kidderminster was reported to be good.

Ref	Quality Standards	South Worcestershire Teams		North Worcestershire Teams	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
MN-501	**Guidelines: Frailty Screening and Care of Older People Living with Frailty (1)** Guidelines on care of older people living with frailty should be in use covering: a. Making reasonable adjustments b. Use of Emergency Care Plan, including notifying the Care Coordinator c. Recognising adults with care and support needs and recognition of abuse d. Indications for frailty screening and use of frailty screening tool e. Criteria for undertaking or referral for holistic frailty assessment f. Criteria for referral for comprehensive geriatric assessment	N	Specific guidelines were not yet in place although the requirements were covered, in general, by the assessment process and assessment documentation. Health-economy wide formats for assessment documentation had not yet been agreed.	N	Specific guidelines were not yet in place although the requirements were covered, in general, by the assessment process and assessment documentation. Health-economy wide formats for assessment documentation had not yet been agreed.

Ref	Quality Standards	South Worcestershire Teams		North Worcestershire Teams	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
MN-503	**Holistic Frailty Assessment / Comprehensive Geriatric Assessment** Guidelines on holistic frailty assessment should be in use covering at least: a. Involving the older person, their family and carers b. Staff who should be involved c. Conducting a holistic frailty assessment using the locally agreed format (if available) and covering at least: i. Any concerns about mental capacity ii. Medical: comorbid conditions, disease severity and nutritional status, including tissue viability, continence and swallowing iii. Mental health: cognition, mood, anxiety and fears, past history of delirium iv. Functional capacity: activities of daily living, eye sight, mouth and teeth, hearing, mobility, gait and balance, activity and exercise status, falls assessment, any concerns about driving ability (if applicable) Social and financial circumstances: informal support, social network and activities, eligibility for care v. Environment: home comfort and facilities, personal safety, potential use of Telehealth/Telecare and assistive technology, transport facilities, accessibility of local resources vi. Medication review (QS ME-502) d. Documentation of the assessment e. Indications for more detailed assessments, including dementia assessment f. Indications for referral to the Frailty Team for a Comprehensive Geriatric Assessment	N	As QS MN-501.	N	As QS MN-501.

Ref	Quality Standards	South Worcestershire Teams		North Worcestershire Teams	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
MN-504	**Guidelines: Medication Review** Guidelines on medication review for older people living with frailty should be in use, covering at least: a. Consideration of de-prescribing and reducing poly pharmacy b. Medication side effects c. Drug interactions d. Appropriateness of dosages e. Persons ability to take medication correctly and safely f. Support required for medicines administration g. Monitoring requirements	Y	Trust policies were in place.	Y	Trust policies were in place.
MN-505	**Clinical Guidelines: Management of Frailty Syndromes** Clinical guidelines on the management of frailty syndromes should be in use, covering at least: a. Intellectual impairment b. Falls c. Immobility d. Incontinence e. Skin care f. Nutrition and hydration	N	Generic Trust guidelines were in place for 'b', 'd', 'e' and 'f', although these were not specific to the management of older people living with frailty.	N	Generic Trust guidelines were in place for 'b', 'd', 'e' and 'f', although these were not specific to the management of older people living with frailty.
MN-701	**Data Collection** The service should collect data on: a. Frailty screens undertaken b. Number of patients identified as frail c. Holistic Frailty Assessments undertaken / Referrals for Holistic Frailty Assessment d. Referrals to the Frailty Team for Comprehensive Geriatric Assessment	N	Data covering all aspects of the QS were not yet routinely collected, although some data were available from the GP EMIS system.	N	Data covering all aspects of the QS were not yet routinely collected.

