Health Education England Wessex
Workforce and Education Initiative
to support the delivery of better
care to patients living with frailty

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1 EXECUTIVE SUMMARY

In the 2015/16 financial year, Health Education England working across Wessex (HEE WES) invited funding application bids from organisations across the patch to support teams delivering an innovative service model to support frail individuals in a community setting. This includes reducing length of stay in hospital, reducing hospital admissions and/or supporting frail individuals to return to their previous place of residence. Following assessment of the bids received, HEE Wessex agreed to award a total sum of £405,271 to fund 4 Community Frailty Workforce and Education Development Initiatives across Wessex for 2016-17 (Figure 1).

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 – Lymington: to provide a timely, effective, multidisciplinary 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 healthcare staff delivering frailty care and to identify the educational resources and training initiatives used by staff to deliver quality care. 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. The recommendations were framed around the theory of the learning organisation.

The aim of the CLAHRC evaluation was to provide Health Education England Wessex with a greater understanding of the training provision across the four frailty initiatives. Outputs of this evaluation will help in delivering future training consistently and effectively in order to meet the needs of people living with frailty.
1.1 **FOUR FRAILTY PATHWAYS IN WESSEX**

- **Salisbury: Older Person’s Assessment and Liaison Team.** The OPAL project aimed to reduce avoidable admissions caused by a lack of Specialist Assessment and onward care planning. Where admission was required, this service aimed to ‘make every contact count’.
  
  **Aim:**
  
  - To facilitate safe, effective, same day discharge home or to a community provider directly from the Emergency Department for adults with frailty.
  - Where acute admission is required, all patients with identified frailty will leave the Emergency Department with a completed initial Comprehensive Geriatric Assessment (CGA) and onward management plan.

  **Location:** Salisbury Foundation Trust
  
  **Team:** Chris, Gill, Sophie, James, and others
  
  **Contact:** Cris Mulshaw, MCSP. Head of Therapies
  
  **Cris.mulshaw@salisbury.nhs.uk**
  
  **Tel.** 01722 336262 ext 3124

- **Weymouth: Developing Frailty Services in Dorset.** The Workforce Development Community Frailty Team 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 addressed the following areas:
  
  - To agree a standardised identification of frailty across health and social care services within the Weymouth and Portland Locality
  - For patients identified as frail - to develop a frailty framework, underpinned by a standardised assessment approach and the development of a Dorset Care Plan
  - To develop a training and education package to enable the above to be consistently delivered, reviewed and monitored across Dorset.

  **Location:** Dorset CCG
  
  **Team:** Sarah, Emma, Laura, and others
  
  **Contact:** Dr Karen Kirkham, Assistant Clinical Chair
  
  **Karen.kirkham@dorsetccg.nhs.uk**
  
  **Tel.** 07967 750255

- **Southampton: Advanced Clinical Practitioners in Frailty.** The work 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.

  **Location:** University Hospital Southampton NHS Foundation Trust.
  
  **Team:** Harnish, Pippa, Rachel and others
  
  **Contact:** Dr Harnish Patel, Consultant Physician
  
  **Harnish.patel@uhs.nhs.uk**
  
  **Tel.** 02381 204354
• **Lymington: Acute Frailty Intervention Team.** The Acute Frailty Intervention Team 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’). These are conditions that most GPs will recognise as being complicated and time consuming. In addition these patients frequently present directly and repeatedly to SCAS (often with a long delay for the ambulance at the scene) and result in inappropriate admission to hospital. In order to build and sustain a workforce for the future, which is equipped to deal with frailty, we are proposing a new model of care which aims to draw on the expertise of health professionals from many disciplines in order to maximise synergy in learning experience and health care delivery and improve the patient pathway and thus patient experience.

