Workforce and education initiative to support the delivery of better care to patients living with frailty: evaluation study

Final Report
Executive summary

In the 2015/16 financial year, Health Education England working across Wessex (HEE WES) invited funding application bids to support teams delivering an innovative service model to support people living with frailty in a community setting. These include reducing length of stay in hospital, reducing hospital admissions and/or supporting people to return to their previous place of residence. Following assessment of the bids received, HEE Wessex funded 4 Frailty Workforce and Education Development Initiatives across Wessex for 2016-17 (Fig. 1).

Fig 1. The Four HEE Wessex funded Frailty Development projects

Health Education England invited the CLAHRC Wessex Data Science Team to evaluate the training element of the workforce development initiatives. The overall aim of each of the initiatives, which developed and implemented new care pathways, were as follows:

- Older Person’s Assessment and Liaison Team (OPAL) – Salisbury: to reduce avoidable admission of frail patients due to lack of specialist assessment and onward care planning.
- Advanced Clinical Practitioners in Frailty – Southampton: to enhance cross-sector working between health care, social care and the voluntary sector.
• The Acute Frailty Intervention Team (AFIT) – Lymington: to provide a timely, effective, multi-disciplinary community-based response to patients presenting with decompensated frailty syndrome (e.g. confusion, falls, ‘off legs’).

• Developing Community Frailty Teams in Dorset CCG – Weymouth: to build on the current work of the existing locality Integrated Care Hub and Elderly Care Service and move from reactive management of people with frailty and complex needs to a proactive approach.

The aims of the evaluation undertaken by the CLAHRC were to identify the educational resources and training initiatives used by staff and the impact on the quality of care delivered. The evaluation also identified gaps in the training currently provided and made recommendations to improve the provision of frailty education and training for healthcare staff. Outputs of this evaluation will help in delivering future training consistently and effectively in order to meet the needs of people living with frailty. The current report presents findings of the evaluation study conducted by the CLAHRC Wessex. The evaluation was informed by focus groups, interviews and observations conducted across the four initiatives with staff involved in the delivery of frailty services.

**Key findings**

The most significant findings are given below and relate to the complexity of frailty and the individual and organisational factors enabling effective training.

Across the projects there was agreement that the concept of frailty was vastly complex, difficult to define, encompassed a wide range of medical conditions, and that it could not be understood without an appreciation of each patient’s physical, psychological and social situations. This necessitated a wide range of additional training that could not be specified.

There was further consensus on the need for combined formal and informal training, as many aspects of frailty care could not be taught, but were learned through the experience of working within the speciality.

A key factor influencing effective training was that all staff wanted to do a good job of caring for frail people and this was an important driver for their enthusiasm to learn more about frailty. On many occasions they talked of integrity of care, shared values and wanting to learn more in order to do the best they could for their patients.

Staff recognised individual responsibility to identify their own knowledge and skills gaps and to seek out appropriate training opportunities.
A proactive and flexible approach was considered to be important in making the most of formal and informal learning opportunities.

Group learning from known case studies was found to be particularly effective.

The skill and enthusiasm of trainers obviously had an impact and staff appreciated training from all professions, particularly from geriatricians.

Working in teams where there was some blurring of roles provided more training opportunities and wider experience.

Shadowing staff within their own teams and also other health professionals working in frailty helped staff to understand the wide and complex nature of frailty more fully and to find out about additional resources for patients and carers. Hospital staff were keen to shadow community staff to learn about frailty care outside of the hospital environment. In particular, they felt that this additional knowledge helped in developing their confidence, improving their decision making and, thereby, making more effective discharge decisions. Similarly, those who chose to carry out frailty care training in the community found that they themselves were learning from care within a different context.

Some teams aimed to embed working and training into their everyday practise developing highly effective informal learning opportunities during handovers, clinical history taking and at other times. This form of training and feedback on skills development had a positive impact on skills development and built confidence, so that staff wanted to learn and do more. Key to this was a supportive team.

