Quality Standards

Care of Older People Living with Frailty: Assessment and Coordination of Care

Version 3.1

November 2020

8831

Review by: October 2022 at the latest

Version No.	Date	Change from previous version
V3	24.10.19	N/A
V3.1	23.11.20	• QRS Contact details amended. • Added in addition to CQC that other regulatory frameworks are in use in the devolved nations. • QS MA-601 amended to include governance for virtual consultations and MP-499 and MP-601 amended to include use of systems and governance arrangements for virtual consultations and include 'were not brought'

Contents

Introduction

These Quality Standards for Care of Older People Living with Frailty: Assessment and Coordination of Care were initially developed in 2015 following a programme of formative reviews as part of the Quality Review Service's work to support NHS organisations in improving the quality of services. These Quality Standards have been revised by a Steering Group (Appendix 1) following a review of the relevant literature published since 2015 (Appendix 2) and comments received following circulation for regional comment. The Steering Group recognised that some health economies may face challenges in meeting the Quality Standards but considered that the Quality Standards should be achievable within two to five years.

The Standards refer to 'older people living with frailty'. This wording has been chosen because frailty is now considered a common long-term condition, often related to age. We are not seeking to label older people as frail. Some older people are, however, living with frailty and they deserve the best possible assessments and coordination of their care as described in the Quality Standards. Identifying frailty has also been shown to result in more person-centred care, improved independence and reduced social isolation.

The Steering Group has been keen to involve older people living with frailty and their families and carers in the development of the Standards. Three representatives are members of the Steering Group, an outline of the Standards was circulated through the Steering Group to interested groups and individuals and some Steering Group members facilitated discussion with older people living with frailty, families and carers in their local area.

Aims of the Quality Standards

The Quality Standards aim to improve care for older people living with frailty through their use locally in self-assessment and monitoring by commissioners and providers, and for peer review visits. We hope that through use of the Quality Standards:

a. Older people living with frailty and their families and carers will know more about the services they can expect.

b. Commissioners will be supported in assessing and meeting the needs of their population, improving health and reducing health inequalities, and will have better service specifications.

c. Service providers and commissioners will work together to improve service quality.

d. Service providers and commissioners will have external assurance of the quality of local services.

e. Reviewers will learn from taking part in review visits.

f. Good practice will be shared.

g. Service providers and commissioners will have better information to give to the Care Quality Commission, NHS England and NHS Improvement. The devolved nations may have different regulatory frameworks in place but these QS can still be used with these frameworks to provide additional assurance to commissioners of services.

Quality Standards are cross-referenced to the reference sources (Appendix 2). Standards are also cross-referenced to Care Quality Commission 'Key Lines of Enquiry' and British Standards Institution PAS16:16 (Appendix 3).

Scope of the Quality Standards

The care of older people living with frailty is complex and often involves many health and social care services. A framework developed for the formative review visits undertaken in 2014 which has been updated (Appendix

4) illustrates this complexity. These Standards concentrate on the underpinning elements of identification, assessment and coordination between services. They are applicable to the care of older people living with frailty in all health and social care settings and to older people with many different needs.

The Quality Standards for Care of Older People Living with Frailty: Assessment and Coordination of Care link with several other QRS Quality Standards, in particular those for:

- Urgent Care
- Transfer from Acute Hospital Care and Intermediate Care
- Falls and Fragility Fractures Pathway
- Care of People with Dementia
- Care of People with Chronic Obstructive Pulmonary Disease
- Mental Health Services

Aspects of the care of older people living with frailty which are already covered by these Quality Standards are not duplicated here.

The Quality Standards for Care of Older People Living with Frailty: Assessment and Coordination of Care should sit within organisations' overall clinical governance arrangements. The QRS Clinical Governance Quality Standards describe the clinical governance arrangements which should be in place. Compliance in NHS provider organisations will usually be assured through other mechanisms. Non-NHS healthcare organisations may wish to use the QRS Clinical Governance Quality Standards to assure themselves of the robustness of their overall clinical governance arrangements.

Latest versions of QRS Quality Standards are available to organisations on the QRS website www.qualityreviewservicewm.nhs.uk

Terms and Abbreviations

Appendix 5 gives a glossary of terms and abbreviations. Key terms essential for understanding the Standards are as follows:

Term	Explanation
Care and Support Plan	A plan summarising the care and support to meet their needs, agreed with a frail older person and their family and carers (where appropriate). Ideally, older people living with frailty will have a single care and support plan.
Care Coordinator	A care coordinator (or key worker or link worker in primary care) has an overview of the health and social care of an older person living with frailty. Coordinating and maintaining this overview of the care pathway (i.e. 'case management') is central to the care coordinator / key worker/ link worker role. The care coordinator will normally also be the person responsible for ensuring a review of the older person's Care and Support Plan takes place as planned. The care coordinator will not be expected to answer all queries and will direct queries appropriately. The role may include providing support for personalised budgets.
Brief/Initial Comprehensive Geriatric Assessment	See Holistic Frailty Assessment.

Term	Explanation
Comprehensive Geriatric Assessment	A holistic, multi-disciplinary assessment of the needs of a frail older person, undertaken with the older person themselves and their families or carers by the Frailty Team. Leads to the formulation of a plan to address issues which are of concern to the older person (and their family and carers when relevant). Interventions are then arranged in support of the plan. Progress is reviewed and the original plan reassessed.
Emergency Care Plans	A simple, accessible, portable, easily available summary of what should happen in an emergency, developed and agreed with their frail older person and their main carers.
Frailty	A common long-term condition related to age, but not directly associated with it, which is characterised by a gradual loss of inbuilt reserves resulting in vulnerability to sudden deterioration as a result of relatively mild stressors. Frailty is commonly categorised as: **Mild Frailty:** These people often have more evidence slowing and need help in high order of Instrumental Dependent Activities of Daily Living (IADLs), for example finances, transportation, heavy housework, medications. **Moderate Frailty:** People need help with all outside activities and with keeping house. Inside they often have problems with stairs and need help with bathing and minimal assistance with dressing. **Severe Frailtly:** Completely dependent for personal care, from whatever cause (physical or cognitive). Even so they seem stable and not at 'high risk of dying (within six months). Further definitions and read codes for each category of frailtly are given in *'Toolkit for general practice in supporting older people living with frailtly' (NHS England 2017).*
Frailty screening	A systematic approach to identifying if an older person is frail.
Frailty screening tool	A systematic approach to undertaking frailty screening. A common frailty screening tool should, ideally, be used across each health and social care economy. Frailty screening should not cause delay in treatment and care. Depending on the severity and complexity of needs, frailty screening may lead to an older person being offered: a. Information and 'signposting' to available services and support b. Holistic frailty assessment (within the service or by referral) c. Referral to the Frailty Team for comprehensive geriatric assessment

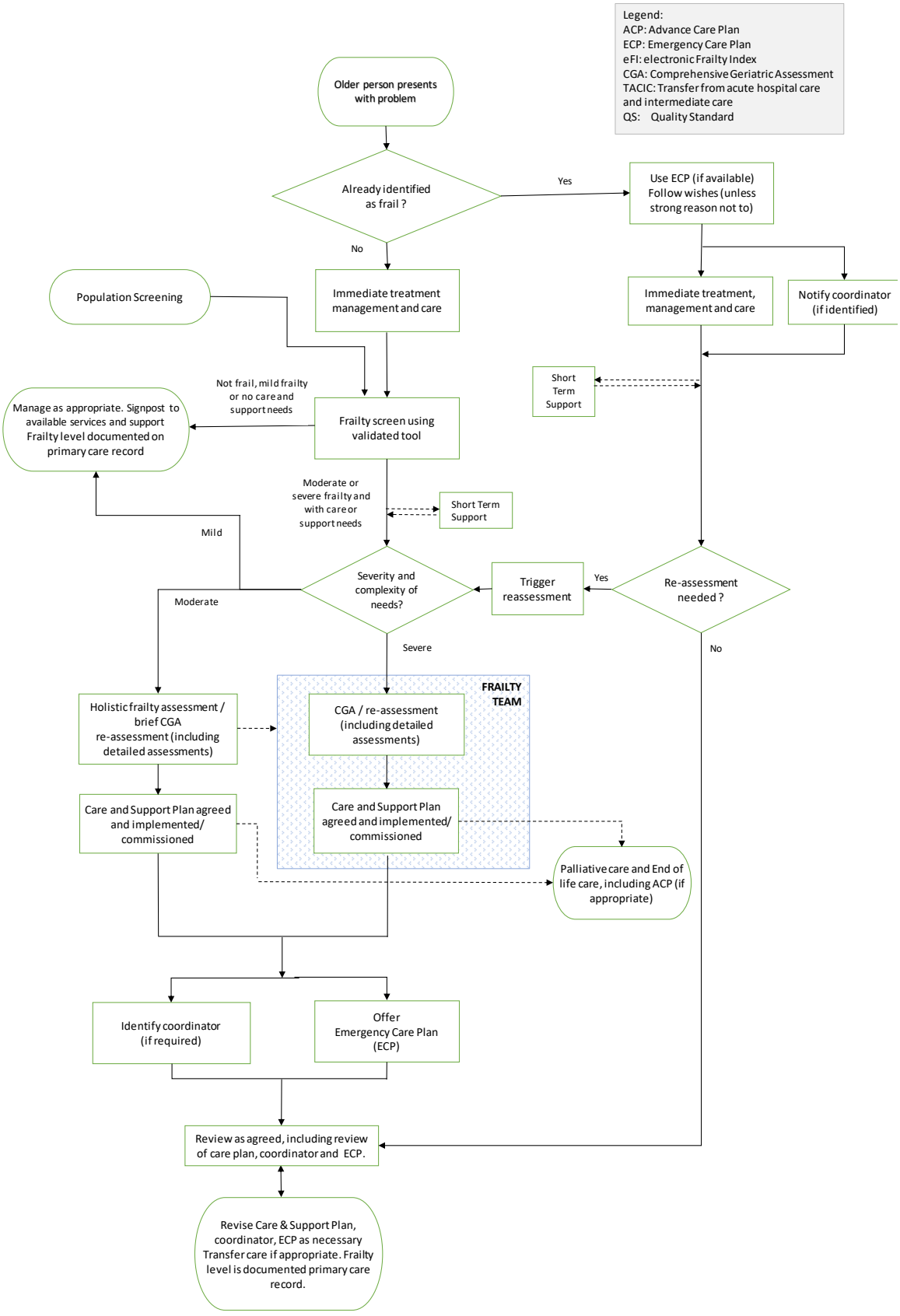
Term	Explanation
Frailty Team (Care of Older People Service)	A multi-disciplinary team providing comprehensive (multi-disciplinary) geriatric assessments and overseeing the care of the most frail older people, as well as providing specialist advice and guidance to other services. The Frailty Team is expected to provide care for these older people living with frailty in the community and if they are admitted to hospital. Models with separate community and hospital frailty teams are unlikely to be an efficient way of meeting the Quality Standards, except in geographical areas which refer to several acute hospitals with no main acute provider. One Frailty Team for each health and social care 'economy' is therefore expected to be the norm. Staff may be employed by different organisations as long as they are commissioned and work as an integrated service. The Frailty Team will need a hospital base as well as working in the community. The Team may not be called a 'Frailty Team' and may have another name, such as 'Care of Older People' service. This approach is consistent with that described in the *NHS Long Term Plan* (Department of Health and Social Care 2019) *and Five Year Forward View (*NHS England, 2014).
Health and social care economy	See Integrated Care System
Holistic frailty assessment (Brief/initial CGA)	A holistic assessment of the needs of a frail older person, undertaken with the older person themselves and their families or carers. This may be called a brief CGA (or some other term). This assessment may be uni-disciplinary but with more detailed assessments available as required. Holistic frailty assessments may be undertaken by a range of services and settings, for example, general practice, social services teams, admission avoidance teams, community nursing teams, admission wards, long-term conditions teams and mental health services. Responsibility for a holistic frailty assessment lies with a registered health or social care professional, although aspects of the assessment may be undertaken by non-registered staff, including voluntary sector organisations, on their behalf.