Location: Chawton House Surgery, Lymington (SW New Forest Vanguard) Team: Debbie, Sarah, Mark, John, Gill, Rose, and others Contact: Dr Ed Reeves edward.reeves@nhs.net Tel. 01590 672953

1.2 **TRAINING AND EDUCATION OF STAFF DELIVERING FRAILTY CARE**

Findings from scoping exercise: focus groups, observations and document analyses framed within the learning organisation theory

1.3 **IMPACT AND SUSTAINABILITY OF THE FOUR INITIATIVES**

Add highlights of each project, with impact and sustainability strategies reported

1.4 **RECOMMENDATIONS FOR THE DEVELOPMENT OF THE WORKFORCE**

Add our key recommendations

1.5 **EVALUATION: THE LEARNING ORGANISATION**

Analysis of the initiatives against the features of the learning organisation to determine their readiness for continuation of the frailty pathway implemented

2 **BACKGROUND**

Estimates indicate that 16.1% of the population in Europe is over the age of 65 years and by 2030, this number is expected to rise to 22% [17]. Following this trend, by 2059 the ratio of people over 65 to those under that age will be two to one. A report from the Department of Health indicate that currently, patients >65 years constitute two-thirds of the general hospital
population and account for 40% of all hospital bed days in the National Health Service (NHS) [6].

Around 10% of people aged over 65 years have frailty, rising to between a quarter and a half of those aged over 85 years [4]. Frailty is a distinct health state related to the ageing process in which multiple body systems progressively lose their in-built reserves [16], 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 health and social care staff receive training in frailty recognition and treatment [16]. 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 healthcare staff include face-to-face lectures, study days, web-based sessions (e-learning), small group work, audio-visual methods, case examples and role-play activities, and practical exercises. These approaches are often combined with implementation strategies that support the staff to acquire skills and 'put knowledge into action'. Strategies include facilitation, coaching, support
for decision-making, multi-professional collaboration, feedback and revisions of protocols [2, 8, 9, 12].

### FRAME 1: HIGHLIGHTS OF THE BACKGROUND

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### 3 AIMS

The evaluation conducted by the CLAHRC was set to provide Health Education England with a greater understanding of education and training available to the workforce delivering care to people living with frailty. The aims of the evaluation were:

- to identify staff delivering frailty care and the educational resources and training initiatives used by staff to deliver quality care
- to identify gaps in the training currently provided
- to make recommendations focused on improving the provision of frailty education and training for healthcare staff
- to explore the organisational characteristics leading to quality improvement in frailty

### 4 DESIGN

This was a qualitative study that adopted the pragmatism approach [13]. It was based on an exploratory scoping exercise, focus groups and telephone interviews. Principles of learning organisation theory informed the analysis [3, 15, 18].

Under pragmatism, multiple sources of knowledge are brought together to gain a greater understanding of people and the world in which we operate [11, 14]. "Knowing in a complex reality, such as clinical nursing practice settings, requires multiple perspectives to be considered, where knowledge is not necessarily always convergent but might be varied, or even contradictory. In recognizing diverse ways of knowing as legitimate truths, the depth and breadth of these multiple truths can lead us to a greater understanding of larger complex truths. Bringing together various sources of knowledge, with the aim of creating a deeper understanding of phenomenon of interest, is a way to study complex problems that may exceed an individual’s capabilities of understanding a phenomenon independently.” [14] Based on these principles, data from documents publicly available (i.e. British Geriatric Society), leaflets and materials produced by the four teams, field notes from observation, and findings from the analysis of
group discussions, focus groups and telephone interviews were collated to reach the aims of this research.

5 METHODS

Following the pragmatism paradigm, the methods adopted in this evaluation consisted of:

- Exploratory scoping exercise aimed at familiarising with the four contexts, staff, and the initiative. The methods used for the exercise were: literature review, group discussions (n=5), and observations (n=6).

- Focus groups conducted 6 months after the services had been implemented (n=2) and telephone interviews throughout the study with staff who were not able to join the focus group due to work commitments (n=3).

Consent for observations, focus groups and interviews was sought from participants prior to the event. Focus groups were audio recorded and transcribed. Data collection was completed in January 2018. The study design allowed us to evaluate how well the initiatives had been embedded in the services when winter pressures took effect and assess how thinking around training changed the initiatives. Dr Alejandra Recio-Saucedo conducted all the activities linked to data collection, transcription and preliminary analysis of the data. Prof Anne Rogers, Dr Melinda Taylor and Dr Thomas Monks were involved in the verification of the thematic framework and in the discussions to inform our report and recommendations.

