WM QRS West Midlands Quality Review Service

NHS

Care of Older People Living with Frailty

East Staffs Health & Social Care Economy

Visit Date: 31st October & 1st November2016 Report Date: February 2017

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UKAS INSPECTION 8831

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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 31st October and 1st November 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; V2.1 2016

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

The report reflects the situation at the time of the visit. The text of this report identifies the main issues raised during the course of the visit. Appendix 1 lists the visiting team which reviewed the services in East Staffordshire 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:

- Burton Hospitals NHS Foundation Trust
- Virgin Care
- South Staffordshire and Shropshire Healthcare NHS Foundation Trust
- NHS East Staffordshire Clinical Commissioning Group

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 East Staffordshire Clinical Commissioning Group.

ACKNOWLEDGMENTS

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

Burton Hospitals NHS Foundation Trust: Burton Hospitals NHS Foundation Trust's services for older people living with frailty at Queen's Hospital and Sir Robert Peel and Samuel Johnson Community Hospitals were provided in close partnership with primary care, social care, voluntary sector and mental health services.

Community Nursing Services: As part of the health economy 'Improving Lives' programme, Virgin Care was the prime contractor responsible for services in East Staffordshire for adults with long-term health conditions and people living with frailty. Virgin Care had set up a number of subcontracts with organisations for example Burton Hospitals NHS Foundation Trust, the NHS 111 service and Age UK South Staffordshire for care navigators. Virgin Care also provided a rapid response team based in the Emergency Department at the Queen's Hospital in Burton.

South Staffordshire and Shropshire Healthcare NHS Foundation Trust: The purpose-built George Bryan Centre provided 12 in-patient and assessment beds for older adults in East Ward, which was co-located with Sir Robert Peel Community Hospital.

Review Process

Reviewers visited Sir Robert Peel and Samuel Johnson Community Hospitals and met with ward staff and representatives of the multi-professional teams. At the George Bryan Centre, reviewers visited East Wing and met with ward staff and the medical lead. At Queen's Hospital, reviewers visited the Emergency Department, the Acute Assessment Centre (AAC), Frailty Wards 4 (Female) and 14 (Male) and the Short Stay Ward. Reviewers also attended a virtual ward meeting which included representatives from Virgin Care community staff, the palliative care team, Age UK and Burton Hospitals NHS Foundation Trust. Reviewers were due to meet with a GP but unfortunately the representative was not able to attend.

The East Staffordshire Clinical Commissioning Group, the lead commissioners of care for older people living with frailty, did not submit a self-assessment or written evidence of compliance with the Quality Standards, but a representative did meet reviewers on the day of the visit.

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.

Pathway	Services Reviewed	Care of People Living with Frailty Applicable Quality Standards (QS)
Primary Care	Primary care was not reviewed during this review visit	All health and social care services QS
Burton Hospitals NHS Foundation Trust	Emergency Department	Urgent care services QS
	In-patient wards	All health and social care services [Services which conduct holistic frailty assessments[1]]QS
	Frailty Team	Frailty Team QS
	Sir Robert Peel and Samuel Johnson Community Hospitals	All health and social care services QS

[1] In-patient wards self-assessed using the Quality Standards for 'all health and social care services'. The Quality Standards for 'services which conduct holistic frailty assessments' would have been more appropriate to the type of care provided.

Pathway	Services Reviewed	Care of People Living with Frailty Applicable Quality Standards (QS)
South Staffordshire and Shropshire Healthcare NHS Foundation Trust	George Bryan Centre	Services which conduct holistic frailty assessments QS
NHS East Staffordshire Clinical Commissioning Group	Commissioning was not reviewed during this review visit	Commissioning QS

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VISIT FINDINGS

HEALTH AND SOCIAL CARE ECONOMY

General Comments and Achievements

Health services for people in East Staffordshire with long-term conditions, including frailty, were going through significant change at the time of the review visit. Virgin Care had taken over responsibility for the care of people with long-term conditions and developed a care coordination centre. Some of the pathways of care were in the early stages of development, and transformation plans were also being developed. Integrated working between hospital and community parts of the pathways of care was not yet well developed.

Good Practice

1 A fortnightly 'virtual ward' round was attended by community matrons, the social worker, a representative from Ward 4, the Frailty Service, occupational therapy, the Virgin Care consultant geriatrician and representatives from the ambulance service and end of life care team. The care of older people living with frailty in the community who were at risk of admission, who had recently been admitted to hospital or for whom ambulances were being called regularly was reviewed.

Immediate Risks: No immediate risks were identified.

Concerns

1 **Delays in discharge: Availability of domiciliary care packages and long-term care**

Reviewers heard from several sources about difficulties and delays in the availability of domiciliary care packages and long-term care. Reviewers were also told that the process of continuing health care assessment was slow and the criteria for admission to the Barton-under-Needwood intermediate care beds was not high enough to support a higher acuity of patients so that many patients were considered unsuitable for these beds. 'Discharge to Assess' beds were not available in the community although there was a ward area that provided rehabilitation and assessment, preparing patients for discharge. Overall, this was resulting in delays in transfer of care from acute wards and community hospitals. Executive leads at Burton Hospitals NHS Foundation Trust met each evening at 5pm to discuss patients whose transfer of care was delayed.

2 **Holistic Frailty Assessment**

The pathway of care described by national guidance, and the WMQRS Quality Standards which are based on this guidance, is that all services will screen for frailty, many services will carry out a 'holistic frailty assessment', and those patients with the most complex and severe needs will be referred to the Frailty Service for a multi-disciplinary 'comprehensive geriatric assessment'. The 'holistic frailty assessment' part of this pathway was not yet well developed in East Staffordshire. Some aspects were in place at the George

Bryan Centre but frailty was not specifically considered. At both community hospitals patients were assessed separately for skin, nutrition, hydration and other needs. There was no framework for bringing these assessments together into a 'holistic assessment' and no criteria for referral to the Frailty Service for a comprehensive geriatric assessment (CGA). Information from a range of initial assessments was not collated and, as a result, patients may not be being referred appropriately for a CGA. It is also possible that, because of the lack of a clear framework, patients were being referred more often than necessary to the Frailty Service.