Term	Explanation
Integrated Care System	NHS organisations, local councils and voluntary sector providers in England working together to coordinate services around the whole needs of each person. The aim is to develop local partnerships to share responsibility so that people can live healthier lives and get the care and treatment they need, in the right place, at the right time. This area will normally be the catchment area for an acute hospital taking acute medical admissions, although special arrangements may be needed in geographical areas which refer to several acute hospitals with no main provider of acute care. The Quality Standards expect that the following should be common across the 'integrated care system': 1. Indications for frailty screening 2. Frailty screening tool 3. Criteria, based on severity and complexity of needs, for undertaking or for referral for: a. Holistic Frailty Assessment b. Comprehensive Geriatric Assessment 4. Holistic Frailty Assessment and Comprehensive Geriatric Assessment formats 5. Emergency Care Plan format 'Care and Support Plans' would, ideally, also be common across the 'integrated care system' but this may not be achievable at this stage.
Primary Care Networks	Some GP practices are part of a local Primary Care Network (PCN). Primary Care Networks are based around GP registered lists of approximately 30,000 to 50,000 patients, encompassing general practice and other partners in community and social care. These networks offer care on a scale which is small enough for patients to get the continuous and personalised care they value, but large enough in their partnership with others in the local health and care system to be resilient.
The Local Health and Social Care 'Older People Living with Frailty' Group	A multi-agency Local Health and Social Care 'Older People Living with Frailty' Group who meets regularly to review implementation of the local strategy and address any problems with coordination of local services.
Population Health Management	Using a systematic, whole population focus to improving the management of risks in a population. This may be described by geography, by a presenting health need or communities. This will assist in preventing disease progression and will allow for interventions to be targeted and prioritised.
Emerging Health Systems	See Integrated Care System

Pathway for Assessment and Coordination of Care

An overview of the pathway for assessment and coordination of care described by the Quality Standards is given in Figure 1.

Figure 1 Pathway for Assessment and Coordination of Care



Structure of the Quality Standards

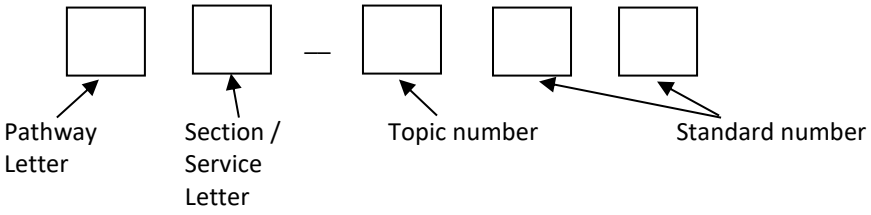
Sections

The Quality Standards for Care of Older People Living with Frailty: Assessment and Coordination of Care are divided into the following inter-linking sections:

- All health and social care services caring for older people living with frailty
- All services conducting a holistic frailty assessment
- General practice
- Urgent care services
- Care homes
- Frailty Team (Care of Older People Service)
- Commissioning

QRS Quality Standards Structure

Each QRS Quality Standard has a unique reference number with the following structure:



Each Standard is structured as follows:

Reference Number (Ref)	This column contains the reference number for each Standard which is unique to these standards and is used for all cross-referencing. Each reference number is composed of two letters and three digits (see below for more detail). The reference column also includes a guide to how the Standard will be reviewed: BI – Background information for the review team Visit – Visiting facilities MP&S – Meeting service users, carers and staff CNR – Case note review or clinical observation Doc – Documentation should be available. Documentation may be written or in the form of a website or other social media. The shaded area indicates the approach that will be used to reviewing the Quality Standard. Appendix 6 summarises the evidence needed for review visits.
Quality Standard (QS) *Notes*	This describes the quality that services are expected to provide. *The notes give more detail about either the interpretation or the applicability of the Standard.*

Pathway and Section Letters:

The Quality Standards for Care of Older People Living with Frailty: Assessment and Coordination of Care use the pathway letter M. The Standards are in the following sections:

M*-	Care of Older People Living with Frailty	All health and social care services caring for older people living with frailty
MA -	Care of Older People Living with Frailty	General Practice. M* Standards also apply. *Note: If General practitioners are also providing Holistic Frailty Assessments (brief CGA), Quality Standards MN- Standards should also be met.*
ME -	Care of Older People Living with Frailty	Urgent Care Services. M* Standards also apply.
MN -	Care of Older People Living with Frailty	All health and social care services which conduct holistic frailty assessments (brief CGA). M* Standards also apply.
MH -	Care of Older People Living with Frailty	Care Homes. M* and MN- Standards also apply.
MP -	Care of Older People Living with Frailty	Frailty Team (Care of Older People Service).
MZ -	Care of Older People Living with Frailty	Commissioning

Figure 2 gives an explanation of how the Quality Standards are applicable to a range of different services.

Figure 2

General Practice	Emergency Department	Community teams (Health and Social Care)	Mental Health Service	Urgent Care Services	Care of Older People Service	Care Home
MA-	**ME-**	**-**	**-**	**ME**	**MP-**	**MH-**
M*-	**M*-**	**M*-**	**M*-**	**M*-**	**-**	**M*-**
MN- See note above in table about applicability to GP for MN	**-**	**MN-**	**MN-**	**MN-**	**-**	**MN-**

Topics: Each section covers the following topics:

-100	Information and Support for Service Users and Carers
-200	Staffing
-300	Support Services
-400	Facilities and Equipment
-500	Guidelines and Protocols
-600	Service Organisation and Liaison with Other Services
-700	Governance

Policies, Protocols, Guidelines and Procedures:

The Standards use the words policy, protocol, guideline and procedure based on the following definitions:

Policy	A course or general plan adopted by an organisation, which sets out the overall aims and objectives in a particular area.
Protocol	A document laying down in precise detail the tests or steps that must be performed.
Guidelines	Principles which are set down to help determine a course of action. They assist the practitioner to decide on a course of action but do not need to be automatically applied. Clinical guidelines do not replace professional judgement and discretion.
Procedure	A procedure is a method of conducting business or performing a task, which sets out a series of actions or steps to be taken.

For simplicity, some standards use the term 'guidelines and protocols' which should be taken as referring to policies, protocols, guidelines and procedures. All clinical guidelines should be based on national guidance, including NICE guidance where available. Local guidelines and protocols should specify the way in which national guidance will be implemented locally and should show consideration of local circumstances.

Excel and PDF Versions

The full text of the Quality Standards and all Appendices are available in a PDF version. A self-assessment form is available in Excel and it is recommended that this is used by services when considering their compliance with the Standards. The Excel version has the following advantages:

- The spreadsheet includes all the relevant QS for each service in separate tables e.g. MA and M*, ME and M* (see figure 2).
- The spreadsheet includes a 'CQC' tab. This updates automatically when a self-assessment is completed and allows services to see, and demonstrate, the extent to which they are achieving the CQC Key Lines of Enquiry. The devolved nations may have different regulatory frameworks in place but these QS can still be mapped to other frameworks to provide additional assurance to commissioners of services.
- Additional columns can be used for subsequent self-assessments, enabling progress to be seen without losing earlier information.

When using the Excel spread sheet it is useful to know the following:

- If the tabs at the bottom of the spreadsheet do not appear, please minimise the spreadsheet and then maximise it again and the tabs should be there.
- 'Alt' and 'Enter' (together) allows you to put a new line within an Excel cell.

Comments on the Quality Standards

The Quality Standards will be revised as new national guidance becomes available and as a result of experience of their use in peer review. Comments on the Quality Standards are welcomed and will be taken into account when the Quality Standards are updated. Comments should be sent to qrs@nhs.net

More information about QRS and its Quality Standards and reviews is available at www.qualityreviewservicewm.nhs.uk

Quality Standards

All Health Services & Social Care Services Caring for Older People Living with Frailty

Ref	Standard
Information and Support for Service Users and Carers	
M*-102 BI Visit MP&S CNR Doc	**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 and supportive communities available to provide help, support and care b. How to access a directory of local services c. How to access a social prescribing link worker d. Maintaining a healthy lifestyle and preventing harm: i. memory loss ii. nutrition and hydration iii. oral health and mouth care iv. staying active and maintaining mobility, including exercises v. falls prevention vi. preventing and managing incontinence vii. skin and foot care viii. managing medication, including reducing polypharmacy ix. maintaining independence x. preventing loneliness and social isolation xi. emotional health and wellbeing e. How to access an advocate f. How to access advice on: i. Safeguarding ii. Mental Capacity and Deprivation of Liberty Safeguards iii. Legal implications of living with frailty, the Office of the Public Guardian and how to access legal advice iv. Advance Care Planning including 'do not attempt cardio-pulmonary resuscitation' v. End of Life Care g. Additional support available in the person's usual place of residence or other housing options. h. Availability of assistive technology i. Relevant national groups and organisations j. How to give feedback on support and care received *Notes:* 1. *Information should be written in clear, plain English and should be available in formats and languages appropriate to the needs of older people and people with learning disabilities.* 2. *Information may also be in the form of a website or other social media. Guidance on how to access information is sufficient for compliance so long as this points to easily available information of appropriate quality. If the information is provided only in individual letters, then examples will need to be seen by reviewers.* 3. *If a social prescribing link worker is not in place then people, their families and carers should have access to information covering a wide range of local agencies who are available to provide help, support and care.* 4. *Information relating to advance care planning and 'do not attempt cardio-pulmonary resuscitation' should be consistent with national guidelines for example ReSPECT guidelines* https://www.resus.org.uk/respect/.

Ref	Standard
M*-104 BI Visit MP&S CNR Doc	**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

Ref	Standard
Staffing	
M*-298 BI Visit MP&S CNR Doc	**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 and learning disabilities b. Use of the locally agreed 'Emergency Care Plan' c. Recognising adults with care and support needs and recognition of abuse d. Safeguarding e. Preventing functional loss (deconditioning) and enabling independence **Staff involved in frailty screening:** f. Recognition of frailty: identification of older people who may have mild, moderate or severe frailty and 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 (brief CGA) ii. criteria for referral for comprehensive geriatric assessment g. 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 *Notes:* 1. *A common frailty screening tool should, ideally, be used across each health and social care economy. Recognised frailty screening tools include: Clinical Frailty Scale, Edmonton and Reported Edmonton Frail Scales, Rockwood Frailty Scale, PRISMA-7 questionnaire. Frailty screening should not cause delay in treatment and care.* *Depending on the severity and complexity of needs, frailty screening may lead to an older person being offered:* *a. Information and 'signposting' to available services and support* *b. Holistic frailty assessment/ brief CGA (within the service or by referral)* *c. Comprehensive geriatric assessment (i.e. referral to Frailty Team)* 2. *Services to prevent harm should include services for falls prevention, continence advice, tissue viability care, safeguarding, memory problems, nutrition advice and medicines management services* 3. *The following skill and competence frameworks should help staff working in services caring for people living with frailty achieve this QS:* *a. Skills for Health: Frailty, A framework of core competences, (2018) www.skillsforhealth.org.uk* *b. The Frailty Toolkit www.frailtytoolkit.org/frailty-toolkit/*

Ref	Standard
Support Services	
M*-301 BI Visit MP&S CNR Doc	**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. same day emergency care (SDEC) for older people being considered for emergency admission 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, including bereavement services *Notes:* *1. The 'single point of access' service should also provide access to equipment needed to manage a crisis at home or to support rapid return home.* *2. More detail of the services which should be available is given in QS MZ-602.* *3. The NHS Long-Term Plan (2019) states that the 'SDEC model should be embedded in every hospital, in both medical and surgical specialties during 2019/20'.*
Facilities and Equipment	
M*-401 BI Visit MP&S CNR Doc	**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 *Note: This QS should be interpreted in relation to the setting where care is provided. Some aspects will not be applicable to all services.*

Ref	Standard
Guidelines and Protocols	
M*-501 BI Visit MP&S CNR Doc	**Guidelines: Frailty Screening and Care of Older People Living with Frailty (1)**[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. Recognition of frailty, indications for frailty screening and use of frailty screening tool e. Criteria for undertaking or referral for holistic frailty assessment (brief CGA) f. Criteria for referral for comprehensive geriatric assessment *Note: These guidelines should link with Trust (or equivalent) safeguarding policies.*
Service Organisation and Liaison with Other Services	
M*-603 BI Visit MP&S CNR Doc	**Population Health Management** Up to date information on people with living with frailty within the local area who have been identified through population health management as at high risk of unscheduled admission to hospital, should be easily available and used to support personalised care planning. *Note: This QS may be met through general practice or health economy-wide arrangements (QS MA-602, QS MZ-605) so long as services have easy access to information about their high-risk service users.*
M*-604 BI Visit MP&S CNR Doc	**Quality Monitoring – All services** Services should monitor: **Community Services:** a. Percentage of older people seen within two hours of referral by the community crisis response team b. Percentage of older people able to access urgent reablement within two working days of referral **Urgent Care Services only:** For older people with moderate or severe frailty urgent care services should monitor: c. Percentage of older people who received a frailty assessment within 30 minutes of arrival d. Percentage of older people with severe or very severe frailty assessed for the presence of frailty syndromes within an hour of their level of frailty being identified Appropriate action should be taken to tackle any issues identified through quality monitoring. *Notes:* *1. Community services' response times (to avoid unnecessary admission and support same day emergency care are expected to be achieved in full by 2023/24 (NHS Long-Term Plan 2019).* *2. This QS links to Commissioning QS MZ-702*

[1] All references to 'early intervention in all care settings' link to this QS

General Practice

These Quality Standards are additional to the Standards for 'All Health Services & Social Care Services Caring for Older People Living with Frailty' (QSs M*-***) which should also be met. General practitioners may also provide Holistic Frailty Assessments (brief CGA), in which case Quality Standards MN-*** should also be met.