5.1 ETHICAL CONSIDERATIONS AND APPROVAL

This study was granted Ethics approval from the University of Southampton Ethics Committee in October 2017 (Ref 27876). Measures to protect participants were followed. Participation to the study was voluntary. A participant information sheet handed to participants clearly stated the procedure in place to protect individual identities from becoming known. Before a focus group or interview took place, participants were given the opportunity to discuss any concerns with the researcher, and the groups were reminded of their right to withdraw participation at any stage of the study without any consequences to themselves. The researcher who conducted the study has vast experience in qualitative approaches to research and remained alert for any indication that a participant did not wish to discuss the topics being explored. The researcher drew upon training and experience to reassure the participant, who were also be given the opportunity to discuss any concerns with another member of the research team or the University of Southampton Research Governance Office.
5.2 SETTINGS

The four initiatives were carried out in Salisbury, Weymouth, Southampton and Lymington. The next section offers a description of the aims and outcomes set by each project.

5.2.1 SALISBURY: OLDER PERSON’S ASSESSMENT AND LIAISON TEAM (OPAL)

Organisation: Salisbury NHS Foundation Trust. Aims:

- To facilitate safe, effective, same day discharge home or to a community provider directly from the emergency department for adults with frailty.

- Where acute admission is required, all patients with identify frailty will leave the Emergency Department with a completed initial comprehensive geriatric assessment (CGA) and management plan.

Objectives:

- To identify frail patients at point of admission in the emergency department and assess their level of frailty using the Clinical Frailty Score (CFS).

- To initiate CGA for all patients identified with frailty (carried out by a Consultant, Senior Nurse, Therapist or Social worker).

- To discharge patient home/place of safety where safely possible.

- To facilitate Rapid Access Referral Pathway to Community Geriatrician and liaise with patient’s GP/Frailty Nurse to ensure future needs are met in line with CGA.

- To promote coordinated pathways across Health and Social care (e.g. Help2Live@Home, A2C, Community Therapy, Intermediate Care).

- To engage with Age UK Salisbury Branch to ensure patients receive a safety check visit, initial needs assessment and any urgent provision by an Age UK Care Manager.

Planned outputs:

- To assess current level of frailty attending emergency departments and current discharge outcomes of those patients in an initial 2-4 week baseline qualitative data gathering period. To repeat audit at intervals through the project to demonstrate improvements or challenges.

- To reduce conversion of frail patients from ED to Acute wards through rapid discharge home with support and collaboration with Primary Care / Community Geriatrician clinics.
• To improve coordinated pathways between Primary Care, Community and Intermediate Care Services, Voluntary services and the Acute Sector built around information sharing and joint working. Potential for integration of teams in the long term (1yr+).

• To reduce or maintain overall admissions of patients aged 65+ (or those with Chronic Long Term illness).

• To increase the 0-24hr discharges from the ED / SSEU.

• To reduce length of stay of those that are admitted, as each patient admitted will be fully assessed using the CGA.

• To reduce readmission of frailty patients.

• To publish a qualitative feedback report from service users to influence long term design.

5.2.2 WEYMOUTH: DEVELOPING FRAILTY SERVICES IN DORSET

Organisations: Dorset Clinical Commissioning Group and Dorset County Hospital Foundation Trust. Aims: To develop an integrated team model that will co-ordinate, proactively manage, reactively assess, and plan together and centralise information and resources.

Objectives:

Phase 1 to develop and implement a holistic person centred assessment plan; and develop a single point of access (the local integrated frailty hub) for care of these vulnerable individuals:

• To review existing plans and identify best practice models.

• To consider physical, mental and social needs of the patient and carer support.

• To agree an appropriate model for Dorset and develop the documentation jointly across health, primary and social care, to ensure effective implementation.

• To pilot the plans with partners.

• To develop a centralised information and administration service, to enable fast-track admissions or transfer of patients out of the acute and into a community or home setting.

Phase 2 to identify the scope of partners and key stakeholders to implement a holistic assessment plan.

• To ensure cross organisational working, and a whole team approach, as well as determination of key skill sets within the team, for both health and social care.

• To secure their feedback to progress the model for the locality.

• To develop an action plan including timescales and key milestones.
• To roll out the new holistic integrated service plan, gaining feedback, monitoring uptake and making appropriate changes as required.

