WM QRS West Midlands Quality Review Service

NHS

Care of Older People Living with Frailty

Walsall Health and Social Care Economy

Visit Date: 19th April 2016 Report Date: July 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 19th April 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 that reviewed the services in Walsall, 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:

- Walsall Healthcare NHS Trust
- Dudley and Walsall Mental Health Partnership NHS Trust
- NHS Walsall Clinical Commissioning Group
- Walsall Metropolitan Borough 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 Walsall Clinical Commissioning Group.

ACKNOWLEDGMENTS

West Midlands Quality Review Service would like to thank the staff and service users and carers of Walsall 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

SERVICES PROVIDED

Walsall Healthcare NHS Trust

1 Walsall Healthcare NHS Trust services worked in close partnership with each other and with primary care, social care, voluntary sector and mental health services in providing care for Walsall's older people living with frailty.

2 Community nursing services were provided by five Integrated Locality Teams, which included district nursing and community matron services. At the time of the review the teams had approximately 200 staff (clinical and administrative) for a caseload of about 5,000 patients, a large proportion of whom were older people living with frailty. The Integrated Locality Teams were based around groups of GP practices, and they offered 24/7 services. Community matrons were band 7 registered nurses who were supported by band 5 case managers. Community matrons were available between 8am and 6pm, seven days a week.

3 The community Rapid Response Service provided a single point of access service for sub-acutely ill patients who required rapid, intensive interventions at home; the service prevented hospital admission and reduced the risk of avoidable harm. Working closely with therapy staff in health and social care, the Rapid Response Service was able to arrange 'wrap-around' care to help people to remain at home and, if necessary, 'step up' to a community bed. The service was available seven days a week from 8.30am to 10pm, with a two hour response time for urgent referrals. A multi-disciplinary meeting with a GP from the Frailty Service was held daily (Mondays to Fridays).

4 The community Intermediate Care Team, comprising registered nurses, physiotherapists, occupational therapists and administrative support, provided rehabilitation in a patient's own home or in a care setting for up to six weeks after discharge from acute hospital care or a 'step-up' community bed, or after attendance at the Emergency Department. This team worked closely with two social workers, one member of the Community Mental Health Team for Older Adults, and re-ablement officers from Walsall Council. In-patient intermediate care was provided in Hollybank House or in up to 10 'spot-purchased' nursing home beds.

5 Other community-based services for older people living with frailty included two community matron in-reach nurses, supported by a band 4 admission avoidance officer. These staff worked with ward staff in Walsall Manor Hospital and with staff providing community-based beds in order to reduce length of stay by speeding up discharge to the care of community teams, intermediate care or 'discharge to assess' beds. Enhanced care in nursing and residential homes was provided by a band 6 nursing home case manager and an Advanced Nurse Practitioner. They identified patients at high risk of hospital admission to increase the number of early interventions, developed personalised care plans – including emergency 'passports', provided additional clinical assessment and nursing care, and provided additional training for nursing home staff. An electronic 'Virtual Ward' held details of people cared for by community services in the community who were considered at very high risk of admission. This served as a communication hub and ensured patients were monitored and reviewed as necessary.

6 The Frailty Service had been operational since January 2016 and was linked very closely with, and supported, all community services. The Frailty Service also assessed patients who had been identified as frail in the Emergency Department or Acute Medical Unit. Up to eight beds on Ward 29 in Walsall Manor Hospital were allocated to the Frailty Service for patients with an expected length of stay of less than 72 hours. A daily multi-disciplinary team meeting was held to review and plan the care of these patients.

Dudley and Walsall Mental Health Partnership NHS Trust

1 Services for older people living with frailty provided by Dudley and Walsall Mental Health Partnership NHS Trust included two in-patient wards, Cedar and Linden, at Bloxwich Hospital, a day hospital (Bloxwich Day Hospital) and Community Mental Health Teams for Older Adults.

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Review Process

Reviewers visited Darlaston Health Centre and met with GPs and representatives of the Integrated Locality Teams, a Residential and Nursing Home Lead, and the Rapid Response Service. At Bloxwich Hospital reviewers visited the Linden and Cedar in-patient wards and the Bloxwich Day Hospital and met with representatives of the Community Mental Health Teams for Older Adults. At Walsall Manor Hospital, reviewers visited the Emergency Department, the Medical Admissions Unit and Ward 29**.**

Reviewers also met representatives from the community matron in-reach service, the integrated discharge team and care homes, and social workers and social care commissioners. Clinical Commissioning Group commissioners of care for older people living with frailty were unable to be present on the day of the visit but submitted written evidence and commented on the draft report.

Table 1 summarises the scope of this review visit and the section of the Quality Standards for the Care of Older People Living with Frailty: Assessment and Coordination of Care applicable to each service.

Table 1 Quality Standards Sections Used in this Review

Topic / Organisation	Section of Quality Standards Used (QS)
Primary Care	• All health and social care services.
Walsall Healthcare NHS Trust	• Urgent care • Services providing holistic frailty assessment • Frailty Team
Dudley and Walsall Mental Health Partnership NHS Trust	• Services providing holistic frailty assessment
NHS Walsall Clinical Commissioning Group	• Commissioning

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Visit Findings

Health and Social Care Economy

General Comments and Achievements

Services were generally working well together to improve the care of older people living with frailty. Several service improvements had been achieved and further developments were planned. Representatives from nursing homes commented that they were treated as valued partners in the provision of care for older people living with frailty.

Good Practice

1 Care home staff were able to access training at Walsall Healthcare NHS Trust at no cost, which was improving the quality of care in care homes as well as improving integration between services.

2 Emergency Care Plans were in place for residents of 12 of Walsall's 13 nursing homes, and these plans were registered with the West Midlands Ambulance Service.

3 Proactive weekly ward rounds were in place in 12 nursing homes. The multi-disciplinary ward rounds included attendance by the patients and their carers / relatives if appropriate.

4 A 'Do Not Attempt Resuscitation' (DNAR) process had been agreed, and there was standard documentation for use across the health economy; this meant that information and documentation was transferred between services, and sensitive discussions with patients and their carers / relatives were not repeated unnecessarily.

Further Consideration

1 The development of services for older people living with frailty was coordinated through the 'Care Closer to Home' Group at Walsall Healthcare NHS Trust, but a Walsall system-wide group focusing on frailty was not in place. This issue was not categorised as a 'concern' because of the extensive progress that had been made through the mechanisms that were in place. A group involving social services and mental health services may be helpful as part of further improvements in the care of older people living with frailty in the borough.

2 Community health services in the west of Walsall had good links with social workers. In the time available, reviewers were not able to establish whether this finding applied to all areas of Walsall. Reviewers were given differing views about the availability of care packages, and social services did not appear to have been fully involved in the development of the Frailty Service. Further discussions to ensure links are working well may be helpful.

3 Residents of one large nursing home did not yet have Emergency Care Plans, and the links with GPs caring for patients in this home were reported to be less good than the links in other areas.