Ref	Standard
Service Organisation and Liaison with Other Services	
MA-601 BI Visit MP&S CNR Doc	**Organisation of Care of Older People Living with Frailty** Each general practice should have arrangements for: a. Targeted case finding of frailty b. Ensuring all older people living with frailty are: i. offered influenza, pneumonia and shingles vaccination ii. considered for inclusion on the practice Palliative Care Register iii. considered for Advance Care Planning c. Multi-disciplinary assessment and review for all older people identified as having moderate or severe frailty 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' f. Governance arrangements for providing virtual consultations, assessments and therapeutic interventions. *Note: Further information on age groups eligible for the shingles vaccination can be accessed via* https://www.nhs.uk/conditions/vaccinations/who-can-have-the-shingles-vaccine/
MA-602 BI Visit MP&S CNR Doc	**Population Health Management** Each practice should be using a multi-disciplinary approach to manage the local population with frailty to enable early detection and interventions to treat underdiagnosed disorders and manage those who are at high risk of unscheduled admission to hospital. *Notes:* 1. *For those older people in the moderate and severe groups a clinician from the primary care team should verify the diagnosis by direct assessment using the Clinical Frailty Scale or a similar validated tool.* 2. *This QS may be met through primary care networks or health economy-wide arrangements (QS MZ-605) so long as individual practices have easy access to information about their patients who are at high risk of unscheduled admission to hospital.*

Ref	Standard
MA-605 BI Visit MP&S CNR Doc	**Quality Monitoring – Primary Care** General practices should monitor: a. Number of patients with frailty b. Influenza, pneumonia and shingles vaccination rates c. Relevant prescribing data d. Number of patients with frailty who have an activated summary care record e. Number paitents who have had an annual medication review using a validated tool. f. Number of patients with frailty identifed as being moderate or severely frail who have received:- i. a multi-diciplinary assessment and review ii. a falls risk assessment Appropriate action should be taken to tackle any issues identified through quality monitoring. *Notes:* 1. *The STOPP START supporting medication review is an example of a validated tool that may be used when reviewing medications with an older person with frailty. STOPFRAIL guidelines may also be used.* 2. *This QS links to Commissioning QS MZ-701* 3. *Further information on age groups eligible for the shingles vaccination can be accessed via* https://www.nhs.uk/conditions/vaccinations/who-can-have-the-shingles-vaccine/

Urgent Care Services

These Standards apply to Urgent Care Centres, Emergency Centres and Specialist Emergency Centres, to Medical and Surgical Admissions Units and to hospital wards accepting acute admissions.

These Standards are additional to the Standards for 'All Health Services & Social Care Services Caring for Older People Living with Frailty' (QSs M*-***) which should also be met. These Standards are also additional to the QRS Urgent Care Quality Standards (version 3, November 2016) which should also be met.

Ref	Standard
Guidelines and Protocols	
ME-502 BI Visit MP&S CNR Doc	**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 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. assessment of their emotional health and wellbeing v. 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. delirium ii. dementia and cognitive disorders iii. falls iv. immobility v. incontinence vi. skin care vii. oral health viii. avoiding functional decline whilst in hospital *Notes:* 1. *The guidelines on recognising adults with care and support needs and recognition of abuse should be more detailed than that expected for 'all health and social care services caring for older people living with frailty' and staff will need more detailed training in this area.* 2. *Medication review should include consideration of de-prescribing.* 3. *Obtaining relevant information from the older person's GP and/or care home may be achieved through electronic access to GP or social care IT systems.*

All Services Conducting a Holistic Frailty Assessment (Brief CGA)

A holistic assessment of the needs of a frail older person, undertaken with the older person themselves and their families or carers. This may be called a 'brief CGA' (or some other term). This assessment may be uni-disciplinary but with more detailed assessments available as required. Holistic frailty assessments may be undertaken by a range of services and settings, for example, general practice, social services teams, admission avoidance teams, community nursing teams, admission wards, long-term conditions teams and mental health services. Responsibility for a holistic frailty assessment lies with a registered health or social care professional, although aspects of the assessment may be undertaken by non-registered staff, including voluntary sector organisations, on their behalf.

As indicated in Figure 1 (page 8), Holistic Frailty Assessments (brief CGA) will usually be carried out with people with moderate frailty. On occasions, people with mild frailty may also be considered appropriate for a Holistic Frailty Assessment (brief CGA) and some people with moderate frailty will need a Comprehensive Geriatric Assessment.

Ref	Standard
Information and Support for Service Users and Carers	
MN-103 BI Visit MP&S CNR Doc	**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. Emergency Care Plan and its use c. Maintaining a healthy lifestyle, preventing harm and managing problems with: i. memory loss ii. nutrition and hydration iii. oral health and mouth care iv. staying active and maintaining mobility, including exercises v. falls prevention vi. preventing and managing incontinence vii. skin and foot care viii. preventing loneliness and social isolation ix. maintaining independence x. emotional health and well-being xi. managing medication, including reducing polypharmacy d. DVLA regulations and driving advice (if applicable) e. Personal health and care budgets f. Legal implications of living with frailty, the Office of the Public Guardian and how to access legal advice g. Advance Care Planning including 'do not attempt cardio-pulmonary resuscitation' h. Sources of further advice and information *Notes:* *1. Information should be written in clear, plain English and should be available in formats and languages appropriate to the needs of older people and people with learning disabilities.* *2. Information may also be in the form of a website or other social media. Guidance on how to access information is sufficient for compliance so long as this points to easily available information of appropriate quality. If the information is provided only in individual letters, then examples will need to be seen by reviewers.* *3. Information relating to advance care planning and 'do not attempt cardio-pulmonary resuscitation' should be consistent with national guidelines for example ReSPECT guidelines* https://www.resus.org.uk/respect/.

Ref	Standard
MN-105 BI Visit MP&S CNR Doc	**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
MN-106 BI Visit MP&S CNR Doc	**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 should include consideration of at least: i. falls prevention plan ii. pressure sore prevention plan iii. oral care and mouth care plan iv. hydration and nutrition plan e. Care Coordinator, including contact details (if required) f. Review date and review arrangements g. Advocate details (if applicable) h. Advance Care Planning directives including 'Do not attempt cardio-pulmonary resuscitation' documentation (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. *Notes:* 1. *Ideally, a frail older person should have a single Care and Support Plan. Care and support plans should allow and enable positive risk-taking if this is what the older person wants. Some parts of the Quality Standard may not be applicable to some older people but this aspect of their needs should be considered and recorded.* 2. *For older people being discharged from acute hospital care, the QRS Quality Standards (QSs) for 'Transfer from Acute Hospital Care and Intermediate Care' (TACIC) provide more detail of the expected care planning process. TACIC QSs should be met as well as QS MN-106.* 3. *The Care Coordinator should normally be the person responsible for arranging the review of the Care and Support Plan. The care coordinator may be a link worker in primary care. Some people with moderate frailty may not need a care coordinator.* 4. *The Emergency Care Plan (QS MN-108) may form part of the Care and Support Plan so long as it is available as a simple, accessible, portable, easily available summary.* 5. *Information relating to advance care planning and 'do not attempt cardio-pulmonary resuscitation' should be consistent with national guidelines for example ReSPECT guidelines* https://www.resus.org.uk/respect/.

Ref	Standard
MN-107 BI Visit MP&S CNR Doc	**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.
MN-108 BI Visit MP&S CNR Doc	**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 Advance Care Planning directives are in place including 'Do not attempt cardio-pulmonary resuscitation' g. Date agreed and review date Guidance on keeping the Emergency Care Plan in an accessible place should be available. *Notes:* *1. The Emergency Care Plan (ECP) should be in the locally agreed format (QS MZ-604). All older people identified as severely frail should have an ECP. It may also be appropriate to offer older people with mild or moderate frailty the option to develop an ECP.* *2. The Emergency Care Plan may also be called a 'Patient Passport' or have another name. Ideally, a version of the plan will be available to local services which may respond in an emergency. It may also include an 'Escalation Plan' to provide short-term support in order, for example, to avoid hospital admission.* *3. Information relating to advance care planning and 'do not attempt cardio-pulmonary resuscitation' should be consistent with national guidelines for example ReSPECT guidelines https://www.resus.org.uk/respect/.*

Ref	Standard
Staffing	
MN-203 BI Visit MP&S CNR Doc	**Staff Competences** All staff should have competences appropriate to their role in: a. Conducting Holistic Frailty Assessments (brief CGA) 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 f. Use of oral health assessment tool and mouth care plans g. Client-centred goal setting h. Palliative care, including indications for referral for specialist palliative care advice i. Recognition that someone is dying *Notes:* *1. Specialist competences appropriate for staff conducting Holistic Frailty Assessments (brief CGA) are suggested in Appendix 7.* *2. Staff training on recognising adults with care and support needs and recognition of abuse should be more detailed than that expected for 'all health and social care services caring for older people living with frailty'.*

Ref	Standard
Guidelines and Protocols	
MN-503 BI Visit MP&S CNR Doc	**Holistic Frailty Assessment (Brief Comprehensive Geriatric Assessment)** Guidelines on holistic frailty assessment (brief CGA) 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 (brief CGA) 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, eyesight, mouth and teeth, hearing, mobility, gait and balance, activity and exercise status, falls assessment, any concerns about driving ability (if applicable) v. emotional health and wellbeing vi. social and financial circumstances: informal support, social network and activities, eligibility for care vii. environment: home comfort and facilities, personal safety, potential use of Telehealth/Telecare and assistive technology, transport facilities, accessibility of local resources viii. 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 g. Arrangements for communicating the outcome of the older person's holistic/comprehensive frailty assessment to all services involved in their care. *Notes:* *1. The Brief CGA uses different terminology but all aspects are covered in the QS, for further information the brief CGA can be accessed via* https://www.cgakit.com/brief-cga-template *2. QS MN-106 gives more detail of the expected content of the Care and Support Plan. QS MZ-604 gives more detail of the locally agreed format and documentation of the assessment.* *3. Holistic frailty assessment / comprehensive geriatric assessment should not cause delay in hospital treatment or rehabilitation. For older people being discharged from acute hospital care, the QRS Quality Standards (QSs) for 'Transfer from Acute Hospital Care and Intermediate Care' (TACIC) provide more detail of the expected care planning process. TACIC QSs should be met as well as QS MN-503.* *4. Responsibility for a holistic frailty assessment lies with a registered health or social care professional, although aspects of the assessment may be undertaken by non-registered staff, including voluntary sector organisations, on their behalf. More detailed assessments may be undertaken within the service or by referral. Comprehensive geriatric assessment should be undertaken by the Frailty Team.* *5. Access to CT scanning and other diagnostic tests may be required.*

Ref	Standard
MN-504 BI Visit MP&S CNR Doc	**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. Person's ability to take medication correctly and safely f. Support required for medicines administration g. Monitoring requirements
MN-505 BI Visit MP&S CNR Doc	**Clinical Guidelines: Management of Frailty Syndromes** Clinical guidelines on the management of frailty syndromes should be in use, covering at least: a. Delirium b. Dementia and cognitive disorders c. Falls d. Immobility e. Incontinence f. Skin care g. Oral health h. Nutrition and hydration
Governance	
MN-701 BI Visit MP&S CNR Doc	**Data Collection** The service should collect data on: a. Frailty screens undertaken b. Number of older people identified as frail c. Holistic Frailty Assessments undertaken / Referrals for Holistic Frailty Assessment d. Referrals to the Frailty Team for Comprehensive Geriatric Assessment

Care Homes

These Standards are additional to the Standards for 'All Health Services & Social Care Services Caring for Older People Living with Frailty (QSs M*-***) and Standards for 'All Services conducting a Holistic Frailty Assessment (brief CGA), (QSs MN-***) which should also be met.