Further Consideration

1 'Trusted Assessor' arrangements were not yet in place. Even staff from the Rapid Response Team in the Emergency Department were not considered as 'trusted assessors'. As a result, patients were undergoing multiple assessments, which was a waste of their time and staff time.

2 Reviewers suggested that involving a representative of mental health services in the 'virtual ward' rounds may be helpful, especially as the patients discussed often appeared to have significant mental health problems.

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PRIMARY CARE

The contribution of primary care to the care of older people living with frailty in East Staffordshire was not reviewed during this visit.

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BURTON HOSPITALS NHS FOUNDATION TRUST: QUEEN'S HOSPITAL, BURTON -UPON -TRENT

General Comments and Achievements

Services at Burton Hospitals NHS Foundation Trust were working well together to improve the care of older people living with frailty. The Elderly People Assistance and Care (EPAC) model to empower all clinical staff to deliver an enhanced level of care to older patients had been launched in 2015. Several improvements had been made and further developments were planned, including some developments in community hospitals. Staff who met the visiting team were enthusiastic and highly committed to providing good care for older people. This report reflects the significant progress already made by the Trust and acknowledges the plans for further work which are already in place.

Concern

1 **Consultant Staffing Levels**

Consultant staffing was low for the number of patients, the range of their needs and the responsibilities being covered. At the time of the review five consultant geriatricians were in post. One led on frailty, one led on the care of patients with dementia, Parkinson's disease or stroke, one had an interest in falls and ortho-geriatrics, one was based at Samuel Johnson Community Hospital only, and a locum was based at Queen's Hospital only. The Frailty Service was staffed by two of these consultants, covering stroke, frailty, Wards 4 and 14 and the community hospitals. A medical staffing review was taking place but this was a long-standing problem. Reviewers considered that an innovative approach was needed, including a review of roles and responsibilities in order to make better use of the time and expertise available.

Good Practice

1 An 'event planner' visited the wards each day and then arranged appropriate activities for older people living with frailty.

2 The Enhanced Care Team included several staff who were undertaking extended roles. 1:1 care was provided by band 3 healthcare staff on an in-house basis. This was considered to be an innovative way to manage patients who required additional care and support in order to remain safe.

3 Patient information leaflets were well written and accessible.

4 Some wards visited by the reviewers had 'Patient Leaders'. These volunteers helped visitors with any queries, and provided information or directed visitors to where information could be found. Families' and carers' queries were therefore dealt with quickly and ward staff were able to spend more time dealing with other queries.

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URGENT CARE

Nurses in the Emergency Department undertook frailty screening and the results were recorded electronically. The results would automatically generate a referral to the Frailty Service or, if urgent, a member of the Frailty Team would be bleeped. Good communication between staff in the Emergency Department and those in the Frailty Service was evident. Facilities in the Emergency Department were not ideal at the time of the review visit but plans to increase capacity were in place.

The Frailty Team visited the Acute Assessment Centre (AAC) and identified any patients who were frail. Patients who were not identified as frail on admission were reassessed within 72 hours.

Good Practice

1 One bay in the Emergency Department was specifically tailored to the needs of people with dementia. A clock was easily visible, decoration was good and distraction therapy items were available.

Further Consideration

1 Reviewers suggested it would be helpful if staff from the Rapid Response Team based in the Emergency Department (run by Virgin Care) were considered as 'trusted assessors' for community-based health and social care services.

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IN-PATIENT WARDS

Work had started on improving the care of older people living with frailty but, at the time of the review visit, frailty screening, supported by appropriate training, was in place only on Ward 4. Some good training sessions had been delivered to staff across the hospital and a phased implementation programme was being considered. The Trust also trained nursing assistants on each ward to act as 'frailty ambassadors' to support the EPAC model of promoting independence and activity when older people were admitted by the Trust.

Further Consideration

1 The role of the discharge coordinator may benefit from review, especially as the service was under-staffed at the time of the review visit. For example, the role included the provision of equipment which may be better provided by occupational therapy staff.

2 Responsibility for the 'care coordinator' function was not clearly understood by several staff on the in-patient wards. Some members of staff thought this role was undertaken by discharge liaison nurses.

Commissioners were clear that care navigators were commissioned by Virgin Care and provided by Age UK, that the Care Coordination Centre was provided by Virgin Care and based at Edwin House and Care Navigators were part of the Care Coordination Centre based at Edwin House, Burton.

Short Stay Unit

Two patients with frailty, both of whom had been identified as frail in the AAC, were on the Short Stay Unit at the time of the review visit. The unit had good access to interpreters, and reviewers commented that staff showed good awareness of vulnerability and the action that needed to be taken when this was identified. A discharge coordinator was proactive in reducing the number of patients whose length of stay exceeded 72 hours.

Ward 4

Reviewers were impressed with the level of care provided on this very busy ward. Patients were effectively 'cohorted' and the ward was calm despite the number of patients. Patients were dressed and activities were taking place. Staff interaction with patients was very good, with staffing levels 1:1 (registered nurse: non-registered for every seven patients. A very good 'Interactive Seal' therapy aid (named Bobby) was in use, which helped patients engage in activities. Patients used hand gel before using Bobby and cleaning took place after each use. There was also good access to a range of sensory adaptations, for example 'twiddle muffs' for calming and distraction, a hearing loop and communication boxes.

Implementation of the good practice evident on Ward 4 could help significantly to improve the quality of care on other wards in Queen's Hospital and at the community hospitals.