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PRIMARY CARE

Good Practice

1 GP practice teams within Walsall were committed to delivering an enhanced service that used a risk stratification programme within the EMIS computer system to identify the two per cent of the GPs' patients with complex multiple morbidity or frailty who may benefit from multi-disciplinary team support. Monthly risk stratification meetings were held, and the patients' management plans were discussed. Representatives of the Integrated Locality Teams, specialist nurses and social care representatives attended these meetings. In addition, patients with multiple long-term conditions who had had four or more hospital admissions during the previous 12 months were identified for case management. Good data on the outcomes of the case management work were available.

2 A system of feedback of 'Quality Concerns' was managed by commissioners. Patients and carers could email comments about their treatment, raise concerns about services or seek advice. The system was monitored daily, with a staff member allocated to respond.

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WALSALL HEALTHCARE NHS TRUST

General Comments and Achievements

The staff who met the visiting team were enthusiastic and highly committed to providing good care for older people living with frailty. There was a good understanding of the roles of different services, and a shared understanding of the local vision for the development of services. Staff also had a good understanding of frailty

and its importance, and were clearly committed to providing care at home whenever possible. Good multi-disciplinary leadership of services for older people living with frailty was evident throughout the services reviewed. Respect for the contribution of different disciplines and different services was also evident. Nursing staff had a good awareness of the universal services that were available and knew how to access these services.

A good range of community-based services was available, including Rapid Response and 'wrap-around' care for those who were acutely unwell. The Frailty Service model had been carefully thought out and implementation was progressing well. The Frailty Service linked well with community services and showed good multi-disciplinary working with a strong focus on decision-making leading to action. Therapy staff took part in the ward round in order to provide input to multi-disciplinary care planning.

Good Practice

1 The 'CANAR' electronic alert system notified community teams through an automatic email when any of their patients attended the Emergency Department or were admitted to Walsall Manor Hospital. This improved communication, avoided unnecessary community visits and ensured community staff could actively support discharge from acute hospital care.

2 Older people identified as frail in the Emergency Department or Acute Medical Unit were reviewed by the Frailty Service consultant or a GP with a specialist interest, who were available five days a week.

3 The Frailty Service telephoned all patients the day after they were discharged from acute hospital care or had attended the Emergency Department. This provided confirmation that all relevant services were in place and that the patient was progressing as expected. If problems were reported then the Frailty Service ensured action was taken, with the aim of preventing re-admission or re-attendance.

4 The Frailty Service ran a two-weekly training programme about frailty which staff from other services were welcome to attend. Operational issues were discussed at the end of the session, which provided the opportunity for staff from a range of services to be involved in the service's review and learning.

5 Good data on admission avoidance was collected on a regular basis, and many of the services reviewed had data on patient outcomes and the effectiveness of the services provided. For example, 90% of patients referred to the Rapid Response Service had avoided a hospital admission, and the community matron in-reach service could demonstrate that the number of patients in hospital who were already known to community services had reduced from over 30 to between eight and 12 at the time of the review. The team providing case management in care homes could demonstrate a 67% reduction in the number of 999 calls made by nursing homes.

Immediate Risks: No immediate risks were identified.

Concerns

1 **Availability of Ward 29 Frailty Beds**

Eight beds on Ward 29 were allocated for patients under the care of the Frailty Service, but these were often occupied by other patients, including patients who were medically fit for discharge. On the day of the review visit, only three Frailty Service patients were in the beds, with other patients appropriate for the care of the team being on other wards. This reduced the team's ability to provide effective interventions for patients with an expected length of stay of less than 72 hours.

2 **Discharge Information from the Emergency Department**

Patients who attended the Emergency Department and were identified as frail had a medical review and a nursing assessment by the Frailty Service. The outcome of the review and assessment was not sent with the patient when they left the department (unless they were admitted). The only information sent with the patient was the yellow Emergency Department communication sheet, which did not include any details of the assessments. As a result, the information from the review and assessment, including medication changes, was not easily available to either those care providers to whom the patient was

transferred or families, carers or staff continuing the patient's care in the community, intermediate care bed or care home.

Further Consideration

1 Reviewers made two other comments about assessments in the Emergency Department. First, if a further medical review was indicated, it was not clear to reviewers how this would be organised and by whom. This may be clear to some staff but others could not articulate the process to reviewers. Secondly, relatively little information about falls and fragility fracture prevention was evident on the day of the visit.

2 The Frailty Service met with Acute Medical Unit staff at 11.15am each day to identify patients suitable for their care. The timing of this meeting and the subsequent ward multi-disciplinary meeting (2.15pm) may benefit from review. Reviewers suggested that both meetings could be held earlier in the day in order to improve the chance of patients being discharged that day.

3 The Frailty Service was operating only five days a week at the time of the review. Staff were still being recruited and the potential to expand to a seven day service was being discussed. Reviewers supported this development. Reviewers also commented that several roles within the team were filled by individual practitioners (a consultant, a GP with a specialist interest, a pharmacist, a physiotherapist, an occupational therapist) and that the team had no allocated social work time. As part of the team's development, it will be important to ensure that effective cover for absences is in place. Some social work time allocated to the team may also improve its effectiveness.

4 The white board on Ward 29 included a 'wish list', and the language on this may benefit from review as the white board is easily visible to passing staff, patients and visitors. Reviewers suggested that the board may be better titled as a 'task' or 'action' list.

5 Much of the Trust's documentation around frailty was in draft form, and some other information was beyond its review date. In particular, the Frailty Pathway was in draft form and some of the team names had changed since the pathway was first written. Several templates had been developed, and it was not clear if these had all been implemented. This was not surprising given that the Frailty Service had been operational only since January. It will be important to ensure that all documentation is finalised and fully implemented, especially as the service grows and new staff are recruited.

6 Community services caring for older people living with frailty had a good understanding of the roles and responsibilities of the different services. A 'care coordinator' or 'designated nurse' model was not in place and reviewers wondered how patients felt about the range of different services involved in their care. Further work to obtain patients' and carers' views should be helpful as part of the ongoing programme of service improvement.

7 The Dudley and Walsall Mental Health Partnership NHS Trust section of this report (see below) identifies several opportunities for improving the care of older people living with frailty through joint working with Walsall Healthcare NHS Trust.

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DUDLEY AND WALSALL MENTAL HEALTH PARTNERSHIP NHS TRUST

General Comments and Achievements

Staff on Cedar and Linden Wards who met the visiting team were enthusiastic about providing care for older people living with frailty and had worked hard to make the environment as appropriate for their care as possible. Both the decoration and the layout of the wards had been changed to make them more suitable, the wards were welcoming and did not have a 'clinical' atmosphere, the day room was well-designed and the bathroom facilities were very good. The on-site coffee shop and conservatory provided good facilities and a welcoming environment for visitors. A policy on the care of service users' physical health needs was in development.

In general, staff did not appear well-prepared for the review visit. Little evidence of compliance with the Quality Standards was available and some staff did not appear to understand the purpose of the visit.