Ref	Standard
Service Organisation and Liaison with Other Services	
MH-601 BI Visit MP&S CNR Doc	**Organisation of Care for Older People Living with Frailty** The care home should ensure: a. All residents have a holistic frailty assessment on admission b. All residents aged 75 and over have a named accountable GP c. All residents have a medication review d. Access to expert advice for those with more complex needs

Frailty Team

A Frailty Team should be a multi-disciplinary team providing comprehensive (multi-disciplinary) geriatric assessments and overseeing the care of the most frail older people, as well as providing specialist advice and guidance to other services. The Frailty Team is expected to provide care for these older people living with frailty in the community and if they are admitted to hospital. One Frailty Team for each health and social care 'economy' is therefore expected to be the norm. Staff may be employed by different organisations as long as they are commissioned and work as an integrated service. Models with separate community and hospital Frailty Teams are unlikely to be an efficient way of meeting the Quality Standards, except in geographical areas which refer to several acute hospitals with no main acute provider. The Frailty Team will need a hospital base as well as working in the community. This approach is consistent with that described in the *NHS Long Term Plan* (Department of Health and Social Care 2019) *and Five Year Forward View (*NHS England, 2014).

Ref	Standard
Information and Support for Service Users and Carers	
MP-101 BI Visit MP&S CNR Doc	**Service Information** Each service should offer older people living with frailty 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 person. Written information may not always be appropriate but written information for carers should be available. *Notes:* *1. Information should be written in clear, plain English and should be available in formats and languages appropriate to the needs of older people and people with learning disabilities.* *2. Information may also be in the form of a website or other social media. Guidance on how to access information is sufficient for compliance so long as this points to easily available information of appropriate quality. If the information is provided only in individual letters, then examples will need to be seen by reviewers.* *3. This may be general Trust-wide (or equivalent) information so long as information relating to the Frailty Team is clearly identified. If the information is provided only in individual letters, then examples of these will need to be available to reviewers.* *4 Information may be combined with condition-specific information (QS MP-103) and should be clear about information family and carers can receive with and without the older person's permission.*

Ref	Standard
MP-103 BI Visit MP&S CNR Doc	**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: c. Advice available to help them identify choices and evaluate options d. Emergency Care Plan and its use e. Maintaining a healthy lifestyle, preventing harm and managing problems with: i. memory loss ii. nutrition and hydration iii. oral health and mouth care iv. staying active and maintaining mobility, including exercises v. falls prevention vi. preventing and managing incontinence vii. skin and foot care viii. preventing loneliness and social isolation ix. maintaining independence x. emotional health and well-being xi. Managing medication, including reducing polypharmacy f. How to access advice on: i. Safeguarding ii. Mental Capacity and Deprivation of Liberty Safeguards iii. Legal implications of living with frailty, the Office of the Public Guardian and how to access legal advice iv. Advance Care Planning including 'do not attempt cardio-pulmonary resuscitation' v. End of Life Care g. Additional support available in the older person's usual place of residence or other housing options. h. DVLA regulations and driving advice (if applicable) i. Personal health and care budgets j. Advance Care Planning including 'do not attempt cardio-pulmonary resuscitation' k. Additional support available in the older person's usual place of residence or other housing options. l. Availability of assistive technology m. Local services and supportive communities available to provide help, support and care n. How to access a directory of local services o. Relevant national groups and organisations p. How to give feedback on support and care received *Notes:* *1. As QS MP-101 notes 1 and 2.* *2. Information may be combined with service-specific information (QS MP-101) and should be clear about information family and carers can receive with and without the older person's permission.* 3. *Information relating to advance care planning and 'do not attempt cardio-pulmonary resuscitation' should be consistent with national guidelines for example ReSPECT guidelines* https://www.resus.org.uk/respect/.

Ref	Standard
MP-104 BI Visit MP&S CNR Doc	**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
MN-105 BI Visit MP&S CNR Doc	**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

Ref	Standard
MP-106 BI Visit MP&S CNR Doc	**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 comprehensive geriatric assessment (QS MP-503) c. Self-management d. Planned care and support e. Care Coordinator, including contact details (if required) f. Review date and review arrangements g. Advocate details (if applicable) h. Advance Care Planning directives including 'Do not attempt cardio-pulmonary resuscitation' documentation (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. *Notes:* *1. Ideally, a frail older person should have a single Care and Support Plan. Care and support plans should allow and enable positive risk-taking if this is what the older person wants. Some parts of the Quality Standard may not be applicable to some older people, but this aspect of their needs should be considered and recorded.* *2. For older people being discharged from acute hospital care, the QRS Quality Standards (QSs) for 'Transfer from Acute Hospital Care and Intermediate Care' (TACIC) provide more detail of the expected care planning process. TACIC QSs should be met as well as QS MP-106.* *3. The Care Coordinator should normally be the person responsible for arranging the review of the Care and Support Plan. The care coordinator may be a link worker in primary care. Some people with moderate frailty may not need a care coordinator.* *4. The Emergency Care Plan (QS MP-108) may form part of the Care and Support Plan so long as it is available as a simple, accessible, portable, easily available summary.* 5. *Information relating to advance care planning and 'do not attempt cardio-pulmonary resuscitation' should be consistent with national guidelines for example ReSPECT guidelines* https://www.resus.org.uk/respect/.
MP-107 BI Visit MP&S CNR Doc	**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.

Ref	Standard
MP-108 BI Visit MP&S CNR Doc	**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 Advance Care Planning directives are in place including 'Do not attempt cardio-pulmonary resuscitation' g. Date agreed and review date Guidance on keeping the Emergency Care Plan in an accessible place should be available. *Notes:* *1. The Emergency Care Plan (ECP) should be in the locally agreed format (QS MZ-604). All older people identified as severely frail should have an ECP. It may also be appropriate to offer older people with mild or moderate frailty the option to develop an ECP.* *2. The Emergency Care Plan may also be called a 'Patient Passport' or have another name. Ideally, a version of the plan will be available to local services which may respond in an emergency. It may also include an 'Escalation Plan' to provide short-term support in order, for example, to avoid hospital admission.* *3. Information relating to advance care planning and 'do not attempt cardio-pulmonary resuscitation' should be consistent with national guidelines for example ReSPECT guidelines* https://www.resus.org.uk/respect/.
MP-195 BI Visit MP&S CNR Doc	**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

Ref	Standard
MP-197 BI Visit MP&S CNR Doc	**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 *Notes:* *1. As QS MP-101 note 1.* *2. This QS is about signposting to relevant services. The actual services available may be different in different areas.* *3. Availability of support services should be appropriate to the case mix and needs of older people living with frailty and their carers.* *4. Information should explain rights under the NHS Constitution.*
MP-198 BI Visit MP&S CNR Doc	**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 *Note: Support for carers may include carer's breaks, emergency response, support for children in the family and cognitive and behavioural therapy, usually accessed through primary care-based psychological therapy services.*
MP-199 BI Visit MP&S CNR Doc	**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 *Notes:* *1. The arrangements for receiving feedback may involve surveys, including the national patient survey, focus groups and /or other arrangements. They may involve Trust-wide arrangements so long as issues relating to the Frailty Team can be identified.* *2. 'b' is specifically included because of the difficulty of obtaining feedback from older people living with frailty.*

Ref	Standard
Staffing	
MP-201 BI Visit MP&S CNR Doc	**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. *Note: Integrated health and social care services may be led by a registered social care professional.*

Ref	Standard
MP-202 BI Visit MP&S CNR Doc	**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 b. Service's role in the local frailty 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 A multi-disciplinary team (MDT) capable of assessing and managing frailty syndromes should be available 10 hours a day, seven days a week. Cover for absences should be available so that the frailty pathway is not unreasonably delayed, and patient outcomes and experience are not adversely affected, when individual members of staff are away. *Notes:* 1. *A clear methodology should, ideally, be used to determine appropriate staffing levels and skill mix for The NICE safer staffing tool for nursing in adult inpatient wards in acute hospitals (2014) provides more information about setting ward staffing establishments. Staff should have time allocated for their role in the service, but roles may be part-time, and staff may be shared with other services.* 2. *Appendix 7 gives more detail of the specialist competences expected for staff of the Frailty Team.* 3. *One example of appropriate accredited training for GPs with a specialist interest in care of older people living with frailty is the RCGP Diploma* https://www.rcplondon.ac.uk/medical-careers-training/postgraduate-exams/diploma-geriatric-medicine 4. *Any specialist nurses should have completed an appropriate post-registration (LBR) education programme.* 5. *Healthcare support workers should normally have, or be working towards, relevant NVQ level 2 or 3 qualifications.* 6. *Reviewers should be concerned about the availability of staff with appropriate competences rather than management arrangements.* 7. *In acute settings, expected timescales for the frailty pathway should be similar throughout the week, including weekends.*

Ref	Standard
MP-203 BI Visit MP&S CNR Doc	**Staff Competences** All staff should have competences appropriate to their role in: a. Conducting Comprehensive Geriatric Assessments 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 f. Use of oral health assessment tool and mouth care plans g. Client-centred goal setting h. Palliative care, including indications for referral for specialist palliative care advice i. Recognition that someone is dying *Notes:* *1. Specialist competences appropriate for staff conducting Comprehensive Geriatric Assessments are suggested in Appendix 7.* *2. Staff training on recognising adults with care and support needs and recognition of abuse should be more detailed than that expected for 'all health and social care services caring for older people living with frailty'.*
MP-204 BI Visit MP&S CNR Doc	**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. *Notes:* *1. Specialist competences appropriate for staff conducting Comprehensive Geriatric Assessments are suggested in Appendix 7.* *2. Staff training on recognising adults with care and support needs and recognition of abuse should be more detailed than that expected for 'all health and social care services caring for older people living with frailty'.* *3. This QS is about the needs of the service and cannot be met solely by individual staff appraisals and personal development reviews (PDRs). Appraisals and PDRs are sufficient for maintenance of competence. Details of individual appraisals and PDRs are **not** required. Reviewers may, however, request information about specific aspects of relevance to the service, in particular, where a therapeutic intervention or activity is undertaken rarely and/or where competence may not be maintained by the individual's usual clinical practice.* *4. For compliance with this QS the service should provide:* *a. A matrix of the roles within the service, competences expected and approach to maintaining competences* *b. A training and development plan showing how competences are being achieved and maintained.* *5. Training may be delivered through a variety of mechanisms, including e-learning, Trust-wide training and departmental training.* *6. The following skill and competence frameworks should help with staff working in services caring for people living with frailty achieve this QS:* *a. Skills for Health: Frailty, A framework of core competences, (2018)* www.skillsforhealth.org.uk b. *The Frailty Toolkit www.frailtytoolkit.org/frailty-toolkit/*

Ref	Standard
MP-298 BI Visit MP&S CNR Doc	**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 and learning disabilities b. Use of the locally agreed 'Emergency Care Plan' c. Recognising adults with care and support needs and recognition of abuse d. Safeguarding e. Preventing functional loss (deconditioning) and enabling independence **Staff involved in frailty screening:** f. Recognition of frailty: identification of older people who may have mild, moderate or severe frailty and 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 (brief CGA) ii. criteria for referral for comprehensive geriatric assessment g. 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 *Notes:* *1. A common frailty screening tool should, ideally, be used across each health and social care economy. Recognised frailty screening tools include: Clinical Frailty Scale, Edmonton and Reported Edmonton Frail Scales, Rockwood Frailty Scale, PRISMA-7 questionnaire. Frailty screening should not cause delay in treatment and care. Depending on the severity and complexity of needs, frailty screening may lead to an older person being offered:* *a. Information and 'signposting' to available services and support* *b. Holistic frailty assessment/ brief CGA (within the service or by referral)* *c. Comprehensive geriatric assessment (i.e. referral to Frailty Team)* *2. Services to prevent harm should include services for falls prevention, continence advice, tissue viability care, safeguarding, memory problems, nutrition advice and medicines management services* *3. The following skill and competence frameworks should help staff working in services caring for people living with frailty achieve this QS:* *a. Skills for Health: Frailty, A framework of core competences, (2018) www.skillsforhealth.org.uk* *b. The Frailty Toolkit www.frailtytoolkit.org/frailty-toolkit/*
MP-299 BI Visit MP&S CNR Doc	**Administrative, Clerical and Data Collection Support** Administrative, clerical and data collection support should be available. *Note: The amount of administrative, clerical and data collection support is not defined. Clinical staff should not, however, be spending unreasonable amounts of time which could be used for clinical work on administrative tasks.*

Ref	Standard
Support Services	
MP-301 BI Visit MP&S CNR Doc	**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. same day emergency care (SDEC) for older people being considered for emergency admission 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, including bereavement services *Notes:* *1. The 'single point of access' service should also provide access to equipment needed to manage a crisis at home or to support rapid return home.* *2. More detail of the services which should be available is given in QS MZ-602.* *3. The NHS Long-Term Plan (2019) states that the 'SDEC model should be embedded in every hospital, in both medical and surgical specialties during 2019/20'.*
MP-302 BI Visit MP&S CNR Doc	**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 *Notes:* *1. Timely is not strictly defined but should ensure that the frailty pathway is not unreasonably delayed. Specific indications for referral to, and timescales for response by, support services may be agreed.* *2. Local community services may include hospital at home, virtual wards and community matrons, or other services with similar functions.*