Teams with a supportive culture were important in enabling individuals to feel sufficiently confident to ask questions and seek clarity without feeling awkward, which helped in developing a good learning environment. They enjoyed working together, learning from each other and gained in confidence and skills.

A sense of staff ownership of the initiative was important and helped to further develop team cohesion, mutual support and learning.

The availability of financial resources to cover training costs was an essential factor.
Recommendations

The list of the recommendations from this evaluation study is:

− Frailty is an area that requires a combination of “on the job” (i.e. experiential learning) plus formal learning (e.g. courses, diplomas, conferences).
− Protect training time.
− Encourage creativity in creating opportunities for teaching and learning.
− Promote working in teams as, in frailty, staff are the mechanism to deliver integrated care.
− Develop a leadership role in training for frailty.
− Develop a library of training resources on frailty.
− Provide training on the electronic frailty index.
− Schedule regular shadowing tasks so staff working in acute care spend time in the community, and staff working in the community spend time in the hospital.
− Replicate the model of "a virtual frailty unit" to deliver care that focusses on the needs and wishes of the patient.
− Set up feedback systems and opportunities for reflection.
− Provide training on IT systems available.

Acknowledgements and funding

Funds for the study were granted by Health Education England working across Wessex in collaboration with CLAHRC Wessex. We thank greatly the time and dedication of the staff involved in the four frailty initiatives. Their commitment to delivering excellent care to people living with frailty is commendable. We would also like to thank the invaluable help of Vivienne Windle, our Patient and Public representative in the project. Her insight and experience were vital to inform our research, guide our discussions and shape our analysis framework.
Final report

Background

Estimates indicate that approximately 16% of the population in Europe is over the age of 65 years and by 2030, this number is expected to rise to 22% [1]. Around 10% of people over 65 years have frailty, rising to between a quarter and a half of those aged over 85 years [2].

Frailty is a distinct health state related to the ageing process in which multiple body systems progressively lose their in-built reserves [3], resulting in exacerbated vulnerability to sudden changes in health status triggered by events including falls, mobility problems, pressure ulcers and incontinence. The frailty state for an individual is not static and it can be improved when timely detection and intervention occur. A report for the recognition and management of frailty by the British Geriatric Society recommend that older people should be assessed for the presence of frailty during all encounters with health and social care professionals, and that staff receive training in frailty recognition and treatment [3]. Successful programmes aimed at improving the services delivered to older people have included an element of training and education of staff. Training, teaching and learning methods used in educational interventions for health care staff include face-to-face lectures, study days, web-based sessions (e-learning), small group work, audio-visual methods, case examples, role-play activities, and practical exercises. These approaches are often combined with ‘training on the job’ strategies that support the staff to acquire skills and apply knowledge in daily practice. Strategies include facilitation, coaching, support for decision-making, multi-professional collaboration, feedback and revisions of protocols [4-7].

Detail of four frailty initiatives

Salisbury: Older Person's Assessment and Liaison Team (OPAL)

The Older Person's Assessment and Liaison Team (OPAL) project aimed to reduce avoidable admissions caused by a lack of specialist assessment and onward care planning. Where acute admission was required, all patients with identified frailty left the Emergency Department with a completed initial Comprehensive Geriatric Assessment (CGA) and onward management plan.

Weymouth: Developing Frailty Services in Dorset

The Workforce Development Community Frailty Team in Weymouth aimed at expanding the work from the Weymouth Integrated Care Hub and Weymouth Elderly Care Service, taking a more proactive approach to the management of people living with frailty. The project agreed a
standardised identification of frailty across health and social care services within the Weymouth and Portland Locality and developed a training and education package to consistently deliver the Dorset Care Plan.