Good Practice

1 The in-patient wards had implemented a good range of assessments of individual aspects of frailty: continence, falls risk, tissue viability, nutrition and hydration and a speech and language therapy assessment. These were particularly well-organised on the Linden dementia unit.

2 Assessments were reviewed and updated regularly and included identification of the individual's personal strengths and what they could achieve, as well as identifying problems. Medication reviews were carried out with a good focus on polypharmacy, and service users were placed in a high, medium or low category in relation to medication risk, which ensured interventions were targeted to those at greatest risk.

Immediate Risks: No immediate risks were identified.

Concerns

1 **Bloxwich Day Hospital**

Reviewers were seriously concerned about the care of older people living with frailty in Bloxwich Day Hospital. Day Hospital staff did not demonstrate a good understanding of frailty, and relevant assessments of physical health were not undertaken routinely. The one set of case notes shown to reviewers did not have relevant baseline observations or information on physical health; the care plan was dated January 2016 and was due for review in February 2016. (This may be related to the multiple record systems, see below.) A paper-based screening tool, which had some questions about physical health, was supposed to be completed for all new attenders, but this did not appear to be completed routinely. It was also not clear that staff had appropriate competences in the care of service users' physical health needs.

The programme of activities at the Day Hospital was not focused on re-ablement, and some aspects of the service appeared to be encouraging dependence rather than independence. Reviewers considered that many of the interventions could have been provided by the service users themselves, possibly with voluntary sector support. Personalised goal-setting and re-ablement plans were not in place.

Staffing levels were high (six staff for six service users on the day of the review visit, comprising band 5, 6 and 7 registered nurses and three healthcare assistants). The function of the Day Hospital was not clear and it did not appear to reviewers that the service was the most effective use of the resources available, especially given the staffing pressures on the in-patient wards and the need for greater mental health service support to Integrated Locality Teams.

Reviewers were told that a review of the Day Hospital function was included as part of the Older Adult Mental Health Quality, Innovation, and Prevention & Productivity (QIPP) Proposals for 2016/17.

2 **Multiple Care Records**

Several different systems of documentation of care provided were in use. Medical staff wrote in the medical notes, community staff used the OASIS system, nursing and therapy staff on the in-patient wards wrote in paper notes and the Day Hospital had its own notes as well as accessing the OASIS system. Some in-patient staff could not access the OASIS system. This situation meant that an overview of care plans and risks assessments was not available, and clinical staff did not have access to a full record of care when they saw a service user. Reviewers were told of delays in the availability of information when someone was admitted to in-patient care, and delays in the availability of information to community and Day Hospital staff when they were discharged. The OASIS system was reported to be complex to use and it was therefore difficult to find information even if staff had access to it.

3 **Access to Therapies**

Physiotherapy was not available for in-patients or for users of the Day Hospital. Physiotherapy services at Walsall Manor Hospital could be accessed, but reviewers were told of long waits for this service, and some staff were not clear how to access it. In-patients who were not able to travel to the Manor Hospital, including some who were admitted to Bloxwich Hospital post-operatively, for example, following a fractured neck of femur, did not have any access to physiotherapy.

A full-time occupational therapy post was vacant and was being covered by a band 5 agency occupational therapist on Fridays and Saturdays. The occupational therapist was not therefore able to contribute to multi-disciplinary team meetings. Clinical supervision was from a consultant occupational therapist although it was not clear if this was actually functioning because of the days worked by the agency occupational therapist. Even if the full-time post had been filled, reviewers considered that one occupational therapist for a 36-bedded hospital and a Day Hospital was insufficient.

Reviewers were told that a Service Level Agreement was being discussed, but the timescale for agreement and the amount of therapy input which it would provide, especially for in-patients, was not clear.

4 **Community Mental Health Teams for Older Adults**

Representatives of the Community Mental Health Teams for Older Adults who met the visiting team also did not demonstrate a good understanding of frailty. No process for holistic frailty assessment was in place and the assessments that were undertaken covered only mental health. Staff said that they were keen to work more closely with Integrated Locality Teams (district nurses and community matrons) but the mechanism by which this closer working was to be achieved was not clear.

5 **Guidelines and Training**

Many of the guidelines and procedures expected by the Quality Standards were not yet in place. A competence framework was available and identified some higher level physical health-related competences. The framework did not cover some of the more basic competences, for example, measuring blood pressure and blood sugar, which would be appropriate for many different registered and non-registered staff.

Further Consideration

1 In general, reviewers considered that there was a real opportunity to improve the quality of care for older people living with frailty through more integrated work between Dudley and Walsall Mental Health Partnership NHS Trust and Walsall Healthcare NHS Trust. The in-patient wards at Bloxwich Hospital had a template for frailty assessment which staff were considering using. Reviewers strongly suggested that this is discussed with the Frailty Service at Walsall Healthcare and, if possible, a common assessment tool used. Reviewers considered that it may also be helpful to bring the existing assessments into this framework. Development of guidelines to underpin the various assessments was also required but, with support from the Frailty Service, this could probably be achieved fairly easily. Closer working between the Community Mental Health Teams for Older Adults and the Integrated Locality Teams had the potential to improve care significantly by improving the coordination and integration of physical and mental health services.

2 The care provided on the in-patient wards, as observed by reviewers, was good, but staffing levels were low (4/4/3) for the dependency of the service users. Several vacancies were being covered by agency and bank staff. Staffing levels were reviewed daily but reviewers commented that the situation may not be sustainable, especially if the number of vacancies increases.

3 Reviewers suggested that it may be helpful to identify a Trust lead for the care of older people living with frailty who could champion the development and integration of services.

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COMMISSIONING

Commissioners had given good support to the development of the community-based services for older people living with frailty and the Frailty Service. A good range of metrics was in place. A 'Frail Elderly Strategy' was in the process of being agreed.

Good Practice

1 See also Health and Social Care Economy good practice section.

2 Patient Representation Groups (PRGs) were in place in practices as part of an enhanced arrangement with practices, and weekly meetings were held with commissioners and the PRG chair person. This forum provided a good process for the exchange of information, and enabled good engagement and input into any strategic and quality work taking place.

3 There was good engagement between commissioners and primary care staff, which included a range of training provided by commissioners, to ensure that lessons were learned from incidents.

Concerns

1 Other sections of this report identify issues that require commissioner attention:

a. Availability of Ward 29 Frailty Beds: See Walsall Healthcare NHS Trust, Concern 1

b. Discharge Information from the Emergency Department: See Walsall Healthcare NHS Trust, Concern 2

c. Bloxwich Day Hospital: See Dudley and Walsall Mental Health Partnership NHS Trust, Concern 1

d. Multiple Care Records: See Dudley and Walsall Mental Health Partnership NHS Trust, Concern 2

e. Access to Therapies: See Dudley and Walsall Mental Health Partnership NHS Trust, Concern 3

f. Community Mental Health Teams for Older Adults: See Dudley and Walsall Mental Health Partnership NHS Trust, Concern 4

g. Guidelines and Training: See Dudley and Walsall Mental Health Partnership NHS Trust, Concern 5

Further Consideration

1 Guidelines covering Frailty Screening and Care of Older People Living with Frailty across the health economy were not yet in place. Some guidance was in place covering some aspects of caring for older people and safeguarding, but these guidelines were not specific about the recognition and management of frailty syndromes or the management of older people living with frailty.