Good Practice

1 Representatives of voluntary sector organisations and care homes attended the 9am 'board round'.

2 The comprehensive geriatric assessment was updated on a weekly basis and used for discharge planning. (Unfortunately, this practice did not continue for patients discharged to community hospitals.)

3 Nurse discharge summaries for patients and carers were very good: they were person-specific, written in clear language and highlighted any particular risk factors. Details of where to access further information were also included.

Further Consideration

1 Reviewers were told that some GPs acted on the nurse discharge summaries and then received a later medical discharge letter which was different. Further investigation of the extent of this problem, and options for resolving it, may be helpful.

Ward 14

Ward 14 had moved from the 'Outwoods site' to the main site at Queen's Hospital. Reviewers did not have a lot of time to spend on Ward 14, but it did not appear to be working as effectively as Ward 4 and implementation of some of the ideas from Ward 4 may be helpful.

Concerns

1 **Medical Cover**

Patients on Ward 14 were under the care of several consultants, and there were no clear arrangements for shared care with consultant geriatricians. Staff could call on the Frailty Team for advice, but reviewers were concerned that, in practice, this may not happen as often as desirable for the needs of the patients on the ward.

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FRAILTY TEAM

The frailty pathway had been introduced in December 2014 and the Frailty Service had been fully operational since January 2015. The team linked very closely with, and supported, all community services. The Frailty Service was very responsive to the needs of the Emergency Department and linked well with the ward 'ambassadors for frailty'. Frailty screening took place in the Emergency Department, and those identified as frail with an expected length of stay of less than 72 hours were allocated to the Frailty Service. A daily multi-disciplinary team meeting was held to review and plan the care of these patients.

The Frailty Service was led by a consultant geriatrician and included three Advanced Clinical Practitioners, three w.t.e. physiotherapists, three occupational therapists, an assistant practitioner and a social care assessor. The service was available from 8am to 7pm seven days a week. The team had undertaken additional training in comprehensive geriatric assessment. A competence framework for these staff was in place and staff who had competed the training wore a badge so that they could be easily identified.

Good Practice

1 Arrangements for liaison with palliative care services were working well, with good evidence of multi-disciplinary working.

2 Each ward had a ward ambassador for frailty who linked well with the Frailty Service, including accessing the team for advice and support.

Immediate Risks: No immediate risks were identified.

Concerns

1 **Consultant Staffing Levels:** See Burton Hospitals NHS Foundation Trust section of this report.

Further Consideration

1 Further work with the Virgin Care consultant geriatrician may be helpful in order to ensure positive co-ordination between this post and the work of the Frailty Service and to ensure there is no overlap. It was not clear to reviewers why a consultant geriatrician was employed separately, rather than being part of the Frailty Service.

2 Education and training about frailty were happening in a number of areas. Reviewers suggested that greater clarity about which staff were receiving which training may be helpful. Continuing to 'roll out' education programmes to staff in the community hospitals was fully supported by the reviewers.

3 Further developing links with, and in-reach to, the community hospitals may be of benefit, especially in support of integrated working and discharge planning for patients in the community hospitals. This could make a positive contribution to reducing the length of stay in community hospitals. The Frailty Service was planning to develop these links.

4 More than one comprehensive geriatric assessment tool was in use at the time of the review. The frailty policy had a different CGA from that being used in practice. Reviewers also commented that the frailty policy may benefit from inclusion of a clear pathway, the contribution of allied health professionals and clear key performance indicators.

5 Some Emergency Department patients who did not meet the criteria for referral to the Frailty Service may benefit from a holistic frailty assessment or comprehensive geriatric assessment. Ward 4 was actively assessing such patients and then referring to the Frailty Service but reviewers were told that this did not happen in all wards. For example, patients who were frail and had a fractured neck of femur were not yet referred to the Frailty Service.

Burton Hospitals NHS Foundation Trust: Sir Robert Peel Community Hospital (RP) and Samuel Johnson Community Hospital (SP)

Both community hospitals provided 'step up / down' rehabilitation either to avoid, or following, an acute admission. Some patients with more complex discharge needs were also admitted while assessments were undertaken and a suitable placement identified. Staff at both community hospitals were highly motivated and keen to improve the service offered. There was good physiotherapy, occupational therapy and pharmacy input to services on both sites. Weekly multi-disciplinary and consultant-led meetings were held at Sir Robert Peel Community Hospital. Staffing levels were one registered nurse to every 12 patients at Sir Robert Peel Community Hospital and one registered nurse to every 8 patients at Samuel Johnson Community Hospital. The *Safer Staffing* tool had been used to assess staffing levels.

The Darwin Team at Samuel Johnson Community Hospital managed the waiting list for all community beds and ensured patients met the admission criteria. Reviewers were told that patients from South Staffordshire often had to find alternative provision as the wait for a bed in the community hospital was so long.

Good Practice

1 On Philip Ward (RP) and Anna Ward (SJ) a 'sleep hygiene' tool was being implemented. This programme involved completing multiple interventions in each bay such as drug and comfort rounds, turning lights down and noise reduction so that patients could settle to sleep.

2 Both wards at Samuel Johnson Community Hospital (Darwin and Anna) displayed a poster explaining how patients, families and carers could book an appointment with the multi-disciplinary team.

3 Anna Ward at Samuel Johnson Community Hospital had implemented the 'Ask 3 questions' campaign (NHS England) to encourage patients to ask three key questions when they are asked to make a choice about treatment.

4 The care of patients with dementia on both wards was very good and Anna Ward had a particularly positive and calm atmosphere. A wide range of well-displayed information was available for patients and carers. Staff interacted well with patients and activities included reminiscence books and use of appropriate furniture. Discussions with catering staff had resulted in changes to the menu for patients with dementia, which had improved nutrition. Darwin Ward was running a 'sports events calendar'.