Ref	Standard
Facilities and Equipment	
MP-402 BI Visit MP&S CNR Doc	**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. *Notes:* *1. Required facilities and equipment are not strictly defined but should be appropriate for the usual number and case mix cared for by the service.* *2. Further detail of 'dementia friendly' facilities is given in 'Enhancing the Healing Environment' (Kings Fund, 2014).*
MP-403 BI Visit MP&S CNR Doc	**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 *Notes:* *1. As QS MP-402.* *2. Timely is not strictly defined but availability of equipment, including consumables, should not unreasonably delay the frailty pathways or adversely affect service users' outcomes and experience.*
MP-499 BI Visit MP&S CNR Doc	**IT System** **IT systems should:** a. Store, retrieve and transmit patient information for patient/client administration, clinical records and outcome information including access to: i. Emergency Care Plans ii. Care and Support Plans iii. Advance Care Plans including 'Do not attempt cardio-pulmonary resuscitation' iv. GP summary records v. Social care records b. Provide mechanisms for the collection of other data to support service improvement, audit and revalidation c. If used to deliver online consultations, assessments and therapeutic interventions, meet audit and governance requirements *Note: IT and records systems should be accessible and integrated to avoid duplicate entry of data on individuals.*
Guidelines and Protocols	

Ref	Standard
MP-501 BI Visit MP&S CNR Doc	**Guidelines: Frailty Screening and Care of Older People Living with Frailty (1)[2]** 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. Recognition of frailty, indications for frailty screening and use of frailty screening tool *Note: These guidelines should link with Trust (or equivalent) safeguarding policies.*
MP-503 BI Visit MP&S CNR Doc	**Comprehensive Geriatric Assessment** Guidelines on Comprehensive Geriatric 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 comprehensive geriatric 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, eyesight, mouth and teeth, hearing, mobility, gait and balance, activity and exercise status, falls assessment, any concerns about driving ability (if applicable) v. emotional health and wellbeing vi. social and financial circumstances: informal support, social network and activities, eligibility for care vii. environment: home comfort and facilities, personal safety, potential use of Telehealth/Telecare and assistive technology, transport facilities, accessibility of local resources viii. medication review (QS MN-504) d. Documentation of the assessment e. Indications for more detailed assessments, including dementia assessment f. Arrangements for communicating the outcome of the older person's comprehensive frailty assessment to all services involved in their care. *Notes:* *1. QS MP-106 gives more detail of the expected content of the Care and Support Plan. QS MZ-604 gives more detail of the locally agreed format and documentation of the assessment.* *2. Holistic frailty assessment / comprehensive geriatric assessment should not cause delay in hospital treatment or rehabilitation. For older people being discharged from acute hospital care, the QRS Quality Standards (QSs) for 'Transfer from Acute Hospital Care and Intermediate Care' (TACIC) provide more detail of the expected care planning process. TACIC QSs should be met as well as QS MP-503.* *3. Responsibility for a undertaking a Comprehensive geriatric assessment lies with the Frailty Team.* *4. Access to CT scanning and other diagnostic tests may be required.*

[2] All references to 'early intervention in all care settings' link to this QS

Ref	Standard
MP-504 BI Visit MP&S CNR Doc	**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. Person's ability to take medication correctly and safely f. Support required for medicines administration g. Monitoring requirements
MP-505 BI Visit MP&S CNR Doc	**Clinical Guidelines: Management of Frailty Syndromes** Clinical guidelines on the management of frailty syndromes should be in use, covering at least: a. Delirium b. Dementia and cognitive disorders c. Falls d. Immobility e. Incontinence f. Skin care g. Oral health h. Nutrition and hydration
MP-595 BI Visit MP&S CNR Doc	**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 *Note: Other services may provide less intensive care for older people whose support needs have reduced or may provide end of life care.*
MP-599 BI Visit MP&S CNR Doc	**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. Service users who have gone missing c. Mental Capacity Act and the Deprivation of Liberty Safeguards d. Safeguarding e. Information sharing f. Palliative care and end of life care

Ref	Standard
Service Organisation and Liaison with Other Services	
MP-601 BI Visit MP&S CNR Doc	**Operational Policy** The service should have an operational policy describing the organisation of the service including, at least: a. Expected timescales for the frailty pathway, including for: b. Start of Comprehensive Geriatric Assessment c. Completion of Care and Support Plan d. Response to requests for routine and urgent domiciliary review e. Responsibility for giving information to service users and carers at each stage of the frailty journey f. Care Coordinator responsibilities and arrangements for cover for absences g. Arrangements for reviewing patients admitted outside of the acute frailty service hours by noon the following day. h. Arrangements for providing specialist advice and guidance to other services in the local area i. Arrangements for providing specialist advice and guidance to same day emergency care units (SDEC) j. Organisation of rapid access ambulatory clinics (7/7) k. Arrangements for routine and urgent domiciliary review l. Arrangements for follow up of service users who 'do not attend' or 'were not brought' m. Governance arrangements for providing consultations, assessments and therapeutic interventions, virtually, in the home or in informal locations. (QS MP-499)
MP-603 BI Visit MP&S CNR Doc	**Population Health Management** Up to date information on people with living with frailty within the local area who have been identified through population health management as at high risk of unscheduled admission to hospital, should be easily available and used to support personalised care planning. *Note: This QS may be met through general practice or health economy-wide arrangements (QS MA-602, QS MZ-605) so long as services have easy access to information about their high-risk service users.*
MP-698 BI Visit MP&S CNR Doc	**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. *Note: The Local Health and Social Care Older People Living with Frailty Group may have another name.*
MP-699 BI Visit MP&S CNR Doc	**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. *Notes:* *1. This QS relates to those services with which liaison is particularly important to ensure an efficient, high quality frailty journey. These services should be listed in QS MP-302 but annual review meetings with all services required in QS MP-302 may not be necessary.* *2. Meetings may be part of a Trust-wide meeting so long as operational issues specific to the service are discussed. This QS is in addition to day to day liaison arrangements and should involve staff with management responsibility for the service.*

Ref	Standard
Governance	
MP-701 BI Visit MP&S CNR Doc	**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. Number of patients whose length of stay in hospital has exceeded 21 days e. 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
MP-702 BI Visit MP&S CNR Doc	**Audit** The service should have a rolling programme of audit of: a. Referrals including: i. whether frailty screening had been undertaken within 30 mins of arrival to an acute service 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
MP-798 BI Visit MP&S CNR Doc	**Multi-disciplinary Review and Learning** All services 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 *Notes:* *1. This QS is about staff within the service learning together. Uni-disciplinary meetings or management meetings are not sufficient for compliance with this QS.* *2. Arrangements for MDT review and learning should be formalised and clearly communicated to staff and should link with organisation-wide (or equivalent) governance arrangements.* *3. This QS links to Pathway Review and Learning QS MZ-798*
MP-799 BI Visit MP&S CNR Doc	**Document Control** All policies, procedures and guidelines should comply with Trust (or equivalent) document control procedures. *Notes:* *1. Specific documentary evidence of compliance is not required. This QS will be determined from the other documentary information provided.* 2. *The organisations document control policy is also required for compliance with this QS.*

Commissioning

Commissioning Quality Standards are the responsibility of Local Authority, Clinical Commissioning Group, Public Health England and NHS England commissioners working in partnership.

Ref	Standard
Staffing	
MZ-298 BI Visit MP&S CNR Doc	**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 QSs M*-298,QS MN-203, MP-298.
Service Organisation and Liaison with Other Services	
MZ-601 BI Visit MP&S CNR Doc	**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: c. Learning disabilities d. Sensory impairment *Note: The needs assessment and strategy for the care of older people may be separate or form part of a wider Sustainability and Transformation Partnerships (STPs)/ Integrated Care System needs assessment and strategy.*

Ref	Standard
MZ-602 BI Visit MP&S CNR Doc	**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. Equipment b. Services to maximise independence c. Services providing rehabilitation d. Admission avoidance schemes, enhanced health services to care homes and response to urgent need e. Influenza and pneumococcal pneumonia vaccination f. Frailty Team g. Services providing: i. support and care in the community ii. support for maintaining a healthy lifestyle and preventing harm iii. support for carers and access to short-term breaks h. Domiciliary dental services for care home residents and others unable to leave their homes *Notes:* 1. *More details of expected timescales and Standards for availability of equipment, services to avoid admission and transfer from acute hospital care and intermediate care are given in the QRS Quality Standards for Transfer from Acute Hospital Care and Intermediate Care. These Standards are available on the QRS website:* www.qualityreviewservicewm.nhs.uk 2. *Services to maximise independence and maintain a healthy lifestyle include falls services and services providing strength and balance training. Services providing support and care in community include psychological and physical therapy.* 3. *Commissioners may also commission additional services such as an Advance Care Planning service.*
MZ-603 BI Visit MP&S CNR Doc	**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. Ambulance service f. Care homes g. Frailty Team h. Mental health services i. Social services j. Relevant local voluntary sector organisations *Notes:* 1. *Other services may also be part of the group.* 2. *The Local Health and Social Care 'Older People Living with Frailty Group' may have another name and be part of an Sustainability and Transformation Partnerships (STPs) but the group should be multi-agency with representatives as defined in the QS.* 3. *Responsibility for running the Group may be delegated to or commissioned from a provider organisation so long as this is clearly identified to all stakeholders.*

Ref	Standard
MZ-604 BI Visit MP&S CNR Doc	**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 *Note: As QS MZ-603 note 2.*
MZ-605 BI Visit MP&S CNR Doc	**Population Health Management** Commissioners should ensure that arrangements are in place whereby: a. Each general practice has up to date information about patients with frailty at high risk of unscheduled admission to hospital (QS MA-602) b. Each service has up to date information on people within the local area identified as at high risk of unscheduled admission to hospital (QSs M*-603, MA-604, MP-603) *Note: This QS may be met through general practice or health economy-wide arrangements (QS M*-603, MA-604, MP-603) so long as services have easy access to information about their high-risk service users.*
Governance	
MZ- 701 BI Visit MP&S CNR Doc	**Quality Monitoring – Primary Care** Commissioners should monitor local general practices: a. Number of older people liviing with frailty b. Influenza and pneumonia and shingles vaccination rates c. Relevant prescribing data d. Number of older people with frailty who have an activated summary care record e. Number paitents who have had an annual medication review using a validated tool. f. Number of older people with frailty identifed as being moderate or severely frail who have received:- i. a multi-diciplinary assessment and review ii. a falls risk assessment *Notes:* 1. *Appropriate action should be taken to tackle any issues identified through quality monitoring. If commissioners are responsible for prison health services, then quality monitoring should include the quality of prison primary care services.* 2. *Further information on age groups eligible for the shingles vaccination can be accessed via* https://www.nhs.uk/conditions/vaccinations/who-can-have-the-shingles-vaccine/

Ref	Standard
MZ-702 BI Visit MP&S CNR Doc	**Quality Monitoring** Commissioners should monitor at least annually: a. Data collected by intermediate care services on expected timescales for: i. achieving a crisis response within two hours ii. access to urgent reablement within two working days. b. Data collected by urgent care services (M*-604) c. Data collected by services providing Holistic Frailty Assessments (QS MN-701). d. Key performance indicators and aggregate data on activity and outcomes from the Frailty Team (QS MP-701) e. Audits of referrals to the Frailty Team (MP-702) *Note: Clinical Quality Review Meetings are sufficient for compliance with this QS **only** if there is evidence of discussion of the specific service.*
MZ-798 BI Visit MP&S CNR Doc	**Pathway Review and Learning** The Local Health and Social Care 'Older People Living with Frailty' Group should have appropriate arrangements for review of, and implementing learning from, positive feedback, complaints, outcomes, incidents and 'near misses' across the local pathway. *Note: These arrangements should link with those for review and learning within individual services (QS MP-798).*

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Appendix 1 Steering Group Membership