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APPENDIX 1 MEMBERSHIP OF VISITING TEAM

Visiting Team

Mandy Aworinde	Clinical Lead, Mental Health	The Dudley Group NHS Foundation Trust
Prisca Cocker	Lead Occupational Therapist for In-patient Mental Health	Worcestershire Health & Care NHS Trust
Louise Crathorne	Specialist Pharmacist, Elderly Care	The Dudley Group NHS Foundation Trust
Annette Darby	Team Manager, Access and Prevention (People)/Sheltered Housing (Place)	Dudley Metropolitan Borough Council
Karen Dawson	Service Manager - Musculoskeletal Integrated Clinical Assessment and	Staffordshire and Stoke on Trent Partnership NHS Trust
Molly Henriques-Dillon	Quality Nurse Team Leader	NHS Wolverhampton CCG
Sara Hilditch	Acting Integrated Service Manager	Staffordshire & Stoke on Trent Partnership NHS Trust
Tracey Jones	Deputy Executive, Quality and Engagement	NHS Telford and Wrekin CCG
Hannah Male	Integrated Care Team Leader	Worcestershire Health & Care NHS Trust
Dr Atef Michael	Medical Service Head, Older People	The Dudley Group NHS Foundation Trust
Josephine Povey	Modern Matron, Neuropsychiatry and Old Age Psychiatry	North Staffordshire Combined Healthcare NHS Trust
Julie Walklate	Matron for Stroke and Coronary Care Services	The Dudley Group 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

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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
Care of Older People Living with Frailty			
Primary Care	16	8	50
Urgent Care Services: Walsall Healthcare NHS Trust	7	4	57
All Services Which Conduct Holistic Frailty Assessment: Walsall Healthcare NHS Trust (Acute Trust and Community Services)	16	7	44
Frailty Team (Care of Older People Service): Walsall Healthcare NHS Trust	37	22	59
All services which conduct holistic frailty assessments: Dudley & Walsall Mental Health Partnership NHS Trust	48	12	25
Bloxwich Hospital - Wards	(16)	(4)	(25)
Bloxwich Hospital - Beeches Day Unit	(16)	(4)	(25)
Walsall Community Mental Health Team - Older Adults	(16)	(4)	(25)
Commissioning	6	1	17
Health Economy	**130**	**54**	**42**

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PRIMARY CARE

Ref	Quality Standards	Met? Y/N	Reviewer Comment
MA-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 was available in primary care for all aspects of the Quality Standard. Practice Review Groups were also in place in each GP practice. These groups provided a two way process for information and gathering information for shaping the quality improvement process within the commissioning agenda. A system for feedback called 'Quality Concerns' was managed by commissioners, whereby patients and carers could email comments about their treatment, raise concerns about services and seek advice. The system was monitored daily, with dedicated staff members available to respond.

Ref	Quality Standards	Met? Y/N	Reviewer Comment
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 Sources of further advice and information	N	Some information was seen during the visit to Darlaston Health Centre but it did not cover all aspects of the Quality Standard.
MA-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	Larger health care centres were able to make reasonable adjustments as defined by the Quality Standard but the process was not fully imbedded in smaller practices. Implementation of the Primary Care Estates Strategy included addressing the availability of 'b - e'.

Ref	Quality Standards	Met? Y/N	Reviewer Comment
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	
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	This was covered in the service specification for the Local Enhanced Service although reviewers did not see examples of care and support plans on the day of the visit.
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	As Quality Standard MN-106

Ref	Quality Standards	Met? Y/N	Reviewer Comment
MN-108	**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	
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	Y	Evidence supplied by commissioners indicated that this was in place, although reviewers did not see reports of training completed which would have confirmed this.

Ref	Quality Standards	Met? Y/N	Reviewer Comment
MA-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 training programme covering all staff involved in frailty screening was not yet in place across primary care. Emergency Care Plans had been implemented in care homes and there were plans to 'roll out' the process across all community services 'a', 'c' and 'd' were met.
MA-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	Y	
MA-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 were not able to determine compliance with this Quality Standard during the course of this review visit.

Ref	Quality Standards	Met? Y/N	Reviewer Comment
MA-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	Guidelines covering the requirements of the Quality Standard were not in place. Guidance covering making reasonable adjustments and use of emergency care plans were in place in care homes.
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	Guidelines on holistic frailty assessment across primary care were not yet in place.

Ref	Quality Standards	Met? Y/N	Reviewer Comment
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	N	Some information was available but did not constitute guidelines for medication review or the detail expected by the Quality Standard for older people living with frailty. In practice guidance was included in the general pharmacy contract with each GP practice for all patients with co-morbidities. Guidance on medication and monitoring was also included in the primary care pathways for respiratory and diabetes.
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	Guidelines covering the management of frailty syndromes were in not yet in place for GPs. Guidance was in place across the community teams and care homes.
MA-601	**Organisation of Care of Older People Living with Frailty** Each general practice should have arrangements for: a. Targeted case finding of frailty b. Allocation of an Accountable GP for patients aged 75 and over c. Ensuring all older people living with frailty are: i. Offered flu and pneumonia vaccination ii. Considered for inclusion on the practice Palliative Care Register iii. Considered for Advance Care Planning d. Medicines reconciliation and medication review for older people living with frailty after discharge from hospital and at least six monthly e. Monitoring hospital admissions of older people living with frailty, including those with 'ambulatory care sensitive conditions'	Y	
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 were not yet collected as required by the Quality Standard, though would be addressed as part of the development of health economy Frail Elderly pathways.

URGENT CARE SERVICES – WALSALL HEALTHCARE NHS TRUST

Ref	Quality Standards	Met? Y/N	Reviewer Comment
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.
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 Emergency Department, though staff were clearly aware of the needs of older people living with frailty and were making reasonable adjustments where possible. The community adult nursing response system (CANAR) allowed teams to be notified immediately when vulnerable adults presented in A&E or any ward (see good practice section of the report).

Ref	Quality Standards	Met? Y/N	Reviewer Comment
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	Training covering all the requirements of the Quality Standard was not yet in place. Staff could attend the education sessions provided by the Frailty Team. Mandatory training was in place which included safeguarding.
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	Y	
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	Though the facilities in A&E area were very crowded.

Ref	Quality Standards	Met? Y/N	Reviewer Comment
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	Reviewers were shown a number of different screening tools but specific guidelines were not yet in place. In practice staff were clear how to seek advice, if required, and Trust-wide guidelines on care of vulnerable adults, safeguarding and recognising and reporting abuse were in place.
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 Quality Standard 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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All Services Which Conduct Holistic Frailty Assessment

Walsall Healthcare NHS Trust (Acute Trust and Community Services)

Ref	Quality Standards	Met? Y/N	Reviewer Comment
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 How to give feedback on support and care received	N	Information was available apart from information covering ‘c (i)’ or ‘e (i)’. Reviewers commented that information was not easily visible to patients and carers on Ward 29.