**Phase 3** to design best practice guidance and a training package to support the implementation of the plan.

• To produce draft guidance on implementing the new integrated team.
• To design a training package to support the implementation.
• To secure feedback in advance of the roll out of the guidance and training from key stakeholders.
• To be ready to roll out the training and guidance, gaining feedback, monitoring uptake and making appropriate changes as required.
• To develop a service model for delivery.

Planned outputs:

• To develop and implement a holistic person centred assessment plan for individuals and care practitioners to use.
• To provide clear guidance and training to ensure a consistent approach to assessments in Dorset.
• To create a co-ordinated health and social care team, reducing duplication and inefficiencies.

Planned outcomes:

• Number of hospital unplanned admissions.
• Length of stay.
• Preferred place of care achieved.
• GP, OOH contact.

**5.2.3 SOUTHAMPTON: ADVANCED CLINICAL PRACTITIONERS IN FRAILTY AND THEIR ROLE IN STREAMLINING THE PROCESS FOR THE RECOGNITION, MANAGEMENT AND DISCHARGE OF OLDER PATIENTS LIVING WITH FRAILTY**

Organisations: University Hospital Southampton (UHS) NHS Foundation Trust, Solent NHS FT, and Southampton City Clinical Commissioning Group (CCG). Aims:
• To define and implement a ‘frailty pathway’ that spans across 2 organisations (UHS NHS FT and Solent NHS FT).

• To develop a cross organisational frailty pathway within Southampton to inform the better management of frail older people across the city.

• To develop a business plan to inform the expansion of frailty pathways.

• To implement a standard method of comprehensive geriatric assessment (CGA) to identify, assess and manage frail patients.

  CGA is a multidimensional and inter-disciplinary diagnostic process to determine an individual’s capability in terms of holistic function and to develop a coordinated and integrated care plan for long term treatment and follow up.

• To provide education and training on the assessment and management of frailty to the multidisciplinary ‘frailty workforce’ team (MDT).

  For primary care teams (GPs), community-based teams (Matrons, Social workers, District Nurses, Therapists, Associate Practitioners and Older Person Mental Health teams), and hospital-based teams (emergency, older persons practitioners).

• To establish an information capture mechanism that can be shared amongst the MDT i.e. through existing IT systems.

• To develop a Virtual Learning Environment (VLE) module on frailty, sarcopenia and CGA.

• To develop an application for android and iPhone on frailty and CGA.

• To develop clinical and leadership expertise in key MDT personnel to oversee the assessment and planning processes for patients living with frailty within the acute setting as well as initiate follow up in the community setting.

• To work cross-organisationally with community follow up and use of frailty GPs.

• To collect and evaluate quantitative data on and qualitative data on patient experience of the pathway.

• To publish the findings of the pilot in peer reviewed journals.

5.2.4  LYMINGTON: THE ACUTE FRAILTY INTERVENTION TEAM (AFIT)

Organisations: West New Forest Vanguard, Southern Health NHS Foundation Trust and South Central Ambulance Service (SCAS). Aims:
January 19, 2018

- To provide a timely, effective multi-disciplinary community based response to patients presenting with decompensated frailty syndrome.

- To create a Mobile Triage Team ("Frailty Ambulance) that can visit patients at home and provide rapid on-site triage for illness and assessment of needs.

  This frailty ambulance will be staffed by a Paramedic or SCAS technician (who can perform a clinical assessment of the patient including ECG, and some near patient testing) and an ICT therapist or associate practitioner (for function or equipment assessment-including the immediate access to some equipment and review of immediate personal care needs). The frailty ambulance assessment will be fed back to the hotline via telephone.

- To create a Frailty hotline at Lymington New Forest Hospital that works with the mobile triage team to manage patients.

  Staffed by specialist clinicians (geriatrician, consultant frailty practitioner, specialist frailty GP).

- To provide on-going support and care for the duration of decompensation via the Integrated Care Team (ICT).

- To provide a comprehensive geriatric assessment (CGA) when the patient is stable to create a care plan.

Planned outputs:

- To allow older people with frailty access the support they need as soon as needed in a crisis.

- To avoid delays, repeated referrals, hand offs, recurrent triage and waiting times for different services. This will directly impact upon non-conveyed patients and alternative pathway for patients who are currently inappropriately conveyed

- To provide immediate clinical triage and assessment of the older person presenting in crisis by combined skills of SCAS and ICT therapist supported by a specialist frailty medic based in LNFH.