Name	Job Title	Organisation
Dr Amit Arora	Consultant Physician/Geriatrician and Honorary Clinical Lecturer	University Hospitals of North Midlands NHS Trust
Malcolm Barber	Patient Representative	Diabetes UK North Staffs Volunteer Group
Becky Beal	Operational Lead, Staying Well Service	Midlands Partnership NHS Foundation Trust
Karen Bowley	Matron, Rehabilitation and Ambulatory Care	The Royal Wolverhampton NHS Trust
Mark Docherty	Director of Nursing, Quality and Clinical Commissioning	West Midlands Ambulance Service NHS Foundation Trust
Dr Ruma Dutta	Consultant Geriatrician	Worcestershire Acute Hospitals NHS Trust
Amanda Futers	Advanced Nurse Practitioner	University Hospitals of North Midlands NHS Trust
Dr Simon Harlin	GP Medical Lead, Frail Elderly Pathway	Walsall Healthcare NHS Trust
Lucy Heath	NHS Right Care Delivery Partner	NHS England & NHS Improvement
Michelle Hosking	Therapy Clinical Team Leader – Inpatient & Community Respiratory Solihull	University Hospitals Birmingham NHS Foundation Trust
Dr Stuart Hutchinson	Consultant Geriatrician	The Royal Wolverhampton NHS Trust
Dr Shrikaanth Krishnamurthy	Consultant Psychiatrist - older people	Birmingham and Solihull Mental Health NHS Foundation Trust
Cath Molineux	Nurse Consultant Primary Care	Shropshire Community Health NHS Trust
Nadine Opiniano	Matron for Older Adults	University Hospitals of North Midlands NHS Trust.
David Orme	Patient Representative	
Carole Roberson	Lead for Corporate Nursing	Worcestershire Health and Care NHS Trust
Dr Kirsten Tay	Consultant in Palliative Medicine	University Hospitals of North Midlands NHS Trust
Joanne Taylor	Commissioning Manager, Preventative care	NHS Dudley CCG
Mandy Thorn MBE	Chairman, The Uplands	The Uplands at Oxon
Craig Wallace	Assistant Director for Education	University Hospitals of North Midlands NHS Trust
Judith Whalley	Patient Representative	
Sarah Broomhead	Assistant Director	Quality Review Service

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Appendix 2 Reference Sources

Year	Publisher	Title	Number
Accessed 17.10.19	NHS England	Reducing Length of Stay; 'Where is best next' https://www.england.nhs.uk/urgent-emergency-care/reducing-length-of-stay/reducing-long-term-stays/	1
2019	National Institute for Health Research Journals Library	Comprehensive geriatric assessment for frail older people in acute hospitals: the HoW-CGA mixed-methods study	2
2019	NHS England and NHS Improvement	Same-day acute frailty services, Published by NHS Improvement, NHS England, the Ambulatory Emergency Care, Network and the Acute Frailty Network	3
2019	NHS Right Care	NHS RightCare: Frailty Toolkit, Optimising a frailty system	4
2019	Community Fund	Quality Assurance for Social Prescribing	5
2019	Resuscitation Council (UK)	ReSPECT: Recommended Summary Plan for Emergency Care and Treatment. https://www.resus.org.uk/respect/.	6
2019	Care Quality Commission	CQC calls for improvements to oral health in care homes https://www.cqc.org.uk/news/releases/cqc-calls-improvements-oral-health-care-home	7
2019	Department of Health and Social Care	Strengths-based approach: Practice Framework and Practice Handbook	8
Accessed 13.05.19	NHS Health Education England	Frailty Toolkit: Person-Centred Care for Older People living with Frailty. www.frailtytoolkit.org	9
2019	Department of Health and Social Care	NHS Long Term Plan	10
Accessed 7.6.19	Skills for Health	Frailty: A core framework of core capabilities	11
2019	National Institute for Health and Care Excellence	Social Care for older people with multiple long-term conditions	12
2019	NHS England	2019-20 Better Care Fund: Policy Framework	13
2018	Public Health England	Guidelines on the management of outbreaks of influenza-like illness in care homes, Version 4.0	14
2018	National Institute for Health and Care Excellence	Care and support of people growing older with learning disabilities. NG96	15
2018	Age UK	Why call it care when nobody cares?' An Age UK Campaign report	16

Year	Publisher	Title	Number
2018	National Institute for Health and Care Excellence and Social Care Institute for Excellence	Improving oral health for adults in care home: a quick guide for home managers	17
2018	National Institute for Health and Care Excellence	Oral health for adults in care homes. NG48	18
Accessed 28.11.18	NHS Leadership Academy	Healthcare Leadership Model: The nine dimensions of leadership behaviour. Version 1.0 www.leadershipacademy.nhs.uk/	19
2018	Royal College of General Practitioners	Spotlight on the 10 High Impact Actions	20
2018	Kings Fund	Approaches to better value in the NHS; Improving quality and cost.	21
2018	Social Care Institute for Excellence	Delivering Integrated care: the role of the multi-disciplinary team (MDTs)	22
2018	National Institute for Health and Care Excellence	Emergency and Acute Medical Care in over 16s. NICE Quality Standard 174	23
2018	National Institute for Health and Care Excellence	Patient experience in adult NHS services	24
2018	NHS England	The Change Model Guide	25
2018	NHS England NHS Improvement Royal College of Physicians	Consultant to Consultant Referrals. Good Practice Guide	26
2018	National Institute for Health Research (NIHR)	Hospital-Wide Comprehensive geriatric Assessment (HoW-CGA)	27
2017	Lavan AH et al.	STOPPFrail (Screening Tool of Older Persons Prescriptions in Frail adults with limited life expectancy): consensus validation. Age and Ageing. 2017;46:600-607	28
2017	National Institute for Health and Care Excellence	Intermediate care including reablement. NG74	29
2017	NHS England LTC Team	Toolkit for general practice in supporting older people living with frailty	30
2016	NHS England	New care Models: The framework for enhanced health in care homes	31

Year	Publisher	Title	Number
2016	University Hospitals of North Midlands NHS Trust	Preventing deconditioning and enabling independence for older people in hospital	32
2016	University Hospitals of North Midlands NHS Trust	Staying Active in Hospital	33
2016	Mental Health Task Force	The five year forward view for mental health	34
2016	National Institute for Health and Care Excellence	Multimorbidity: clinical assessment and management NG56	35
2015	National Institute for Health and Care Excellence	Older People: independence and mental wellbeing. NG32	36
2015	British Geriatrics Society	Fit for Frailty Part 2: Developing, Commissioning and Managing Services for People Living with Frailty in Community Settings	37
2019	NHS England	Standard General Medical Services Contract. April 2019. Gateway Reference: 08653	38
2014 revised 2017	British Geriatrics Society	Fit for Frailty Consensus: Best Practice Guidance for the Care of Older People Living with Frailty in Community and Outpatient Settings	39
2014	National Voices	Person Centred Care 2020: Call and Contributions from Health and Social Care Charities	40
2014	British Geriatrics Society	Good Practice Guide: Recognising Frailty	41
2014	Centre for health Service Economics & Organisation (CHSEO)	Understanding Emergency Hospital Admissions of Older People	42
2014	Health & Social Care Information Centre	General Practice Extraction Service (GPES) Customer Requirement Summary - Named GP for patients aged 75 and over	43
2014	Health Service Journal and Serco	Commission on Hospital Care for Frail Older People	44
2014	NHS Cambridgeshire and Peterborough CCG	Proposals to Improve Older People's Healthcare and Adult Community Services: Clinical Evidence behind the Case for Change for Older People and Adult Community Services	45
2014	NHS Somerset CCG	Somerset Pathway for Frail Older People	46
2014	Research One	1st National Frailty Workshop - White Paper	47

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2014	NHS England	Safe, Compassionate Care for Frail Older People using an Integrated Care Pathway: Practical Guidance for Commissioners, Providers and Nursing, Medical and Allied Health Professional Leaders	48
2014	HM Government	Personalised Health and Care 2020	49
2014	National Institute for Health and Care Excellence	Safe staffing for nursing in adult inpatient wards in acute hospitals	50
2013	NHS Cumbria CCG	STOPP START Toolkit Supporting Medication Review	51
2013	British Geriatrics Society	BGS Commissioning Guidance – High Quality Healthcare for Older Care Home Residents	52
2013	National Audit Office	Emergency Admissions to Hospitals: Managing the Demand	53
2013	The Health Foundation	Improving the Flow of Older People: Sheffield Teaching Hospital NHS Trust's Experience of the Flow Cost Quality Improvement Programme	54
2013	The King's Fund	Developing Supportive Design for People with Dementia: The King's Fund's Enhancing the Healing Environment Programme 2009-2012	55
2012	Multiple Authors[3]	Quality Care for Older People with Urgent and Emergency Care Needs (Silver Book)	56
2012	AGILE Chartered Physiotherapists	Elderly Mobility Scale (EMS)	57
2012	British Geriatrics Society	Transfer of Care of Frail Older People for Community Care Health and Social Support	58
2012	Department of Public Health, Oxford	Evidence Summary of a Cochrane Effective Practice and Organisation of Care Group Systematic Review: Does Inpatient Comprehensive Geriatric Assessment Improve Care for Frail Older Adults admitted to Hospital?	59
2012	Medical Crises in Older People and The University of Nottingham	Medical Crises in Older People. Discussion Paper. The Role of the Interface Geriatrician across the Acute Medical Unit / Community Interface	60
2012	NHS Interim Management and Support	Effective Approaches in Urgent and Emergency Care Paper 3: Whole System Priorities for the Discharge of Frail Older People from Hospital Care	61

[3] Age UK, Association of Directors of Adult Social Services, British Geriatrics Society, Chartered Society of Physiotherapy, College of Emergency Medicine, College of Occupational Therapists, Community Hospitals Association, National Ambulance Service Medical Directors, Society for Acute Medicine, Royal College of General Practitioners, Royal College of Nursing, Royal College of Physicians and Royal College of Psychiatrists

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2012	Royal College of Physicians	Acute Care Toolkit 3: Acute Medical Care for Frail Older People	62
2012	The King's Fund	The Care of Frail Older People with Complex Needs: Time for a Revolution	63
2011	Newport City Council	Health, Social Care & Wellbeing Strategy 2011-14	64
2010	British Geriatrics Society	Comprehensive Assessment of the Frail Older Patient	65
2010	NCEPOD	An Age Old Problem: A Review of the Care Received by Elderly Patients Undergoing Surgery	66
2010	NHS Institute for Innovation and Improvement	Delivery Quality and Value: Focus on Frail Older People	67
2010	The Health Foundation	Evidence Scan: Personal Health Budgets	68
Undated	Age UK	A Practical Guide to Health Ageing	69
Undated	National Voices	Care and Support Planning Guide	70
Undated	Leicester, Leicestershire and Rutland Frail Older People's Network	Interface Geriatrics – Acute Care for Older People in Leicester, Leicestershire and Rutland	71
Undated	NHS Wales	Report 1: Frail Older People	72
Undated	Royal College of General Practitioners, British Pharmaceutical Society of Great Britain Department of Health NHS Primary Care Contracting.	Guidance and Competences for the provision of services using practitioners with special interests (PwSIs) http://www.rcgp.org.uk/clinical-and-research/clinical-resources/~/media/Files/CIRC/GPwSI/RCGP_GPwSI_older_people.ashx	73

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The table below shows the links between the Quality Standards and guidance documents. Quality Standards without a reference source are based on the consensus of the Steering Group, following consultation, or on other QRS Quality Standards.

