

## Healthy Ageing Programme Wessex Acute Frailty Audit

### 1.0 Executive Summary

Following on from the publication of the National Institute for Health Research (NIHR) Dissemination Centre 'Comprehensive Care: Older people living with frailty' themed review in 2017, the Wessex Acute Frailty Audit looks at the standard of care that is provided for a person living with frailty in our local acute hospitals.

The project was run by the Wessex Academic Health Science Network (AHSN) in collaboration with 8 acute trusts (covering 9 hospital sites) and a community hospital (which has some acute beds) to gain a regional understanding of care provision. The audit aimed to identify areas of good practice and also significant gaps in frailty identification, personalised assessment and care planning, and hospital wide provision of frailty training with an overall aim to regionally drive up standards of care and improve patient outcomes.

The audit and subsequent workshop identified gaps in frailty service provision and opportunities for service improvement across Wessex.

Two working groups have been convened by the Wessex AHSN Healthy Ageing programme as a result of the audit outcomes;

Planned outputs from these clinically led working groups include: -

- Development of Frailty awareness and training tools to support Tier 1 and Tier 2 Skills for Health Frailty Competency Framework<sup>1</sup> to be accessible to acute, community, and GP colleagues to support the concept of frailty awareness from "Board to Porter". It is also proposed to provide access to the material to patients, carers and family members.
- Development of a Wessex AHSN Gold Standard for frailty screening, capture of frailty identification, and the sharing of information with all clinical stakeholders (hints and tips)
- Development local case studies showcasing delivery of best practice for frailty screening, identification and sharing of information

The development and completion of the audit has also enabled the following opportunities:

- ***Sharing of knowledge and experience of the audit journey with other AHSNs and clinicians***
- ***Consideration of sharing the audit tool with other interested AHSN sites, with a view that the Wessex AHSN will seek consent to host the tool to enable national analysis.***

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<sup>1</sup> <https://www.skillsforhealth.org.uk/services/item/607-frailty-core-capabilities-framework>

- ***Provided a vehicle to promote the outputs of the service improvement projects to promote best practice and spread new initiatives both locally and nationally.***
- ***Provision of a platform to influence the national agenda with national frailty leads.***
- ***Showcased the collaborative working with Wessex AHSN and NHS Benchmarking to showcase and champion the audit work***
- ***Promotion of the frailty agenda in specialities outside of Medicine for Older People, “The frailty audit we did with the surgical team helped to make contacts and raise awareness” [Trust feedback]***

The Healthy Ageing Programme plan to re-audit acute trusts in 2020 and will enable measurement of improvement from the baseline audit in 2018.

## **2.0 Project Background & Introduction**

### **2.1 Context**

The NIHR themed review<sup>2</sup> provides strong evidence that management of frailty indices and Comprehensive Geriatric Review (CGA) can reduce harms e.g falls and admission to residential care.

However, it was found that there is:

- poor transfer of information between social care, primary care and secondary care
- low awareness of the frailty syndromes outside specialist older people’s services;
- only 42% of acute Trust undertake early CGA and not all care is patient-centred.

The Wessex Acute Frailty Audit aimed to capture information and evidence to baseline our local acute hospitals against best practice and to inform future service improvement activities to drive up the standards of care across Wessex.

The project has been a collaboration between the following organisations and representatives from the Wessex Healthy Ageing Programme Acute Sector Expert Group:

- Basingstoke and North Hampshire County Hospital
- Dorset County Hospital
- Health Education England
- Lymington New Forest Hospital
- NIHR Dissemination Centre
- Poole Hospital
- Queen Alexandra Hospital
- Royal Hampshire County Hospital
- The Royal Bournemouth and Christchurch Hospital

<sup>2</sup> <https://www.dc.nihr.ac.uk/themed-reviews/frailty-in-hospital-research.htm>

- Salisbury District Hospital
- St Marys' Hospital
- University Hospital Southampton
- NHS Benchmarking

## **2.2 NHS Benchmarking**

In tandem to the Wessex AHSN data collection, during July to September 2018, NHS Benchmarking collected high level organisation information as part of their national benchmarking return, “Managing older people in an acute setting and delayed transfers of care”<sup>3</sup>. This data set provided complementary information to the local data collection.