- To keep a Common Care Record for the period of decompensation and after comprehensive geriatric assessment a single integrated Care and Wellbeing Plan.

- To de-layer the traditional primary care/secondary care interface.

- To improve General Practice sustainability by impacting workload pressures (reducing unplanned emergency visits).
• To improve General Practice retention by providing an attractive, supportive option for career development (specialist frailty GPs will be part of the hotline).

• To reduce hospital admissions in the short-term by co-ordinated unhurried decision making by a specialised experienced team and in the long-term by care plan modelling.

5.3 PARTICIPANTS: HEALTH CARE STAFF GROUPS

Staff involved in the initiatives, including geriatricians, nurses, occupational therapists, physiotherapists, general practitioners, community nurses, and social care staff, will be invited by their project coordinator to participate in the focus groups. When staff cannot attend a group discussion, they will be offered the option of a phone interview where the same themes guiding the focus group will be used. Recruitment of participants will be managed by project coordinators.

5.4 DATA COLLECTION

Data collection started in May 2017 and was completed in January 2018. Observations, discussions, focus groups and interviews were arranged through the coordinator of each intervention. Consent to participate in the group discussions and focus groups was sought from participants at the start of the sessions. All group discussions and focus groups were recorded and transcribed verbatim. The participant names were anonymised and findings aggregated at the staff-group level, this is, quotes and conclusions for a staff-group (e.g. nurse practitioners, geriatricians, physiotherapists) would be from data collected in any of the four initiatives. The study design (scoping exercise at the beginning of the initiatives and focus groups six months later) allowed us to evaluate how well the initiatives were embedded in the services when winter pressures took effect and assess how thinking around training changed. Please see Table 1 for a full description of the methods utilised and the data collected for individual initiatives.

5.4.1 EXPLORATORY SCOPING EXERCISE: LITERATURE REVIEW, GROUP DISCUSSIONS, OBSERVATIONS, AND DOCUMENT ANALYSIS

An exploratory scoping exercise was conducted in the first 6 months of this evaluation study. Group discussions with staff were organised in all four settings. The objectives of the discussions were to becoming familiar with the settings of the four initiatives, understanding the processes linked to the frailty services under implementation, getting to know the staff groups, and developing the thematic framework that guided the analysis of the focus groups, telephone interviews and field notes from observations.
**TABLE 1: DATA COLLECTED ACROSS ALL PROJECTS.**

<table>
<thead>
<tr>
<th>Data collection activity</th>
<th>Salisbury</th>
<th>Weymouth</th>
<th>Southampton</th>
<th>Lymington</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observations of training</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>—</td>
<td>SCAS staff &amp; AFIT coordinator</td>
</tr>
<tr>
<td>Focus groups</td>
<td>Two</td>
<td>One</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>AFIT ambulance</td>
</tr>
<tr>
<td>Documents</td>
<td>CGA, discharge plan, end-of-study report</td>
<td>Frailty toolkit, leaflets, online frailty module, end-of-study report</td>
<td>End-of-study report</td>
<td>Frailty pathway, patient case-based scenario, end-of-study report</td>
</tr>
</tbody>
</table>

**Literature review**

A review of the literature on implementation of frailty pathways was completed to inform the topics that were going to be observed or explored in the focus groups and interviews. Databases and grey literature sources were searched to identify evidence on evaluating staff training initiatives linked to frailty pathways. A search strategy based on terms found in the literature [10, 5] was developed and used in three databases, namely: Embase [1996 to 2017 Week 19], MEDLINE(Ovid), and CINAHL (Ebsco). The key terms used were:

1. clinical pathways or critical pathways or care paths or integrated care pathways or case management plans or clinical care pathways or care maps
2. training or education or development
3. health care staff or clinicians or multidisciplinary teams or nurse or social worker or matron
4. evaluation or assessment
Search strategy in MEDLINE

1. (clinical pathways or critical pathways or care paths or integrated care pathways or case management plans or clinical care pathways or care maps).mp. [mp=ti, ab, hw, tn, ot, dm, mf, dv, kw, fx, nm, kf, px, rx, ui, sy]