**Southampton: Advanced Clinical Practitioners in Frailty**

The work conducted in Southampton defined and implemented a ‘frailty pathway’ spanning across two organisations - University Hospital Southampton NHS Foundation Trust (UHS FT) and Solent NHS, supported by Southampton City clinical Commissioning Group (CCG). The proposal incorporated cross-sector working through health care (medical, nursing, therapy), social care and the voluntary sector. It was supervised by a senior consultant geriatrician and led by an advanced nurse practitioner and an allied health professional therapist.

**Lymington: Acute Frailty Intervention Team**

The Acute Frailty Intervention Team (AFIT) project aimed to provide a timely, effective multi-disciplinary community based response to patients presenting with decompensated frailty syndrome (e.g. confusion; falls; ‘off legs’). In order to build and sustain a workforce for the future, which is equipped to deal with frailty, AFIT created a new model of care, drawing on the expertise of health professionals from many disciplines (e.g. geriatricians, ambulance service staff, nurses, GPs, community nurses, physiotherapists, occupational therapists, advanced care practitioners) in order to maximise synergy and health care delivery, thus improving patient experience.

**Data collection**

Data collection started in May 2017 and was completed in January 2018. Observations, focus groups and interviews were arranged with the coordinator of each initiative. Consent to participate in the focus groups and interviews was sought from participants at the start of each event. Focus groups and interviews were recorded and transcribed verbatim. Participants’ names were anonymised and findings aggregated at the staff-group level, across the four initiatives, this is, quotes and conclusions for a staff-group (e.g. nurse practitioners, geriatricians or physiotherapists) would be from data collected in any of the four initiatives. Table 1 presents a summary of the data collected in each initiative.
Table 1. Data collection per site

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Salisbury</th>
<th>Weymouth</th>
<th>Southampton</th>
<th>Lymington</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data collection activity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Observations of training sessions</td>
<td></td>
<td>Locality frailty meeting</td>
<td>CGA training session &amp; Target meeting</td>
<td>SCAS training session</td>
</tr>
<tr>
<td>Phone interviews</td>
<td></td>
<td>Geriatrician at DHUFT</td>
<td>Study coordinator</td>
<td>South Coast Ambulance Service staff &amp; AFIT coordinator</td>
</tr>
<tr>
<td>Focus groups*</td>
<td>Three</td>
<td>Two</td>
<td>One</td>
<td>Two</td>
</tr>
<tr>
<td>Observations on-the-job</td>
<td>OPAL team short-stay ward</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Documents</td>
<td>CGA, discharge planform</td>
<td>Frailty toolkit, leaflets, on-line frailty module</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>
*See Appendix A for the list of questions that guided the focus groups and interviews

Analysis

To explore the data collected through focus groups, observations, and telephone interviews, we adopted a thematic analysis approach [4-5]. AR-S and MT coded all the transcriptions and developed the thematic framework, validating the themes through discussions. Discussions of the themes continued until no new themes were identified. A third researcher, TM, coded a random sample of the transcriptions to validate the final framework. Inter-rater agreement was calculated, reaching 70% consensus.

Findings

The thematic framework that resulted from the analysis included 11 main themes are summarised in Table 2. The table shows a list of the themes relevant to staff training and development identified from the focus groups and interviews, and the strength of the views expressed. Positive views or
experiences on training and development are indicated by ‘+’ and negative views by ‘-’. The strength or intensity of view is expressed by the number of symbols, from one to three.

Table 2: Themes identified from focus groups, observations and interviews.