Immediate Risks: No immediate risks were identified.

Concerns

1 **Length of Stay at Sir Robert Peel Community Hospital**

Average length of stay at Sir Robert Peel Community Hospital was 27 days at the time of the review, and some patients were staying between 70 and 90 days in the hospital. Reviewers considered this was a very long stay for a rehabilitation facility. Reviewers were told that delays were due to problems with accessing packages of care, especially for people with mental health problems.

2 **Holistic Frailty Assessment:** See health and social care economy section of this report.

Further Consideration

1 Reviewers suggested that improving links with community service providers would be helpful. These links did not appear well-developed, which may be contributing to delays in discharge.

2 Some nursing staff and allied health professionals did not have full access to the Queen's Hospital electronic patient records. Some staff had 'read only' access but could not update patients' records.

3 Staff at Sir Robert Peel Community Hospital had not yet had training in frailty screening (or holistic frailty assessment). Staff at Samuel Johnson Community Hospital had had some training. Some staff who met the visiting team were not clear about frailty syndromes and the stage at which referral to the Frailty Team

should be made. Staff were also not clear about when a further medical review was indicated, how this would be organised and by whom. This may be clear to some staff but others could not clearly articulate the process to reviewers.

South Staffordshire and Shropshire Healthcare NHS Foundation Trust: George Bryan Centre

General Comments and Achievements

Staff on East Wing were enthusiastic about providing care for older people living with frailty and had worked hard to provide high quality care. Patients who met with the visiting team said that they were listened to and were satisfied with their care. People with both functional and organic problems were admitted to the ward. Staffing levels were satisfactory for the 12 beds in use at the time of the visit (two registered and two non-registered on early and late shifts and one registered and two non-registered overnight). Staffing levels were increased using staff from the Trust bank if patients with high observation needs were admitted. The ward manager was a supernumerary post. The ward also had one w.t.e. occupational therapist and one w.t.e. physiotherapist. A dietician, and psychology and pharmacy staff, provided support as required. An activities coordinator was in place five days a week and a car was available to take patients out to activities when appropriate. Activity boxes were available for times when the coordinator was not available.

Good links had been established with the local hospice, who provided advice and support for any patient with palliative care needs and their families or carers.

The discharge planning checklist 'Questions you might want to ask at our discharge planning meeting' was good but had not yet been tailored for older adults (for example, it still included 'what shall I tell my employer?'). The service had plans to improve liaison with other agencies such the fire and police services. A competence framework was available and included some higher level competences related to physical health.

Good Practice

1 An 'About me' tree display shared information about staff and their interests. This replicated the patients' profiles and helped to build confidence and links between patients and staff. The staff photo board included pictures of who was on duty rather than names.

2 A good process was in place for undertaking medicines reconciliation very soon after admission.

3 Staff involved third sector organisations such as Age UK in discharge planning meetings with patients and carers, which had been found to reduce their worries about the discharge process.

4 Patients could choose what they wished to eat, and the food was brought to them to show what was available. Staff had found that this helped patient nutrition.

5 Each Monday the activities coordinator asked patients about activities they would like to do that week, and these were arranged if possible.

6 If the ward needed to be locked then there was clear signage which explained why and what patients and visitors should do.

7 The patient's named nurse met with their carer twice weekly and sessions could be held at weekends if necessary.

Immediate Risks: No immediate risks were identified.

Concerns

1 **Holistic Frailty Assessment**

See 'health and social care economy section' of this report.

2 **Guidelines**

Many of the guidelines and procedures expected by the Quality Standards were not yet in place.

Further Consideration

1 Care planning arrangements may benefit from review to make them more patient- and carer-friendly. For example, information to say that patients and, where appropriate, carers and families could have access to care and support plans was not easily visible. Some of the care plans seen by reviewers were written in clinical language and were not in a format that was easily understandable by patients, especially when printed. It was also not clear that patients and carers had been involved in the development of the care plan or had reviewed what was written.

2 Reviewers were told that the average length of stay on the ward was approximately 77.6 days, which they considered was too long for an assessment centre. Reviewers were told of delays in the allocation of a social worker and continuing health care assessments.

3 A very good range of information was available, some of which was aspirational rather than reflecting the situation at the time of the visit. Work with patients and carers about the value of this information may be helpful. Reviewers considered that a smaller range of more targeted information may be more useful. It was also not clear if there was a process for reviewing the information available and removing out of date information.

4 The activity room and reminiscence room were quite cluttered and the reminiscence room was used for storage of physiotherapy equipment. The lighting levels in some areas were low, and it was not clear how often the reminiscence room was used.

5 One bedroom had a low ligature risk but sometimes patients with a higher risk of suicide were nursed in other rooms with increased observation. The need for a second low ligature risk bedroom may benefit from further consideration, especially because of the mixture of patients with organic and functional problems on the ward. Annual ligature risk assessments had been undertaken and local action plans were being implemented.

6 The 'About me' documentation was not available in some rooms and the reasons for this were not clear. Further work auditing the availability of this documentation may be helpful.

7 Access to podiatry services was no longer available. Staff told reviewers that if a patient was experiencing any problems then a podiatrist was funded from 'petty cash'.

8 Physiotherapists and occupational therapists had undertaken training in cognitive behavioural therapy. Consideration could be given to nurses also undertaking this training especially as this would provide the opportunity to continue with therapy at weekends.

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COMMISSIONING

See the 'Health and social care economy' section of this report.

Further consideration

1 Reviewers considered that there was significant potential for commissioners to re-model the beds available for the care of older people living with frailty. Seven intermediate care beds were available at Barton-under-Needwood, but the admission criteria were quite restrictive. Queen's Hospital and both community hospitals were experiencing extended lengths of stay, and 'Discharge to Assess' beds were not yet available.