Ref	Quality Standards	Met? Y/N	Reviewer Comment
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	N	There was little information covering 'maintaining a healthy lifestyle' or DVLA regulation and driving advice. The information on memory loss included information about dementia and reviewers considered development of separate information which covered just memory loss may be helpful.
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	

Ref	Quality Standards	Met? Y/N	Reviewer Comment
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	Staff across all areas were able to articulate the process for providing information on advice about making choices, accessing support and availability of advocacy services.
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	
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	Multidisciplinary review of care and support plans was in place across all areas. Care coordinators were in place in the locality teams. The frailty team held a daily multi-disciplinary team meeting. Shared use of care plans was in place with nursing homes.

Ref	Quality Standards	Met? Y/N	Reviewer Comment
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.	N	Use of emergency care plans had been implemented in nursing homes and were in the process of being implemented in the community with the locality teams.
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	Some aspects of the Quality Standard were covered by mandatory training and external providers but these did not cover all aspects of the Quality Standard. The frailty team did provide some frailty-specific training for some staff.

Ref	Quality Standards	Met? Y/N	Reviewer Comment
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. Training covering all the requirements of the Quality Standard was not yet in place, including training in frailty screening for appropriate staff.
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 v. Services providing: vi. Support and care vii. Support for maintaining a healthy lifestyle and preventing harm viii. Support for carers c. End of life care	Y	
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	

Ref	Quality Standards	Met? Y/N	Reviewer Comment
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. Reviewers were shown a number of different screening tools including a standardised tool with inclusion and exclusion criteria and the 'Edmonton' tool. In practice the requirements of the Quality Standard were covered, in general, by the assessment process and assessment documentation.
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 Quality Standard MN-501. Health-economy wide formats for frailty screening had not yet been agreed.

Ref	Quality Standards	Met? Y/N	Reviewer Comment
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. Community teams used the 'stop start guidance' approach and had a medication review tool.
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 'a', 'c', 'd', 'e' and 'f ' although these were not specific to the management of older people living with frailty. Guidance covering falls management of older people living with frailty was not yet in place. A Falls Recording form was in use but this did not include any other information about falls prevention or services to access for further advice.
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 on the number of holistic frailty assessments were not yet collected. Data were collected on admission avoidance and number and sources of referral to the Frailty Service.

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FRAILTY TEAM (CARE OF OLDER PEOPLE SERVICE) WALSALL HEALTHCARE NHS TRUST

Ref	Quality Standards	Met? Y/N	Reviewer Comment
MP-101	**Service Information** Each service should offer patients and their carers information covering: a. Organisation of the service, such as opening hours and clinic times b. Staff and facilities available c. How to contact the service for help and advice, including out of hours Information should be in a format suitable for the individual patient. Written information for patients may not always be appropriate but written information for carers should be available.	Y	However an up to date information booklet was in the process of review. Staff on Ward 29 and the Frailty Team who met with the visiting team were able to articulate how they kept patients and carers informed about the service available.
MP-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	N	Information was available apart from information covering ‘c (i)’, ‘c (iv)’ or ‘e (i)’. Reviewers commented that information was not easily visible to patients and carers on Ward 29.

Ref	Quality Standards	Met? Y/N	Reviewer Comment
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	N	As Quality Standard MN-103
MP-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	

Ref	Quality Standards	Met? Y/N	Reviewer Comment
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	Staff were able to articulate the process for providing information on advice about making choices, accessing support and availability of advocacy services.
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	
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	Review of care and support plans were undertaken for those patients under the care of the Frailty Team. The frailty team held a daily multi-disciplinary team meeting. Shared use of care plans was in place with nursing homes.

Ref	Quality Standards	Met? Y/N	Reviewer Comment
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.	N	At the time of the visit the use of Emergency Care plans was not in place in the acute trust. The format of the Emergency Care plans had been agreed across the health economy and implementation of their usage had commenced in nursing homes.
MP-195	**Transition to Other Services** Older people living with frailty approaching the time when their care will transfer to another service should be offered: a. The opportunity to discuss the transfer of care with the service/s involved b. A named coordinator for the transfer of care c. A preparation period prior to transfer d. Written information about the transfer of care including arrangements for monitoring during the time immediately afterwards	Y	
MP-197	**General Support for Older People and Carers** Older people living with frailty and their family and carers should have easy access to the following services and information about these services should be easily available: a. Interpreter services, including British Sign Language b. Independent advocacy services c. Complaints procedures d. Social workers e. Benefits advice f. Spiritual support g. HealthWatch or equivalent organisation h. Relevant voluntary and other organisations providing support and advice	Y	
MP-198	**Carers' Needs** Carers should be offered information on: a. How to access an assessment of their own needs b. What to do in an emergency c. Services available to provide support	Y	

Ref	Quality Standards	Met? Y/N	Reviewer Comment
MP-199	**Involving Older People and Carers** The service should have: a. Mechanisms for receiving regular feedback about treatment and care from: i. Older people living with frailty ii. Families and carers of older people living with frailty b. An audit of feedback received from older people themselves c. Mechanisms for involving older people living with frailty and their families and carers in decisions about the organisation of the service d. Examples of changes made as a result of feedback and involvement of older people living with frailty and their families and carers	Y	Mechanisms were in place but as the ward had only been open for three months, examples of changes made as a result of feedback was limited.
MP-201	**Lead Clinician** A nominated lead clinician should have responsibility for staffing, training, guidelines and protocols, service organisation, governance and for liaison with other services. The lead clinician should be a registered healthcare professional with appropriate competences for the role and should undertake regular clinical work within the service.	Y	

Ref	Quality Standards	Met? Y/N	Reviewer Comment
MP-202	**Staffing Levels and Skill Mix** Sufficient staff with appropriate competences should be available for the: a. Number of older people living with frailty usually cared for by the service and the usual case mix of patients b. Service's role in the patient pathway and expected timescales, including: i. Provision of Comprehensive Geriatric Assessments ii. Care and support planning and reviews iii. Care coordination of older people living with frailty cared for by the team, including liaison with other services involved in their care iv. Specialist advice and guidance to other services in the local area v. Provision of training in the care of older people living with frailty for other services in the local area vi. Rapid access ambulatory clinics (7/7) vii. Routine and urgent domiciliary review Staffing should include, at least: a. Care of older people consultant b. Other medical staff with accredited specialist competences in the care of older people living with frailty c. Nurse/s with specialist competences in the care of older people living with frailty d. Social worker/s e. Therapists with time in their job plan for work with the Frailty Team f. Nurse/s with specialist competences in the care of people with dementia g. Pharmacist/s with time in their job plan for work with the Frailty Team Cover for absences should be available so that the patient pathway is not unreasonably delayed, and patient outcomes and experience are not adversely affected, when individual members of staff are away.	N	The frailty service was relatively new and the Trust was still in the process of building the team. Capacity demand data were being collected to help inform service development. Staffing consisted of: 1 w.t.e Geriatrician who did not have cover for absences. 0.8 w.t.e occupational therapy support and therefore cover for the Emergency Department was limited. 0.9 w.t.e. physiotherapy. 1 w.t.e non-medical prescribing pharmacist was available Monday to Friday but there was no cover for absences. 1 w.t.e. pharmacist was available Monday to Friday, though there was no cover for absences. 1 w.t.e Band 8a lead nurse, 4.8 w.t.e Band 7 clinical sisters, 3 w.t.e. Band 8a trainee advanced clinical practitioners and 3 w.t.e. clinical support workers. Staff were in the process of accessing relevant Learning Beyond Registration education for their specific roles within the team. There was some access to 'hot clinics' for follow up.