<table>
<thead>
<tr>
<th>Theme</th>
<th>Presence/strength</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge of intervention</td>
<td></td>
</tr>
<tr>
<td>Clarity of aims</td>
<td>++</td>
</tr>
<tr>
<td>Shared vision for process and goals</td>
<td>++</td>
</tr>
<tr>
<td>Knowledge of training to be provided</td>
<td></td>
</tr>
<tr>
<td>Awareness of programme</td>
<td>+/-</td>
</tr>
<tr>
<td>Perceived appropriateness</td>
<td>++/--</td>
</tr>
<tr>
<td>Awareness of support for training and development</td>
<td></td>
</tr>
<tr>
<td>Existing</td>
<td>++/--</td>
</tr>
<tr>
<td>Desired</td>
<td>++</td>
</tr>
<tr>
<td>Accessed</td>
<td>+</td>
</tr>
<tr>
<td>Perceived fit between training and initiative</td>
<td></td>
</tr>
<tr>
<td>Relevance to existing skills base</td>
<td>++/-</td>
</tr>
<tr>
<td>Duration of training</td>
<td>++/--</td>
</tr>
<tr>
<td>Protected training time</td>
<td>+/-</td>
</tr>
<tr>
<td>Knowledge of local/national policies/resources</td>
<td></td>
</tr>
<tr>
<td>As an influencing factor for the initiative</td>
<td>+</td>
</tr>
<tr>
<td>As shared resource for training</td>
<td>+/-</td>
</tr>
<tr>
<td>Perceived factors enabling effective training</td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>++</td>
</tr>
<tr>
<td>Organisational</td>
<td>++</td>
</tr>
<tr>
<td>Perceived barriers to training</td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>--</td>
</tr>
<tr>
<td>Organisational</td>
<td>--</td>
</tr>
<tr>
<td>Suggested measures to address barriers</td>
<td>++</td>
</tr>
<tr>
<td>Leadership</td>
<td>++/-</td>
</tr>
<tr>
<td>Perceived impact of training</td>
<td></td>
</tr>
<tr>
<td>On delivery of patient care</td>
<td>++</td>
</tr>
<tr>
<td>Directly upon patients/their carers</td>
<td>+++</td>
</tr>
<tr>
<td>Individual skills/role development</td>
<td>++</td>
</tr>
<tr>
<td>Continuation/adoption of initiative</td>
<td>++/--</td>
</tr>
<tr>
<td>Definition/complexity of frailty</td>
<td>+++</td>
</tr>
</tbody>
</table>

Knowledge of the intervention

Having a clear aim and shared vision for the process and goals of the initiative was essential in establishing joint working within the teams, supporting each other, and developing an environment conducive to learning and development.
Knowledge of the training to be provided

Views on this were mixed with some being very clear on what they thought the training involved and considering it appropriate, with others less so.

Awareness of support for training and role development

Knowledge of the support available for training and development varied but a number of staff had considered the type of additional training they felt necessary for their particular role development and several had already begun accessing this, either in formal training courses, online courses or informally via other staff within their teams or other professions.

Perceived fit between training and initiative

Views on the duration and relevance of training varied between teams and individual staff. Generally, there was agreement that the training provided was appropriate in developing existing skills in order to implement the initiative. Some staff would have liked more time for activities such as shadowing to understand the roles of others. However, a small number of others commented that they felt their previous experience had not been recognised.

Training for the e-Frailty initiative was essentially a process to act upon a list of at-risk patients generated in GP practices and therefore, in this respect was very different to the training for the other three initiatives which involved direct patient care. However, while some of those involved had reservations about the tool used to generate the list as it had previously been in use and rejected, they were supportive of the overall aim and wanted to know more about the tool itself and the criteria underlying the generation of data, so that they could understand the output better and work with it more effectively.

The protection of training time was not straightforward. Training sessions were scheduled but might be cancelled due to the need to prioritise patient care at busy times; lack of other staff to cover training times; individuals not prioritising training; and cultural influences on cancelling training due to work pressure. This is mentioned again as a barrier to training.

Knowledge of local/national policies/resources

Staff were aware of how local and national policies were driving the initiatives and the relevance of improving the quality of frailty care.
A number of staff were knowledgeable about relevant external training resources, free and charged, formal and informal, and some online, while others had little awareness of these.

**Factors enabling effective training**

**Individual**

A key factor noted with all of the projects was that staff wanted to do a good job of caring for frail people and this was an important driver for their enthusiasm to learn more about frailty. On many occasions they talked of integrity of care, shared values and wanting to learn more in order to do the best they could for their patients.