Concerns

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

a. **Delays in discharge**: Availability of domiciliary care packages and long-term care: see Health and Social Care Economy, Concern 1

b. **Holistic Frailty Assessment**: see Health and Social Care Economy, Concern 2

c. **Consultant Staffing Levels:** see Burton Hospitals NHS Foundation Trust, Queen's Hospital, Burton - Upon -Trent, Concern 1

d. **Medical Cover**: see In-Patient wards, Concern 1

e. **Consultant Staffing Levels**: see Frailty Team, Concern 1

f. **Length of Stay at Sir Robert Peel Community Hospital**: see Burton Hospitals NHS Foundation Trust, Sir Robert Peel Community Hospital and Samuel Johnson Community Hospital, Concern 1

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APPENDIX 1 MEMBERSHIP OF VISITING TEAM

Visiting Team

Debbie Allport	Senior Sister	Walsall Healthcare NHS Trust
Yvonne Brown	Head of Service Community Nursing	Coventry & Warwickshire Partnership NHS Trust
Liz Colley	Community Matron	Coventry & Warwickshire Partnership NHS Trust
Kay Crowther	Clinical Lead for Community Nursing	Walsall Healthcare NHS Trust
Maria Doyle	Safety and Quality Co-ordinator, Secondary Care Mental Health Services	Coventry & Warwickshire Partnership NHS Trust
Tracey Jones	Deputy Executive, Quality and Engagement	NHS Telford & Wrekin CCG
Joann Larner	In-patient Lead	Dudley & Walsall Mental Health Partnership NHS Trust
Geraldine McMurdie	Mental Health Commissioner	NHS Corby CCG
Dr Irfan Qazi	Consultant Physician and Geriatrician - Frailty	Walsall Healthcare NHS Trust
Gaynor-Kay Travis	Head of Therapy Services	University Hospitals of North Midlands NHS Trust
Jean Waller	Service User	

WMQRS Team

Sarah Broomhead	Assistant Director	West Midlands Quality Review Service
Bie Grobet	Associate	West Midlands Quality Review Service

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APPENDIX 2 COMPLIANCE WITH 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			
All health and social care services caring for older people living with frailty: Burton Hospitals NHS Foundation Trust	12	9	75
Community Hospitals: Sir Robert Peel, Samuel Johnson	(6)	(4)	(67)
Queen's Hospital	(6)	(5)	(83)
Urgent Care: Burton Hospitals NHS Foundation Trust	7	5	71
All services which conduct holistic frailty assessments: George Bryan Centre - South Staffordshire and Shropshire Healthcare NHS Foundation Trust	16	5	31
Frailty Team (Care of Older People Service): Burton Hospitals NHS Foundation Trust	38	28	74
Commissioning	6	0	0
Health Economy	**79**	**47**	**59**

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ALL HEALTH AND SOCIAL CARE SERVICES CARING FOR OLDER PEOPLE LIVING WITH FRAILTY

		Community Hospitals: Sir Robert Peel (RP) Samuel Johnson (SJ)		Queen's Hospital	
Ref	**Quality Standards**	**Met? Y/N**	**Reviewer Comments**	**Met? Y/N**	**Reviewer Comments**
M*-102	**Information and Support for Older People Living with Frailty and their Families and Carers** Information and support for older people at risk of or living with frailty, and their families and carers, should be available covering at least: a. Local services available to provide help, support and care b. How to access a directory of local services c. Maintaining a healthy lifestyle and preventing harm: i. Memory loss ii. Nutrition and hydration 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 range of information was available in the wards for patients and carers, although it was not frailty-specific. Ward-specific information was in place, and leaflets about providing personalised information for people with dementia ('About me') were in use. Some work was being undertaken to provide frailty-friendly meals. Information about memory loss or lifestyle was not clearly displayed. **SJ:** See also good practice section of the report.	Y	

		Community Hospitals: Sir Robert Peel (RP) Samuel Johnson (SJ)		Queen's Hospital	
Ref	**Quality Standards**	**Met? Y/N**	**Reviewer Comments**	**Met? Y/N**	**Reviewer Comments**
M*-104	**Reasonable Adjustments** Reasonable adjustments should be made for older people living with frailty using the service including: a. Flexible appointment times and extended appointment times, if required b. Good availability of parking bays for people with disabilities c. Easy availability of wheelchairs d. Facility for supporting communication with people with hearing deficits, such as a loop system and/or room suitable for private discussions e. Communication aids suitable for use with people with visual impairments f. Discussion and information sharing with informal carers who are acting in the best interest of the older person	Y	At both community hospitals, good joint appointment arrangements were in place, reducing the need for multiple appointments. Although some reasonable adjustments were made, these were not frailty-specific. Out of hours, communication aids were available from the reception area.	Y	

		Community Hospitals: Sir Robert Peel (RP) Samuel Johnson (SJ)		Queen's Hospital	
Ref	**Quality Standards**	**Met? Y/N**	**Reviewer Comments**	**Met? Y/N**	**Reviewer Comments**
M*-298	**Training Programme** A rolling programme of training should be run for staff covering: **All staff:** a. Making reasonable adjustments for older people living with frailty, including those with dementia b. Use of the locally agreed 'Emergency Care Plan' c. Recognising adults with care and support needs and recognition of abuse d. Safeguarding **Staff involved in frailty screening:** e. Indications for frailty screening and use of the locally agreed frailty screening tool (QSs M*-501) including: i. Criteria for undertaking or referral for holistic frailty assessment ii. Criteria for referral for comprehensive geriatric assessment f. Main local services available for the care of older people living with frailty and referral for: i. Support and care ii. Maintaining a healthy lifestyle iii. Preventing harm iv. Support for carers	N	Training on recognition of frailty syndromes was in the process of being delivered. Staff had a good understanding of elderly care ('a'-'d'). Wards had link nurses for, for example, tissue viability and nutrition.	Y	Training covered how to identify and diagnose frailty, including some competence-based elements. 'Road show' sessions about frailty had been run, with further sessions planned for ward and departmental staff.