COMMISSIONING - NHS REDDITCH AND BROMSGROVE, NHS SOUTH WORCESTERSHIRE, NHS WYRE FOREST CCGS

Ref	Quality Standards	Met? Y/N	Reviewer Comments
MZ-298	**Local Training Programme** The Local Health and Social Care 'Older People Living with Frailty' Group should have agreed and implemented a training programme for all health and social care services providing care for older people living with frailty, covering the requirements of QS M*-298.	N	A training programme on dementia had taken place. All health and care staff had training in relation to care and support needs and safeguarding adults. A training programme focussed on older people living with frailty was not yet in place.
MZ-601	**Needs Assessment and Strategy** The Local Health and Social Care 'Older People Living with Frailty' Group should have an agreed: a. Needs assessment b. Strategy for the care and support of older people living with frailty The needs assessment and strategy should include consideration of older people living with frailty who have special needs, including those with: i. Learning disabilities ii. Sensory impairment	N	Reviewers did not see a specific strategy relating to care of older people living with frailty. This client group was seen as a priority within the Joint Strategic Needs Assessment, and GPs, especially in South Worcestershire, had undertaken work to identify older people at risk of hospital admission. Several strategies mentioned older people with frailty but this was not brought together into a clear strategy for their care and support.
MZ-602	**Commissioning of Services** Integrated health and social care services for the care and support of older people living with frailty should be commissioned including, at least: a. Carers support and access to short-term breaks b. Equipment c. Services to maximise independence d. Admission avoidance schemes and response to urgent need e. Influenza and pneumococcal pneumonia vaccination f. Frailty Team g. Services providing: i. Support and care ii. Support for maintaining a healthy lifestyle and preventing harm iii. Support for carers	N	'a' was met. 'b' was met, although reviewers were told of some problems with accessing small equipment in the north of the county. 'c', 'd' and 'e' were met. 'f' was not met as there was no identified Frailty Team. Some aspects of a team were in place but these were not brought together. 'g' was met.

Ref	Quality Standards	Met? Y/N	Reviewer Comments
MZ-603	**Local Health and Social Care 'Older People Living with Frailty' Group** Commissioners should ensure that a multi-agency Local Health and Social Care 'Older People Living with Frailty' Group meets regularly to review implementation of the local strategy and address any problems with coordination of local services. The Group should involve representatives of at least: a. Older people living with frailty and their families and carers b. Primary health care c. Urgent care services d. Providers of holistic frailty assessments e. Care homes f. Frailty Team g. Mental health services h. Social services i. Relevant local voluntary sector organisations	N	A multi-agency Urgent Care / Best Practice Board was in place and each CCG had an Alliance Board with wide representation. There was no forum that concentrated specifically on frailty, and consultant geriatricians were not part of any of the groups that were in place. There was no Frailty Team in Worcestershire.
MZ-604	**Local Agreements** The Local Health and Social Care 'Older People Living with Frailty' Group should have agreed the following for use across the local health and social care economy: a. Indications for frailty screening b. Frailty screening tool c. Criteria, based on severity and complexity of needs, for Holistic Frailty Assessment and Comprehensive Geriatric Assessment (multi-disciplinary) d. Format and documentation of: i. Holistic Frailty Assessments and Comprehensive Geriatric Assessments ii. Emergency Care Plans	N	A range of frailty tools was used across Worcestershire, with each service having its own tools. Reviewers were told that Emergency Care Plans were in place in nursing homes in South Worcestershire and for patients of the virtual wards in North Worcestershire. Reviewers saw an Emergency Care Plan template but did not see examples in the homes visited. Assessments were carried out in a range of formats.
MZ-701	**Quality Monitoring** The Local Health and Social Care 'Older People Living with Frailty' Group should monitor at least annually: a. Data collected by services providing Holistic Frailty Assessments (QS MN-701) b. Key performance indicators and aggregate data on activity and outcomes from the Frailty Team (QS MP-701) c. Audits of referrals to the Frailty Team (MP-702)	N	Monitoring of admissions to hospital of people aged over 75 was in place and this was analysed by care home and by practice. Referrals, activity and outcomes of the Frailty Team were not yet monitored, as a team (as such) was not yet in place.

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