Falls, frailty and care and support planning

Pilot feasibility across Newcastle and Gateshead CCG

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Executive Summary

This successful Academic Health Science Network (AHSN) study which brought together implementors and evaluators demonstrated that the identification and prevention of falls is feasible as part of routine care and support planning (CSP) for people with (largely) mild and moderate frailty. It enables falls detection and prevention to be included as routine parts of a wider approach to holistic care. Modified pathways, resources, training and support for general practice teams are now available, and important lessons for implementation have been identified.

CSP is a systematic approach to providing the space for a 'better conversation' between a prepared person and a trained practitioner which brings together all the issues the person may live with, and includes prevention. CSP is forward looking and solution focussed, and combines traditional clinical issues with support for problem-solving during day to day living. Practical modifications and specific training developed for this project enabled issues of falls and frailty to be included in CSP, with reported benefits for patients and staff.

The Regional Frailty Framework reports that local communities have most to gain from proactive prevention and intervention. Previous studies have focussed either on those with severe frailty or identified high risk cohorts for one-off preventive intervention. This project provides the first step of an exploratory phase of learning about how to incorporate early intervention within routine general practice settings.

Specific learning about CSP for falls and frailty

1. The study cohort involved 2,061 people over the age of 65 with a clinically validated frailty score attending 1 of 7 general practices with diverse populations, organisational arrangements and record systems. This ensured that the learning could be generalised.
2. While the project has not defined with confidence the overlap between those with frailty, long term conditions (LTCs) and CSP, headline figures show that at least half of those in this target group for falls are already seen as part of CSP in Newcastle and Gateshead Clinical Commissioning Group (NGCCG). This suggests that CSP potentially provides a practical vehicle for introducing a systematic approach to regular review and preventive activities for frailty and falls in general practice.
3. The study also suggested that where practices included a greater percentage of their population with LTCs more of those in the falls risk group would be automatically included. However, including those over 65 with or without frailty who do not have LTCs will require further resource, and further research, to clarify the falls risk here.
4. Enabling staff to probe issues of falls including balance, trips and slips etc. identified a group of people, previously unidentified, for whom measuring lying and standing BP revealed postural hypotension and resulted in a focus on their medication. Whether this reduces the risk of falls in this group needs further study.
5. Staff were positive about the training, their experience and the relevance of including issues of frailty and falls in CSP processes.
6. Training and learning in-practice led to an increase in staff understanding about falls as an issue, including their knowledge and confidence in talking about frailty and falls which some said they were extending across their other work.

7. Some staff expressed lack of confidence/awareness of available options for referral and community support (such as strength and balance classes). Some staff needed support in order to describe the sessions and how patients would benefit.
8. Patient views on issues and challenges of ethnicity were not sought at this stage but would need to be examined in the future.

Specific learning about wider introduction/spread

1. Practice teams were able to get up and running quickly and contribute important insights to the project because they were already experienced in running CSP routinely in their practices as part of a NGCCG Local Incentive Scheme (LIS). The pilot activity consisted of additional falls questions during the CSP process and people's responses to these. Practices without this background would require greater time and resource to implement the changes.
2. A training programme in falls and frailty was developed. The key modules could be delivered to groups or in-practice. In-practice delivery (the preference of staff) addresses practice variation while group learning provides powerful peer learning and problem solving.
3. Practical challenges and solutions such as measuring lying and standing BP were routinely identified but would need to be specifically addressed in training with new practices.
4. All practices expressed a need for ongoing in-house support in addition to initial training to iron out specific issues and build on early learning.
5. A key observation was that the culture, organisation and approach to team working in some practices made it easier to incorporate the project changes than in others who required more intensive individual and 'just in time' input.
6. Greater availability of, and information about, community support would need to be addressed by the CCG if all the benefits of CSP are to be realised.

1. Purpose of the project

The aim of the pilot programme was to develop and evaluate the inclusion of falls assessment and prevention (in the context of frailty) within existing care and support planning processes (CSP) in general practice; and to inform a local incentive scheme (LIS) articulating the learning for use by the CCG and across the region.

2. Background

Frailty is a key issue in current healthcare delivery and falls is an important component. The number of people living with frailty is increasing year on year, placing an increasing burden on our health and social care systems. So far, research has involved separate programmes of work aimed at identifying those at high risk of falling or working with those with advanced levels of frailty. This project aims to focus on early prevention by linking falls and frailty as part of routine care in general practice using CSP.

2.1 Frailty and falls

Frailty, as a functional state, has the features of a long-term health condition characterised by loss of physical, emotional and cognitive resilience as a result of the accumulation of multiple health deficits[1]. An individual living with increasing frailty is more vulnerable to poorer health outcomes, even from a minor illness or stressor event[2]. Severe frailty can be relatively easy to identify however lesser degrees of frailty where intervention may be important[3] can be difficult to recognise. Early signs of developing frailty may include loss of muscle strength, "slowing up" in everyday life and reported falls[4].

There is an increasing body of research aimed at understanding falls and the associated risk factors. Those living with frailty are at higher risk due to declining mobility and lower reserves[1]. Other common risk factors include polypharmacy, nutritional compromise, alcohol intake, environmental hazards and functional decline[5]. These may be modifiable through interventions such as medicine review, environmental assessment and participation in targeted exercise[6].There is a significant body of research that supports strength and balance training both in preventing falls and ameliorating frailty[7,8,9]. This suggests that discussing and addressing potential risk factors as part of a preventative approach to supporting older adults to 'age well' could offer considerable benefits.

2.1.1 Recording of frailty in general practice

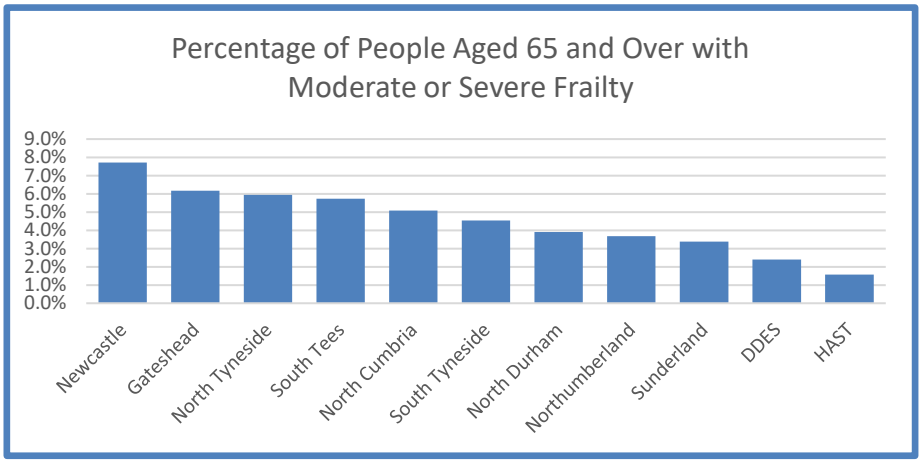
The eFI (Electronic Frailty Index)[10] uses 36 items available in GP electronic health records and is updated continuously. Half of these items are indirectly or directly related to the presence of a long-term condition. The score can be used to indicate mild, moderate or severe frailty and correlates with vulnerable health status in the elderly. GP practices are required to identify the category for each registered person over 65 years. The Clinical Frailty Scale[11] (CFS) is a functional scale which broadly maps to the eFI but which practices have found is a more useful tool to identify frailty in routine care with most practices now validating and recording the frailty status of an individual using the CFS. This is the approach used in this project and referred to as the 'Rockwood' scale by some practices.

[1] British Geriatrics Society 2020

2.2 Regional context

Newcastle and Gateshead incentivise the search for, and report the greatest numbers of, those living with moderate or severe frailty in the region (Figure 1).

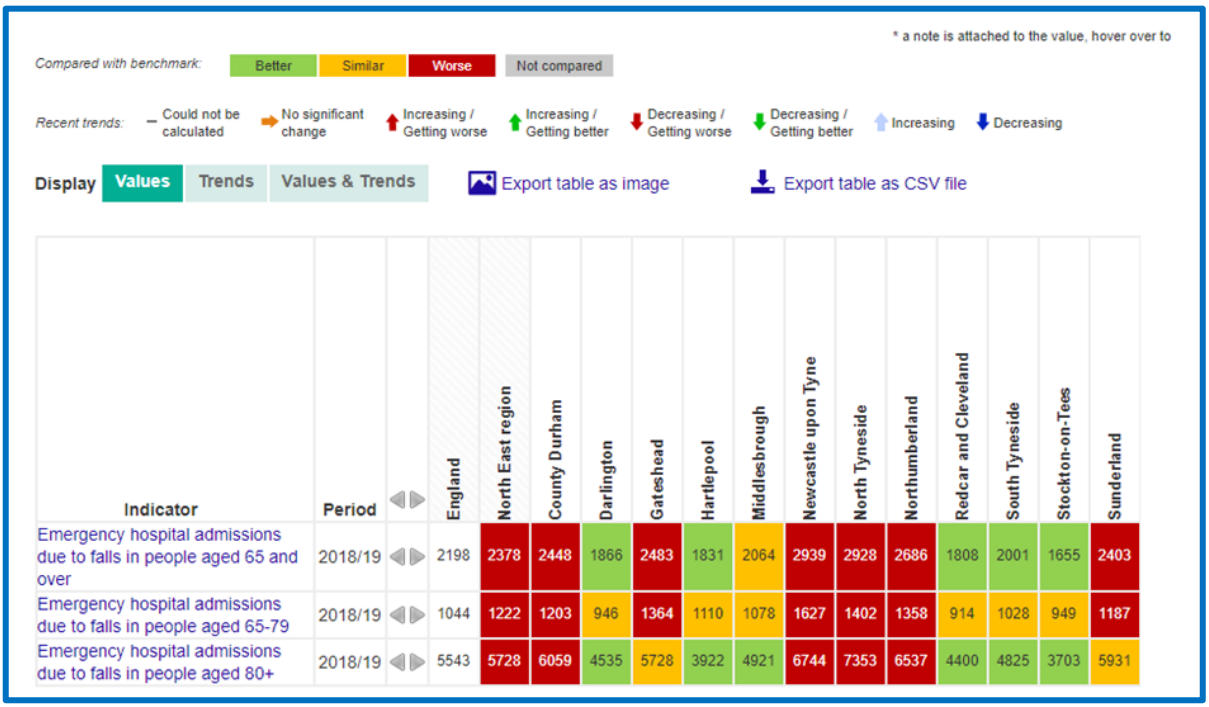
Figure 1: Frailty and falls in the North East of England



Source: North of England Commissioning Support Unit (NECS), March 2020.

Falls as a recognised frailty feature follow this trend. Figure 2 shows the number of emergency admissions due to falls which are significantly higher than the national average. This will inevitably create considerable burden on the local health and social care system.

Figure 2: Emergency admissions due to falls in those aged 65 and over (per 100,000 of the population)



Indicator	Period	England	North East region	County Durham	Darlington	Gateshead	Hartlepool	Middlesbrough	Newcastle upon Tyne	North Tyneside	Northumberland	Redcar and Cleveland	South Tyneside	Stockton-on-Tees	Sunderland
Emergency hospital admissions due to falls in people aged 65 and over	2018/19	2198	2378	2448	1866	2483	1831	2064	2939	2928	2686	1808	2001	1655	2403
Emergency hospital admissions due to falls in people aged 65-79	2018/19	1044	1222	1203	946	1364	1110	1078	1627	1402	1358	914	1028	949	1187
Emergency hospital admissions due to falls in people aged 80+	2018/19	5543	5728	6059	4535	5728	3922	4921	6744	7353	6537	4400	4825	3703	5931

Source: Public Health England. Public Health Profiles. [July 2020] https://fingertips.phe.org.uk © Crown copyright [2020]

Prevention, early assessment and appropriate management of frailty is a strategic priority for the North East and North Cumbria Integrated Care System (NENC ICS) and the AHSN which is supporting it. These issues have been brought together in a comprehensive approach (iCARE)[2] and community of practice to promote and support real life implementation of evidence-based practice in the North East and North Cumbria. This strategy recommends CSP as best practice for frailty, however there is relatively little known about how to introduce this systematically as 'business as usual' across primary care.

Dedicated workstreams have been established to focus on falls and frailty prevention across Newcastle and Gateshead. As part of this work, it was recognised that those living with single and multiple long-term conditions (LTCs) form a specific group who may benefit from a preventative approach to falls and frailty. Many already receive routine care within general practice. A local incentive scheme (LIS) includes verification of frailty status for those over 65 years and person centred, proactive CSP using the Year of Care approach for many of those with multiple conditions. This created an opportunity to explore a systematic approach to falls and frailty, within the context of meaningful discussions around prevention and self-management.

Our aim was to test the feasibility of introducing prevention, assessment and proactive management of falls within the context of frailty into existing CSP processes as an evaluated pilot project, prior to incorporating the learning into the design of an incentive scheme across NGCCG. Also, how to introduce CSP for people with frailty more generally.

2.3 Who is Year of Care Partnerships?

Year of Care Partnerships (YOCP) is an NHS organisation, based within Northumbria Healthcare NHS Foundation Trust (NHCFT), set up to offer commissioners and providers expertise, practical support and training to introduce CSP into routine practice for people with LTCs as part of a whole system approach. The team designed the initial Year of Care (YOC) Programme and have over a decade of experience of further development and implementation, providing training and support to embed the organisational and cultural changes required.[12]

2.4 What is Care and Support Planning?

CSP is a systematic approach to providing the space for a 'better conversation' between a prepared person and a trained practitioner which brings together all the issues a person may live with and includes prevention. It is forward looking, and solution focussed and brings together traditional clinical issues with support for self-management and problem-solving during day to day living, including the opportunity to link with supportive activities in the community (social prescribing)[13].

In order to implement CSP GP practices reorganise care pathways to include a comprehensive data gathering appointment with a health care assistant (HCA) in which all screening, assessments, tests and tasks are completed for any condition the person lives with or is at risk of developing. IT templates are used to record information and when all routine data has been returned from laboratories and triaged by the practice it is sent to the patient by a member of the administrative team in a pre-formatted preparation prompt/letter. This happens around 1 week before the CSP conversation with

[2] iCARE: A Regional Frailty Toolkit – preventing frailty and supporting older people, carers, families and communities living with frailty 2018

the nurse or GP and gives the person an opportunity to think about the questions, concerns and ideas that they wish to discuss with the health care professional during the conversation.

The aim of the CSP conversation is to ensure that what matters most to the person (patient) is discussed alongside any professional concerns that have been identified. The conversation has a particular style and flow with the practitioner taking on the role of 'facilitator' rather than 'fixer'.

The 5 steps of CSP are summarised in Figure 3 and the detail of the process and consultation framework in Figure 4.