2. (training or education or development).mp. [mp=ti, ab, hw, tn, ot, dm, mf, dv, kw, fx, nm, kf, px, rx, ui, sy]

3. (health care staff or clinicians or multidisciplinary teams or nurse or social worker or matron or community or general practitioner or gp).mp. [mp=ti, ab, hw, tn, ot, dm, mf, dv, kw, fx, nm, kf, px, rx, ui, sy]

4. (evaluation or assessment).mp. [mp=ti, ab, hw, tn, ot, dm, mf, dv, kw, fx, nm, kf, px, rx, ui, sy]

5. (frail or frailty).mp. [mp=ti, ab, hw, tn, ot, dm, mf, dv, kw, fx, nm, kf, px, rx, ui, sy]

6. 1 and 2 and 3 and 4

7. 5 and 6

The search strategy produced twelve studies relevant to clinical pathways and frailty. Two of the 12 studies were literature reviews that explored conceptual frameworks for training and education of healthcare staff outside frailty [9, 12]. Full review of the studies generated a list of five topics that were used as guiding questions during the group discussions. These topics were:

- what are the staff groups across health sectors (e.g. community, primary and secondary care) currently receiving training on frailty and what are the means in which the training is delivered?
- what are the methods (in place or planned) aimed at supporting change in practice from the training received?
- what learning materials on frailty are available to health care staff or the general public?
- are there learning resources currently in use that could be shared to show good practice of care?
- what are the mechanisms that will be used to measure or assess the impact of the initiative on patient outcomes?
Group discussions
Based on the key topics identified in the literature, they key questions that guided observations and group discussions were:

- 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?
- What training will be received to deliver the initiative?
- 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)
- In your view, how is staff development linked to the success of the initiative?
- What training support would help you to continue the initiative in the long-term?
- Are there local or national resources available that could be shared as good practice for the recognition, diagnosis and/or treatment of frailty?

Observations Observations consisted in visits to staff workplace (e.g. in community hospitals and short-stay wards), training sessions, nurses’ workshops and a day with the AFIT ambulance team. Field notes from these visits were made and analysed with the framework generated from the analysis of the data collected during the scoping exercise.

Document analysis The following documents were collected in order to interrogate the evidence on training strategies and topics for health care staff providing care to people living with frailty.

1. Quality standards for the care of older people with urgent / emergency care needs: the “Silver Book” (Multiple stakeholders including: Age UK, BGS, College of Emergency Medicine, RCN, Society for Acute Medicine, and others)
2. Fit for Frailty (parts 1 and 2) (British Geriatrics Society)
3. Safe, compassionate care for frail older people using an integrated care pathway (NHS England)

5.4.2 FOCUS GROUPS

Focus groups were conducted 6 months after the frailty initiatives had been implemented. Two focus groups were conducted between November 2017 and January 2018. Interviews were offered to staff who were not able to join the focus group session due to work commitments.

Based on the findings of the first set of group discussions, a second set of questions were prepared to guide the focus groups. These questions were:
1. If you have received training on frailty during the study, what elements of training have helped to the development of your role? What mechanisms and support have assisted your development?

2. What aspects of training do you think could be improved to better meet the needs of your role and your patients?

3. What training methods in the project are working particularly well?

4. What features of the project enable training?

5. 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?

6. Thinking back to when AFIT started, have changes to practice (linked to training) had a positive impact on the delivery of patient care?

7. Have you been able to assess or measure the difference that training has made to the patient?

8. 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/)?

### 5.5 DATA ANALYSIS

We adopted a thematic analysis approach [2, 8] to explore the data collected through group discussions, focus groups, observations, documents and telephone interviews. The findings were later explored under the light of the learning organisation features. This second stage
of analysis allowed us to identify key features of each intervention that align with the learning organisation theory and explore their success from that point of view.

5.5.1 THEMATIC FRAMEWORK

Insert thematic framework after scoping exercise. Briefly list the steps involved in conducting thematic analysis. Then describe the framework generated. For coding agreement, indicate that the initial coding was conducted by AR and corroborated with TM and MT.