Wessex AHSN commissioned a Wessex cut of the data to complement findings from both data collections and to highlight the added value the local Wessex tool provided. All Trusts, with the exception of St Marys Hospital IoW, submitted an NHS Benchmarking return. Lymington New Forest Hospital was excluded from the national return as it is a community hospital.

The detailed analysis is provided in **Appendix D** and provides and organisational context to the local audit data.

## **2.2 Aim**

The purpose of the Wessex Acute Frailty Audit was to benchmark services against evidenced best practice for the identification and management of people living with frailty who are admitted to hospital, with the aim to reduce the unintended variation of care, therefore increasing the quality of care across the region.

## **2.3 Objectives**

To gain a regional understanding of frailty care provision by:

- Identifying areas of best practice
- Identifying gaps in frailty identification, personalised assessment and care planning, and hospital wide provision of frailty training
- Using benchmarking to identify local variation and to compare with nationally aggregated findings to facilitate service improvement.
- Identifying potential service improvement projects within and across the local geography

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<sup>3</sup> <https://www.nhsbenchmarking.nhs.uk/>

### 3 Methods

#### 3.1 Project development

To inform the Trusts about the project and to enable their NHS Benchmarking and Wessex Acute Frailty audit data to be shared with other organisations and benchmarked, all participating hospitals signed a letter agreeing to take part in both pieces of work and to share their information with the other participating organisations

During February – June 2018, a core group of the Healthy Ageing Programme Acute Sector Expert Group held regular meetings to develop the audit questions using Delphi methodology, utilising the themes of frailty screening, identification, management and awareness training which were identified in the NIHR Dissemination Centre themed review ‘Comprehensive Care; Older people living with frailty’ . The Acute Sector Expert Group validated the audit questions<sup>4</sup>.

During July – August 2018, the audit questions were trialled in The Royal Bournemouth and Christchurch Hospital and University Hospital Southampton using a spreadsheet template. The questions being rigorously reviewed for clarity and consistency using the Plan, Do, Study, Act Methodology (PDSA) methodology to finalise the questions.

Our approach aimed to obtain a snapshot for current practice rather than a comprehensive review. The final questions used for the audit are detailed in **Appendix A**.

It was agreed that the questions should be asked across the following clinical areas to highlight the variability within and across hospital settings. These included:

- Emergency Department (ED)
- Acute Medical Unit (AMU)
- Acute Frailty Unit (AFU)
- General Medicine (GM)
- General Surgery (GS)
- Medicine for Older People (MOP)
- Trauma and Orthopaedics (T&O)

In June 2018, it was agreed to use Online Surveys<sup>5</sup> for the audit due to its ease of administration and data collection as well as use within academic research. A unique feature of the online survey tool is the ability for multiple organisations to input the same survey to get answers to common questions or issues.

The audit tool was built during July 2018 using the agreed questions; a flow diagram (**Appendix B**) was developed to ensure that all questions held within the tool were captured for each specialty area.

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<sup>4</sup> <https://www.dc.nihr.ac.uk/themed-reviews/frailty-in-hospital-research.htm>

<sup>5</sup> <https://www.onlinesurveys.ac.uk/>

The audit tool was tested in Salisbury NHS Foundation Trust and University Hospital Southampton Foundation Trust between August and September 2018 to identify any process issues in data collection using the electronic tool.

There were no reported issues, and it was confirmed that the data collection process took no longer than 30 minutes to complete for each specialty area.

### **3.1 Data collection**

During October 2018, eight data collectors from across the participating hospitals were trained in the completion of the audit tool. The training was to ensure consistency of approach to the data collection and how questions were interpreted.