Figure 3. The 5 steps of the CSP approach

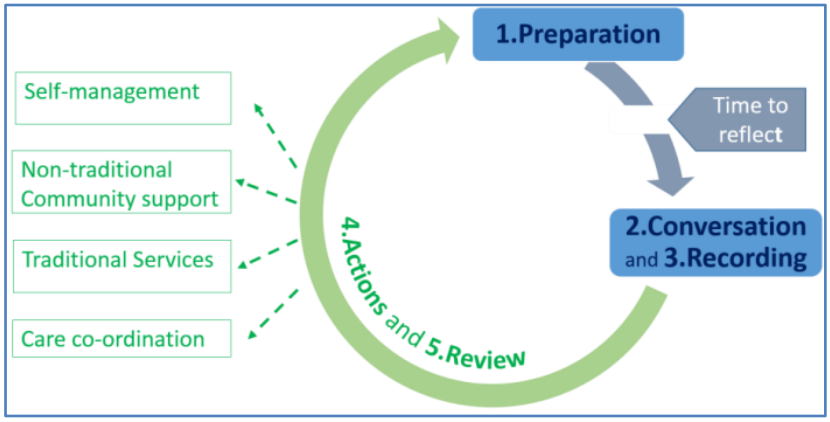
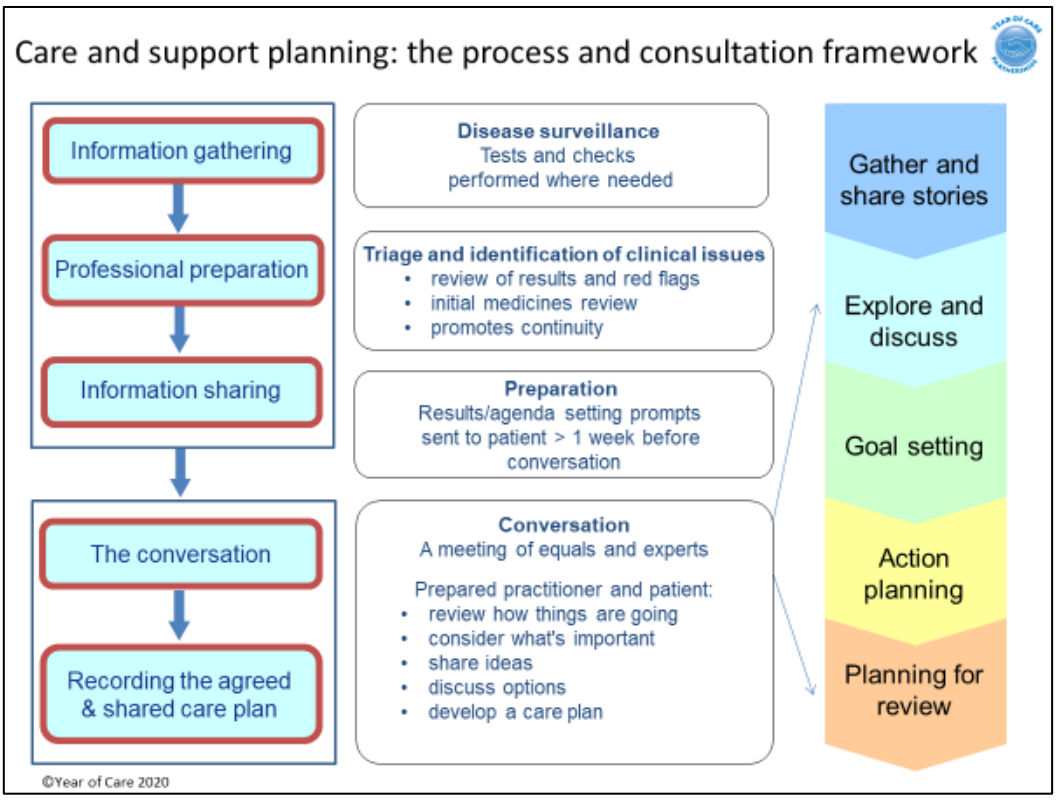


Figure 4. CSP: The process and consultation framework



2.5 Care and support planning in general practice in Newcastle and Gateshead CCG

CSP, using the YOC approach, has been successfully introduced as routine care within general practice for people living with multiple long-term conditions (2 or more of 6 named conditions) across NGCCG. 57 out of 60 practices are now actively delivering this process, although the scope of conditions included varies from practice to practice. This provided a 'laboratory' of systematic practice in which to incorporate the additional issues of falls and frailty.

3. The pilot programme

The pilot programme was a feasibility study designed to demonstrate if and how falls assessment and prevention could be incorporated in routine CSP in the context of frailty, establishing the training, support and resources required. Taking an iterative approach working closely with general practice teams meant that learning was incorporated as the project proceeded. Where variations in plans, processes or the linked evaluation were agreed these were recorded and are discussed in detail in Section 3.6.

3.1 Operational Group

The project Operational Group (Appendix 1) acted as an advisory/steering group with monthly 'task and finish' meetings focussing on both operational and evaluation issues.

The group worked through adaptations and additions to the CSP process ensuring they were acceptable in terms of clinical practice and linked with training and practice support. This was achieved by combining the expertise of a falls coordinator and expert (HK), a consultant physician and geriatrician with an interest in falls (FS), experienced practice nurses (DD, PU), trainer and lead (DD) and the Year of Care team (LO and SR). Membership of the group also included the CCG who hosted and administered the pilot (SHa/LP), the research lead from North East Commissioning Support (NECS) (SHo) and the qualitative research team members thus ensuring everyone was involved in or aware of the iterative activities and could participate in the synthesis of emerging learning.

The project had the support of relevant local organisations including NGCCG, Gateshead GP Federation, Gateshead Transformation Board and Care Closer to Home Network.

3.2 The evaluation team

The qualitative evaluation team was made up of two researchers from NECS (JS, MF) led by TF (Northumbria University). Collectively, the team is experienced and expert in applied health research using mixed methods, and particularly qualitative research methodology. The team also provided disciplinary knowledge in sociology, psychology and implementation science/Normalisation Process Theory (NPT).

Data specialists within NECS provided project specific analyses of routine data supplemented by expertise in GP IT systems from within the Operational Group.

3.3 Pilot GP practices

The pilot practices were recruited via the CCG network (bulletins and newsletters) and informal approaches to practices who were either interested in frailty, strong advocates of CSP or had already expressed interest in taking forward work around frailty and CSP. All practices had to have

established CSP processes as judged by data returns to the LIS and direct knowledge of working with the practice teams. Practices were chosen to include a wide range of sociodemographic characteristics and also both EMIS and SystmOne IT systems to allow development of templates in both. Each was offered a small honorarium to acknowledge their involvement and data collection.

Practices were asked to name a Falls Champion for the duration of the project, who would lead in the practice and be a key contact to disseminate resources and actions to the relevant people.

3.4 How the CSP process was adapted to include falls – proposal

The Operational Group worked together to add the additional elements for falls into the CSP process and used training as a vehicle to share, and at times adapt, the process (Table 1). A core aim was to ensure this was not burdensome to practitioners and would fit seamlessly within existing CSP processes. An overview of this can be found in a flowchart in Appendix 2.

The project cohort was based on those individuals already chosen by the practice to receive CSP routinely. The additional components were provided for anyone over 65 within this group with a validated frailty score.

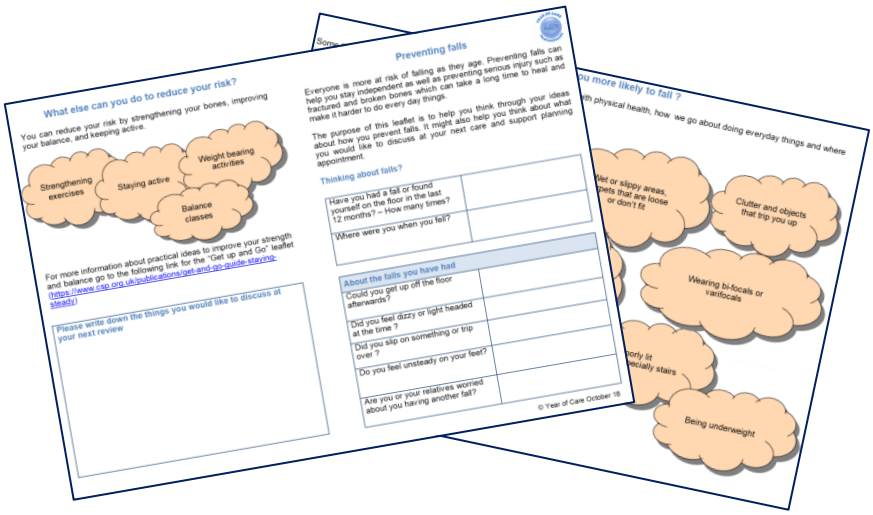
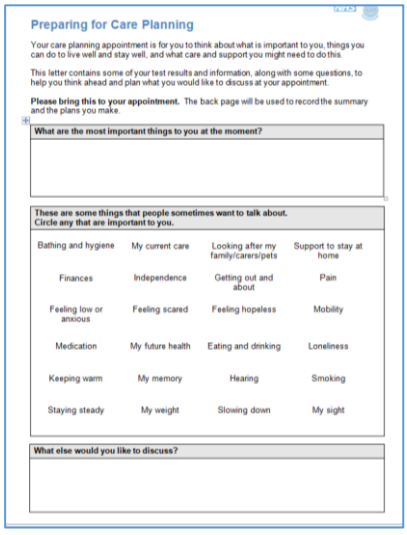
At the information gathering appointment the HCA asked additional questions about falls or the risk of falls. Training ensured they understood the purpose and importance of these. The questions were developed by the frailty and falls experts to ensure they were clinically credible. For anyone who answered positively to any of the 3 falls questions the HCA measured and recording lying and standing blood pressure. The CSP IT template was modified and Read codes identified to enable these readings to be recorded.

Resources were developed to prompt people to think about their options around falls prevention in preparation for the CSP conversation. Practices were supplied with *'Get Up and Go - Guide to Staying Steady'* booklets to offer to patients as and when they thought it would be helpful.

Practitioners involved in CSP conversations were then trained to be able to support those who answered positively to the new questions around falls (See Table 1).

Table 1: Adaptations made to the CSP process for the project

Information gathering appointment	The following additions were made to the information gathering template for the health care assistant: **Ask falls questions and record answer** **In the last 12 months:** 1. Have you had a fall including a slip or trip? 2. Have you had a blackout or found yourself on the floor? 3. Have you noticed any problems with your balance (e.g. whilst walking, standing up from a chair or dressing?)

	Positive answer to any question: HCA completes and records lying and standing BP Patients who respond positively to questions are given a Preventing **Falls self-assessment leaflet by the HCA** and encouraged to bring it to the CSP conversation having thought about issues 
Information sharing/preparation	Preparation materials now include a **generic prompt for frailty** to replace the multi-morbidity version, alongside routine results for any long-term conditions people live with. 
Conversation	**Identify any concerns about falls/risk of falls, agree a plan and refer on as appropriate.** These options and interventions were a core component of training practitioners. This included completing outcomes cards to allow the team to assess the professional 'advice' and options for managing falls.

3.5 Training and facilitation – falls and frailty

Content: An introductory training session was developed to support primary care practitioners to deliver the intervention. The content was based on best evidence and covered a range of topics within the context of falls and frailty:

1. What is frailty and how it is identified?
2. Falls risk factors
3. Undertaking and interpreting lying/standing blood pressure
4. Having meaningful conversations about falls and frailty
5. Interventions to support healthy ageing/prevention
6. How to incorporate the new process into care and support planning

The aim was to enable HCAs and nurses to feel more confident in their roles when exploring falls and frailty. During the information gathering appointment HCAs were encouraged to use eye contact and body language to facilitate openness around the falls history. The correct technique for undertaking lying and standing blood pressure was demonstrated (as outlined by the RCP) and resources provided to support first line advice e.g. around hydration. Staff were also made aware of the template modifications.

In relation to the CSP conversation, practitioners were provided with tools to frame discussions on falls. This included the use of SPLATT (symptoms, previous falls, location, activity, time, trauma) which can help to identify potential underlying causes of falls. There was a strong focus on options for prevention and signposting, such as strength and balance programmes, environmental assessment and detailed medication review. Practitioners were provided with details of experienced local clinicians who could advise and support clinical decision making as required.

Delivery: It was initially proposed that training would require 2.5–3 hours to cover these topics in sufficient detail. However, due to practice demands and availability of staff sessions were limited to 90 minutes. These were facilitated by 1-2 senior practitioners (HK and DD) and on some occasions were supported by staff from the YOC team.

The varying practice constraints on the ability to release staff from regular clinical commitments meant that the site of delivery and participant attendance was tailored to the different requirements. 5 practices attended sessions within the Time In Time Out (TiTO) programme (a dedicated Primary Care training forum) and the remaining 3 had sessions held at each practice. Health care assistants, nurses, administrators and practice managers were invited. The number of attendees varied by practice, ranging from 2-12, with those held in the practice yielding the highest number of attendees. 6 of the training sessions were observed by at least 1 member of the evaluation team.

Practice Support: Practice falls champions were contacted over the first 2-3 weeks of planned implementation to review progress. Practice visits by the falls coordinator were offered to address any queries or concerns raised by the nursing teams. 3 of the 8 practices had follow-up visits to help address early implementation challenges or to receive additional training for staff.

Each practice was provided with a resource folder during their respective training sessions. This contained details of the new process (laminated), relevant documentation, as well as information

about local services, referral routes and signposting options to support healthy ageing. This was followed up with an electronic version.

3.6 Omissions and protocol variations

It was intended to recruit 2 practices each from Gateshead and Newcastle to test early assumptions and refine training and then to recruit a further 4 practices to test the proposed pathway and resources over a four-month period. Difficulties with releasing staff for meetings and training at relatively short notice resulted in these phases being merged and learning accumulated over a 7-month period (July 2019 – Jan 2020) from 8 practices.

Two practices had specific problems. Practice 6 were very keen and donated time to share their experience, provided advice during the design stage and took part in the early training. However key members of the nursing staff left unexpectedly, and the practice was not able to take part in delivery or data collection during the relevant time period. Practice 3 were challenged both by the geography of the practice premises and limited time allotted for the HCA which made measuring lying and standing BP and asking the new questions unmanageable. Although staff were positive about their experience and potential to find solutions they stopped delivery after 2 months.

Since these challenges reflect real life issues for implementation, we have included the limited data collected in practice 3 and our observations on all 8 practices on an 'intention to take part' basis.