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M*-102	5,6,7,15,16,20,21, 24,31,32,33,34,36,3 7,39,45,48,53,57,67 ,69	M*-401	31,55,63,64,72	MA-601	4,10,12,15,20,21,24,30, 31,32,35,43,48,55,72
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MN-105	4,8,15,16,24,31,37, 39,40 46,58,70	MN-203	7,8,10,15,16,27,31, 48,6061	MN-701	4,45,48,54,61
MN-106	4,6,7,8,10,12,15,16, 17, 18,21,22,24,29,30,3 1,32,33,34,37,39,40 ,46,48,58,64	MN-503	4,12,15,23,27,29,30 ,31, 35,37,39,48,55,57,5 8,59,60,62,64,65,67 ,71,72	MH-601	4,9,14,15,16,17,18,21,31 40,41,43,48,52,58,61,65, 67,69
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MP-107	4,8,10,12,15,16,17,18, 1921,22,24,29,30,31, 34,37,39,46,48,58,70	MP-301	1,3,12,15,20,31,32,3 4,3642,48,72	MP-603	4,12,30,32,33
MP-108	4,6,8,10,21,24,30,37, 39,40,46,48,58,64,70,7 2	MP-302	4,26,34,46,48,54,55, 56,59,61,62,65,66,67	MP-698	4,37,48,72
MP-195	4,10,12,24,29,37,39, 58,61,66,67,70	MP-402	55,63,64,72	MP-699	4,10,12,37,39,42, 48,53,56,58,62,72
MP-197	2,4,10,21,34,47,57,63, 68,69	MP-403	4,46,55,63,64,72	MP-701	1,4,30,37,39,45,46, 53,61
MP-198	4,10,12,15,16,34,48, 58,64,69,70	MP-499	10,12,46,47,63,64,72	MP-702	3,4,45,46,49
MP-199	4,21,24,61,70	MP-501	4,12,31,34,35,36,37, 38,39,44,56,67,72	MP-798	4,8,10,16,21,25,34 44,45,46,61
MP-201	4,11,12,16,19,25,37, 39,50,61,62,63	MP-503	4,12,15,23,27,29, 30,31,35,37,39,48,55 ,57,58,59,60,62,64,6 5,67,71,72	MP-799	

QS reference	Guidance documents	QS reference	Guidance documents	QS reference	Guidance documents
MZ-298	4,12,48,53,56	MZ-603	4,10,15,18,21,22, 25,46,48,54,63,67	MZ-701	4,45,46,61
MZ-601	4,12,16,26,37,39, 44,45,46,48,53,63,64,67	MZ-604	4,12,22,25,27,37, 39,42,45,46,48,53,56 ,58,59,62,67,71	MZ-702	4,10,20,44,45,46, 53,61
MZ-602	4,12,13,15,16,21, 22,25,29,36,37,39,44,45,46,48,53,63,64,67	MZ-605	4,12	MZ-798	4,8,10,16,22,25,34, 44,45,46,61

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Appendix 3 Cross-References to British Standards Institution PAS16:16 and Care Quality Commission Key Lines of Enquiry (KLOEs)

The tables below show with an 'x' where a QRS Quality Standard addresses one of the following:

British Standards Institution PAS1616:2016 Healthcare – Provision of Clinical Services Specification

Ref	Requirements for the provision of clinical services
3	Leadership, strategy and management
4	Operational delivery of the clinical service
5	Systems to support clinical service delivery
6	Person-centred treatment and/or care
7	Risk and safety
8	Clinical effectiveness
9	Clinical service users with complex needs
10	Staffing a clinical service
11	Improvement, innovation and transformation
12	Educating the future workforce

Care Quality Commission's Key Lines of Enquiry (June 2017)

Ref	CQC Five Key Line of Enquiry
S	Are they safe?
E	Are they effective?
C	Are they caring?
R	Are they responsive?
W	Are they well-led?

	British Standards Institute PAS 1616: 2016 3-12	CQC Five Key of Enquiry Questions																										
		Safe						Effective						Caring			Responsive				Well-Led							
		S1	S2	S3	S4	S5	S6	E1	E2	E3	E4	E5	E6	C1	C2	C3	R1	R2	R3	R4	W1	W2	W3	W4	W5	W6	W7	W8
M*-102	6			x	x			x			x	x	x	x	x		x	x										
M*-104	6	x		x				x				x		x	x		x	x	x									
M*-298	4, 10, 12	x	x					x		x											x	x	x		x	x		
M*-301	4, 5, 6, 8,9	x	x	x				x	x	x	x		x	x	x	x	x	x	x					x	x	x	x	
M*-401	5,7	x		x				x									x											
M*-501	6,8,9			x				x				x	x	x	x													
M*-603	8																							x				
M*-604	4, 7, 8,11					x	x	x	x													x	x	x	x	x	x	x
MA-601	3,4,6, 7, 8, 9,		x	x	x			x		x	x	x	x		x									x				
MA-602	5,8,9																							x				
MA-605	3.2, 4, 7, 8,11					x	x	x	x													x		x	x	x	x	x
ME-502	6,8,9			x				x				x	x	x	x													
MN-103	6			x	x			x			x	x	x	x	x		x	x										
MN-105	6,8,9			x								x	x	x	x		x	x										
MN-106	6		x	x	x			x			x	x	x	x	x		x	x										
MN-107	6	x		x				x			x	x	x	x	x		x	x										
MN-108	6,8,9			x							x	x	x	x	x		x	x										
MN-203	4, 10, 12	x	x					x		x											x	x	x		x	x		
MN-503	6,8,9			x				x				x	x	x	x													
MN-504	6,8,9			x	x			x				x	x	x	x													
MN-505	6,8,9			x				x				x	x	x	x													

	British Standards Institute PAS 1616: 2016 3-12	CQC Five Key of Enquiry Questions																										
		Safe						Effective						Caring			Responsive				Well-Led							
		S 1	S 2	S 3	S 4	S 5	S 6	E 1	E 2	E 3	E 4	E 5	E 6	C 1	C 2	C 3	R 1	R 2	R 3	R 4	W 1	W 2	W 3	W 4	W 5	W 6	W 7	W 8
MN-701	3, 4, 7, 8,11					x	x	x	x	x												x		x	x	x	x	x
MH-601	3,4,6, 8, 9,		x	x		x	x	x		x	x	x		x	x		x	x	x					x	x			
MP-101	6				x			x				x	x	x	x			x										
MP-103	6			x	x			x			x	x	x	x	x		x	x										
MP-104	6	x		x				x				x		x	x		x	x	x									
MP-105	6,8,9			x								x	x	x	x		x	x										
MP-106	6		x	x	x			x			x	x	x	x	x		x	x										
MP-107	6	x		x				x			x	x	x	x	x		x	x										
MP-108	6,8,9			x							x	x	x	x	x		x	x										
MP-195	6		x	x				x			x	x	x	x	x		x	x										
MP-197	6	x						x							x		x			x								
MP-198	6							x				x			x		x											
MP-199	3, 7, 6						x								x				x								x	
MP-201	3, 4, 10,12	x	x					x		x											x				x	x		
MP-202	4, 10, 12	x	x					x		x											x	x	x		x	x		
MP-203	4, 10, 12	x	x					x		x											x	x	x		x	x		
MP-204	4, 10, 12	x	x					x		x											x	x	x		x	x		
MP-298	4, 10, 12	x	x					x		x											x	x	x		x	x		
MP-299	4, 10,12	x	x							x												x	x					
MP-301	4, 5, 6, 8,9	x	x	x				x	x	x	x		x	x	x	x	x	x	x					x	x	x	x	
MP-302	4, 5, 6, 8,9	x	x	x				x	x	x	x		x	x	x	x	x	x	x					x	x	x	x	
MP-402	5,7	x		x				x									x											

	British Standards Institute PAS 1616: 2016 3-12	CQC Five Key of Enquiry Questions																										
		Safe						Effective						Caring			Responsive				Well-Led							
		S1	S2	S3	S4	S5	S6	E1	E2	E3	E4	E5	E6	C1	C2	C3	R1	R2	R3	R4	W1	W2	W3	W4	W5	W6	W7	W8
MP-403	5,7	x		x				x									x											
MP-499	5, 7	x		x				x								x			x									
MP-501	6,8,9			x				x				x	x	x	x													
MP-503	6,8,9		x				x				x	x	x	x														
MP-504	6,8,9			x	x			x				x	x	x	x													
MP-505	6,8,9			x				x				x	x	x	x													
MP-595	6,8,9			x				x				x	x	x	x													
MP-599	6,8,9			x				x				x	x	x	x													
MP-601	3,4,6, 7, 8, 9, 10, 11, 12		x	x		x	x	x			x	x	x	x	x		x	x	x					x	x			
MP-603	8																							x				
MP-698	8, 9,10,11					x	x	x	x	x														x	x	x	x	x
MP-699	8,9																							x		x	x	
MP-701	6				x			x				x	x	x	x			x										
MP-702	6			x	x			x			x	x	x	x	x		x	x										
MP-798	3, 4, 7, 8,11					x	x	x	x	x														x	x	x	x	x
MP-799	5			x																								
MZ-298	6				x			x				x					x	x										
MZ-601	6,7,8,9,10,		x	x		x	x	x			x			x	x		x	x	x					x	x			
MZ-602	3,6,7,8,9,10,11			x	x			x			x	x					x	x	x			x		x				
MZ-603	8, 9,10,11						x																		x	x	x	x
MZ-604	6,9						x																		x	x	x	x
MZ-605	5,8,9																							x				

	British Standards Institute PAS 1616: 2016 3-12	CQC Five Key of Enquiry Questions																									
		Safe						Effective						Caring			Responsive				Well-Led							
		S 1	S 2	S 3	S 4	S 5	S 6	E 1	E 2	E 3	E 4	E 5	E 6	C 1	C 2	C 3	R 1	R 2	R 3	R 4	W 1	W 2	W 3	W 4	W 5	W 6	W 7	W 8
MZ-701	3.2, 4, 7, 8,11					x	x	x	x													x		x	x	x	x	x
MZ-702	3.2, 4, 7, 8,11					x	x	x	x													x		x	x	x	x	X
MZ-798	3.2, 4, 7, 8,11				x	x	x	x	x											x			x	x	x	x	x	x

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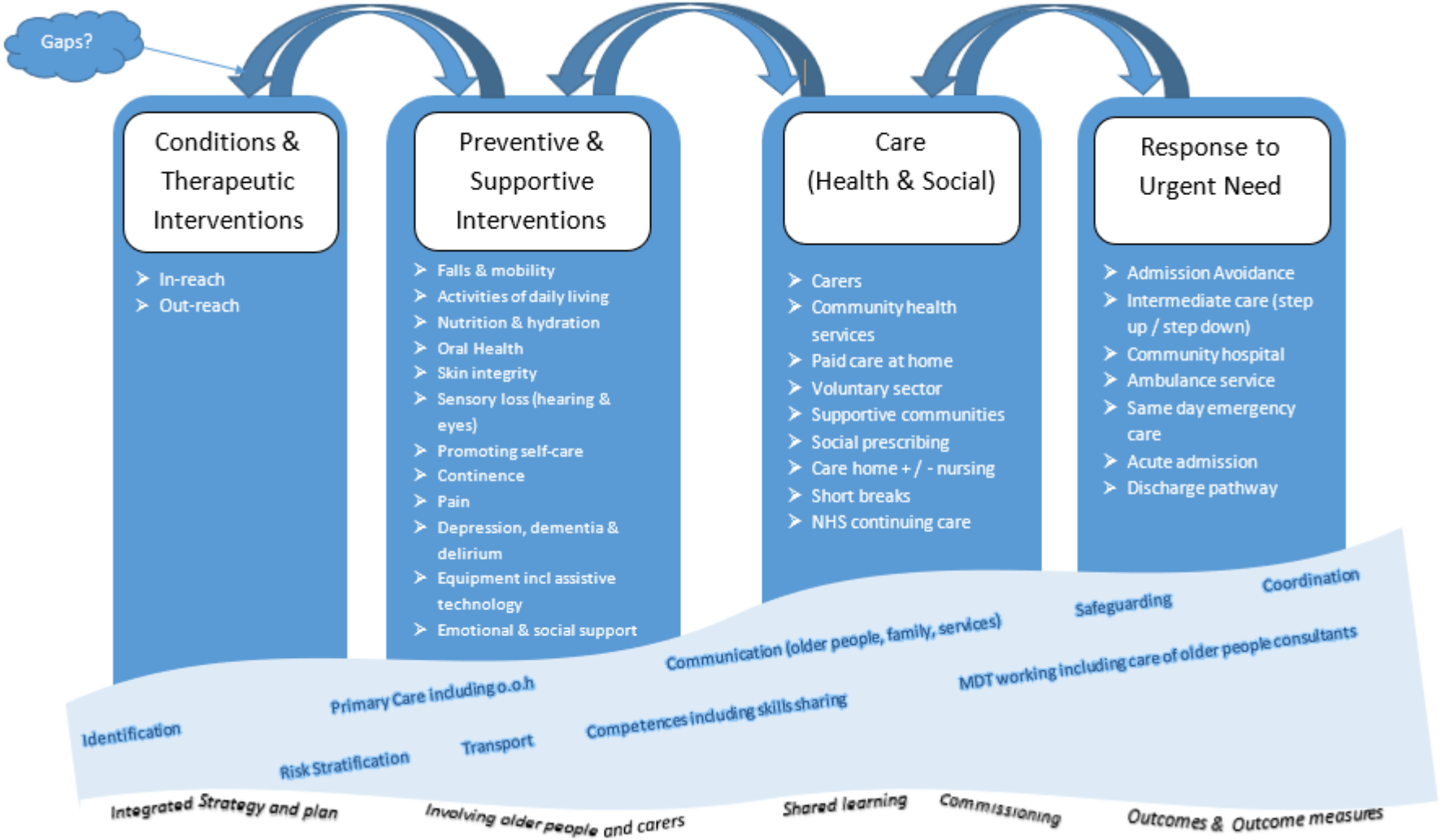
Appendix 4 The Framework



Appendix 5 Glossary of Terms and Abbreviations

ACP	Advance care planning is the term used to describe the conversation between people, their families and carers and those looking after them about their future wishes and priorities for care. Advance care plans provide direction to healthcare professionals when a person is not in a position to make and/or communicate their own healthcare choices
Advocacy	Advocacy means to speak up for someone. It is about making things change because people's voices are heard and listened to. It's about making sure that people can make their own choices in life and have the chance to be as independent as they want to be.
BI	Background information to review team
Carer	Throughout the Quality Standards the term 'carer' applies to both family carers and paid carers or support workers.
CGA	Comprehensive geriatric assessment undertaken by a multi-disciplinary team
Brief CGA	More in-depth than a holistic frailtly assessment and enables an initial care plan to be developed.
CFS	Clinical Frailty Scale: Mild frailty equates to the following scores: Mild frailty a score of four to five, moderate frailty a score of six, severe frailty a score of seven or above.
CCG	Clinical Commissioning Group
Commissioner	A commissioner decides how NHS and / or social care resources are spent, with the aim of improving health, reducing inequalities, and enhancing service users' experience.
CNR	Case note review or clinical observation
CT	
CQC	The Care Quality Commission is the independent regulator of health and social care in England.
DH	Department of Health
Doc	Documentation should be available. Documentation may be in the form of a website or other social media.
DVLA	Driver and Vehicle Licencing Agency
eFI	electronic Frailty Index is a tool that uses routine health record data to automatically calculate a score which can identify whether a person in likely to be fit or living with mild, moderate or severe frailty.
End of Life Care	'End of life care' usually refers to the last year of life, although for some people this will be significantly shorter. See also palliative care.
GMS	General Medical Service
GP	A GP is a medical doctor, sometimes called a family doctor. They are usually the first person older people see for their health care, and they help their patients to access other services.