It was felt that there was an individual responsibility to identify one’s own areas of knowledge and skills needing development and to seek out appropriate training opportunities.

Being proactive and having a flexible approach was considered to be important in making the most of available learning opportunities, formally and informally, engaging with one’s own team and others, and being active, rather than waiting for training to be offered.

Staff benefitted from and enjoyed reflecting on case studies of patients they had been involved with and felt that they learned a lot from real, known situations. This was a particularly favoured option for training that staff wanted to have more access to.

**Organisational**

Group learning from known case studies was particularly effective and staff appreciated input from geriatricians with this and also valued the training sessions that geriatricians provided.

The skill and enthusiasm of trainers obviously had an impact.

Working in teams where there was some blurring of roles provided more training opportunities and wider experience.

Staff felt that they learned a lot from shadowing staff within their own teams and also other health professionals working in frailty. It helped them to understand the wide and complex nature of frailty more fully and to find out about additional resources for patients and carers. This was considered to be especially important by hospital staff, who were keen to shadow community staff and learn from them about frailty care outside of the hospital environment. In particular, they felt that this additional knowledge helped in developing their confidence, improving their decision making and, thereby, making more effective discharge decisions.
Some teams aimed to embed working and training into their everyday practise and found the informal learning opportunities highly effective, such as clarifying aspects of a clinical condition as it arose during a handover. Staff were also able to receive feedback in this way, for example, one staff member saying that she had received comments on how well her history taking and handovers had improved. This form of training and feedback had a positive impact on skills development and built confidence, so that staff wanted to learn and do more. Key to this was a supportive team.

Teams with a supportive culture were important in enabling individuals to feel sufficiently confident to ask questions and seek clarity without feeling awkward, which helped in developing a good learning environment. They enjoyed working together, learning from each other and gained in confidence and skills.

A sense of staff ownership of the initiative was important and helped to further develop team cohesion, mutual support and learning.

Those who had taken the opportunity to carry out training in the community rather than only within a hospital setting found that by doing so, they were themselves learning about community issues while providing training.

There was a perception of availability of financial resources to cover training costs.

**Perceived barriers to training**

**Individual**

The individual barriers to training largely concerned staff not protecting their own training time, mainly due to pressure of work and their concern to prioritise patient care over training. If scheduled training coincided with a time that was busy, training was likely to be missed. While this overlaps to some extent with organisational barriers, it does reflect individual attitudes towards training time.

Similarly, if staff unexpectedly had some quiet time, they were unlikely to use this for training, prioritising direct patient care matters.

Staff were more likely to attend formal training courses, feeling more comfortable that this was recognised, booked time that they would be away, than informal, on the job training. Online courses were not always completed.
In some cases, a lack of recognition of previous experience generated some resistance towards initiatives so that while the overall aim was viewed positively, there was less enthusiasm for the training.

**Organisational**

As noted above, time constraints featured as an organisational barrier so that work at busy times would take precedence over training and development; there appeared to be both an individual and cultural approach to not protecting training time. This also impacted on the lack of time to reflect on particular cases and learn from them, which was considered to be an important process. Essentially, staff felt that there were insufficient resources to free up sufficient training and development time.

This extended to the availability of financial resources to cover the cost of courses outside of that provided in-house specifically for the initiatives, but considered important in developing the skills required to work in frailty care.

Limited geriatrician input was a concern for some teams who would have welcomed more of their time for training and to follow up cases.

Some participants said that they had received very little training for their specific initiative. Others felt overwhelmed with presentations on many topics. There were also comments that some presentations lacked a clear mechanism for implementing initiatives or aspects.