These issues provided challenges for the qualitative evaluation and some variations to the original study protocol were made during the study. Initially one to one semi-structured interviews were intended for data collection with staff involved in the pilot practices. It became apparent that group interviews (focus groups) were more feasible, preferred by staff and fit better with the work processes within the practices. However, in two practices (6 and 3), challenges with the pilot process and COVID-19 meant staff became unavailable for interview and data collection had to be halted slightly earlier than expected.

It was also intended that the programme would be developed for implementation during co-production workshops, and these were to be observed in addition to the training events. In practice the programme and training materials were developed more iteratively over time, and in different spaces, that included team meetings as well as online feedback on materials by members of the project team.

Despite these protocol amendments, the volume and focus of qualitative evaluation data collection was as planned.

The unexpected arrival of COVID-19 had an impact in the latter stages of the project when the intense workload pressure on practices limited data checking and validation of findings with practices themselves.

4. Evaluation methodology

The evaluation design used a mixed methods approach to answer two high level questions:

1. How do we introduce falls prevention and assessment in a systematic way to general practice for people already experiencing CSP?
2. What needs to be done to introduce CSP for people living with frailty in the future?

This involved developing an understanding of organisational issues, health care professional skills and expertise and impact on service design.

Quantitative data was used to demonstrate the scale and reach of the pilot and its overlap with frailty, long term conditions and multi morbidity. Also with current practice of CSP which was assessed for fidelity to the YOC approach. Qualitative evaluation focused on the experiences of staff involved in the programme, and understanding the barriers and facilitators of implementation within general practice.

Table 2: Summary of quantitative and qualitative data sources

Quantitative	Qualitative
1. National data on practice size and demographics 2. NECS: Background data on frailty, LTCs and CSP from LIS scheme across NGCCG 3. NECS: Pilot practice data on pilot scheme activity from NECS 4. Practice desktop exercise 5. Outcome Cards	1. Training observations 2. Semi-structured interviews with practice staff

Throughout the project the value of 'informal' data (conversations, meeting minutes, emails etc.) in understanding challenges of implementation across different settings became more apparent. These data were all drawn on as appropriate, in reporting of the qualitative study findings and at the level of the Operational Group where it was brought together with numerical data supplemented by previous knowledge of the practices from YOCP and CCG practice facilitators. This synthesis was undertaken at a series of meetings undertaken from March to August 2020. This has enabled several headline conclusions to be drawn and hypotheses generated which could form the basis of further work.

4.1 Participants in the evaluation

A number of general practice staff contributed to the multiple data sources collected in addition to their role in implementing the new intervention. This included data collected via training observations and completion of outcome cards. A smaller number took part in group interviews (as described in section 4.3.2.2).

Practice administrative staff were critical both in supporting the intervention and their colleagues, and in completing the desktop exercise.

4.2 Quantitative data collection

Data on practices and their registered populations (rounded to support anonymity) was obtained from National General Practice Profiles[14] and local enquiry.

Data on CSP before and during the project was collected from NGCCG wide databases held by NECS (derived from practice registers) and from practices themselves. This included routine reports on previous CSP activity (Appendix 3) and special reports for the project (Tables 5,6,7) based on the intervention process chart (Appendix 2) and specification provided by the Project team (Appendix 4).

Review of the analysis towards the end of the project identified missing analyses and further reports were written and run.

It had been intended that practices would run a 'desktop exercise' identifying the characteristics and activity of people, however writing technical reports to extract the relevant data was too onerous within the time frame. It was thought that since much of the same data would be available within NECS it was irresponsible to ask overworked practices to repeat this. A limited desktop exercise (in two versions) looking at previous CSP practice was ultimately completed by 7 out of 8 practices (Appendix 5 and 6).

4.2.1 Codes and templates

NGCCG practices gather patient information using Read codes in templates that sit within EMIS and SystmOne, the two commonly used clinical information systems. CBC Health, the Gateshead GP Federation, had already developed a template for the information gathering part of the YOC process which the CCG had recommended for use in Newcastle. It was decided to add a section to capture data for this project. There is no facility in either clinical system to write new, unique Read codes so existing codes were identified that were unlikely to be used frequently enough elsewhere to confound the results.

These codes related to the questions asked in the information gathering appointment with the HCA (Appendix 7) about falls, slips and trips and mobility/balance and whether the person had been given a falls self-assessment leaflet. For those who had lying and standing BP measured it was recorded in the template (using standard codes) along with the presence or absence of postural drop, as defined by the RCP guidelines.

4.2.2 Outcome cards

To determine the potential impact of the pilot for patients, practitioners were requested to complete 'outcome cards'. These were designed to be a record of the recommendations/plans that were made between the patient and the professional during any CSP conversation that had explored falls and potential risk factors. Outcomes were divided into 4 broad categories: self-management advice, onward referral/signposting to preventative exercise, referral to the GP and referral to an external service (e.g. falls service/occupational therapy). Cards were anonymous and practices were instructed to place them in a designated tray from where they were collected by members of the project team at regular intervals during the pilot. An example outcome card can be seen in Appendix 8.

4.2.3 Quantitative data management and analysis

Quantitative data was presented and discussed at 'operational meetings', enabling gaps and inconsistencies to be identified and where possible rectified via discussion with the data sources. Final analysis, integrated with qualitative findings, was shared virtually across the Operational Group because of the COVID-19 pandemic which prevented feedback from individual practices involved.

4.3 Qualitative data collection

4.3.1 Theoretical underpinning

The evaluation is theoretically informed, drawing primarily on Normalization Process Theory (NPT)[1516]. This has been used to loosely inform the topic guides for interviews (allowing scope for interviewee driven responses to emerge) and to provide an overall framework for synthesising the project findings.

NPT is a sociologically informed theory of how new interventions in (health and care) practice are implemented and become embedded as 'normal' practice. It focuses on how different groups of participants involved in the process of implementation *work together* to achieve implementation in relation to four key domains of activity: making sense of the practice change and gaining a shared understanding of the purpose and value of it (coherence), participation and sustained engagement in the activity (cognitive participation), successfully working together with the new practice within its setting (collective action) and reflecting on and appraising the impacts of the activity in ways that can be used to improve the process for those involved (reflexive monitoring).

4.3.2 Observations

Over the course of the pilot programme qualitative data was collected from multiple sources, which are described below.

4.3.2.1 Training observations

Representatives from the evaluation team attended the training sessions with practice staff, with the first phase of training sessions taking place in May and June 2019, and the second phase during September and October 2019. When attending a training session, either in a group or at a practice, the evaluators recorded observational notes which covered themes such as who the participants were, what was covered, how aims of the programme were explained and received by participants, any challenges or concerns raised, questions that were asked and the researchers' own reflections (Appendix 9 Training observation grid). A more detailed summary of these observations is included in section 5.2 (Qualitative findings).

4.3.2.2 Interviews

In total, seven group interviews were conducted at six of the pilot GP practices between November 2019 and February 2020. 31 nurses and HCAs were interviewed in small groups (ranging from pairs up to 8 members of staff).

As described, the majority of the practice staff became familiar with members of the evaluation team at their initial training session. Following the training session and after sufficient time had passed such that practice staff had experience of the pilot process (practices had 'gone live'), the project lead sent an email to each falls champion to introduce the idea of the evaluation, introduced the evaluators and invited staff to participate in a group interview. The evaluators subsequently sent a follow-up email, introducing themselves and requesting dates and times to meet with as many of the HCAs and nursing team as possible. Further emails were sent to falls champions and practice staff where no responses were received. Reminders were sent via email ahead of pre-arranged group interviews, which included participant information sheets (Appendix 10), consent forms (Appendix 11) and highlighting the request from the evaluators to audio record the discussion.

At the time of the group interview, evaluators attended each GP practice and met with practice staff in an office, clinic room or meeting room. The evaluator introduced themselves and explained that the purpose of the interview was to explore staff experiences of implementing the falls CSP pilot process. Where staff had not received or had not had time to read and sign a consent form this was facilitated ahead of any further discussion. During the interview the evaluators followed a semi-structured interview guide (Appendix 12) which covered questions in relation to the training, potential impacts of training and processes of implementation of the programme. Due to the nature of general

practice there were at times some interruptions and staff who could not stay for the planned duration of the interview. On average the group interviews lasted 30 to 40 minutes.

Table 3: Practice staffing and interview summary

Practice name	Month	No. of staff	Staff mix	Actions
Practice 1	December	3	Practice nurse, nurse, HCA	Feedback given to Task & Finish Group in January 2020
Practice 2	December	2	HCA, practice nurse	Contacted clinical lead for clarification of minor issues
Practice 2 – 2nd visit	January	8	HCA, nurses, admin	
Practice 3*				
Practice 4	November	4	3 x HCAs, practice nurse (able to prescribe)	Feedback given to Task & Finish Group
Practice 5	February	2	Nurses	Three queries re. referral services, 'Get up and Go' booklet etc. Emailed clinical lead
Practice 6*				
Practice 7	January	4	HCA, nurses, practice nurse	
Practice 8	November	8	HCAs, practice nurse, nurses	
Total		**31**		

* see omissions and protocol variations section 3.6

4.3.3 Data management and analysis

Interviews and focus groups were audio-recorded with participants' consent, transcribed and anonymised for analysis. Qualitative data were analysed collectively by the research team, using thematic analysis[17]. Transcripts were initially read independently by at least two members of the research team, with initial codes noted against data on the transcripts. In subsequent team analysis sessions (2-3 team members) transcripts were taken in order to identify key issues, discuss and agree coding labels to build an analytical map of key themes and connections between themes in the data. As each key theme was developed, it was tested against examples from different data sources, and from different practices in the pilot. In this way, challenges to initial interpretations of data were actively sought out. This was an important part of the process of understanding variation in practices, and experiences at the different study sites, with reference to features of the practice contexts. Care has been taken in the reporting of findings to ensure that data is not attributable to individual participants and sites/GP practices. In reporting quotes we refer to sources in relation to practice number and professional role only.

5. Evaluation findings

5.1 Quantitative findings

5.1.1 The pilot practices (Appendix 14)

The wide range of list size, demographics, social deprivation and prevalence of frailty for the 8 practices shown in Table 4 means the learning is likely to be generalisable. Both the electronic record systems in common use were represented. Issues and challenges of ethnicity were not specifically sought or addressed.

Table 4: Practice profiles

Practice number	Months of data collected	List size (rounded)	% >65 years	Social deprivation quintile*	BME %	Electronic medical record
Gateshead						
Practice 1	4	10,000	18.2	4	1.9 Asian, 1.7other non-white	EMIS Web
Practice 2	2	16,000	22.0	4	1.3 Asian	EMIS Web
Practice 3	7	16,000	28.1	8	1.1 Asian	EMIS Web
Practice 4	7	6,000	12.4	2	1.2 mixed, 3.6 Asian,1.2 Black, 1.0 other non-white	EMIS Web
Newcastle						
Practice 5	4	10,000	11.2	2	2.0 mixed, 28.6 Asian, 3.3 black, 2.7 other non-white ethnic	SystmOne
Practice 6	0	10,000	13.9	1	1.7 mixed, 11.6 Asian, 3.3 black, 2.1 other non-white ethnic	EMIS Web
Practice 7	4	13,000	22.8	9	1.5 mixed, 7.5 Asian, 2.3 other non-white ethnic	SystmOne
Practice 8	7	10,000	21.4	2	1.4 mixed, 7.6% Asian, 1.9 black	EMIS Web

*Practice demographics (https://fingertips.phe.org.uk/profile/general-practice)

The data collection period reflects the different start times for practices which was usually soon after they had attended training.

5.1.2 Data quality

A number of issues emerged during the project relating to data recording as well as reporting and analysis, which should be born in mind when interpreting them.

The NECS CSP data across all NGCCG practices for previous years as well as during the project lacks internal consistency within and across practices. This is more marked in Newcastle than Gateshead. In only 1 practice (Practice 1) are the three steps of CSP[3] recorded consistently (Appendix 3). There

[3] The steps of CSP which have specific codes are *Information gathering*, *Information sharing* and *CSP conversation*

are currently no incentives to validate data entry by different staff recording different components of the CSP pathway.

Newcastle practices also record lower activity levels for CSP than in Gateshead across all data tables. This does not reflect the CSP practice observed as part of routine practice support and in other projects, where it is broadly similar across the two health communities. Potential reasons for this discrepancy include long standing collaborative work across Gateshead practices including development of a Gateshead Master Template and Read codes which were used in NECS data extraction. The pilot practices in Newcastle lacked this historical focus on data consistency and had often set up their own systems with varying approaches to coding which may impact on data trapped by NECS. All data is shown either in the appendices or within this section of the report. Gateshead figures have been used to illustrate conclusions where other data sources back this up and to improve readability.

Project numbers cannot always be compared directly across the tables as denominators differ. e.g. 'one or more' or 'two or more' of 6 LTCs. The desktop exercise – although modified during the project – was open to different interpretation by practices and with hindsight should have been piloted. It was not possible within the project (time constraints and COVID-19) to check potential inconsistencies related to frailty recording (i.e. clinical use of eFI, CFS) and the occasional implausible data item.

The assumption that the codes chosen for the key activities related to falls were not in routine use proved not to be the case. The code for 'history of falls' (to be recorded by the HCA) was already used sporadically especially in Newcastle and thus did not reflect exclusive pilot activity. This impacted on the quality of the analysis (see 6.2).

5.1.3 Background rates of CSP (Appendix 3)

NECS data on CSP collected on behalf of NGCCG as part of the local LIS for 2019-2020 demonstrated a high level of CSP activity across the whole CCG. Two thirds of all patients on practice registers with 2 or more of 6 defined QOF conditions were receiving CSP as normal care. In the Gateshead pilot practices this figure was between 85-98% and included between 47-63% of those also registered with frailty because of pre-existing LTCs.

5.1.4 The study cohort: activity and workload

The study cohort (Table 5) is made up of 2,061 individuals aged 65 or over with a validated 'functional' frailty score receiving routine CSP for LTCs in the pilot practices between July 2019 and January 2020. The majority (77%) were seen in 4 Gateshead practices over 2–7 months. The remaining (23%) were seen in Newcastle over 4-7 months (Table 4).

79% (1,620) of the cohort had 1 or more of the 6 target conditions required by the LIS. The remainder had other LTCs and were included in CSP at the discretion of the practice.

The cohort included 1,588 (61% - range 50-64%) of the 2,620 people over the age of 65 with a frailty score in Gateshead. In Newcastle the figures for 1,456 individuals with a frailty score receiving CSP was 473 (32% - range 30-33%). This may reflect the differing recording practice between the two sites seen over previous years.

The practice desktop exercise (Appendix 6) suggests that between 82-98 % of those with a validated frailty score who were involved in CSP have mild or moderate frailty in both Gateshead and Newcastle.