Ref	Quality Standards	Met? Y/N	Reviewer Comment
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	Some aspects of the Quality Standard were covered by mandatory training. Some training was being accessed by external providers and once staff completed this Quality Standard would be met.
MP-204	**Service Competences and Training Plan** The competences expected for each role in the service should be identified. A training and development plan for achieving and maintaining competences should be in place.	N	Training needs analysis was seen for some staff but not for the Frailty team.
MP-298	**Training Programme** A rolling programme of training should be run for staff covering: 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 e. 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	Y	A training programme was in place and had covered health assessment and prescribing. Twice a month staff from the frailty team provided education sessions for any staff to attend. These sessions also include discussion of any operational issues.
MP-299	**Administrative, Clerical and Data Collection Support** Administrative, clerical and data collection support should be available.	Y	

Ref	Quality Standards	Met? Y/N	Reviewer Comment
MP-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	Y	
MP-302	**Support Services** Timely access to an appropriate range of support services should be available, including: a. Imaging, including CT scanning b. Pathology services, including availability of appropriate point of care testing c. Specialist services for the care of people with dementia d. Specialist services for the care of older adults with mental health problems e. Local intermediate care services f. Local community services providing care for older people living with frailty g. Local voluntary sector services providing care and support for older people living with frailty	Y	
MP-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 environment on Ward 29 was spacious and felt welcoming.
MP-402	**Facilities** Appropriate facilities for the usual number and case mix of older people living with frailty should be available. Facilities should be 'dementia friendly' wherever possible.	Y	

Ref	Quality Standards	Met? Y/N	Reviewer Comment
MP-403	**Equipment** Timely access to equipment appropriate for the service provided should be available including: a. Aids and adaptations b. Pressure-relieving equipment, including mattresses c. Appropriate tele-care equipment	Y	
MP-499	**IT System** IT systems for storage, retrieval and transmission of patient information should be in use for patient administration, clinical records and outcome information, including access to: a. Emergency Care Plans b. Care and Support Plans c. Advance Care Plans d. GP summary records e. Social care records IT systems should also support collection of data for service improvement, audit and revalidation.	N	Multiple IT systems were in use across the health economy. Lorenzo and Fusion system were accessible by community and hospital staff.
MP-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. Reviewers were shown a number of different screening tools including a standardised tool with inclusion and exclusion criteria and the 'Edmonton' tool. In practice the requirements of the Quality Standard were covered, in general, by the assessment process and assessment documentation.

Ref	Quality Standards	Met? Y/N	Reviewer Comment
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 Quality Standard MN-501. Health-economy wide formats for frailty screening had not yet been agreed.
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. However in the medication review guidelines, reducing poly pharmacy would benefit from being more detailed. There was a Non-medical Prescribing Pharmacist as part of the Frailty Team and reviewers were told that they ensured that relevant medication information was communicated to the patient's GP.

Ref	Quality Standards	Met? Y/N	Reviewer Comment
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 'a', 'c', 'd', 'e' and 'f' although these were not specific to the management of older people living with frailty. Guidance covering falls management of older people living with frailty was not yet in place. A Falls recording form was in use but this did not include any other information about falls prevention or services to access for further advice.
MP-595	**Transition to Other Services** Guidelines on transition of older people living with frailty to other services should be in use covering, at least: a. Involvement of the older person and, where appropriate, their family and carer in planning the transfer of care b. Involvement of the older person's general practitioner in planning the transfer c. Joint meeting between services in order to plan the transfer d. Allocation of a named coordinator for the transfer of care e. A preparation period prior to transfer f. Arrangements for monitoring during the time immediately after transfer	Y	The generic policy covered all aspects of transition to other services and was very comprehensive.
MP-599	**Care of People with Care and Support Needs** Guidelines for the care of older people living with frailty should be in use, in particular: a. Restraint and sedation b. Missing patients c. Mental Capacity Act and the Deprivation of Liberty Safeguards d. Safeguarding e. Information sharing f. Palliative care g. End of life care	N	Restraint and sedation policies ('a') covering care of the older person were not yet in place. All other polices were in place.

Ref	Quality Standards	Met? Y/N	Reviewer Comment
MP-601	**Operational Policy** The service should have an operational policy describing the organisation of the service including, at least: a. Expected timescales for the patient pathway, including for: i. Start of Comprehensive Geriatric Assessment ii. Completion of Care and Support Plan iii. Response to requests for routine and urgent domiciliary review b. Responsibility for giving patient and carer information at each stage of the patient journey c. Care Coordinator responsibilities and arrangements for cover for absences d. Arrangements for providing specialist advice and guidance to other services in the local area e. Organisation of rapid access ambulatory clinics (7/7) f. Arrangements for routine and urgent domiciliary review g. Arrangements for follow up of patients who 'do not attend'	N	The operational policy was in the process of being agreed and covered pathways and descriptions for all teams and services within the frailty pathway.
MP-698	**Attendance at Local Health and Social Care Older People Living with Frailty Group** At least one representative of the service should attend each meeting of the Local Health and Social Care Older People Living with Frailty Group.	N	A Local Health and Social Care Older People Living with Frailty Group as defined by the Quality Standard was not yet in place, but being considered.
MP-699	**Liaison with Other Services** Review meetings should be held at least annually with key support services to consider liaison arrangements and address any problems identified.	N/A	The Frailty team had only been in place for 3 months and so this Quality Standard was not yet applicable.
MP-701	**Data Collection** Regular collection and monitoring of data should be in place, including: a. Referrals to the service, including source and appropriateness of referrals b. Number of Comprehensive Geriatric Assessments undertaken c. Number of transfers of care to other services and location and type of care after transfer d. Key performance indicators, including achievement of expected timescales for: i. Start of Comprehensive Geriatric Assessments ii. Completion of Care and Support Plan iii. Response to requests for routine and urgent domiciliary review	N	Frailty team activity data were collated but only covered 'a' &'c'. Data covering other aspects of the QS were not yet collected.