A definition document to support the terminology used in the tool was also supplied for reference to the data collectors as part of the training exercise and was also used to ensure consistency of understanding when completing the audit tool on the wards. **(Appendix C)**

The data collectors were asked:

- to contact clinical leads from a ward area in each speciality to arrange a mutually convenient time to meet
- to provide the clinical leads with an overview of the purpose of the audit
- to complete the audit on the ward to capture a real-time snapshot of practice to evidence the variability in process across specialities
- to keep a note of specific comments that would help provide further insight into current practice and plans as well as identifying barriers to change.

During October and November 2018, the audit tool was available for the trained data collectors to capture responses to the frailty audit questions.

### **3.3 Data Analysis**

In December 2018 and January 2019 initial analysis was undertaken by the Insight Team at the Wessex AHSN to identify key themes arising from the audit. The data was presented in the format of a benchmarking heatmap. This analysis was reviewed by Healthy Ageing Programme Acute Sector Expert Group and further analysed by the Healthy Ageing Programme. Participating Trusts were given the opportunity to validate their submissions. Three Trusts reviewed their submissions and made minor amendments.

Further detailed analysis was then undertaken by the Healthy Ageing Programme categorising the output into the themes of screening and identification, management and discharge, training and workforce. Data was split by speciality and benchmarked per Trust.

In tandem to the local analysis, NHS Benchmarking (NHSB) provided a Wessex cut of the national return “Managing older people in an acute setting and delayed transfers of care”<sup>6</sup>. The Wessex cut of the data

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<sup>6</sup> <https://www.nhsbenchmarking.nhs.uk/>

was provided via a peer group on the national benchmarking toolkit and a Wessex specific report. This provided further breadth and organisational context to the local audit. The NHS Benchmarking report was disseminated to all Wessex acute trusts.

The benchmarked trusts were anonymised but were given an identifiable code for their own hospital which matched their national NHS Benchmarking identifier.

The detailed analysis of the Wessex Acute Frailty Audit is detailed in **Appendix E**.

### ***3.4 Feedback to Trusts***

A joint workshop with NHS Benchmarking took place on 26th February 2019 to present the findings from both data collections. Frailty clinicians and senior executives from 7 of the acute trusts who participated in the audit attended the event. In addition, there was representation from Health Education England, National Institute for Health Research, NHS England, NHS Improvement, Public Health England and Oxford AHSN. Professor Martin Vernon (Clinical Director for Older People NHS England), Dr Adrian Hopper (Geriatric Medicine Clinical Lead for GIRFT (Getting It Right First Time)) Dawne Garrett (Royal College of Nursing Professional Lead for Older People and Dementia) were also in attendance. The NHS Benchmarking Network provided facilitation at the local event.

The workshop provided an opportunity for the data from the audit to be shared with frailty experts and key decision makers from across Wessex, and for the AHSN to showcase the added depth and value the local audit provided as well as enabling local acute hospital action planning and identification of service improvement projects to be identified to improve the quality of care of patients living with frailty.

## **4 Results**

### ***4.1 Caveats and assumptions***

The data collected in the audit tool are based in a snapshot in time and it is acknowledged that Trusts may have subsequently improved on initial audit findings.

The audit responses are also based on the auditor and view of staff on the ward completing the audit.

### ***4.2 Analysis***

100 % of Trusts completed the Wessex Acute Frailty Audit (9 acute hospitals and Lymington Hospital) covering 58 ward areas during October and November 2018. All Trusts with the exception of St Marys Hospital IoW also submitted an NHS Benchmarking return

Initial themed analysis of both the NHS Benchmarking return and the audit was carried out in December 2018 and January 2019, evidenced gaps and variation within and across hospitals and has identified opportunities for improvement particularly around training and identification and management of those patients living with frailty. This analysis was reviewed at the workshop.

#### 4.1 Identification and screening:

**Table 1** summarises high level findings from screening and identification questions in the audit tool. The questions presented in the table below relate to whether screening for frailty takes place within a setting and whether a frailty alert is recorded either in the patients notes or electronically, split by hospital and speciality.

Responses were colour coded according to responses e.g red = gap in process, amber = process happens sometimes, green= process embedded. Where there are gaps e.g white spaces this means that the question was not answered for that specialty area.