Table 5: Activity data for those 65+ on practice registers in 7 pilot practices (over study period)

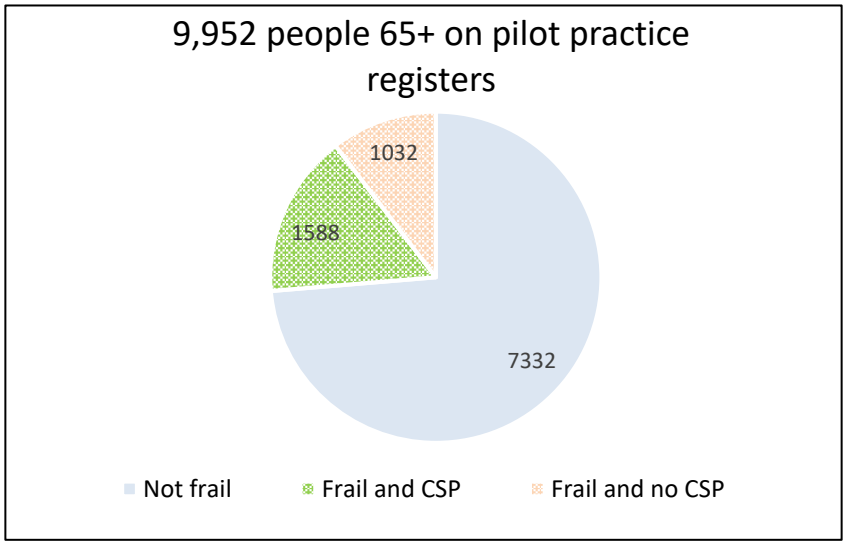
Practice Name	Num. 65+ on register	Validated frailty status (Mild, Moderate Severe)	% all >65 who have frailty score	CSP (for 65+ who have frailty code)	% of all 65+ on register who get CSP	% of 65+ with a frailty code who get CSP
Gateshead						
Practice 1	1626	610	38%	376	23%	62%
Practice 2	3353	970	29%	588	18%	61%
Practice 3	4302	774	18%	492	11%	64%
Practice 4	671	266	40%	132	20%	50%
Total Gateshead	**9,952**	**2,620**	**26%**	**1,588**	**16%**	**61%**
Newcastle						
Practice 5	1010	478	47%	144	14%	30%
Practice 7	2880	306	11%	109	4%	36%
Practice 8	1930	672	35%	220	11%	33%
Total Newcastle	**5,820**	**1,456**	**25%**	**473**	**8%**	**32%**
Grand Total	**15,772**	**4,076**	**26%**	**2,061**	**13%**	**51%**

5.1.5 Learning about workload

The study provides some indication of the workload that might be involved in introducing a focus on falls or other preventive activity associated with mild and moderate frailty as part of routine CSP across the CCG. This section looks firstly (a) at take-up of CSP across the whole 65+ population and then (b) what this might mean at practice level in terms of CSP capacity.

a. Figure 5 uses Gateshead data from Table 5 to show that of those 65+ years 26% (2,620) have a validated frailty score (range 18-40%). Of these 1588 (61%) were already included in CSP. This represents 16% (range 11-23%) of the over 65 years population on practice registers for this time period.

Figure 5. CSP and frailty for those 65+ in Gateshead (study period)



However, this analysis should be treated with caution. The caveats related to data quality outlined throughout this report are compounded by the variation in interpreting and recording frailty status between practices. This is evidenced by the lack of consistency between NECS data extrapolated on an annual basis and the desktop exercise, as well as inconsistencies between the prevalence of frailty recorded here and the demographic differences between the practice populations. This suggests further work is required to establish the true number of those in the ageing population who might be offered the current approach.

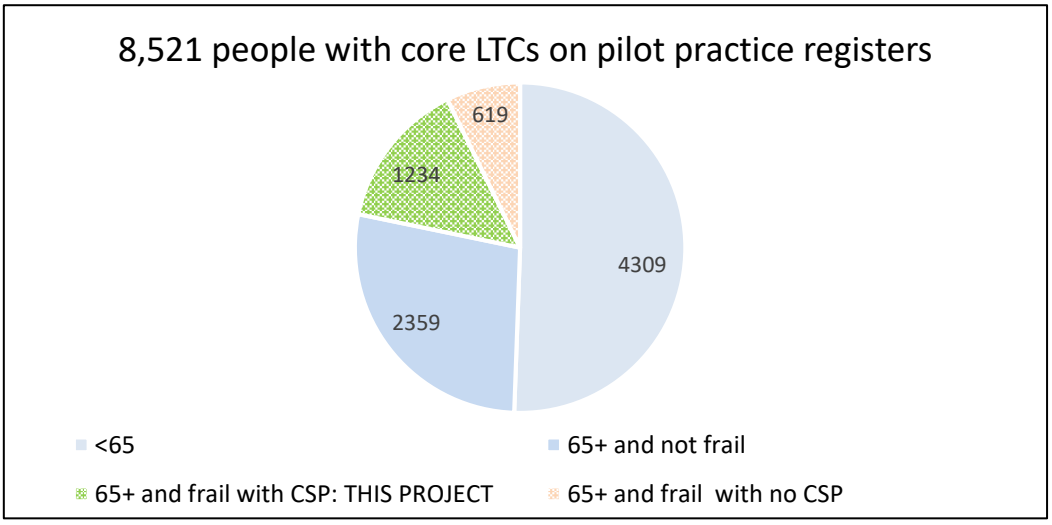
b. Looking at it from a practice workload perspective, Table 6 outlines the activity within the pilot for those with 'core' LTCs, the current focus of the local incentive scheme.

Table 6: Activity data for those with 'core' LTCs on pilot practice registers

Practice Name	No. on 1 or more of 6 target registers	No. 65+	% 65+ on core registers	No 65+ with frailty status	% of 65+ with frailty status	CSP (No)	% of 65+ and frail who have CSP
Gateshead							
Practice 1	1637	724	44%	472	65%	340	72%
Practice 2	2910	1481	51%	680	46%	434	64%
Practice 3	2956	1653	56%	506	31%	340	67%
Practice 4	1018	354	35%	195	55%	120	62%
Total Gateshead	**8,521**	**4,212**	**49%**	**1,853**	**44%**	**1,234**	**67%**
Newcastle							
Practice 5	1530	535	35%	343	64%	121	35%
Practice 7	1955	1042	53%	185	18%	85	46%
Practice 8	1799	915	51%	464	51%	180	39%
Total Newcastle	**5,284**	**2,492**	**47%**	**992**	**40%**	**386**	**39%**
Grand Totals	**13,805**	**6,704**	**49%**	**2,845**	**42%**	**1,620**	**57%**

Figure 6 then extrapolates the relevant Gateshead data from Table 6 to demonstrate the degree to which the current CSP workload is reaching the 65+ population.

Figure 6. Numbers with frailty on core LTC practice registers in Gateshead (study period)



At present 49% (35-56%) of those on core (incentive scheme) LTC registers are 65+ and of these 44% (31-65%) have a validated frailty score (mild, moderate or severe). Of these 67% (62-72%) received CSP. This proportion (roughly 2 thirds) is similar to the percentage of all those with LTCs recalled for CSP reported for the previous years and suggests that age and/or frailty does not affect uptake but does mean a third do not access the benefits.

In Newcastle there are similar percentages for those 65+ on core registers (47%, range 35-51%), wider variation on frailty recording (40%, range 18-51%) and lower figures for CSP (39%, range 35-46%) reflecting the recognised coding and recording issues.

5.1.6 What happened to the study cohort?

Of the 1,588 people who were frail and had CSP in Gateshead 487 (32%) gave positive answers to one or both of questions (2) and (3) below. The code used for Q1 proved unreliable because it is sometimes already used within the clinical record. In Newcastle 102 of the 473 people (22%) gave positive answers.

In the last 12 months:

1. *Have you had a fall including a slip or trip?*
2. *Have you had a blackout or found yourself on the floor?*
3. *Have you noticed any problems with your balance (e.g. whilst walking, standing up from a chair or dressing?)*

In Gateshead 32% (156) and in Newcastle 84% (86) of those who gave positive answers went on to have lying and standing BP measured. In Gateshead 74% (115) and in Newcastle 58% (50) recorded a postural drop. The ranges (50-82%) are given in Table 7.

Table 7: Falls and BP in CSP cohort (65+ and frail)

Practice Name	CSP (in 65+ who have frailty code)	No. giving positive answer to Q2/3	% giving positive answer	No. given Falls self-assessment booklet	No. Lying and Standing BP	% who had BP taken	No. with Postural drop	% with postural drop
Gateshead								
Practice 1	376	169	45%	49	84	50%	69	82%
Practice 2	588	184	31%	0	19	10%	9	47%
Practice 3	492	85	17%	15	16	19%	11	69%
Practice 4	132	49	37%	15	37	76%	26	70%
Total Gateshead	**1588**	**487**	**31%**	**79**	**156**	**32%**	**115**	**74%**
Newcastle								
Practice 5	144	61	42%	14	43	70%	23	53%
Practice 7	109	18	17%	1	26	144%*	13	50%
Practice 8	220	23	10%	3	17	74%	14	82%
Total Newcastle	**473**	**102**	**22%**	**18**	**86**	**84%**	**50**	**58%**
Grand Total	**2,061**	**589**	**29%**	**97**	**242**	**41%**	**165**	**68%**

*Implausible result – see data issues

Had question 1 been included in the analysis the number giving positive answers to the falls questions might have been even higher than 31% found in the Gateshead cohort. The size of this group reflects the selection of a sample with LTCs expected to have high levels of polypharmacy. Even so the high rate of postural hypotension overall in those where the lying and standing BP was measured was surprising, particularly as those with the most severe frailty were excluded. This

suggests that a clinically significant number of people with LTCs can be identified where remedial action might be possible, and/or the increased risk be acknowledged within the CSP conversation, self-management plans and community support.

5.1.7 Outcome Cards

In total 30 outcome cards were completed by practice staff and collected from practices by members of the project team or evaluators. The table below shows the breakdown of outcome cards by practice; importantly not all practices completed or returned these.

Practice	Number of outcome cards
Practice 1	11
Practice 4	5
Practice 5	9
Practice 8	5
Total	**30**

One of the first observations to make is the low return in relation to the numbers receiving CSP and engaging in conversation appointments with a nurse. Secondly, there were also some confused and inconsistent responses captured on the cards. For example, 'no' had been selected to indicate that advice or an onwards referral had not been made, however written comments in the details box stated "Advised of available groups" or "Task sent to pharmacy hub", which suggested action had been taken.

Nearly all of the outcome cards indicated that self-management advice had been given (29/30 cards). However, 11 cards did not provide any detail. Of the 18 cards where this was recorded, nurses reported that patients were given the 'Get Up and Go - Guide to Staying Steady' booklet and topics such as eyesight, footwear, home environment, physical activity, medication, blood pressure and dizziness were discussed. Additional detail was captured regarding the stimulus for the discussion including unsteadiness, knee problems, inadequate glasses, uneven path near home and trips over curbs and hose pipes.

With regard to referrals or signposting to exercise groups, there was a mixture of responses. For example, some outcome cards indicated that patients had declined information or a referral (4/30), whereas others had been signposted to staying steady classes (6/30) or the frailty nurse (1/30). Other patients were already attending staying steady classes (4/30) or involved in physiotherapy or wellbeing groups (2/30). In this category, it was difficult to determine what had taken place other than where clearly stated. For example, some responses simply stated 'staying steady' or 'staying steady classes', without an indication of whether a discussion, information or a referral had been made.

In the category enquiring about onwards referral to GPs within the pilot practices, only two outcome cards recorded that a further GP appointment was required. The nurses mainly highlighted that medication reviews had been identified and undertaken as a result of CSP for frailty, either conducted by themselves where appropriately qualified (4/30), by a nurse practitioner (3/30) or pharmacy hub (3/30). A further five cards indicated a medication review had taken place but there was a lack of information about which professional in the practice or external organisation had

conducted this. Three highlighted that medication reviews and assessments had been undertaken by external services (3/30), namely Belsay and the syncope service.

Finally, 16 of the 30 outcome cards documented that no onward referrals were made as result of CSP. Three people were reported to have declined a referral, due to caring responsibilities and previous assessment by an OT. Five others were awaiting a further appointment with an optician or nurse practitioner, or had already been referred/under the care of the falls team, Belsay, ophthalmology or rheumatology. Three outcome cards detailed that referrals to cardiology, the frailty nurse and adult social care had been made.

Overall, the outcome cards demonstrate the various impacts that the pilot had on patient care, and discussions and advice given during the CSP conversation with the nurse. The outcome cards also demonstrate the impact the pilot had on identifying additional needs (i.e. medication reviews) and signposting/referring to external services namely exercise classes, pharmacy hubs and opticians.

5.2 Qualitative findings

5.2.1 Training observations

Six training sessions were observed by at least one member of the evaluation team. The evaluation team recorded brief information during the training sessions about how the pilot was presented, including the desired outcomes, the atmosphere and mood in the room and questions and anticipated problems or challenges from attendees. Training sessions were attended by a good mix of staff members including GPs, practice managers, HCAs, nurses, a pharmacist and student nurses.

Training sessions took place during TITO sessions and were held at different venues, including Newcastle Racecourse, the Lancastrian Suite conference venue in Gateshead, as well as, in some instances, GP practices. Some of these venues weren't ideal for the training due to their size, temperature, distractions or IT facilities. Focus groups suggested that in most cases it would be preferable to hold the training in the practice building. This would have the added benefit of demonstrating elements of the intervention in-situ.

Some sessions were attended by one practice team only (where held in the practice), in other instances several teams were present. The latter had the benefit of allowing discussion between teams regarding some elements of the training, how challenges might play out in different settings and what could be put in place to address them. One team was expected to attend a joint session but, in the event, did not turn up. It was later arranged to repeat the training for this team in their own practice. Despite initially seeming enthusiastic, the practice subsequently dropped out of the pilot citing staff absences/changes and perceived burden as reasons for this decision. Due to some miscommunication about the nature of the training, one participating practice attended the training twice. When a focus group was conducted with this team later on, some participants felt that, whilst not necessarily intentional, the repetition of some of the learning was actually beneficial and, in part, it was this discussion that led to the recommendation that the intervention would benefit from check-ins or top-ups for participating practices (see below).

The training itself consisted of a good mix of 'ice breakers' (e.g. Frailty Quiz), learning about frailty (e.g. definitions, frailty scales) and explanation of the intervention, including process (e.g. slips and trips questions, lying and standing BP, patient involvement, second appointment) and rationale (e.g.

early intervention, re-thinking frailty). Overall, it seemed that participants felt engaged, enthusiastic and able to ask questions. In some instances training sessions were also used to identify falls champions.