Ref	Quality Standards	Met? Y/N	Reviewer Comment
MP-702	**Audit** The service should have a rolling programme of audit of: a. Referrals including: i. Whether frailty screening had been undertaken ii. Outcome of the frailty screen and action taken b. Achievement of older people's wishes and goals c. Transfers of care to other services and location and type of care after transfer d. Compliance with evidence-based clinical guidelines (QS MP-500s) e. Standards of record keeping	N	Data were not yet collected on whether frailty screening had been undertaken and actions. Data had been collected for the first three months activity, including sources of referral to the Frailty Service.
MP-703	**Key Performance Indicators** Key performance indicators (QS MP-701) should be reviewed regularly with Trust (or equivalent) management and with commissioners.	Y	
MP-798	**Multi-disciplinary Review and Learning** The service should have multi-disciplinary arrangements for a. Review of and implementing learning from positive feedback, complaints, outcomes, incidents and 'near misses' b. Review of and implementing learning from published scientific research and guidance c. Ongoing review and improvement of service quality, safety and efficiency	Y	The frailty team provided training for all interested stakeholders and operational meetings issues were also discussed.
MP-799	**Document Control** All policies, procedures and guidelines should comply with Trust (or equivalent) document control procedures.	Y	

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All services Which Conduct Holistic Frailty Assessments - Dudley and Walsall Mental Health Partnership NHS Trust

		Bloxwich Hospital - Wards		Bloxwich Hospital - Beeches Day Unit		Walsall Community Mental Health Team - Older Adults (CMHT OA)	
Ref	**Quality Standards**	**Met? Y/N**	**Reviewer Comment**	**Met? Y/N**	**Reviewer Comment**	**Met? Y/N**	**Reviewer Comment**
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. Work was also taking place on reviewing the process and policy for end of life care which would include updating information	N	Reviewers were told that clients attending the day hospital had a care coordinator who ensured information was provided and this was recorded on OASIS, but in the notes seen by reviewers not all areas were covered by assessments or had documented that information was given.	N	It was not clear from talking to staff that information was easily accessible to clients via the CMHT OA.

		Bloxwich Hospital - Wards		Bloxwich Hospital - Beeches Day Unit		Walsall Community Mental Health Team - Older Adults (CMHT OA)	
Ref	Quality Standards	Met? Y/N	Reviewer Comment	Met? Y/N	Reviewer Comment	Met? Y/N	Reviewer Comment
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	N	Information relating to the frailty team was not yet included in the client information packs. Other information was included.	N	Information relating to the frailty team was not yet available for those attending the day hospital. Reviewers were told that other information was discussed with clients as part of pre discharge or review meetings.	N	Information relating to the frailty team was not yet included in the client information packs. Other information was included.

		Bloxwich Hospital - Wards		Bloxwich Hospital - Beeches Day Unit		Walsall Community Mental Health Team - Older Adults (CMHT OA)	
Ref	Quality Standards	Met? Y/N	Reviewer Comment	Met? Y/N	Reviewer Comment	Met? Y/N	Reviewer Comment
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	N	This Quality Standard was met apart from access to wheelchairs.	Y		Y	Reasonable adjustments could be made in relation to agreeing appointment times.
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		Y	Though documentation of advice and advocacy was not seen in the records seen by reviewers.	Y	Compliance is based on self-assessment as community records were not available to reviewers at the time of the visit.

		Bloxwich Hospital - Wards		Bloxwich Hospital - Beeches Day Unit		Walsall Community Mental Health Team - Older Adults (CMHT OA)	
Ref	Quality Standards	Met? Y/N	Reviewer Comment	Met? Y/N	Reviewer Comment	Met? Y/N	Reviewer Comment
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.	N	Care plans were part of the CPA (Care Programme Approach) documentation but a process for undertaking a holistic frailty assessment was not yet in place across the Trust. Care plans did included documentation of clients 'personal strengths' at the time of the initial assessment.	N	Care plans were part of the CPA (Care Programme Approach) documentation but a process for undertaking a holistic frailty assessment was not yet in place across the Trust. From the records seen the care plans were not always completed or reviewed.	N	Care plans were part of the CPA (Care Programme Approach) documentation but a process for undertaking a holistic frailty assessment was not yet in place across the Trust.

		Bloxwich Hospital - Wards		Bloxwich Hospital - Beeches Day Unit		Walsall Community Mental Health Team - Older Adults (CMHT OA)	
Ref	**Quality Standards**	**Met? Y/N**	**Reviewer Comment**	**Met? Y/N**	**Reviewer Comment**	**Met? Y/N**	**Reviewer Comment**
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	Clients were admitted and so review of care plans did occur during their stay on the ward.	Y	Compliance is based on the self-assessment as care coordinators within the community team undertook review of care plans.	Y	Records were not available, so compliance is based on the self-assessment and discussions with staff. Reviewers were told that care coordinators undertook reviews of care plans with clients.

		Bloxwich Hospital - Wards		Bloxwich Hospital - Beeches Day Unit		Walsall Community Mental Health Team - Older Adults (CMHT OA)	
Ref	Quality Standards	Met? Y/N	Reviewer Comment	Met? Y/N	Reviewer Comment	Met? Y/N	Reviewer Comment
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.	N	Emergency care plans had not yet been agreed for use across the local health and social care economy. Some aspects of the Quality Standard were covered locally as part of the Care Programme Approach (CPA) process.	N	Emergency care plans had not yet been agreed for use across the local health and social care economy. Some aspects of the Quality Standard were covered locally as part of the Care Programme Approach (CPA) process.	N	Emergency care plans had not yet been agreed for use across the local health and social care economy. Some aspects of the Quality Standard were covered locally as part of the Care Programme Approach (CPA) process.

		Bloxwich Hospital - Wards		Bloxwich Hospital - Beeches Day Unit		Walsall Community Mental Health Team - Older Adults (CMHT OA)	
Ref	**Quality Standards**	**Met? Y/N**	**Reviewer Comment**	**Met? Y/N**	**Reviewer Comment**	**Met? Y/N**	**Reviewer Comment**
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	Training on conducting holistic frailty assessments were not yet in place across the Trust. Reviewers were told that this would be completed when a frailty assessment tool was implemented. Evidence that all staff had competences on conducting nutritional assessments (MUST) were not seen. Staff did have competences covering safeguarding training, Mental Capacity Act and Deprivation of Liberty Safeguards and challenging behaviours.	N	Training on conducting holistic frailty assessments were not yet in place across the Trust. Reviewers were told that this would be completed when a frailty assessment tool was implemented. Evidence that all staff had competences on conducting nutritional assessments (MUST) were not seen. Staff did have competences covering safeguarding training, Mental Capacity Act and Deprivation of Liberty Safeguards and challenging behaviours.	N	Training on conducting holistic frailty assessments were not yet in place across the Trust. Reviewers were told that this would be completed when a frailty assessment tool was implemented. Evidence that all staff had competences on conducting nutritional assessments (MUST) were not seen. Staff did have competences covering safeguarding training, Mental Capacity Act and Deprivation of Liberty Safeguards and challenging behaviours.