Emergency Department (ED)  
Acute Medical Unit (AMU)  
Acute Frailty Unit (AFU)  
General Medicine (GM)  
General Surgery (GS)  
Medicine for Older People (MOP)  
Trauma and Orthopaedics (T&O)

This format was used for each table.

**Table 1: Wessex Acute Frailty Audit – Comparison of Hospitals Specialities: Screening and Identification**

Site	AFU		AMU		ED		GM		GS		MOP		T&O	
	Screening	Frailty Alert	Screening	Frailty Alert	Screening	Frailty Alert	Screening	Frailty Alert	Screening	Frailty Alert	Screening	Frailty Alert	Screening	Frailty Alert
MF138			Always	Yes	Always	Yes	Sometimes/Never	No	Always	No	Sometimes/Never	Yes	Sometimes/Never	No
MF125			Sometimes	No	Always	Yes	Always	No	Sometimes/Never	No	Sometimes/Never	No	Sometimes/Never	No
Site A			Sometimes	No	Always	No	Sometimes/Never	No		No			Sometimes/Never	
MF170	Sometimes	No	Sometimes	Yes	Sometimes	No	Sometimes/Never	No	Sometimes/Never	No		No	Sometimes/Never	Yes
MF139	Always	Yes	Never	Yes	Sometimes	Yes	Sometimes/Never	Yes	Sometimes/Never	No	Sometimes/Never	Yes	Sometimes/Never	No
MF244	Always	No	Sometimes	No	Sometimes	No	Sometimes/Never	No	Sometimes/Never	No	Sometimes/Never	No	Sometimes/Never	No
MF176			Sometimes	No	Never	No	Sometimes/Never	No	Sometimes/Never	No	Sometimes/Never	No	Sometimes/Never	No
MF169	Never	No	Sometimes	No	Sometimes	No	Sometimes/Never	No	Sometimes/Never	No	Always	No	Sometimes/Never	No
MF196			Sometimes	No	Never	No	Sometimes/Never	No	Sometimes/Never	No	Sometimes/Never	No	Sometimes/Never	No
Site B			Sometimes	No			Sometimes/Never	No		No				

The table above illustrates the variability in screening and identification of frailty;

- Specialties other than at the front door (e.g. AFU, ED and AMU) do not routinely screen for frailty., In some front door departments, screening only happens “sometimes”
- Only one trust uses a frailty alert flag in the patient’s records to identify patients living with frailty within an acute frailty unit setting and only three trusts use a frailty flag within an ED setting

- The most frequently used screening tool is the Rockwood Clinical Frailty Score (CFS)<sup>7</sup> followed by the presence of more than one of the frailty syndromes. Other tools are also used to screen patients.<sup>8</sup>
- Patients living with frailty are not routinely flagged in a patient record; where they are flagged, this is not electronic or shared with other healthcare professionals

Workshop delegates were assigned to small groups to review the findings; to identify examples of best practice and areas for opportunity and improvement. The themes from this session included:-

- Requirement for consistent screening on admission across all settings
- Inclusion of a frailty score in discharge letters with GP and patient
- Flagging of frailty is key and should follow the patient
- Access to community records key to ensure consistent care

The identification of these themes are key in improving the delivery of care to patients living with frailty and illustrate the need and the importance of embedding screening across Wessex.

Screening is important to ensure that the patient receives the most appropriate care in the correct setting.

These findings support Romero et al (2015)<sup>9</sup> paper looking at the association of the Clinical Frailty Score (CFS) with hospital outcomes and conclude that the score, “captures complexity risk and helps target specialist geriatric resources within a hospital”.

#### **4.2 Management and Discharge:**

**Table 2** summarises high level findings from the management and discharge questions in the audit

The questions in the table below relate to whether a Comprehensive Geriatric Assessment (CGA) is carried out within each setting. CGAs should include a holistic approach using personalised problem list to generate a frailty care plan and should involve both patients and carers; the table provides a snapshot as to whether this happens within each setting in each Trust.