		Community Hospitals: Sir Robert Peel (RP) Samuel Johnson (SJ)		Queen's Hospital	
Ref	**Quality Standards**	**Met? Y/N**	**Reviewer Comments**	**Met? Y/N**	**Reviewer Comments**
M*-301	**Support Services** Access to the following services should be available: a. 'Single point of access' for services to manage a crisis at home or to enable those older people living with frailty to return home quickly b. Frailty Team for: i. Advice and support ii. Rapid access ambulatory clinics c. Services providing: i. Support and care ii. Support for maintaining a healthy lifestyle and preventing harm iii. Support for carers d. End of life care	Y	Access to all services was available. The frailty team was available for advice and support, but was based at Queen's Hospital. Some clinics were provided on site, and consultant geriatricians attended the wards weekly at RP and more often at SJ. Support from the palliative care team was very good.	Y	
M*-401	**Facilities and Equipment** Facilities and equipment should be appropriate for the needs of older people living with frailty, including: a. Appropriate signage b. Noise reduction in busy areas and at night c. Access to health and social care records containing details of the care of the older person	Y	Butterfly signage at bedsides was used. See also good practice section of the report about the 'sleep hygiene' programme.	Y	

		Community Hospitals: Sir Robert Peel (RP) Samuel Johnson (SJ)		Queen's Hospital	
Ref	**Quality Standards**	**Met? Y/N**	**Reviewer Comments**	**Met? Y/N**	**Reviewer Comments**
M*-501	**Guidelines: Frailty Screening and Care of Older People Living with Frailty (1)** Guidelines on care of older people living with frailty should be in use covering: a. Making reasonable adjustments b. Use of Emergency Care Plan, including notifying the Care Coordinator c. Recognising adults with care and support needs and recognition of abuse d. Indications for frailty screening and use of frailty screening tool e. Criteria for undertaking or referral for holistic frailty assessment f. Criteria for referral for comprehensive geriatric assessment	N	Guidelines as defined by the QS were not yet in place in the community hospitals. Trust guidelines covering comprehensive geriatric assessment were available, but these were not in use in the community hospitals.	N	Guidelines as defined by the QS were not yet agreed. Trust guidelines covering comprehensive geriatric assessment were in place.

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URGENT CARE

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

		Burton Hospitals NHS Foundation Trust	
Ref	**Quality Standards**	**Met? Y/N**	**Reviewer Comments**
ME-298	**Training Programme** A rolling programme of training should be run for staff covering: **All staff:** a. Making reasonable adjustments for older people living with frailty, including those with dementia b. Use of the locally agreed 'Emergency Care Plan' c. Recognising adults with care and support needs and recognition of abuse d. Safeguarding **Staff involved in frailty screening:** e. Indications for frailty screening and use of the locally agreed frailty screening tool (QSs M*-501) including: i. Criteria for undertaking or referral for holistic frailty assessment ii. Criteria for referral for comprehensive geriatric assessment f. Main local services available for the care of older people living with frailty and referral for: i. Support and care ii. Maintaining a healthy lifestyle iii. Preventing harm iv. Support for carers	Y	
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	N	Noise reduction at night was not easily achievable. Access to health and social care records containing details of the care of the older person was not yet in place. The layout of the department was not ideal, but one of the bays had been specifically decorated and equipped to care for people with dementia – see good practice section of the report.

		Burton Hospitals NHS Foundation Trust	
Ref	**Quality Standards**	**Met? Y/N**	**Reviewer Comments**
ME-501	**Guidelines: Frailty Screening and Care of Older People Living with Frailty (1)** Guidelines on care of older people living with frailty should be in use covering: 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	Y	Guidance for screening in the Emergency Department was in place. Staff used an electronic screening tool which would trigger an automatic referral to the frailty team.
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	Assessment guidelines were in place, but these were not specific to frailty. Guidelines on management of frailty syndromes ('d') were not yet in place covering intellectual impairment or incontinence for all genders. Clinical guidelines were in place covering: Falls, Skin Bundles, Nutrition and Feeding at Risk, and Male Urinary Incontinence.

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ALL SERVICES WHICH CONDUCT HOLISTIC FRAILTY ASSESSMENTS

		George Bryan Centre - South Staffordshire and Shropshire Healthcare NHS Foundation Trust	
Ref	**Quality Standards**	**Met? Y/N**	**Reviewer Comments**
MN-102	**Information and Support for Older People Living with Frailty and their Families and Carers** Information and support for older people at risk of or living with frailty, and their families and carers, should be available covering at least: a. Local services available to provide help, support and care b. How to access a directory of local services c. Maintaining a healthy lifestyle and preventing harm: i. Memory loss ii. Nutrition and hydration iii. Maintaining mobility, including exercises iv. Falls prevention v. Preventing and managing incontinence vi. Skin and foot care vii. Managing medication, including reducing polypharmacy d. How to access an advocate e. How to access advice on: i. Mental capacity and Deprivation of Liberty Safeguards ii. Power of Attorney iii. Advance Care Planning iv. End of Life Care f. Support available for carers g. Availability of assistive technology h. Relevant national groups and organisations i. How to give feedback on support and care received	N	Information for patients covering mobility, foot care and managing medication was not seen.