Facilitators gave good working examples which attendees seemed to respond to and take on board, such as use of the fire service for home assessments, clinical or personal examples regarding elderly patients or relatives and tips on asking falls questions in a conversational manner. Both facilitators appealed to the staff to try and test out the pilot, offer feedback on this new process (i.e. what is and isn't working), find solutions and take part in the evaluation.

The facilitators were recognised by some of the practices who had attended falls and frailty training, and/or YoC events. Some practices received a recap of CSP from YOC facilitators attending, other practices did not. Regardless of this, the facilitators were eager to assure participants that the pilot was designed to be not onerous (e.g. no new patients needed to be recruited), that any aspects of the training the teams were able to try out and feedback on would be of benefit and that the main focus was to find out what worked and what didn't.

5.2.1.1 Content, questions and challenges during training sessions

The main training messages were clear – age alone is not an indicator of frailty, the intervention is not just about age or medical conditions, there is a reluctance to admit to having had a fall, older people are more susceptible to side effects of medication and as the number of LTCs increases so does the list of prescribed medication.

It was important during the training for staff to understand who would be doing which appointment during the process. Facilitators explained that this would be the same as for current CSP, but individuals with different roles focused on different elements of the new pilot i.e. HCA would ask the slips and trips questions, gather frailty information rather than the practice nurse.

The training acknowledged previous initiatives from the CCG and/or centred on the CFS. Practice staff were keen to understand how what they had been asked to do previously was related to this pilot (i.e. previous initiatives were about identifying frailty using the CFS (Rockwood), telephone calls and recording etc.).

Practice staff were encouraged to work out their appointment structure with the addition of lying/standing BP and the falls questions, as well as consider the importance of language when discussing frailty (self and other's perceptions of frailty).

Relevant aspects such as practice clinical systems, primary care navigators and the 'frailty force' were brought up by both attendees and facilitators.

A number of practical aspects were raised ranging from nurses ability to spot what to look out for during appointments (including observation of patient's ability to walk into a room, use of aid, speed of walking), challenges regarding standing and lying BP (e.g. availability of couches within clinical rooms and timing within appointment were raised as barriers), whether and how templates can be made available on SystmOne (an issue which was also picked up in the focus groups) and whether there would be a Read code attached to the intervention and whether additional training may be required for HCAs to validate the CFS (Rockwood) score (the facilitators reassured participants that validating the score is not a complex or difficult task). Other questions that were raised revolved

around housebound patients and home visits, what the involvement of GPs/wider practice teams would be and concerns about the relative absence of GPs/wider practice teams from the training sessions.

5.2.1.2 Summary of training observations

The venue for training was observed to be as important as who delivers it. The facilitators seem to have got the overall approach, breadth and depth of the training right and this helped to remove reluctance to implement the learning and increased buy-in. The content of the training was well pitched and there was a sense of genuine learning during the sessions.

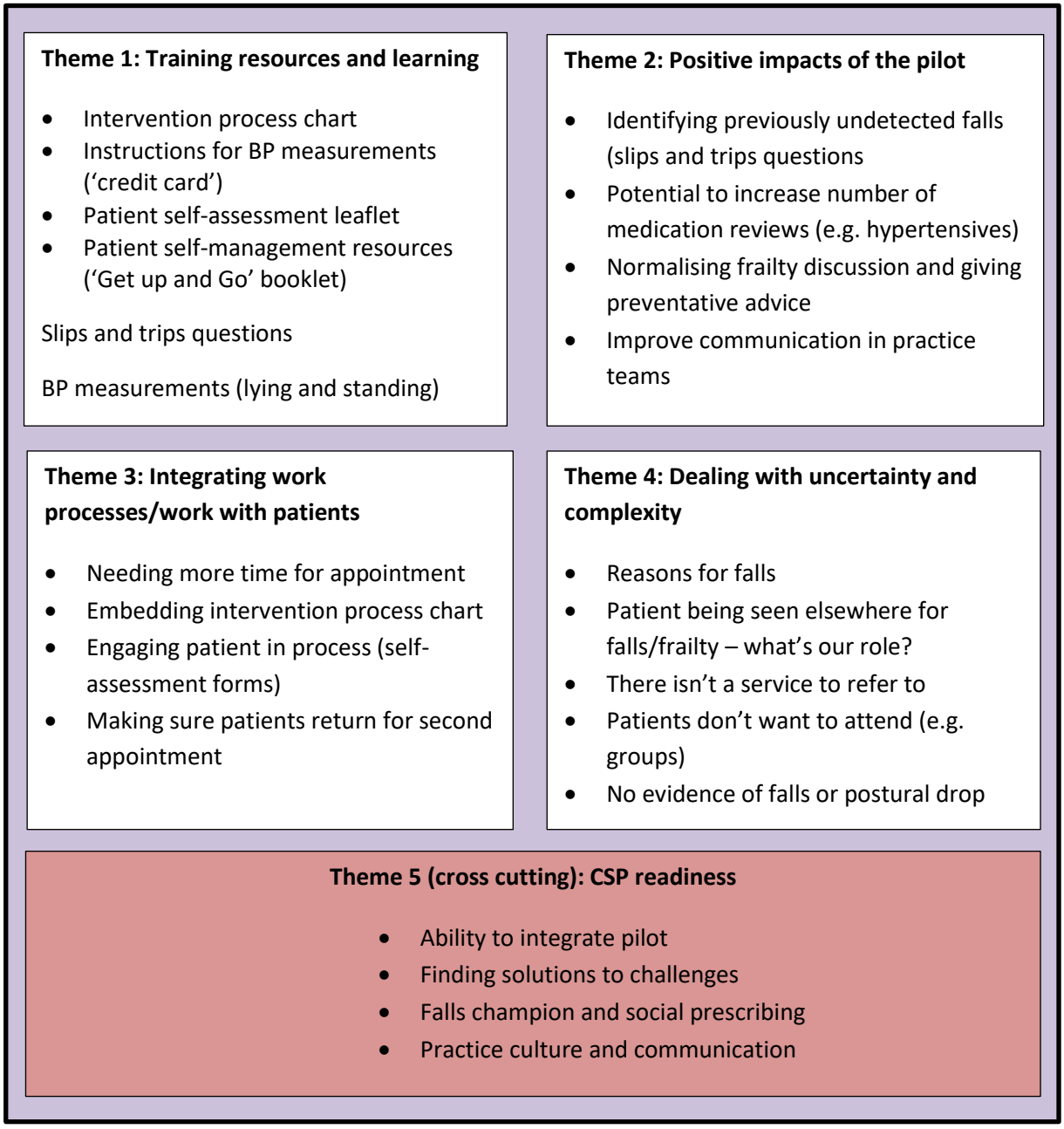
5.2.2 Interviews/focus groups - theme development

Some of the findings from training observations were further elaborated on in the focus groups. The following section moves onto a more in-depth discussion of participating practices' experience with the training and their attempts to implement the learning during the pilot.

An overview of the findings from the qualitative data is provided in Figure 7. The discussion is organised according to the following key themes:

1. Training resources and learning
2. Positive impacts of the pilot
3. Integrating work processes/work with patients
4. Dealing with uncertainty and complexity
5. CSP readiness – this is cross cutting theme

Figure 7. Summary of findings – overview



The themes illustrate in more detail the learning from the training, the perceived benefits for staff and patients alike and key challenges with the implementation of the intervention. Site readiness for CSP is a cross-cutting theme that runs through the other data themes; as such, findings in relation to the data themes are reported with reference to the observed readiness of the sites for CSP integration, before reporting further details about CSP readiness. Suggestions for rolling out and embedding the intervention beyond the pilot phase are included within the discussion and recommendations.

5.2.2.1 Theme 1: Training resources and learning

Feedback overall suggests that the training was well received by all practices. It was considered a well-designed balance between background information and practical tools and the delivery was engaging and motivating.

5.2.2.1.1 Training resources

The training included a number of resources intended to facilitate implementation and increase patients' levels of active involvement in their CSP.

- Intervention process chart
- Instructions for lying and standing BP measurements
- Falls self-assessment leaflet
- Patient self-management resources (e.g. 'Get Up and Go - Guide to Staying Steady' booklet)

It differed from practice to practice which of these resources were used and how, ranging from participants never having seen any of them or not associating them with the pilot, to some individual staff members/groups using resources but others not, to active engagement and integration of the resources into everyday work flow.

Table 8: Feedback on resources

Resource/Tool	**Feedback**
Intervention process chart **The chart illustrates the intended implementation steps of the pilot intervention assigned to different staff groups sitting within the wider CSP birth month recall context**	Ranged from teams saying they had • never seen the chart ⇨ evaluator having to explain the chart during the focus groups to • laminated copies in consultation rooms and integrating aspects of it into their computer templates.
Instructions for lying and standing BP measurements ('credit card') **Outlining the step-by-step process of taking lying and standing blood pressure**	• the credit card sized BP process instructions were popular with participants, even in practices where the process was still unclear to staff. Many had the cards to hand, most often slipped into the back of their lanyard.

Patient self-assessment leaflet **To be used as a tool that encourages patients to play an active role in their CSP conversation/second appointment with nurse or GP**	• Participants liked the patient self-assessment leaflets as they provided a focus for both the patient and the HCP for the follow up appointment. • Whether these forms made it into the everyday workflow depended on who attended the training and how proactively they fed the learning and the process back into their team ('CSP-readiness') • Forms should be available in a format that can be integrated into computer systems.
Patient self-management resources **(e.g. 'Get Up and Go - Guide to Staying Steady' booklets)**	• Participants found the patient self-management and educational resources really good and they tended to be the most used resource. • 'Get up and Go' booklet was given out routinely and facilitates falls prevention conversations with patients. It was well liked and found to be useful by practices.

5.2.2.1.2 Learning from training

5.2.2.1.2.1 'Slips and trips' questions

One perceived key benefit from the training was to give participants the tools to ask patients more effectively about whether they've had a fall by using the 'slips and trips' questions.

Participants felt that ordinarily they wouldn't have asked patients about falls and they certainly would not have done it with the level of nuance the training has encouraged them to.

> *Well yes because we wouldn't have asked them if they'd had a fall, at all […]. We would have let them tell us they'd had a fall but we would never have asked them if they'd had a fall. (Practice 8, nurse)*

> *And I always remember […] at the training [they] said 'be careful how you word it' and she just said 'just mention slips, trips and falls' rather than saying 'have you fallen?' because they will instantly go 'no'. So the first thing I say is 'have you had any slips, trips or falls in the last 12 months?' (Practice 8, nurse)*

The learning in this respect could be higher for the less CSP-ready practices where staff said they may have been less likely to ask patients about falls at all.

The slips and trips questions are seen to have raised awareness of frailty overall and equipped participants with a more nuanced understanding of falls and their causes, and more confidence.

> *A lot of the people who fall, when you drill down you find it's to do with something that might have been avoided. And it's really trying to get in before that […] by asking those questions, to get people to think a bit more. (Practice 2, nurse)*

5.2.2.1.2.2 BP measurement

The intervention requires HCPs to take two blood pressure measurements if people answered positively to the slips and trips questions in order to assess a possible postural drop.

Some participants felt this required them to re-think the flow of the appointment as they adjusted to this new technique.

> *I'm trying to get into the habit because you get in routines of how you do your reviews (others agree) and my review always started with the blood pressure but obviously my review needs to start with the question because if I've already done the blood pressure and then they answer the question I'm doing it again. (Practice 8, HCA)*

Several participants said they had not known that it was possible to take a lying BP measurement by asking patients simply to elevate their legs onto a chair whilst sitting. Although trainers made it clear that guidance supported taking a lying measurement, leg elevation was seen as preferable to sitting alone. This was grasped as useful learning and less disruptive to the information gathering appointment. This should be recognised as a pragmatic compromise during this project and needs to be handled with greater clarity in the future.

> *I think if they can lie down, great, but this offers a different way of doing it which apparently is just as good. Because I didn't know! I mean I've been a nurse for years and I didn't know that. (Practice 7, nurse)*

There was consensus that being able to take a lying BP by simply asking the patient to remain seated and rest their legs on a chair greatly facilitated this.

> *You're still messing round trying to get a chair, trying to get them then to do other bits. And sometimes the questions that you're doing in between, unless they're diabetic, there's only two like 'what's your diet like?' it's still not very long in between, even for their blood pressures and things. So I mean it's trying to figure out in your head what to do (Practice 8, HCA)*

Several teams discussed whether two or three BP measurements should be taken and there was also discussion about the specific moment in the appointment that would be best suited to take these measurements. HCAs in particular were unsure whether and how they need to proceed following this step.

> *So basically, I'm doing the lying and standing BP, documenting it and then I think that's me done (other participants agree). So I don't know if I'm supposed to do any more or whether it's up to whoever sees the patient next. (Practice 2, HCA)*

In the CSP-ready practices there were fewer questions about this step.

> *Anyway, so all this is happening, it's just that we have incorporated this into what we were already doing. So we do long term condition reviews anyway, we do Year of Care […]. So routinely they come in, they have their preparation appointment and then the results are sent out to them with their preparation paperwork. Which obviously, if appropriate the falls things are added into that, and then they come back and see ourselves for the second appointment, for the care and support planning appointment […]. So we're not doing anything different, we've just added in the falls pilot to it. So [HCA] has been working very hard doing all the lying, standing BPs and asking the questions! (Practice 1, practice manager)*

Overall, simply discussing how and when to take BP measurements in line with the intervention process focused individual staff members and teams to take stock of how they organise their CSP consultations and where there might be room for improvement.

One practice team who fully embraced all elements of the process made sure that the flow diagram became everyday business for the entire team by keeping a copy of it in every consultation room, much like they would do with other information/reminders.

> *We've got copies, laminated copies of [the flow chart] in all the rooms so that we can just follow them. (Practice 5, nurse)*

Another practice integrated the key elements of the intervention process chart into their own computer templates to ensure that slips and trips questions and BP measurements were remembered and the resulting information captured on the system.

> *We've just designed this ourselves so that it doesn't get forgotten. So we know that anyone who comes in for Year of Care, if they are over 65, it's the first thing that comes up when the health care assistants go on the template so that we know it gets done. And then they fill that in, because there's three questions that they ask, so if they've had a fall then they would continue with the rest of it and then they would do a lying-standing blood pressure. (Practice 7, nurse)*

Several participants said that they would prefer the training to take place in their own practice, not least because they felt that an in-situ demonstration of some of the required changes would be beneficial and facilitate implementation. This applied particularly to the requirement to take two BP measurements.