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<sup>7</sup> <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1188185/>

<sup>8</sup> <https://ihub.scot/media/1742/frailty-screening-and-assessment-tools-comparator.pdf>

<sup>9</sup> Romero et al (2015) Association of the clinical frailty score with hospital outcomes; QJM: An international journal of Medicine 205 Vol 0

**Table 2: Wessex Acute Frailty Audit – Comparison of Trusts, Specialities: Management and Discharge**

Site	AFU				AMU				ED				GM				GS				MOP				T&O				
	CGA Carried out	Holistic personalised problem list and frailty care plan	Involves patients and carers in planning		CGA Carried out	Holistic personalised problem list and frailty care plan	Involves patients and carers in planning		CGA Carried out	Holistic personalised problem list and frailty care plan	Involves patients and carers in planning		CGA Carried out	Holistic personalised problem list and frailty care plan	Involves patients and carers in planning		CGA Carried out	Holistic personalised problem list and frailty care plan	Involves patients and carers in planning		CGA Carried out	Holistic personalised problem list and frailty care plan	Involves patients and carers in planning		CGA Carried out	Holistic personalised problem list and frailty care plan	Involves patients and carers in planning		
MF138				Yes	Always	Always	Yes	Yes				No				No				Yes	Always	Always	Yes	Always	Always	Yes	Always	Always	
M125				Yes	Sometimes	Always	Yes	Sometimes				Yes	Sometimes	Always	Yes	Sometimes	Always	Yes	Sometimes	Always	Yes	Sometimes	Always	Yes	Always	Always	Yes	Always	Always
Site A				Yes	Never	Never	Yes	Sometimes				No			No										No				
MF170	Yes	Always	Always	Yes	Sometimes	Always	Yes	Sometimes				Yes	Always	Always	No					Yes			Yes	Sometimes		Yes	Sometimes		
MF139	Yes	Sometimes	Always	No			Yes					No			No					Yes	Sometimes	Sometimes	Yes	Never	Always	Yes	Never	Always	
MF244	Yes	Always	Always	Yes	Always	Sometimes	Yes	Sometimes				No			Yes	Always	Always			Yes	Always	Always	No			Yes	Sometimes		
MF176				No			No					No			No					No			No			No			
MF169	Yes	Always	Always	No			No					No			No					Yes	Sometimes	Always	No			Yes	Sometimes		
MF196				Yes	Sometimes	Always	No					No			No					Yes	Sometimes	Sometimes	No			Yes	Sometimes		
Site B				No								No																	

Analysis of these themes found that;

- 1/3 of wards always involve the patient/next of kin as standard practice during the discharge process.
- Outside of Medicine for Older People wards and some Emergency Departments and Acute Medical Units, Comprehensive Geriatric Assessments (CGAs) are not routinely carried out
- CGA's rarely involve patient or carer input.
- Most Trusts and wards do not make reference to a frailty plan in the patients discharge summary

Workshop delegates shared ideas to improve the management of frailty across Wessex. The themes from this session included:

- Involve patient and carers in decision making and management
- Electronic accessibility to Comprehensive Geriatric Assessment (CGA) key. Where CGAs are completed, they are often are completed on paper and held within the patients notes and not always shared with any other healthcare professionals within the Trusts or colleagues within the community
- A Patient centred frailty passport may help with the sharing of information across setting,

***“A unified IT system owned by the patient and accessible to anyone in primary and secondary care with seamless transactions between the two to enable clinicians to access complex history and to view CGAs!” [Trust feedback]***

The identification of these themes is integral in improving the delivery of holistic care to patients. In particular;

- The British Geriatrics Society (2014) suggests that, “Any interaction between an older person and a health or social care professional should include an assessment which helps to identify if the individual lives with frailty”<sup>10</sup>
- Comprehensive Geriatric Assessment (CGA) by a multidisciplinary team and follow-on care planning reduces the number of people who are unexpectedly readmitted to hospital. CGA also increases the likelihood that an older person will be living in their own home up to twelve months later. For every 20 people assessed in this way, one long-term care home placement can be avoided.<sup>11</sup>
- Person-centred care is one of the 13 fundamental standards of care that the Care Quality Commission (the independent regulator of health and social care in England)<sup>12</sup> requires healthcare providers to meet. Delivering person-centred care involves caring for patients beyond their condition and tailoring care suit their individual wants and needs.
- NIHR research co-produced with patients found that poor discharge planning caused considerable stress to families, and they recommend a mutually agreed written discharge plan<sup>13</sup>
- Vital information is not shared with other healthcare professionals to support the patients ongoing care within the hospital and within the community. Having a portable digital solution, owned by the patient may help overcome present information sharing issues.