		George Bryan Centre - South Staffordshire and Shropshire Healthcare NHS Foundation Trust	
Ref	**Quality Standards**	**Met? Y/N**	**Reviewer Comments**
MN-103	**Frailty-Specific Information** Information for older people and their family and carers should be available covering, at least: a. Assessment process b. Care and Support Planning, including: i. Advice available to help them identify choices and evaluate options ii. Access to an advocate for people with substantial difficulty in being actively involved with planning their care c. Emergency Care Plan and its use d. Maintaining a healthy lifestyle, preventing harm and managing problems with: i. Memory loss ii. Nutrition and hydration iii. Maintaining mobility, including exercises iv. Falls prevention v. Preventing and managing incontinence vi. Skin and foot care vii. Managing medication, including reducing polypharmacy e. DVLA regulations and driving advice (if applicable) f. Personal health and care budgets g. Advance Care Planning h. Sources of further advice and information	N	As QS MN-102. All other information was in place, and staff provided information verbally.
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	A hearing loop facility was not available but there was a suitable room for private discussions.

		George Bryan Centre - South Staffordshire and Shropshire Healthcare NHS Foundation Trust	
Ref	**Quality Standards**	**Met? Y/N**	**Reviewer Comments**
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.	N	All care plans were documented on RiO. Care plans were printed and sent as part of the discharge information to GPs. Holistic frailty assessment ('b') was not yet in place, although individual assessments would be completed if triggered for, for example, nutrition and skin care. 'About me' documentation was in place but was not clearly displayed on the day of the visit. Information to say that patients and, where appropriate, carers and families could have access to care and support plans was not displayed. Two care plans were reviewed on the day of the visit. Both plans were written in clinical language and were not in a format that was easily understandable by patients, especially when printed. From the documentation seen it was not clear that patients had been involved in the development of the care plan or had reviewed what was written. One care plan included very detailed information from the falls policy.

		George Bryan Centre - South Staffordshire and Shropshire Healthcare NHS Foundation Trust	
Ref	**Quality Standards**	**Met? Y/N**	**Reviewer Comments**
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.	N	Care Programme Approach reviews were held, but reviewers did not see evidence of systematic reviews of care and support plans.
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	In practice, Emergency Care Plans as defined by the QS were not developed or available when patients were admitted. Patients would have any issues included in their relapse or contingency plans.
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	Mandatory training covered all except 'a'. Training on completion of assessment checklists on RiO was undertaken as part of the induction of new staff to the ward, but these checklists, taken together, did not constitute a holistic frailty assessment.

		George Bryan Centre - South Staffordshire and Shropshire Healthcare NHS Foundation Trust	
Ref	**Quality Standards**	**Met? Y/N**	**Reviewer Comments**
MN-298	**Training Programme** A rolling programme of training should be run for staff covering: **All staff:** a. Making reasonable adjustments for older people living with frailty, including those with dementia b. Use of the locally agreed 'Emergency Care Plan' c. Recognising adults with care and support needs and recognition of abuse d. Safeguarding **Staff involved in frailty screening:** e. Indications for frailty screening and use of the locally agreed frailty screening tool (QSs M*-501) including: i. Criteria for undertaking or referral for holistic frailty assessment ii. Criteria for referral for comprehensive geriatric assessment f. Main local services available for the care of older people living with frailty and referral for: i. Support and care ii. Maintaining a healthy lifestyle iii. Preventing harm iv. Support for carers	N	Staff training programme covered all but 'e'. Staff would access advice and additional training as required and had undertaken training on the delivery of subcutaneous fluids.
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 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	Staff could contact both Single Point of Access services (mental health services and physical health services). Access to the frailty team was via referral to the team. Staff would also refer to services at Sir Robert Peel Community Hospital or GPs. If patients were already known to any community specialist service then staff would make contact and ask for advice as required.

		George Bryan Centre - South Staffordshire and Shropshire Healthcare NHS Foundation Trust	
Ref	**Quality Standards**	**Met? Y/N**	**Reviewer Comments**
MN-401	**Facilities and Equipment** Facilities and equipment should be appropriate for the needs of older people living with frailty, including: a. Appropriate signage b. Noise reduction in busy areas and at night c. Access to health and social care records containing details of the care of the older person	Y	The ward provided care for those with organic and functional disorders. The ward areas were cluttered and lacked storage space for equipment; for example, the reminiscence room was used for storage of physiotherapy equipment. Reviewers considered that signage could be improved to be more 'dementia friendly'. Reviewers were impressed with the privacy screens, which had been customised and included pictures.
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	'a'-'c' were covered in other Trust policies. Guidelines were not yet in place covering other aspects of the QS.

		George Bryan Centre - South Staffordshire and Shropshire Healthcare NHS Foundation Trust	
Ref	**Quality Standards**	**Met? Y/N**	**Reviewer Comments**
MN-503	**Holistic Frailty Assessment / Comprehensive Geriatric Assessment** Guidelines on holistic frailty assessment should be in use covering at least: a. Involving the older person, their family and carers b. Staff who should be involved c. Conducting a holistic frailty assessment using the locally agreed format (if available) and covering at least: i. Any concerns about mental capacity ii. Medical: comorbid conditions, disease severity and nutritional status, including tissue viability, continence and swallowing iii. Mental health: cognition, mood, anxiety and fears, past history of delirium iv. Functional capacity: activities of daily living, eye sight, mouth and teeth, hearing, mobility, gait and balance, activity and exercise status, falls assessment, any concerns about driving ability (if applicable) v. Social and financial circumstances: informal support, social network and activities, eligibility for care vi. Environment: home comfort and facilities, personal safety, potential use of Telehealth/Telecare and assistive technology, transport facilities, accessibility of local resources vii. 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 for holistic frailty assessment and indications for a comprehensive geriatric assessment were not yet in place. Assessments which covered 'ci'-'e' were undertaken.
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	The pharmacists visited every weekday and were available to meet with patients and carers as required. Staff who spoke to reviewers were aware of drug monitoring and could request medication reviews in order to reduce poly-pharmacy.