Those teams less versed in CSP expressed some uncertainties about the process and would have liked to have seen additional check-ins or the opportunity to ask for clarification, rather than a one-off training session. This was echoed by those practices who were proactive in implementing the learning from the training who would have liked the opportunity to share their experiences and learning with other teams in order to most effectively implement in their workflow.

5.2.2.2 Theme 2: Positive impacts of pilot

Overall there were a number of recorded benefits from having participated in the pilot. Participants reported increased skills in identifying previously undetected falls by asking the slips and trips questions, the potential to increase the number of medication reviews being undertaken as a consequence, being more confident to discuss frailty with patients and giving preventative advice.

One of the positive outcomes of the training was that it led to ***greater awareness of falls*** and the slips and trips questions in particular may help to detect otherwise unnoted falls. Consequently, one of the benefits of the training was an increase in awareness of frailty more generally and being able to normalise conversations about frailty. This has the potential to improve patient experience/outcomes.

Participants noted that they were picking up more people who were falling but may also be better equipped to determine root causes for falls, which may not always be associated with frailty but often have circumstantial reasons.

The questions are good but I suspect the self-assessment is even better, because they go home and they chat and then their husband says 'actually, that's the third time you've tripped on that doormat!' (Practice 2, nurse)

There are also indications that this increased awareness and skill may lead to an ***increase in medication reviews*** and, ultimately, better outcomes for patients.

I don't know whether it's from this pilot but I'm more proactive at reducing people's medication, especially their antihypertensive […]. (Practice 4)

Participants reported that they gained an overall **increased confidence to talk to their patients about frailty**, to pick up associated problems that may otherwise have gone unnoticed, and to suggest paths of action they might not have thought of.

I suppose it highlights with the patient that it's not normal, they don't have to just put up with it. So… because a lot of them they will say 'ah, that's just me age' but I suppose it just says 'it doesn't have to be like that, there's something you can do'. (Practice 4, nurse)

But as well it made me think about some of the other things that I wouldn't always think about. So opticians, for example, obvious things but it gave me a bit of a checklist almost of things to think about. Which has been really useful. And also, when we do home visits now, the preparation for the home visits is different […] it's just kind of helped with doing the visits and having the information. (Practice 1, nurse)

In some instances, the learning from the training has improved communication in the practice team and encouraged HCPs to take a more active overview of a patient's care needs/trajectory.

Frailty and falls, before doing the training, I wasn't really sure what to do with it. And I think just being able to speak to people about that. But also […] just being able to speak to the GPs about maybe changing their meds slightly if they are on anti-hypertensives. But I suppose also talking to them about staying hydrated and things like that. So yeah, I guess that's kind of where I'm at with all of it. (Practice 2, nurse)

5.2.2.3 Theme 3: Integrating work processes/work with patients

Despite the learning many participants reported not all found it easy to adjust their workflow in a way that accommodated the intervention in accordance with the intervention process chart.

Practices who were newer to CSP reported finding it more difficult to keep sight of the intervention and to integrate it into their workflow.

"For me personally, because I'm dealing with everything else, it's not the top of my priority list, and I'm sorry about that but you know […] there's no reason it shouldn't be, but it's just because I'm not used to it, you know what I mean, it's something quite new. (Practice 8, HCA)

In the practices where CSP was less established it might have been considered an unnecessary burden or that there was simply **not enough time during the appointment** to fit all the required elements in.

Yeah we haven't seen those [resources] and we haven't got sufficient time to do a standing and lying blood pressure either, they only get a normal BP done. (Practice 2, HCA)

This could be related to particular staff members' levels of confidence in spotting the necessary problems, in how to address them and who to refer to.

It could also be related to practices having set up communication, appointments and workflow in a way that does not easily converge with the intervention process chart.

The more 'CSP-ready' practices seemed to have found it easier to talk to colleagues.

> *If I'm concerned about somebody then if they've got a second appointment for Year of Care then I put it in the consultation for the second appointment and then these two ladies will see it when they see the patient next. If they haven't got a second appointment and I'm concerned, then I'll get in touch with the GP and send a (task) to a GP. (Practice 2, HCA)*

If the intervention was to be sustainable many participants felt there needed to be some flexibility in appointment length.

> *I think they haven't got time to be artistic! Well you know, making it sound nicer or going around the houses and making it fancy. They're coming in and you've got what you've got to do and you've got to do it. We can maybe talk a bit more, like that, but I think the girls have just got to get it done. (Practice 8, practice nurse)*

> *I must admit, it's not always something I've remembered to ask. And afterwards I think 'oh damn, I never asked about that fall' but it's too late, you know, it's not my top priority at that point. (Practice 8, HCA)*

Participants also commented on the barriers posed by **patients who may simply refuse to engage in the process** (e.g. second appointment, engaging with resources, accepting referrals).

> *I liked the motivation [of the training team], we're really motivated but then I think sometimes we feel a bit disheartened when we come back and try do it in General Practice and we've got an elderly person sitting in front of us saying 'I'm not going to go to an exercise class, howay pet!'. (Practice 5, nurse)*

Some participants tried to mitigate patients' resistance by very actively engaging patients in the process.

> *It's raising awareness in the first appointment with the patients so they can maybe focus on that and focus thoughts on that and bring it with the results. It all becomes incorporated then in the whole thing that there is a specific focus for them about falls. Through conversation and having the first appointment and having the lying and standing BP done and why we're doing it. So you're giving them information, raising awareness, ready for the second appointment. (Practice 1, nurse)*

In particular making sure that patients come back for their **second appointment** was seen as a significant barrier and different practices have different mechanisms in place to avoid patients missing their follow-up appointment.

> *They'll (either) forget. If they don't want to make it then I usually say 'go straight to reception on your way out' because they'll get out the front door and then it's gone. Because sometimes they don't want to make the appointment on the day because they don't know what their diaries like- […] But once they've got it there's more chance they'll come back-[…] or sometimes I'll say 'well we'll just make this appointment, you can change it at a later date if you want' so at least they have got an appointment and it's not just going to go out their mind as soon as they walk out of the door. (Practice 7, nurse)*

5.2.2.4 Theme 4: Dealing with uncertainty and additional complexity

Despite picking up more falls in conversation by using the slips and trips questions, participants were not always sure how to proceed when falls were either caused by reasons other than frailty/dizziness (e.g. tripping over the rug) or if patients were already seen by other services such as specialist teams or other support.

The intervention process chart did not make it sufficiently clear for HCPs what to do with those patients who do not sit neatly within the process.

> *For instance, this morning I had somebody in and she said that she was a little bit dizzy but she's had no falls. So straight away then my line of questioning changed a little bit different direction and what we ended up coming up with was, because her blood pressure was slightly on the low, we'd do more water intake and stuff like that, you know. And pop back and see us if there was any problems. Her daughter was there, which was well on board, she says 'I'm pleased you're seeing this' because what you're doing is reinforcing everything I have been saying, you know. But she'd had no falls as such but even the dizziness, that made me think 'hm, hold on' you know, and took a different turn you know. So on the frailty's (scoreboard) it sort of went up a little bit but it was noted 'no falls' but thinking this blood pressure might be… you know, so. (Practice 2, HCA)*

Similarly a recurring question participants had was what to do with those patients who were already seen by other, specialist, services not least because it was considered a wasted appointment by some.

> *One of [my patients] was already under Falls, the Falls Clinic. So I was a bit confused as to what to do with them, because they're already technically under the team as it is. (Practice 8, HCA)*

> *And then there was another one, he answered positive to the slips and trips but they were unstable with their mobility, they were already on crutches and they were already under orthopaedics and things as well. So when they were already under people for things and the falls were contributing to something, like it's from our end, what to do with them? (Practice 8, nurse)*

> *It seems a waste of an appointment when they're already under a team and getting dealt with. (Practice 8, HCA)*

> *So I had somebody in today that had fallen down but it was his own fault! (Laughs) You know what I mean, there wasn't a medical reason for it. (Practice 2, nurse)*

5.2.2.5 Theme 5: CSP for frailty readiness

As indicated in the reporting of the data themes thus far, a key factor in the successful and consistent implementation and the degree to which practices embraced the pilot is the level of their existing frailty work.

> *Yeah, we've always tried to do what we can when we see people for their reviews. Whether that's referring them to Social Services or referring them here, there or everywhere or if they need some extra support with whatever. So we've always done that when we see them. And then for the last couple of years when the frailty's been, sort of on the agenda and we've had to start scoring everybody, it's kind of stepped up again. And then obviously just adding this in has just made a little bit more comprehensive I suppose. (Practice 4, nurse)*

In practices where CSP is 'normal', the feedback demonstrates an engagement with and understanding of the training that reflects the key changes/additions to the YOC process: asking the slips and trips questions, taking an additional BP measurement and handing out appropriate resources/referring the patient to the most appropriate health care professional or service, either in-house or external. In these practices the willingness, ability and confidence to do this were high as teams could see the benefits of doing so and they did not feel that the intervention asked them to do anything too onerous.

> *I think literally the only difference is asking three extra questions which takes no time at all and having their feet up so they're nice and relaxed and doing an extra blood pressure but you would more blood pressures anyway if the first one was going to be (high). So it's not like… it's not really any extra time, well, not for me anyway. (Practice 1, HCA)*

> *To be quite honest, […] because you're checking the frailty score and then following on to that, I think a lot of us were doing that anyway […]. So I think it just seemed to all tie in with what we were previously doing to start with. But obviously [the training] gave more reason to why we're doing it. (Practice 2, nurse)*

> *We do the frailty assessments anyway, it's something that's in our minds anyway. It's something that we ask about when we see them, even if not at the initial appointment then at the second appointment we ask about that kind of thing anyway. So this has just made it easier really because you're asking about it at the initial appointment and then you're already putting things in place to be able to review things. Whereas before, we might have asked about it at the second appointment and then they might have needed to come back in for lying and standing BP and for further assessment and things. So it's making it more a part of that second appointment by having it already done. (Practice 1, nurse)*

Table 9 highlights key challenges and enablers to implementing the intervention according to practice levels of CSP-readiness. The qualitative data suggested that the more established in CSP and frailty a practice was the more willing and proactive they were at finding solutions to some of these challenges.

Table 9: Characteristics of 'CSP ready' and 'CSP hesitant' practices

"CSP-ready" CSP for frailty is 'normal' for the practice and YoC model is well established/embedded. Possibly a falls champion.	**"CSP hesitant"** CSP for frailty constitutes a big change and YoC is not well embedded. No falls champion.
• training reinforces what these practices already do • practices are used to good communication between staff groups (HCAs, nurses, GPs and admin staff) • social prescribing and care navigation works well/better in these practices • clear process in place to integrate second BP and slips and trips questions	• intervention seen as a big ask • uncertainties around process • clarifications needed regarding appointment structures, BP measurements, resources associated with training (process diagram, patient forms) • less informal communication between staff groups (HCAs, nurses, GPs, and admin staff) • less likely to have a 'Falls Champion'

• willingness and resource to adapt appointments accordingly, if necessary • proactively finding ways to incorporate intervention and learning from training into workflow and seeing benefits of doing so for patients and staff	• more likely to be resistant to change and sceptical of intervention as 'flavour of the month' (practice culture) • more likely to require training team to check in to clarify they are 'doing it right'

Some challenges were shared across all practices regardless of levels of CSP-readiness, in particular uncertainty around those who did not easily fit into the frail category but had reported slips, trips or falls caused by unrelated issues (e.g. tripped over carpet) and/or those patients who were already seen by other specialists (e.g. falls clinic) or elsewhere.

There was also uncertainty around what to do if there isn't a service to refer a patient to, or if the patient does not want to engage, and what should be done if there is evidence of frailty but no evidence of falls or a postural drop.

6. Discussion

This project successfully demonstrated an effective method of incorporating elements of falls and frailty prevention in those over 65 years living with frailty into routine, annual CSP processes in 8 diverse general practices. As a result of the study modified pathways, resources, support and training are available for practices to implement the approach. Recommendations to support wider implementation have been developed.

Using the CSP approach is important for several reasons. The regular, usually annual, proactive contact with patients enables issues to be identified early as they develop for each person. It 'normalises' the concept of regular reflection and self-reflection on health issues which is a central ethos of CSP, engaging people in their health and enhancing their knowledge, skills and confidence to self-manage and problem solve issues as they arise. CSP enables falls risk, and potentially other amenable issues of ageing, to be assessed and discussed within a holistic framework focussed on 'what matters' to each person in living their life, in contrast to projects with irregular recall based on service and condition defined characteristics[18].

The project demonstrated the wider benefits of linking all health issues related to frailty within CSP to staff development. Those involved reported enhanced interest, understanding, knowledge and confidence in talking about frailty and falls in general. Staff welcomed this; a number described it as a worthwhile extension of what they are doing both within CSP and with potential for their overall work within the practice.

The project captured a group of people with mild to moderate frailty. This is the group where regional iCARE framework (for frailty) reports the local community has most to gain from proactive prevention and intervention. As part of an exploratory phase of learning it provides an opportunity to show how CSP promoted within iCARE can be used within a primary care setting. Planned care for LTCs previously focussed on specific condition management such as diabetes and respiratory conditions, this pilot helped broaden the focus of clinicians to include issues to do with frailty and daily living including falls, changing both clinician mind-sets and patient agendas.

Enabling staff to probe issues of falls including balance, slips and trips etc. highlighted a group of people, previously unidentified, for whom measuring lying and standing BP revealed postural hypotension. This was reported to increase the focus on their medication including polypharmacy. Whether this reduces the risk of falls in this group, or indeed whether postural hypotension is more common than previously envisaged in people with multiple long-term conditions, needs further study.

The project was not designed to assess health related outcomes and provides no evidence on whether this routine, holistic approach to the ageing population would provide direct health benefit to individuals. Several cohort studies have suggested a range of beneficial interventions with most evidence for strength and balance interventions[19,20,21]. Routine CSP needs to be seen as part of a more complex intervention in which the outputs of the conversation are linked to these activities. Although this was recognised as a critical component of a local joined up approach to falls prevention staff in this project were not confident in how to go about this. Interviewees reported that strength and balance classes were not widely available and were unclear about referral mechanisms for this and other relevant 'social prescribing' activities despite its current high profile. Work by the CCG and Primary Care Networks (PCNs) to develop these services will need to focus on embedding better understanding among practice teams.

The study generated important learning for wider implementation and spread to other sites. A key message is that incorporating the specific elements related to falls and frailty was only possible within the time frame because practices were already experienced at delivering CSP for those with multiple LTCs. Starting from scratch should be possible but could take longer and require more intensive training and support with the possibility of a practice developing their own staged approach.