5.5.2 FEATURES OF THE LEARNING ORGANISATION

Write here the features of learning organisations from the literature. Follow references [15] and [18]

1. Mission and vision
2. Leadership
3. Experimenting culture
4. Transfer of knowledge
5. Teamwork and co-operation

Also [1, 7]

6 FINDINGS

Go back to the aims of the study

• to identify staff delivering frailty care and the educational resources and training initiatives used by staff to deliver quality care

• to identify gaps in the training currently provided

• to make recommendations focused on improving the provision of frailty education and training for healthcare staff

• to explore the organisational characteristics leading to quality improvement in frailty
6.1 EVALUATING TRAINING INITIATIVES USING DATA FROM THE SCOPING EXERCISE

6.1.1 STAFF DELIVERING CARE TO PEOPLE LIVING WITH FRAILTY

Professions identified through the study

1. frailty GP
2. health and social care coordinator
3. integrated community lead for community care team
4. practice manager
5. community matron case manager
6. deputy community matron
7. social practitioner
8. senior practitioner in frailty
9. consultant practitioner
10. advanced nurse practitioner
11. nurse
12. physiotherapist
13. occupational therapist
14. therapy assistant
15. geriatrician
16. geriatric medicine registrar
17. paramedic
18. technician assessor in ambulance service

Add also the number of staff who has been participating (n=40 approx) Sources: NVivo files and ppt presentation of the meeting in October
6.1.2 TRAINING AND EDUCATION STRATEGIES FOR THE FRAILTY WORKFORCE ACROSS WESSEX

Training and education strategies for the frailty workforce

1. seminars for junior doctors (teaching programme in departmental meetings)
2. formal learning
3. interdisciplinary learning when working together
4. with geriatrician
5. from experience
6. from other initiatives
7. from other trusts or practices
8. learning during events/conferences (e.g. older people awareness days)
9. in teaching sessions for doctors or other staff
10. when preparing for appraisals
11. in ward or departmental meetings
12. brainwave session during tea

Topics on frailty that staff receive or would like to receive training on (in no particular order)

1. comprehensive geriatric assessment
2. DNAR
3. environmental factors that impact on frailty
4. Rockwood, electronic frailty index
5. identifying at-risk patients
6. Parkinson’s
7. dementia
8. falls
9. osteoporosis
10. rheumatologic problems in the elderly
11. polypharmacy

Add findings here: key source material, NVivo files and ppt presentation of the meeting in October

<table>
<thead>
<tr>
<th>Barriers</th>
<th>Opportunities</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. awareness of formal training-education initiatives available</td>
<td>1. Implement rolling training sessions</td>
</tr>
<tr>
<td>2. difficulties to find the time to attend training</td>
<td>2. buddy-system to promote interdisciplinary learning</td>
</tr>
<tr>
<td>3. lack of fixed schedule of training sessions</td>
<td>3. create or have more opportunities to reflect and discuss cases</td>
</tr>
<tr>
<td>4. uncertainty of training required</td>
<td>4. feedback staff groups from outcomes of cases</td>
</tr>
<tr>
<td>5. value given to personal-professional development and treating patients</td>
<td>5. in-service training</td>
</tr>
<tr>
<td>6. competence-based training (in development)</td>
<td>6. raise the skills of staff who becomes a 'link' between acute, primary and community for the patient</td>
</tr>
<tr>
<td></td>
<td>7. educating the patient about frailty</td>
</tr>
<tr>
<td></td>
<td>8. training new or care homes (non-clinical) staff</td>
</tr>
</tbody>
</table>

BARRIERS AND OPPORTUNITIES TO TRAINING AND EDUCATION.

6.2 SUCCESS AND SUSTAINABILITY OF THE FOUR INITIATIVES

This section presents first an analysis of the individual projects against their original aims, planned outputs and outcomes. The section ends with an overall review of success across the four initiatives.

- Salisbury. New frailty area in ED
- Weymouth Roll out of the tool kit training - get figures and data from the video
- Southampton To talk with Pippa and Rachel about it
- AFIT has been commissioned. Point out the differences between AFIT and the new service

6.2.1 Salisbury

6.2.2 Weymouth

The initiative in Weymouth was successful. Details of the objectives planned and how these were achieved can be seen in figure 2.