One of the projects was using an e-Frailty tool that staff had previously rejected. Training in the use of the tool was limited. Staff did not understand how the data it produced for them was generated and, while they did not view it with a great deal of confidence, were persevering with it, hoping for future clarity. One staff member was more enthusiastic about it and had spent time comparing the generated data with patient notes. However, this was done during annual leave rather than work time.

Disjointed IT systems presented a barrier as staff in some instances had difficulty in accessing relevant patient information. This was closely associated with feedback on outcomes of care. Staff felt it was important to know the outcomes of decisions made and care given but often, this information was not available, so staff did not know how effective their interaction with the patient had been.

There were several comments that training and work should be done within work time, although this was often not the case, other than for some formal, scheduled training.
Further issues raised concerned the cost of producing training materials and support in preparing them, for example, in developing a training module from a particular case study.

**Suggested measures to address barriers**

The teams identified a number of strategies to counter the barriers to training and development.

- Encouraging staff to identify gaps in skills and knowledge to provide focussed training rather than having either too wide a range of topics or too little training.
- Establishing a system that allows shadowing of more senior staff and those within other professions.
- Promoting a culture in which people feel able to ask questions without pressure.
- Setting up fixed schedules for training with a minimum number of attendance sessions to encourage staff to attend regularly.
- Promote views of training being as valuable as treating patients for skill development.

**Leadership**

Visible and enthusiastic leaders and frailty champions inspired a keenness to learn more about frailty and had a positive influence on training.

However, where such a leader was also in a position of seniority and/or had significant demands on their time, reliance upon them for supervision or formal training sessions could be detrimental due to their limited availability or being called away at short notice. Some staff suggested that to counter this, teams should be proactive and prepared to get on with training from a range of sources, protecting the time that had been made available and using it.

Role in which someone – not a trainer – keeps up to date with developments in frailty care and training and matches that to requirements of team.

**Perceived impact of training**

Training and development was considered by the teams to have had a positive impact on the delivery of patient care, individual skills and role development. Most significantly, they felt that it had had a direct improvement on the care and services provided to patients and their carers.

Most felt that the training and beneficial outcomes it produced would have a positive impact on the continuation of the initiatives.
Their concerns about the future of the initiatives were that there would be insufficient funding to provide staff cover for the additional training that would be required and for the training itself, and to extend the initiatives to provide twenty-four hour cover, seven days each week.

**Definition/complexity of frailty**

There was agreement across the themes that it was extremely difficult to arrive at a comprehensive definition of frailty. The concept was considered to be vastly complex, encompassing a wide range of medical conditions and that it could not be understood without an appreciation of each patient’s physical, psychological and social situations. The potential need for additional relevant training was, therefore, significant yet difficult to fully specify.

The consensus on the need for a combination of formal and informal learning was absolutely clear. There was agreement that some aspects of frailty care required formal training but that a very important part of learning about it could not be taught; it had to be learned by the experience of working within frailty. One example given was of a patient who had repeated falls while trying to get to the toilet quickly. Within a frailty context it was important to investigate the underlying reasons for needing to get there quickly, both medical, psychological and social, and insufficient to simply suggest measures such as the use of pads and putting a commode close to the bed or sitting room.

This shared understanding by the teams of the complex nature of frailty was associated with their frequent comments on having shared values within their teams, as noted in relation to the individual factors enabling effective training. Several discussions developed amongst the teams on their concerns that new recruits to frailty care teams might not have sufficient experience to work in the area. They were certainly concerned that new recruits should not be newly qualified staff. It was important to them that new team members should share their values and have similar attitudes towards frailty care and openness to learning.

**Recommendations**

The following is a list of recommendations generated from the findings of our evaluation study.

Frailty is an area that requires a combination of “on the job” (*i.e. experiential learning*) plus formal learning (*e.g. courses, diplomas, conferences*). Embedding formal and informal training in daily practice creates opportunities for learning that meets the needs of working in frailty, which requires highly experienced staff to work generically, across professions and health sectors.
Protect training time not only of courses taken away from staff workplace, but also of the training that takes place on the wards or with colleagues (e.g. shadowing). Scheduling informal learning will protect the time similar to the way that time is protected to receive formal learning. It will also develop a culture driven to training within the organisation.