The close observation of and discussion with practice staff by the qualitative research team identified key practical issues, validated the value of training, suggested where improvements might be made and emphasised the importance of linkages to other aspects of support.

A key observation was the need for those involved in all forms of support to recognise that one size does not fit all for practice teams. The research team were able to identify two broad groups of practices. One group were confident in their approach to CSP and previous work with frailty and found implementation of change and new work around falls relatively easy. For others it was less so. Some of the differences involved specific components of CSP and frailty. Others seemed to relate to broader practice characteristics and routine practices.

All these features influenced the effectiveness of initial training and the request for additional in-practice and 'just in time' top ups. The research team also observed that opportunities to meet together for both groups, although difficult to organise and time consuming, offered additional value providing a forum to share experiences, learn from each other and work out solutions to thorny practical problems. They recommend that going forward training and support must be flexible, building in options and tailored to practice need which might involve specific work to identify this.

The operational group agreed that while the initial training programme to support implementation proved essential and received positive feedback there were improvements identified for the future. These might include a modular approach around separate topics such as frailty awareness, falls risk identification and management and the process of integrating the approach into routine CSP. This

approach could be supplemented by targeted 'specialist' sessions looking at relevant factors, such as postural hypotension, medication, etc.

The falls champion was planned as a key, named member of the team who volunteered to act as a conduit between the practice staff and project team; to support practice implementation, introduce resources and highlight any issues. Feedback from the focus groups suggests this was not as successful as intended. For instance, some participants had not been provided with the expected information and resources prior to training and this would need to be checked in the future. However, a 'champion' role, as a focus for a special interest in a specific subject as well as CSP in general, has been helpful in previously successful implementations of CSP and could be important in embedding understanding of falls and frailty in the future. The role and support of such 'champions' and tailored facilitation are aspects that need to be considered in the future.

6.1 Strengths of the study

The project was coordinated and managed by a committed multidisciplinary steering group adopting a systematic but pragmatic approach. They developed excellent working relationships and proved flexible in responding to iterative findings and adapting and sharing roles as implementers and evaluators. This ensured delivery of the project against its aims and is recommended as a model for delivery of similar projects in the future.

The overall size of the cohort and wide range of demographics, social deprivation and prevalence of frailty for the 8 pilot practices means the learning is likely to be generalisable.

Despite difficulties with the validity of the detailed numerical data this has been triangulated with 5 robust themes identified by qualitative methods, supplemented by previous knowledge of the practices from YOCP and CCG facilitators and informal meetings throughout the project. This has enabled robust recommendations to be drawn and hypotheses generated which could form the basis of further in-depth research work.

The systematic qualitative evaluation based around a robust theoretical evaluation framework (NPT)[22] strengthened the recognition that the organisation, culture and relationships within individual practice teams made it easier to incorporate the new components in some practices than others which required more intensive support. From an NPT perspective 'coherence' of the falls CSP programme was relatively high; staff generally recognised the value of incorporating falls and frailty routinely and its positive impact on patient care. This helped to increase confidence in the enhanced CSP conversation. The ease with which the new elements were included into the process, or the 'workability' of the programme in practice (as described in NPT's concept of collective action), was linked to the degree practices had previously embraced and implemented the YOC model and a systematic approach to frailty. In those where the model was well embedded, staff were more positive of the approach, appreciated its relevance within CSP and were able to engage more fully across the different components ('cognitive participation'). Clarity around roles and ascribed tasks also seemed to support more successful implementation. This is valuable learning for further implementation.

6.2 Limitations of the study

The sample was based on people who were already having CSP for LTCs. Around half of those 65 and over registered with frailty across a practice were thus automatically included because of underlying

conditions. Whilst this suggests that CSP provides a potential practical vehicle for a systematic approach to regular review and preventive activities for frailty and falls in this high-risk group, the project criteria excluded those over 65 years without the core LTCs, with or without frailty, who may still be at risk of falls. Understanding the overlap between LTCs, frailty and CSP was hampered by the data issues and needs further clarification.

The project also highlighted that around a third of those with LTCs currently identified for CSP recall do not eventually take part and this also proved to be the case for the 65+ group. Whether this is due to practice or patient characteristics or a mixture of both needs specific enquiry. Issues and challenges of ethnicity were also not specifically sought or addressed.

In relation to the quantitative data there were several limitations that may have impacted on the project findings. Firstly, the lack of internal consistency in CSP data recording across all practices, and historically lower levels of recording cross Newcastle compared to Gateshead, hampered the learning that could be extracted. This highlighted that there are also no incentives within practices in either community to validate data entry by different staff recording different components of the CSP pathway at different time points.

It is evident that there is a huge amount of data related to clinical activity (including CSP) within GP records, however this is not readily available for research purposes. It is either collected, extracted and used for clinical care (usually for individual use) within the practice or for performance management at CCG level (pooled data); there is no automatic overlap. Data challenges were partially overcome with additional post-hoc data extraction and analysis from NECS and by renegotiating a desktop data collection exercise with practices. However, due to time constraints and the impact of COVID-19, it was not possible within the pilot term to check fully for potential inconsistencies directly with practices. This may have affected the quality of the data.

The limitations of using existing codes for the analysis was also evident, as data could not always be applied reliably to the project activity. This was particularly relevant in the 'history of falls' question. Future projects need a specific system for recording and analysis designed around an identified research cohort with mechanisms for checking accuracy built in from the start. Reports may be also required throughout to guide the development of iterative projects. This will require specific funds to be identified within any research proposal.

It proved difficult to trap the outputs of the CSP conversations and thus referrals to internal support, such as medication reviews, to supportive activities in the community such as strength and balance classes or to individual approaches to self-management. The outcome cards designed for this purpose were poorly completed. This has been a challenge in other CSP projects [23]. No useful metrics or means to monitor social prescribing within general practice have yet been identified in recent national and local initiatives. This will be an important topic for further research projects focussed on patient outcomes.

There was a range of staffing issues that impacted upon the project. Difficulties releasing staff meant that the length of training sessions had to be reduced, affecting the quality of delivery. Staff changes during the project and difficulties disseminating the information within practices meant that some sites started later than planned. Pre-booked clinics also limited staff availability for evaluation focus

groups, though overall the volume and focus of the qualitative data collection was as planned. These issues of real-life delivery need to be addressed in future projects.

Logistical challenges were also identified within the practices in terms of space/environments for conducting essential tests (e.g. lying and standing BP). One practice withdrew after 2 months, because despite developing a solution to BP measurement and recognising its advantages this proved too burdensome on the practice as a whole. Practices differed in how they organised the work of the CSP process e.g. some matched HCA time to the tasks, some fitted tasks to the time available for the HCA. Practices largely worked out solutions for themselves with the support of the project team. While this can be seen as a strength of the study it may be an important constraint in future roll out or research work.

No attempt was made to monitor the quality of the interaction between the person and the practitioner at either the information gathering visit or during the CSP conversation itself. While staff reported increased confidence in the technical issues of falls and frailty, the health benefits of CSP are hypothesised to depend at least partly on the degree to which the person is actively engaged with the issues and solutions and this was not directly monitored.

The unexpected arrival of COVID-19 meant that findings and discussion could not be validated with practices, though the delivery and evaluation of the project was not otherwise affected.

7. Conclusion

This project, funded by the AHSN to bring together implementers and evaluators around a pressing local issue identified by the CCG achieved its core aim; that is to evaluate the feasibility of incorporating the identification and prevention of falls for those living with frailty within routine CSP. At a time of unprecedented pressure on primary care, practices volunteered to take part in working through the changes needed to incorporate a potential benefit for their elderly population that they felt was a logical extension to their current work. Not only did this prove possible but highlighted the potential for this approach to increase and embed greater interest and understanding of ageing, frailty and falls in their day to day work as a component of staff development.

The project also provided practical learning for the CCG to understand the issues of incorporating falls and frailty within routine CSP and how to support practices to achieve this.

Finally, this exploratory project provided an important first step in a potentially larger body of work on frailty and ageing within general practice. It enabled the contents of further research projects to be more clearly defined so that a robust programme of research can be developed and funded.

8. Recommendations

8.1 Practice level

1. GP practices and primary care teams who are interested in furthering their work on frailty and ageing can use the CSP approach and resources described in this report, accessing the support of the project implementers.
2. Where practices are not already involved in CSP the core learning, training and organisation will be required which can then have the falls and frailty element overlaid onto it.
3. Practices will be most successful in this work if they

- Access training and practical preparation
- Access ongoing support
- Develop their skills and knowledge through practice
- Ensure all staff groups know their role in the process
- Nurture a supportive 'environment' – CSP readiness, good communication across the team, good understanding of roles within the practice
- Recognise /plan the need to deal with and manage the 'unexpected' or more complex issues

4. Ensure the process surrounding BP measurements is clear and the flow of work for the HCA allows them to more easily incorporate this into their workflow with sufficient time to complete this aspect of information gathering.
5. Identify leadership for CSP within the practice ideally linked with a 'falls champion' or 'frailty lead' to provide additional ongoing expertise.

8.2 Support for practices (CCGs and PCNs)

1. The resources, training and expert support that have been developed need to be made easily available for practices to use flexibly, considering economies of scale and quality assurance.
2. Practical issues include
    - A process template outlining flow of activities, conversations, and outputs that can be embedded into practice IT systems, made widely available within the practice and at training with appropriate SNOMED codes embedded into the system.
    - Provide training on falls and frailty linked to the CSP process
        - for practices who are already doing CSP demonstrate how to incorporate falls and frailty into the current process and feel confident to handle discussion within a CSP conversation about falls and prevention
        - for any practice new to CSP include the learning from the falls project, and also include within CSP processes
        - Recognising that 'one size doesn't fit all' and tailoring training and support to identified practice need and offering a range of linked modules and approaches
    - Introduce check-in/top up sessions/visits to give practices a chance to ask questions and to keep the intervention on their radar both at individual practice level and across practices for opportunities to share and work out solutions.
    - Provide specific support for better understanding and availability of social prescribing (e.g., strength and balance classes).
    - Expect a key point of contact/clinical champion in the practice.

8.3 NGCCG/commissioner level

1. Include the identification of falls and frailty using CSP within local strategies and incentive schemes.
2. Ensure population coverage and quality assured CSP is in place; support the identification (as part of these schemes) of those not taking part in CSP.
3. Take an active part in understanding and commissioning practice support.
    - Be aware that there is no 'one size fits all' approach to the intervention and tailor certain aspects of it to individual practices.
    - Recognise this will be influenced by core practice characteristics as well as their previous level of CSP or frailty

- Coordinating training and support in flexible packages based on these criteria (assessing practices for need) targeting those practices who do not have a clear approach to CSP or frailty

3. Ensure appropriate systems for social prescribing and link workers.
4. Ensure that sufficient and relevant activities with an emphasis on strength and balance are easily available.

8.4 Regional (ICS) groups on frailty and falls

1. Explore how the findings align and reflect the priorities identified through the Regional iCARE and Ageing Well programmes and promote through these networks.
2. Examine the synergies and links with specific components of these including the Comprehensive Geriatric Assessment (CGA).
3. Recognise that this work provides an exemplar for frailty at practice level.

8.5 AHSN and future research agenda

1. There remain a number of 'exploratory' questions to be answered before the impact on falls outcomes of this approach can be determined. Unanswered questions include
   - Greater understanding of the cohort involved/not involved e.g. the characteristics of the elderly frail population who were not included, the characteristics and issues for the 30% of people who do not attend CSP
   - The 'quality' of the CSP conversation as it applies to falls and frailty
   - The outputs of the CSP conversation including the referral and uptake of specific interventions such as strength and balance groups
   - How best to support individual practices to achieve the best for their population
   - How to support practices with turnover of key team members and ensuring staff understand the purpose behind the activities embedded within the templates
2. The specific issue of asymptomatic hypotension as a risk for falls needs further clarification.
3. This study demonstrated that data issues around research in general practice would need to be addressed before these questions can be answered with confidence.
   - The initial expectation that most of the numerical data items required would be available from routine sources proved not to be the case. Although there is a huge amount of data related to clinical activity (including CSP) within GP records this is not readily available for research purposes, because of technical issues.
   - Writing the technical reports to extract relevant data from practice systems is onerous and new reports may be required as new issues /questions arise.
   - Specific codes may be needed for new projects. Even when these are standardised there are no practice incentives to ensure that the many staff who may be involved across a pathway are consistent and diligent in completing them.
   - Recording the issues involved in monitoring social prescribing in general has no current solution. There was no easy way of recording the outcomes of the discussions and so data on this aspect was limited.
   - Future projects need a specific database designed around an identified research cohort with mechanisms for checking accuracy built in from the start. Reports may be also be required throughout to guide the development of iterative projects. This will require specific funds to be identified within any research proposal. The option of embedding a data handler/analyst to work at practice level should be considered.