		George Bryan Centre - South Staffordshire and Shropshire Healthcare NHS Foundation Trust	
Ref	**Quality Standards**	**Met? Y/N**	**Reviewer Comments**
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 on the management of frailty syndromes were not yet in place. Trust polices were in place covering falls, skin care and intellectual impairment. Policies covering incontinence or immobility 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 as defined by the QS were not yet collected.

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FRAILTY TEAM

		Burton Hospitals NHS Foundation 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	Open visiting was in place on the 'care of the elderly' wards.

		Burton Hospitals NHS Foundation Trust	
Ref	**Quality Standards**	**Met? Y/N**	**Reviewer Comment**
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	Y	The frailty team had also introduced a patient feedback tool.

		Burton Hospitals NHS Foundation Trust	
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	Y	Information was also available on the Trust website and via Age UK.
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	

		Burton Hospitals NHS Foundation Trust	
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.	N	Care and support plans had been introduced on Ward 4 but not in other ward areas. The Trust had plans to 'roll out' the implementation of care and support plans for use in other patient areas. Trust care plans were in use and were documented on the electronic system. Paper copies of care plans were shared with other agencies and GPs. On Ward 4 the comprehensive geriatric assessment was sent with the GP discharge letter.
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.	N	Care and support plans were reviewed for patients who were discussed as part of the virtual ward meeting. Robust arrangements for review of care and support plans for other patients were not yet in place.

		Burton Hospitals NHS Foundation Trust	
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	Patient passports or emergency care plans were not developed whilst patients were in hospital. Patient passports were in place for some patients with long-term conditions. Care plans for in-patients were documented on the electronic system, and paper copies were shared with other agencies and GPs.
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	Nursing discharge letters were also included in the patients' discharge packs.
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	

		Burton Hospitals NHS Foundation Trust	
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	N	Some feedback had been received as part of the Trust Meridian In-patient Survey, but it was not clear that that feedback specifically related to the care of people living with frailty. The frailty team was in the process of implementing a patient feedback tool.
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	

		Burton Hospitals NHS Foundation Trust	
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 team was operational between the hours of 8am and 7pm seven days a week and consisted of the following: Consultant Geriatrician, 3 w.t.e Advanced Clinical Practitioners (Nurses and Allied health Professions , 3 w.t.e physiotherapists, 3 w.t.e. occupational therapists, an assistant practitioner, and a social care assessor. Pharmacist time ('g') for work with the team and rapid access to ambulatory clinics 7/7 were not yet in place.
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	Frailty team staff had also completed a 'comprehensive assessment' course.

		Burton Hospitals NHS Foundation Trust	
Ref	**Quality Standards**	**Met? Y/N**	**Reviewer Comment**
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.	Y	Competences had been developed and were in the process of being completed by staff.
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	
MP-299	**Administrative, Clerical and Data Collection Support** Administrative, clerical and data collection support should be available.	Y	
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	

		Burton Hospitals NHS Foundation Trust	
Ref	**Quality Standards**	**Met? Y/N**	**Reviewer Comment**
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	This QS was met on the wards visited by the reviewers.
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	
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.

		Burton Hospitals NHS Foundation Trust	
Ref	**Quality Standards**	**Met? Y/N**	**Reviewer Comment**
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	Y	
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) v. Social and financial circumstances: informal support, social network and activities, eligibility for care vi. Environment: home comfort and facilities, personal safety, potential use of Telehealth/Telecare and assistive technology, transport facilities, accessibility of local resources vii. 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	Y	

		Burton Hospitals NHS Foundation Trust	
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	The Trust medicines management policy covered medicine reconciliation but not other aspects of the QS.
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	Clinical guidelines were not yet in place covering intellectual impairment or incontinence for all genders. Clinical guidelines were in place covering: Falls, Skin Bundles, Nutrition and Feeding at Risk, and Male Urinary Incontinence.
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	Multidisciplinary team meetings were held prior to complex discharges.
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	Y	

		Burton Hospitals NHS Foundation Trust	
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'	Y	A Frail Elderly Pathway Operating Policy had been agreed in April 2016 but would benefit from being updated to include the pathway and operational changes.
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.	Y	
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.	Y	
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	KPIs had been agreed and were detailed in the pathway policy but it was not clear if timescales had been agreed ('d'). Reviewers did not see any data covering 'c', 'di' or 'dii'. A Frailty CQUIN was in place and reviewers were told that the Trust had met the requirements defined.

		Burton Hospitals NHS Foundation Trust	
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	Documentation was not available to reviewers for compliance with the QS to be assessed. A Frailty CQUIN was in place but did not cover all the requirements of the QS.
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	
MP-799	**Document Control** All policies, procedures and guidelines should comply with Trust (or equivalent) document control procedures.	Y	

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COMMISSIONING

Ref	Quality Standards	Met? Y/N	Reviewer Comments
MZ-298	**Local Training Programme** The Local Health and Social Care 'Older People Living with Frailty' Group should have agreed and implemented a training programme for all health and social care services providing care for older people living with frailty, covering the requirements of QS M*-298.	N	Evidence of compliance with the QS was not available.

Ref	Quality Standards	Met? Y/N	Reviewer Comments
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	Evidence of compliance with the QS was not available.
MZ-602	**Commissioning of Services** Integrated health and social care services for the care and support of older people living with frailty should be commissioned including, at least: a. Carers support and access to short-term breaks b. Equipment c. Services to maximise independence d. Admission avoidance schemes and response to urgent need e. Influenza and pneumococcal pneumonia vaccination f. Frailty Team g. Services providing: i. Support and care ii. Support for maintaining a healthy lifestyle and preventing harm iii Support for carers	N	Evidence of compliance with the QS was not available.
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	Evidence of compliance with the QS was not available.

Ref	Quality Standards	Met? Y/N	Reviewer Comments
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	Evidence of compliance with the QS was not available.
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	Evidence of compliance with the QS was not available.

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