#### **4.3 Workforce and training:**

**Table 3** summarises high level findings from the workforce and training questions in the audit tool.

The training questions were supplemented with 5 follow up questions to qualify the answers further. These are detailed in **Appendix F**.

The questions relate to how frailty training is provided within each organisation, whether it is mandated and where it is delivered whether this is face to face or online;

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<sup>10</sup> <https://www.bgs.org.uk/resources/introduction-to-frailty>

<sup>11</sup> <https://www.bgs.org.uk/resources/nihr-themed-review-comprehensive-care-for-older-people-living-with-frailty-in-hospitals>

<sup>12</sup> <https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-9-person-centred-care>

<sup>13</sup> <https://www.dc.nihr.ac.uk/themed-reviews/frailty-in-hospital-research.htm>

<sup>14</sup> National Audit office (2016). Discharging older patients from hospital. <https://www.nao.org.uk/report/discharging-older-patients-from-hospital>

**Table 3: Wessex Acute Frailty Audit – Comparison of Trusts, Specialities: Workforce and Training**

Trust			AFU		AMU		ED		GM		GS		MOP		T&O	
Is Frailty training part of Trust induction?	If training is provided is it mandatory?	Frailty training carried out?	Format of training	Frailty training carried out?	Format of training	Frailty training carried out?	Format of training	Frailty training carried out?	Format of training	Frailty training carried out?	Format of training	Frailty training carried out?	Format of training	Frailty training carried out?	Format of training	
MF138				No		Yes	Face to Face	Don't know		No	Face to face	Yes		Don't know		
MF125				Yes	Face to face, Lectures and Workshop	Yes	Face to face, Lectures and Workshop	Yes	Face to face, Lectures and Workshop	Yes	Face to face, Lectures and Workshop	Yes	Face to face/online	Yes	Face to face Workshop	
Site B				Yes				Yes								
MF169	No	No	Yes	Face to face	No	No		No		No		Yes	Face to Face	Yes	Face to face	
MF170	No	No	No		Yes	Face to face	Yes	Face to Face	No		Yes	Face to face	Yes	Face to Face	No	
MF244			Yes	Face to face	Yes	Face to face	Yes		No		Yes	Face to face	Yes	Face to Face	No	
MF139			No		No		Yes	Face to Face	No		No		No		No	
MF176	No	No			Yes	Face to face	Yes	Face to Face, Lectures	No		No		No		No	
Site A	No	No			Yes		Yes		No							
MF196					Yes	Face to face	No		Don't know		No		Yes	Face to face	Yes	Face to face

The audit and follow up questions identified the following themes;

- Frailty training and awareness is not mandatory or included in induction programmes
- There is presently no requirement for Trusts to deliver induction or mandatory training relating to frailty.
- If training is provided it is carried out face to face with small groups of staff
- Information on who has carried out training and taken part in the training is not routinely held within organisations
- Some good examples of developing training modules in a number of Trusts cited but still at early stages
- Good access to Frailty Teams within the Emergency Department, Acute Medical Units and Medicine for Older People wards, but variable access in General Medicine and General Surgery wards.
- However, access to Frailty teams can be variable in and out of hours. Some teams offer a 7 day /12 hour service others a more limited 5 day service
- Frailty awareness and training is everyone's' business from 'Board to Porter'
- Mandatory, tiered training to reflect colleagues needs and competencies required to deliver effective care to those living with frailty
- Consider role of Universities in delivering undergraduate training in frailty; Undergraduate nurses and junior doctors are not routinely taught the concept of frailty

The identification of the themes illustrates the need for formalised training and is important as;

- The lack of mandatory, formalised, structured training means that colleagues are unable to access standardised training (appropriate to their role need), resulting in patchy awareness and knowledge.
- The development of a standard approach to training will enable accessibility to all staff groups and increase awareness of frailty across the region with the potential for better care for patients living with frailty.