		Bloxwich Hospital - Wards		Bloxwich Hospital - Beeches Day Unit		Walsall Community Mental Health Team - Older Adults (CMHT OA)	
Ref	Quality Standards	Met? Y/N	Reviewer Comment	Met? Y/N	Reviewer Comment	Met? Y/N	Reviewer Comment
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	The Trust were planning to included specific training needs covering use of emergency care plans and undertaking holistic frailty assessments once the process had been agreed. Other aspects of the Quality Standard were included as part of essential/mandatory training.	N	The Trust were planning to included specific training needs covering use of emergency care plans and undertaking holistic frailty assessments once the process had been agreed. Other aspects of the Quality Standard were included as part of essential/mandatory training.	N	The Trust were planning to included specific training needs covering use of emergency care plans and undertaking holistic frailty assessments once the process had been agreed. Other aspects of the Quality Standard were included as part of essential/mandatory training.

		Bloxwich Hospital - Wards		Bloxwich Hospital - Beeches Day Unit		Walsall Community Mental Health Team - Older Adults (CMHT OA)	
Ref	**Quality Standards**	**Met? Y/N**	**Reviewer Comment**	**Met? Y/N**	**Reviewer Comment**	**Met? Y/N**	**Reviewer Comment**
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 iii. Services providing: iv. Support and care v. Support for maintaining a healthy lifestyle and preventing harm vi. Support for carers c. End of life care	N	A single point of access including health, social care and mental health was not yet in place. Single point of access for older people's services out of hours was managed by crisis services.	N	A single point of access including health, social care and mental health was not yet in place. Single point of access for older people's services out of hours was managed by crisis services.	N	A single point of access including health, social care and mental health was not yet in place. Single point of access for older people's services out of hours was managed by crisis services.

		Bloxwich Hospital - Wards		Bloxwich Hospital - Beeches Day Unit		Walsall Community Mental Health Team - Older Adults (CMHT OA)	
Ref	Quality Standards	Met? Y/N	Reviewer Comment	Met? Y/N	Reviewer Comment	Met? Y/N	Reviewer Comment
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	N	Appropriate signage in the wards was not in place. Staff did not have access to health and social care records from other providers.	N	Signage about directions to the day hospital were not clear. The environment was adequate but could benefit from being more 'dementia friendly' in terms of decoration. Staff commented that noise from the main corridor disturbed those attending the day hospital. Staff did not have access to health and social care records from other providers.	N	Staff did not have access to health and social care records from other providers.

		Bloxwich Hospital - Wards		Bloxwich Hospital - Beeches Day Unit		Walsall Community Mental Health Team - Older Adults (CMHT OA)	
Ref	Quality Standards	Met? Y/N	Reviewer Comment	Met? Y/N	Reviewer Comment	Met? Y/N	Reviewer Comment
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. In practice some requirements of the Quality Standard in terms of making reasonable adjustments, recognition of adults with care and support needs and recognition of abuse were covered by the CPA assessment process and assessment documentation.	N	Specific guidelines were not yet in place. In practice some requirements of the QS in terms of making reasonable adjustments, recognition of adults with care and support needs and recognition of abuse were covered by the CPA assessment process and assessment documentation.	N	Specific guidelines were not yet in place. In practice some requirements of the QS in terms of making reasonable adjustments, recognition of adults with care and support needs and recognition of abuse were covered by the CPA assessment process and assessment documentation.

		Bloxwich Hospital - Wards		Bloxwich Hospital - Beeches Day Unit		Walsall Community Mental Health Team - Older Adults (CMHT OA)	
Ref	**Quality Standards**	**Met? Y/N**	**Reviewer Comment**	**Met? Y/N**	**Reviewer Comment**	**Met? Y/N**	**Reviewer Comment**
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 Quality Standard MN-503.	N	As Quality Standard MN-503.	N	As Quality Standard MN-503.

		Bloxwich Hospital - Wards		Bloxwich Hospital - Beeches Day Unit		Walsall Community Mental Health Team - Older Adults (CMHT OA)	
Ref	**Quality Standards**	**Met? Y/N**	**Reviewer Comment**	**Met? Y/N**	**Reviewer Comment**	**Met? Y/N**	**Reviewer Comment**
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 medicines management guidelines were not explicit about 'a', 'b', 'c', 'd', and 'g'. Other aspects were covered in other policies. In practice support was available via the pharmacy team and side effects and dosages monitored. Prescribing monitoring audits were undertaken. The Pharmacy service had also developed competence training covering polypharmacy and medicine interactions.	Y	Trust medicines management guidelines were not explicit about 'a', 'b', 'c', 'd', and 'g'. Other aspects were covered in other policies. In practice support was available via the pharmacy team and side effects and dosages monitored, though documentation of medicines reviews were not seen in records seen by reviewers. Prescribing monitoring audits were undertaken. The Pharmacy service had also developed competence training covering polypharmacy and medicine interactions.	Y	Trust medicines management guidelines were not explicit about 'a', 'b', 'c', 'd', and 'g'. Other aspects were covered in other policies. In practice support was available via the pharmacy team and side effects and dosages monitored. Prescribing monitoring audits were undertaken. The Pharmacy service had also developed competence training covering polypharmacy and medicine interactions.

		Bloxwich Hospital - Wards		Bloxwich Hospital - Beeches Day Unit		Walsall Community Mental Health Team - Older Adults (CMHT OA)	
Ref	Quality Standards	Met? Y/N	Reviewer Comment	Met? Y/N	Reviewer Comment	Met? Y/N	Reviewer Comment
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 'a', 'b', 'c', 'd', and 'e', although these were not specific to the management of older people living with frailty. Trust guidelines on nutrition and hydration were not yet in place although a nutrition assessment template was included in the admission packs.	N	Generic Trust guidelines were in place for 'a', 'b', 'c', 'd', and 'e', although these were not specific to the management of older people living with frailty. Trust guidelines on nutrition and hydration were not yet in place.	N	Generic Trust guidelines were in place for 'a', 'b', 'c', 'd', and 'e', although these were not specific to the management of older people living with frailty. Trust guidelines on nutrition and hydration were not yet in place.
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 Quality Standard were not yet collected.	N	Data covering all aspects of the Quality Standard were not yet collected.	N	Data covering all aspects of the Quality Standard were not yet collected.

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COMMISSIONING

Ref	Quality Standards	Met? Y/N	Reviewer Comment
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	Good evidence of training for community, hospital and care home staff was available.
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	The strategic plan and health and well-being strategy included frailty. An older people needs strategy had been commissioned but was still in draft and due to be published in early June. Reviewers saw no evidence relating to the needs of older people living with frailty and learning disabilities or sensory disabilities.
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	Y	

Ref	Quality Standards	Met? Y/N	Reviewer Comment
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	See main report (health and social care economy, further consideration section).
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', 'b', 'c' and 'd (i)' were in place within Walsall Healthcare NHS Trust but had not been agreed for use across the health and social care economy. 'd (ii)' was met.
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	Quality monitoring was in place but data covering all the requirements of the Quality Standard were not yet collected.

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