Goal setting	Setting a goal helps people to identify what they want to achieve and is the first step towards translating intention into action. An action plan identifies what steps are needed to get there by breaking it down into achievable chunks.
HealthWatch	The 'consumer champion' for both health and adult social care and should be the independent, influential and effective local voice of the public on health issues.
LBR	Learning beyond registration
MP&S	Meeting service users, carers and staff
NHSLA	NHS Litigation Authority
NVQ	National Vocational Qualification
Palliative care	The term palliative care is often used interchangeably with end of life care. However, palliative care largely relates to symptom management It also involves psychological, social and spiritual support for service users and their family or carers. Service users will often receive palliative care earlier in their illness.
PDR	Performance Development Review
Provider	A health or social care organisation which provides services to older people living with frailty
QRS	Quality Review Service, formally the West Midlands Quality Review Service (WMQRS)
QS	Quality Standard
RCGP	Royal College of General Practitioners
Service commissioner	*See 'Commissioner'*
Service provider	*See 'Provider'*.
Social Prescribing	**'**Social prescribing' is a way for local agencies to refer people to a link worker. Link workers give people time, focusing on 'what matters to me' and taking a holistic approach to people's health and wellbeing. They connect people to community groups and statutory services for practical and emotional support. What older people and carers can take part in will depend on what services are available locally.
STPs/ICTS	Sustainability and Transformation Partnerships are areas covering all of England, where local NHS organisations and councils take a place -based approach to planning and delivering health and social care services. From April 2021 STPs will evolve to become integrated care systems (ICS).
Trust	A NHS Trust, NHS Foundation Trust or other organisation with management responsibility for the service.

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Appendix 6 Presentation of Evidence for Peer Review Visits

Each Quality Standard reference column includes a box that illustrates how compliance will be reviewed.

BI	**Background information**	This means that the information should be included in the background report or self-assessment.
Visit	**Visiting facilities**	Reviewers will look for the information while they are visiting the service.
MP&S	**Meeting service users, carers and staff**	These Standards will be discussed with service users, carers and/or staff as appropriate.
CNR	**Case note review or clinical observation**	A few Quality Standards require reviewers to look at case notes or observe clinical practice.
Doc	**Documentation**	These are policies, guidelines and other documentation that reviewers will need to see.

The following table summarises the evidence needed for each Quality Standard.

QS Ref. No	QS Short Title	Background information	Visiting facilities	Meeting service users, carers & staff	Case note review or clinical observation	Documentation	Illustration of Documentation Required
		BI	Visit	MP&S	CNR	Doc	
M*-102	**Information and support**		X	X			
M*-104	**Reasonable adjustments**		X	X			
M*-298	**Training Programme**			X		X	Evidence to show that a training programme for staff has been implemented
M*-301	**Support Services**	X	X	X			
M*-401	**Facilities and Equipment**		X	X			
M*-501	**Guidelines:** Frailty Screening and Care of Older People Living with Frailty (1)			X		X	**Guidelines:** Frailty screening and care older people living with frailty
M*-603	**Population Health Management**	X		X			
M*-604	**Quality Monitoring – All services**			X		X	Documentation depends on local arrangements for example, documentation of monitoring, review of key performance indicators and service quality reports

QS Ref. No	QS Short Title	Background information	Visiting facilities	Meeting service users, carers & staff	Case note review or clinical observation	Documentation	Illustration of Documentation Required
		BI	Visit	MP&S	CNR	Doc	
MA-601	**Organisation of Care of Older People Living with Frailty**			X			
MA-602	**Population Health Management**			X		X	General practices have evidence to show that information on people within the local areas at high risk of unscheduled admission to hospital is identified through populational health management systems
MA-605	**Quality Monitoring Primary care**			X		X	Quality monitoring report identifying number of patients with frailty and relevant prescribing data
ME-502	**Clinical Guidelines:** Care of Older People Living with Frailty (2)			X	X	X	**Guidelines:** Urgent Care guidelines covering care of older people living with frailty.
MN-103	**Frailty-Specific Information**		X	X			
MN-105	**Advice and Advocacy**		X	X	X		
MN-106	**Care and Support Plan**			X	X		
MN-107	**Review of Care and Support Plan**			X	X		
MN-108	**Emergency Care Plan**		X	X	X		
MN-203	**Staff Competences**			X		X	Competence framework covering the areas details in the QS
MN-503	**Holistic Frailty Assessment / Brief CGA**			X	X	X	**Guidelines:** Agreed holistic frailty assessment and comprehensive geriatric assessment
MN-504	**Guidelines:** Medication review			X	X	X	**Guidelines:** Medication review
MN-505	**Clinical Guidelines:** Management of Frailty Syndromes			X	X	X	**Guidelines:** Management of frailty syndromes covering the areas details in the QS
MN-701	**Data Collection**			X		X	Examples of data collected showing compliance with the QS
MH-601	**Organisation of Care for Older People Living with Frailty**			X	X	X	Data /Information showing compliance with the QS
MP-101	**Service Information**		X	X			

QS Ref. No	QS Short Title	Background information	Visiting facilities	Meeting service users, carers & staff	Case note review or clinical observation	Documentation	Illustration of Documentation Required
		BI	Visit	MP&S	CNR	Doc	
MP-103	**Frailty-Specific Information**		X	X			
MP-104	**Reasonable Adjustments**		X	X			
MP-105	**Advice and Advocacy**		X	X	X		
MP-106	**Care and Support Plan**			X	X		
MP-107	**Review of Care and Support Plan**			X	X		
MP-108	**Emergency Care Plan**		X	X	X		
MP-195	**Transition to Other Services**			X	X		
MP-197	**General Support for Older People and Carers**		X	X			
MP-198	**Carers' Needs**			X			
MP-199	**Involving Older People and Carers**			X		X	Examples of methods of receiving feedback. Examples of changes made as a result of feedback
MP-201	**Lead Clinician**	X					
MP-202	**Staffing Levels and Skill Mix**	X		X			
MP-203	**Staff Competences**			X		X	Competence framework covering the areas details in the QS
MP-204	**Service Competences and Training Plan**			X		X	Training and development plan and competence framework
MP-298	**Training Programme**			X		X	Training programme
MP-299	**Administrative, Clerical and Data Collection Support**	X		X			
MP-301	**Support Services**	X	X	X			
MP-302	**Support Services**	X		X			
MP-402	**Facilities**		X				
MP-403	**Equipment**		X				

QS Ref. No	QS Short Title	Background information	Visiting facilities	Meeting service users, carers & staff	Case note review or clinical observation	Documentation	Illustration of Documentation Required
		BI	Visit	MP&S	CNR	Doc	
MP-499	**IT System**		X	X			
MP-501	**Guidelines:** Frailty Screening and Care of Older People Living with Frailty (1)			X		X	**Guidelines:** Frailty screening and care older people living with frailty
MP-503	**Comprehensive Geriatric Assessment**			X	X	X	**Guidelines:** Agreed comprehensive geriatric assessment
MP-504	**Guidelines:** Medication review			X	X	X	**Guidelines:** Medication review
MP-505	**Clinical Guidelines:** Management of Frailty Syndromes			X	X	X	**Guidelines:** Management of frailty syndromes covering the areas details in the QS
MP-595	**Transition to Other Services**			X		X	**Guidelines:** Covering arrangements for transition to other services
MP-599	**Care of People with Care and Support Needs**			X		X	**Guidelines:** 'a-g' as detailed in the Quality Standard
MP-601	**Operational Policy**			X		X	Service operational policy
MP-603	**Population Health Management**	X		X			
MP-698	**Attendance at Local Health and Social Care Older People Living with Frailty Group**			X		X	Documentation depends on local arrangements, and may include, for example, minutes of review and learning meetings.
MP-699	**Liaison with Other Services**			X		X	Documentation of review meetings held
MP-701	**Data Collection**	X				X	Examples of data collected showing compliance with the QS
MP-702	**Audit**					X	Audit programme or plan. Examples of completed audits
MP-798	**Multi-disciplinary Review and Learning**			X		X	Documentation depends on local arrangements, and may include, for example, minutes of review and learning meetings held within the service.
MP-799	**Document Control**					X	Compliance determined from other documentation presented
MZ-298	**Local Training Programme**			X		X	Evidence to show that a local training programme has been implemented

QS Ref. No	QS Short Title	Background information	Visiting facilities	Meeting service users, carers & staff	Case note review or clinical observation	Documentation	Illustration of Documentation Required
		BI	Visit	MP&S	CNR	Doc	
MZ-601	**Needs Assessment and Strategy**			X		X	Local needs assessment and strategy
MZ-602	**Commissioning of Services**			X		X	Documentation depends on commissioning arrangements in place
MZ-603	**Local Health and Social Care Older People Living with Frailty Group**			X		X	Documentation depends on local arrangements, and may include, for example, minutes of review and learning meetings.
MZ-604	**Local Agreements**			X		X	Local agreements for the areas as defined in the QS
MZ-605	**Population Health Management**	X		X		X	Documentation depends on local arrangements but should show that arrangements are in place to provide information on people within the local areas at high risk of unscheduled admission to hospital is identified through populational health management systems
MZ-701	**Quality Monitoring –** Primary Care			X		X	Documents relating to key performance indicators monitored.
MZ-702	**Quality Monitoring**			X		X	Documentation depends on local arrangements, and may include, for example, minutes of clinical review meetings as long as there is evidence of discussion of the specific service
MZ-798	**Pathway Review and Learning**			X		X	Documentation depends on local arrangements, and may include, for example, minutes of review and learning meetings held with commissioners and the local network.

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Appendix 7 Specialist Competences for Staff undertaking Holistic Frailty Assessments (brief CGA) or Comprehensive Geriatric Assessments

1. Interest in older people and a non-ageist approach to working with them and their families and carers
2. Use of frailty screening tools
3. Undertaking assessment of the following domains, including identifying problems in each area that require specialist assessment:
    a. Any concerns about mental capacity
    b. Medical: comorbid conditions, disease severity and nutritional status, including tissue viability, continence and swallowing
    c. Mental health: cognition, mood, anxiety and fears, past history of delirium
    d. 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)
    e. Social and financial circumstances: informal support, social network and activities, eligibility for care
    f. Environment: home comfort and facilities, personal safety, potential use of Telehealth/Telecare and assistive technology, transport facilities, accessibility of local resources
4. Communication with older people and their carers, including:
    a. Listening with empathy, understanding and respect
    b. Understanding their goals and wishes
    c. Providing medication administration advice
5. Communication with other agencies about the care of older people living with frailty
6. Knowledge of common illnesses and disease presentations in older people
7. Knowledge of common drug-related causes of presenting problems in old age
8. Skills in recognition of common illnesses and disease presentations in older people
9. Creating Care and Support Plans, including:
    a. Offering advice to help older people living with frailty and their families and carers identify choices and evaluate options
    b. Offering an opinion or recommendation on appropriate care and support, if requested.
    c. If the older person has substantial difficulty in being actively involved with planning their care, offering access to an advocate
    d. Supporting and enabling positive risk-taking where this is what the person wants
    e. Promoting healthy lifestyles and preventing harm
    f. Coordinating and involving other agencies in agreeing the plan
10. Safeguarding, recognising adults with care and support needs
11. Mental Capacity and Deprivation of Liberty Safeguards