Encourage creativity in creating opportunities for teaching and learning keeping in mind that every encounter with patients and with other staff may be a learning opportunity. Liaise with staff in charge of developing and managing the training strategy on frailty in the organisation.

The challenges that patients present increase the importance of working as a group where staff are the mechanism to deliver integrated care.

Have clarity of aims and mechanism for achieving learning. Shared values bonds teams more tightly.

Develop a leadership role in training for frailty. This role does not necessarily require a trainer but a person in the organisation who encourages staff to identify knowledge gaps in the team and find the right training for them, either through formal courses or informally by working with some other member of staff. The role requires a formal job description. The duties of this position would include development of a training strategy in frailty (linked to individual CPD and developing individual profile), bringing resources together and managing access to resources (local or external to the organisation). Ideally, the role would be taken by staff with experience in frailty because they will understand and be able to identify the training needs of the teams and individuals.

Develop a library of training resources on frailty, including case studies and materials that can be used for training.

Provide training on the electronic frailty index to ensure that the codes being used to risk-assess patients are understood and used in a standard way.

Schedule regular shadowing tasks so staff working in acute care spend time in the community, and staff working in the community spend time in the hospital. This is mainly because frailty does not happen in one health context in isolation, and learning from groups of staff across community, primary and secondary care will enhance staff decision-making. Set up regular training opportunities to ensure that changes in regard to frailty services taking place in hospital or the community are continuously communicated to staff.

Replicate the model of the virtual frailty teams that integrates staff working across sectors (ambulance service, community nurses, GPs, social worker, nurse specialists, and geriatricians) and
function as a virtual frailty unit that specialises in delivering care across boundaries of the physical organisations, focussing on the needs and wishes of the patient.

Set up feedback systems and opportunities for reflection to know whether staff decision-making is correct, measured against patient outcomes.

Provide training on IT systems available.
References


Appendix A. Guide questions of focus groups and interviews

Questions to guide focus groups and interviews were drawn from the literature reviewed for the evaluation study. For the first set of focus groups, these questions were:

1. What are the aims of the initiative and how do you expect that services to patient care will change in the short and mid-term because of it?
2. What training will be received to deliver the initiative?
3. Are there training mechanisms in place that support your role development? (e.g. goal identification, small group discussion, self-reflection, peer collaboration, access to information, feedback, and follow-up)
4. In your view, how is staff development linked to the success of the initiative?
5. What training support would help you to continue the initiative in the long-term?
6. Are there local or national resources available that could be shared as good practice for the recognition, diagnosis and/or treatment of frailty?

The following questions were explored during the second set of focus groups:

1. If you have received training on frailty during the study, what elements of training have helped to the development of your role?
2. What mechanisms and support have assisted your development?
3. What aspects of training do you think could be improved to better meet the needs of your role and your patients?
4. What training methods in the project are working particularly well?
5. What features of the project enable training?
6. In our first discussion, the groups identified the following barriers to training and education:
   - lack of awareness of formal training-education initiatives available
   - difficulties to find the time to attend training;
   - lack of fixed schedule of training sessions
   - uncertainty of training required to raise the skills of staff delivering care to people living with frailty in different settings
   - lack of feedback staff groups from outcomes of cases
   - personal-professional development valued less than treating patients
   - uncertainty of how to train new or care homes (non-clinical) staff

What strategies would you suggest could be implemented to address the barriers identified?

7. Thinking back to when the initiative was implemented, have changes to practice (linked to training) had a positive impact on the delivery of patient care?
8. Have you been able to assess or measure the difference that training has made to the patient?
9. Have you designed your training to fit with NHS England guidance around frailty (e.g. 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 https://www.england.nhs.uk/ourwork/pe/safe-care/)?