This is a very nice photo from some of the staff of the Weymouth team. I will see how it looks in figure 3. The team acknowledged the participation of Two Harbours healthcare, Weymouth and Portland frailty project team, Dorset HealthCare University Foundation Trust, and Dorset Clinical Commissioning Group.
<table>
<thead>
<tr>
<th><strong>Objectives</strong></th>
<th><strong>What the initiative delivered</strong></th>
<th><strong>Planned outputs</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>To agree a standardized approach to the identification and stratification of frailty across health and social care services within the Weymouth and Portland locality. For patients identified as frail, to develop a frailty framework, underpinned by a standardized assessment approach. To develop a training and education package to enable the standard identification and assessment to be consistently delivered, reviewed and monitored across Dorset.</td>
<td>Structure of multidisciplinary team meetings in GP practices with MDT Discussion Tool</td>
<td>A standard approach to the identification and stratification of frailty was met through the use of the Efi and MDT discussion tool. The Dorset Frailty Toolkit is now available in the Dorset CCG as the education and training package for the identification and management in the community of people living with frailty.</td>
</tr>
<tr>
<td><strong>Planned outcomes</strong></td>
<td>Implementation of process measures: Dorset Care Plan, complete CGA, Identification of patients with mild, moderate and severe frailty, complete Rockwood score</td>
<td>Implementation of complete CGA and Dorset Care plan enhances a holistic person-centred assessment plan. Rolling out of the Dorset Frailty Toolkit ensures that the standards are adopted consistently.</td>
</tr>
<tr>
<td>Number of hospital unplanned admissions. Length of stay. Preferred place of care achieved. GP, OOH contact.</td>
<td>Access to e-learning frailty module across Dorset CCG. The module is aimed at increasing frailty knowledge of all staff who come into contact with people living with frailty</td>
<td>Measurement of the impact of the initiative on the planned outcomes is ongoing.</td>
</tr>
</tbody>
</table>

**Impact**

The model and toolkit were adopted by Dorset HealthCare and the Dorset Clinical Commissioning Group. It is being rolled out as the gold standard of frailty work to be implemented in all localities over the next year.

**Next steps**

Creation of a Comprehensive Geriatric Assessment (CGA) template between primary and community services to reflect and enable the gold standard for the management of frailty in older people and a holistic, multidimensional, interdisciplinary assessment of an individual by specialists of multiple disciplines in older people’s health.

**FIGURE 2: OBJECTIVES AND OUTPUTS OF THE FRAILTY SERVICES IN DORSET INITIATIVE**
6.2.3 SOUTHAMPTON

6.2.4 LYMINGTON

6.3 IMPACT OF FOUR FRAILTY PATHWAYS ON PEOPLE LIVING WITH FRAILTY

Write this section using data from the presentations and materials sent by the projects

6.4 ORGANISATIONAL CHARACTERISTICS LEADING TO QUALITY IMPROVEMENT IN FRAILTY

Are the four initiatives showing characteristics of learning organisations?

FRAME 3: HIGHLIGHTS OF FINDINGS

Some text will be written here

7 RECOMMENDATIONS AND CONCLUSIONS

From initial findings, these are recommendations discussed with the teams
1. Establish a programme of rolling sessions of frailty topics with the goal of meeting the requirements of a competencies curriculum or a skills framework (valid locally, regionally or nationally)

2. Define skills of generic roles

3. Define skills of staff who links acute care with GP and community

4. Develop mechanisms to inform staff of education opportunities available

5. Set up feedback systems and opportunities for reflection

6. Develop materials for case-based learning seminars

7. Train staff on IT systems available, access profiles (read/write); promote use through analysis of cases with and without electronic CGAs recorded

8. Raise recognition of training being as important as treating patients (e.g. establishing a track and assessment programme)

**FRAME 4: HIGHLIGHTS OF RECOMMENDATIONS**

Some text will be written here
9 RESOURCES

1. CLAHRC Wessex webpage
2. Material from Weymouth (toolkit, video, leaflets, poster)
3. Material from AFIT (case study; pathway)
4. CGA from Southampton
5. CGA from Salisbury?
6. Other external: North Hants CCG

HIGHLIGHTS OF THE STUDY AND FUTURE WORK

Some text will be written here

PERSONAL DOMAINS INVOLVED IN FRAILTY.
References