***“ More education is needed for the detrimental effect of leaving patients in bed for prolonged periods of time and the long term effect this can have on frail patients, making it harder to get back to their baseline and with the additional cost to the Trust increased length of stay” [Trust feedback]***

***“Better knowledge around frailty and frailty specialist training for multidisciplinary team [ Trust Feedback]***

Collaboration with local universities will be important development of the undergraduate curriculum will ensure that emerging workforce will understand the importance of recognising frailty<sup>15</sup>

### **5.0 Next steps:**

In March 2019, the Acute Sector Expert Group met to review the outputs from the workshop and agreed that two working groups would be convened to:

- Review existing materials and develop frailty training and awareness tools for use Wessex wide
- Review tools available to screen and identify frailty, with a view to promote a suite of tools and approach for use across the Wessex geography.

In tandem to this, projects arising from the workshop from the participating Trusts will be shared via the Healthy Ageing Programme Acute Sector expert Group to allow group learning and to identify projects with potential for wider adoption.

Support from Trust Executives, STPs, and Health Education England will be sought to deliver these objectives as and when required by the working groups.

### **6.0 Recommendations**

The following steps are also recommended to enhance the audit tool and learning from the project:

- ***Review of audit questions to identify questions to be removed/modified***
  - Whilst the final analysis utilised all of the data collected, some questions did not provide any added value to the baseline questions.

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<sup>15</sup> [https://www.kingsfund.org.uk/sites/default/files/field/field\\_publication\\_file/the-care-of-frail-older-people-with-complex-needs-mar-2012.pdf](https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/the-care-of-frail-older-people-with-complex-needs-mar-2012.pdf)

- ***Update of options to include whether practice is standard/non-standard and to identify hours of practice***
  - Feedback from the data collectors found that the use of, “yes”, “no” and the options of “always”, “sometimes” and “never” did not always provide an adequate reflection of practice within a setting. For example, in an Acute Medical Unit it maybe standard practice to have access to a frailty team Monday to Friday, but not always at weekends; the tool did not allow this to be captured.
- ***Review of analysis/output to streamline and enable key messages to be easily conveyed***
  - The resultant analysis from the output tool was difficult to manipulate and interpret. A review of tool to present the output is required to ensure efficiency of data collection to enable more effective presentation of the data at the end of the audit.
- ***Agreement to run audit on a bi-annual basis to ensure improvements are evidenced***
  - The Wessex Acute Frailty Audit tool has provided a baseline for all of the local acute trusts in how they are screening, identifying, managing frailty and delivering training. The supporting working groups will provide a vehicle to drive service improvements forward. The running of the audit bi-annually will enable these changes in practice and improvements to be measured and clearly evidenced.
- ***Sharing of knowledge and experience of the audit journey with other AHSNs***
  - Our experience in developing the tool will help inform other AHSNs and localities approaches and to build a national picture of delivery.
- ***Sharing of tool with other interested AHSN sites, with a view that the Wessex AHSN will seek consent to host the tool to enable national analysis.***
  - This will enable the Wessex AHSN to pull together a national view of the results from the key themes in the audit.
- ***Continue to promote the outputs of the service improvement projects to promote best practice and spread new initiatives.***
  - The Wessex AHSN will provide a vehicle to support local Trusts in the delivery of key workstreams identified in the workshop event. These include training and awareness in frailty from Board to Porter and the review of frailty screening tools, as well as sharing the outputs from local service improvement projects. Further research on the impact of the impact of the frailty educational tool development will be explored.
- ***Explore linkage and opportunities for influencing the national agenda with national frailty leads***
  - With the publication of the NHS Long term plan<sup>16</sup>, this project links into one of the three national priorities for older people relating to quality improvement for existing acute and community services to ensure people get the appropriate care when they need it.
- ***Continue to build on the relationship with NHS Benchmarking to showcase and champion the Wessex AHSN audit work***
  - Collaboration with NHS Benchmarking has enabled the programme to evidence the added value the local audit can provide to the national NHS Benchmarking data return to inform local decision makers in areas for improvement. It has provided a communication platform

<sup>16</sup> <https://www.longtermplan.nhs.uk/>

to share the audit tool development and output to a wider audience and it is envisaged this relationship will continue for future iterations of the project.

- The Acute Sector Expert group will continue to encourage local Trusts to participate in the NHS Benchmarking Network annual data return to demonstrate progress across baseline metrics identified in 2018.
- **Development of a Wessex Community Frailty Audit**
  - Following on from the Wessex Acute Frailty Audit , key clinical stakeholders from the Healthy Ageing Programme’s Acute and Community and Primary Expert Groups expressed the need for a complementary Community Frailty Audit ensuring a whole system review of how best practice is currently implemented across the region for the identification of those people living with frailty, and the subsequent holistic assessment and care planning. The audit will be run September - October 2019.

## 7.0 Acknowledgements

The Healthy Ageing Programme would like to acknowledge the support, drive and enthusiasm by the core working group in developing this innovative audit:

John Duffy	Consultant Physician Royal Hampshire County Hospital
Lucy Lewis	Consultant Practitioner Trainee Health (Frailty) Education England
Pippa Collins	Clinical Doctoral Research Fellow/Advanced Practitioner Frailty, UHSFT
Caroline Wade-Smith	Lead Physiotherapist, Older Person Assessment and Liaison Team, Salisbury

A further thank you is extended to the other members of the sub-group and the wider Acute Expert Group in supporting the audit and to the data collectors in each Trust.

## Version Control

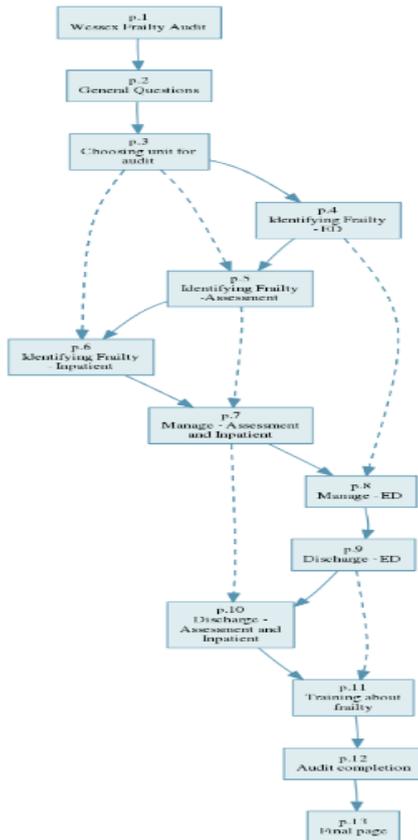
Version	Date	Author	Comment
V1.0	17 <sup>th</sup> May 2019	Cheryl Davies	Final Version

## 6.0 Appendix A : Wessex Acute Frailty Audit Questions



Wessex AHSN  
NHSBN Wessex Acute

## Appendix B: Wessex Acute Frailty Audit Flow Diagram



## Appendix C: Definition document



Definitions for Audit  
v1.docx

## Appendix D : NHS Benchmarking Data Analysis



Managing Frailty  
Wessex summary rep



Managing Frailty  
Wessex AHSN summa

## Appendix E: Wessex Acute Frailty Audit Summary of output



Wessex Acute Frailty  
Audit Summary Sprea

## **Appendix F: Frailty Training: follow up questions**

1. Contact details of your training/awareness lead for Frailty within your Trust
2. The type of frailty training that is provided e.g. level of detail and whether it differs depending on audience e.g. HCAs receive X training, AMU Nurses Y training.
3. Is the training mandated for all colleagues?
4. Does any frailty training/awareness take part in Trust induction?
5. How frequently this training is carried out?
6. How do colleagues find out about the training? How many colleagues have attended these training/awareness sessions over the past year (January 2018 – January 2019)