9. Communication strategy

This work highlights that CSP does provide a robust structure in many practices to embed preventive elements of care, including detection of at-risk groups and potential opportunities to raise clinical issues or/and link to social prescribing. In terms of a strategy to disseminate learning, we feel there are a number of strands to follow:

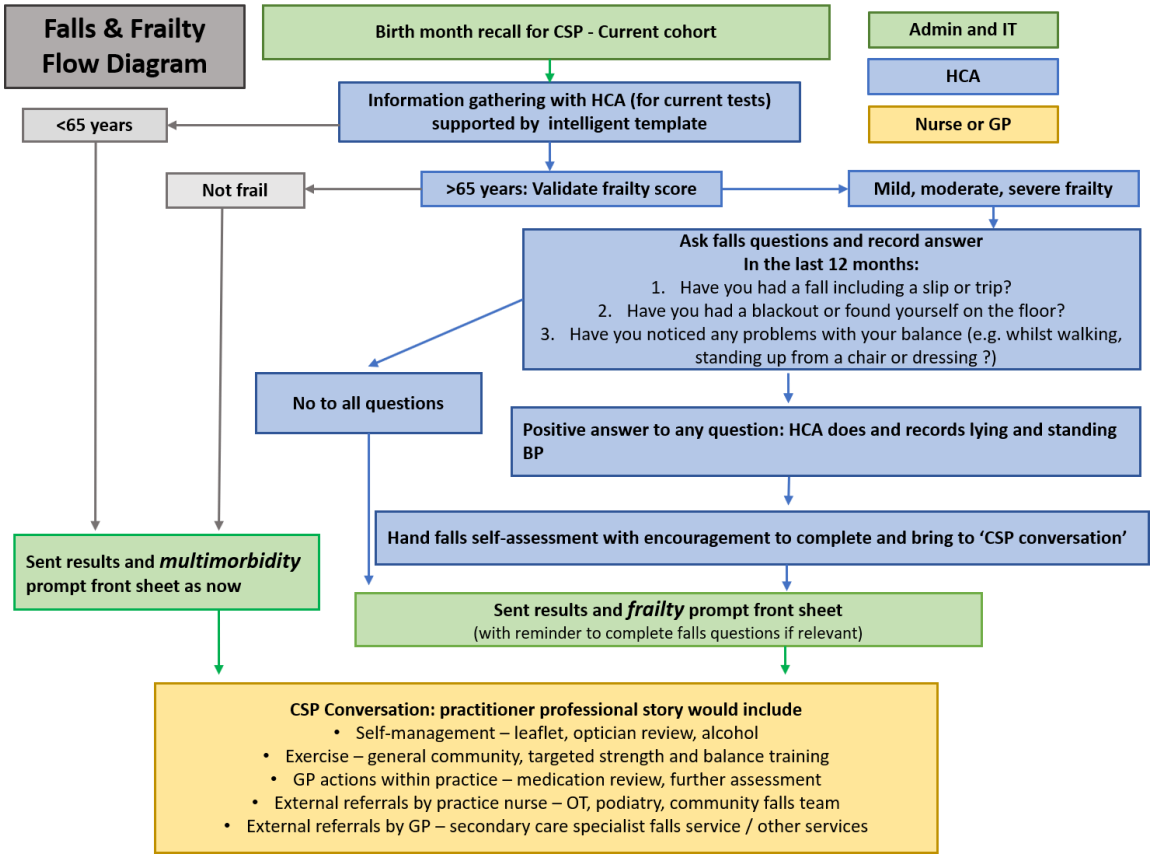
1. Engagement with practices, individually or via PCNs, including those already doing CSP (or setting up CSP) in order to embellish the current process by including falls and frailty following the learning from this project. This would involve making the case for change and demonstrating the learning, support and training options available.
2. Engagement with the Regional and Place Based (ICP) falls groups (providers as well as commissioners) to share the learning from this project and how it fits into an overall strategy around frailty, including learning about the benefits of training for clinical teams.
3. Engagement with Regional (ICS) and Place Based (ICP) frailty groups to demonstrate similar strategic fit. This would include the Ageing Well board, Frailty iCARE Community of practice and local frailty forums.
4. Engagement with NECS R&E team on strategic and delivery issues to share findings across CCGs and Primary Care in NE and North Cumbria.
5. Academic publications.

Appendices

Appendix 1: Operational Group members

Operational Group members	Job title	Role/area of expertise
Deborah Dews (DD)	Advanced Nurse Practitioner (Gateshead)	Primary care/clinical care
Michaela Fay (MF)	Independent Research Consultant	Qualitative evaluation
Tracy Finch (TF)	Professor of healthcare and Implementation Science (Northumbria University)	Implementation science and research
Shona Haining (SHa)	Head of Research & Evidence North of England Commissioning Support (NECS)	Quantitative and qualitative evaluation
Samantha Hood (SHo)	Clinical Commissioning Manager LTC (NGCCG)	Commissioning in LTC care
Lindsay Oliver (LO)	National Director (Year of Care Partnerships)	Care and support planning
Helen Kleiser (HK)	Falls coordinator and clinical educator (Gateshead Health NHS Trust)	Chair of the group and falls expertise
Lynne Paterson (LP)	Delivery project lead (NGCCG)	Project support/coordination
Sue Roberts (SR)	Chair (Year of Care Partnerships)	Care and support planning, service design and implementation
Fiona Shaw (FS)	Consultant Physician and Geriatrician (Newcastle Upon Tyne NHS Foundation Trust)	Frailty and falls
Joanne Smith (JS)	Research Manager (NECS)	Qualitative evaluation
Patricia Urwin (PU)	Advanced Nurse Practitioner (Newcastle)	Primary care/clinical care

Appendix 2: Intervention process chart for practices in falls project



Falls & Frailty Assessment Project – Practice Guidance

Summary

The aim of the pilot is to test out the use and effectiveness of asking 3 simple questions during the data-gathering appointment for those over 65 identified as having mild, moderate or severe frailty attending for annual LTC review, to assess the impact on other services and identify any gaps.

A research team will gather information and evaluate the pilot, using Read codes recorded in the master template and from interviews with staff that will inform the development of the project and roll out to other practices.

The pilot will not capture patient feedback at this stage but there is a patient questionnaire being released shortly that will facilitate patient feedback on their annual review.

A "Falls Project" tab will be added to the master template that will include the new Read codes for use during the data gathering consultation and there is a card to be completed after the Care and Support planning consultation to record the outcomes and any interventions.

At initial Data-gathering appointment

Rockwood score (in template)

In the last 12 months:

- Have you had a fall including a trip or a slip? If yes, collect number in last year.
- Have you had a blackout or found yourself on the floor?
- Have you noticed any problems with your balance e.g. whilst walking, standing up from a chair or dressing.

If "Yes" to any questions from above:

- Check lying and standing BP and record in template.
- Use code in template to record "postural drop" or "no postural drop"
- Give "Preventing Falls" self-assessment leaflet and ask the patient to complete it and bring back to review appointment with the other C&SP results sharing leaflet.

At Review Appointment (PN/GP)

- Ask patient for completed Falls and C&SP leaflets to use as the basis for the conversation.
- Identify any concerns about falls/risk of falls, agree a plan and refer on as appropriate.
- Record outcome and disposal on card and ensure safe keeping for collection by pilot team.
- Please let us know if at any point you identify a problem or have any ideas that would improve the process for staff and patients.

Appendix 3: Data on CSP in LTCs and frailty from NGCCG practices for 2018-19 provided by NECS as part of NGCCG LIS monitoring programme: i.e. prior to Falls Project.

Table (a): Summary data for all practices in LIS scheme: CSP activity 2018 -19 for 'core' scheme (i.e. 2 or More of Asthma, COPD, Stroke, TIA, PAD, Diabetes, CHD)

	Information gathering	Information sharing	CSP conversation
Gateshead Total	65.7%	44.7%	66.3%
Newcastle Total	60.6%	47.7%	48.2%
Total	**63.2%**	**46.2%**	**57.5%**

Table (b): Summary data for all practices in LIS scheme: CSP activity 2018 -19 for 'All' LTCs (Asthma, COPD, Stroke, TIA, PAD, Diabetes, CHD, Hypertension, Heart Failure, AF, Cancer, CKD, Epilepsy, Osteoporosis, RA) *(NB: this is a list previously agreed by a CCG group of clinicians and does not include 'all LTCs' such as Parkinson's, mental health issues and others which may be of relevance to 'frailty')*

	Information gathering	Information sharing	CSP conversation
Gateshead Total	41.7%	23.8%	37.7%
Newcastle Total	36.9%	26.0%	26.5%
Total	**39.3%**	**24.9%**	**32.2%**

Table (c): Data for falls pilot practices only: CSP activity (2018-19) for 'all' LTCs and 'core' LTCs

Using codes for key steps of CSP (information gathering, information sharing and CSP conversation)

	Asthma, COPD, Stroke, TIA, PAD, Diabetes, CHD, Hypertension, Heart Failure, AF, Cancer, CKD, Epilepsy, Osteoporosis, RA				***2 or More of Asthma, COPD, Stroke, TIA, PAD, Diabetes, CHD***			
	All LTC No.	***Info. Gath.***	***Info. Sharing***	***CSP Conv.***	***Core LTC No.***	***Info. Gath.***	***Info. Sharing***	***CSP Conv.***
Gateshead								
Practice 1	2,644	38.0%	37.0%	38.8%	341	85.9%	91.8%	88.6%
Practice 2	4,986	67.1%	52.7%	67.1%	636	79.6%	65.6%	80.8%
Practice 3	5,022	64.7%	63.1%	63.3%	551	79.3%	83.3%	84.9%
Practice 4	1,513	40.2%	29.3%	30.9%	218	98.6%	82.6%	77.5%
Newcastle								
Practice 5	2,084	19.2%	36.4%	10.6%	348	23.9%	45.1%	14.7%
Practice 6	2,744	56.4%	10.9%	8.2%	480	75.0%	11.5%	16.5%
Practice 7	3,273	25.8%	25.1%	11.8%	337	66.5%	63.5%	39.5%
Practice 8	2,836	8.3%	52.4%	4.7%	448	14.7%	68.3%	10.7%

Table (d): CSP activity for frailty in 2018-19 in pilot practices (Frailty defined by clinical judgement – usually Rockwood (Clinical Frailty score – CFS) score total/mild/moderate/severe)

Practice	*Total Frail Population (Mild, Mod. Severe)*	*CSP Interventions (Nos.)*			*CSP Interventions (%)*		
		Info Gathering	*Info Sharing*	*CSP Conv*	*Info Gathering*	*Info Sharing*	*CSP Conv*
Gateshead							
Practice 1	563	299	347	286	53%	62%	51%
Practice 2	821	517	373	496	63%	45%	60%
Practice 3	624	382	425	449	61%	68%	72%
Practice 4	266	124	92	83	47%	35%	31%
Newcastle							
Practice 5	445	59	130	44	13%	29%	10%
Practice 6	376	203	16	45	54%	4%	12%
Practice 7	281	68	59	38	24%	21%	14%
Practice 8	501	64	309	40	13%	62%	8%

Appendix 4: Falls & frailty search definition for special reports from NECS

Using codes specified in Appendix 7

Based on Currently Registered Patients

- Patients who are aged 65 and over as at 30.6.2019
- 65+ with a validated frailty status of mild/moderate/severe before or on 30.9.19
- 65+/frailty who have one or more Falls code (see code list) between 1.7.19 and 30.9.19
- Of those with a falls code count patients who have a Falls self-assessment code between 1.7.19 and 30.9.19
- Of those with a falls code count patients who have either a lying or standing BP between 1.7.19 and 30.9.19
- Of those with a lying or standing BP count patients who have a Postural Drop or No Postural Drop between 1.7.19 and 30.9.19

Based on patients in any of the 6 target groups (defined as asthma/CHD/COPD/diabetes/ PAD/stroke/TIA)

- Patients who are aged 65 and over as at 30.6.2019
- 65+ with a validated frailty status of mild/moderate/severe before or on 30.9.19
- 65+/frailty who have one or more falls code (see code list) between 1.7.19 and 30.9.19
- Of those with a falls code count patient who have a Falls self-assessment code between 1.7.19 and 30.9.19
- Of those with a falls code count patients who have either a lying or standing BP between 1.7.19 and 30.9.19
- Of those with a lying or standing BP count patients who have a Postural Drop or No Postural Drop between 1.7.19 and 30.9.19

Appendix 5: Desktop exercise - blank

The questionnaire was modified following feedback. This is the second version.

Care and support planning – Falls and Frailty

To quantify the impact of including falls within the care and support planning (CSP) process we would like to be able to get some data from each practice. This is to help us understand:

- The scope of your current care and support planning work – which patients get the Year of Care approach?
- What proportions of people with frailty are included in the Care & Support Planning you deliver?
- What proportions of people with frailty are currently not included in the care and support planning and what conditions (if any) they have?
- For your practice, how much falls has been an issue identified within CSP?

We would be grateful if you could complete the following:

Name of practice: ……

List size: ……

Completed by: …… i……

Date: ……

1. The scope of your current care and support planning work – who gets the Year of Care approach?

Name of conditions you recall to the full care and support planning process – please list each one separately and add rows if you need to	**Included as a single condition (please tick)**	**Included only if multi-morbidity (please tick)**
Ischaemic heart disease (IHD) / CHD / Heart failure		
Diabetes mellitus (DM)		
Cardiovascular disease (defined as patients on Stroke or TIA registers)		
Peripheral artery disease (PAD)		
Asthma		
Chronic obstructive pulmonary disease (COPD)		
Mental health		
Rheumatoid arthritis		
Hypertension		
Frailty		
MSK		
CKD		

2. What proportion of people with frailty are included in the care and support planning your practice delivers?

2.1 Total number of patients (over 65yrs) on frailty register in all categories in last 12 months

2.2 Total number of patients (over 65yrs) received care and support planning in last 12 months

2.3 Now please tell us, of those over 65yrs, receiving CSP in last 12 months, how many are mildly, moderately and severely frail;

Frailty numbers	Numbers of those recalled to CSP in your practice
CSP Mild Frailty	
CSP Moderate Frailty	
CSP Severe Frailty	
CSP No Frailty	

3. Can you give us an impression of what other conditions patients might have, who are frail but DO NOT attend for CSP appointments (including those with no LTC)?

4. Is there anything else you would like to mention about Frailty and Falls in your practice or relating it to Care and Support planning?

Thank you for completing this desk top exercise.

This information will help support future plans around Falls and Frailty.

You will receive £500 for being part of the Falls and Frailty Pilot on receipt of this document.

Appendix 6: Desktop exercise

A sample (4 questions) from questionnaire in shown in Appendix 5.

Responses to main questions from 7 practices.

	List size	(Q1) No. of cond. included as single cond.	(Q1) No. of cond. included as part of MM	(Q2.1) No. 65+ on frailty reg. total M,M,S in last 12 month	(Q2.2) No. 65+ receiving CSP in 12 months	(Q2.3) No. 65+ receiving CSP in 12 months.			
						not frail	**mild**	**mod**	**Sev.**
Gateshead									
Practice 1	9388	6	15	436	653	217	320	102	14
Practice 2	16023	9	14	899	725	1339	459	188	67
Practice 3	15837	10	13	1356 M 816 M 468 S 72	510	2523	386	260	64
Practice 4	5600	13	14	289	46 (since July)	300	99	56	14
Newcastle									
Practice 5	10000		16	(Q2.2) 455	(Q2.1) 410	66	83	51	2
Practice 7	12771	6	7	(Q 2.2) 146	(Q 2.1) 1052	906	45	92	21
Practice 8	9534	19	19	688	378 (164 since July)	198	417	150	121

Q3 asked about other LTCs more common in frailty but not included in current CSP reviews. Practice 1 noted Parkinson's, Hypertension, OA, and Practice 3 MSK and mental health, Practice 4 noted osteoporosis, OA, 'any'

Appendix 7: Recommended codes for use in project

EMIS codes	SystmOne 1 codes
16D6 = falls	1912002
16D2 = number of falls in last year	391002003
1B6 = disturbance of consciousness	3006004
1B52 = unsteadiness present	267084003
246S = lying systolic BP	407556006= lying systolic BP
246T= lying diastolic BP	407557002= lying diastolic BP
246GN= standing systolic BP	400974009= standing systolic BP
246P= standing diastolic BP	400975005= standing diastolic BP
38GK= falls risk assessment tool	839781000000108
2468 – O/E – BP reading postural drop	163029008 = postural drop
246J – O/E – BP reading no postural drop	313005002 = postural drop

Appendix 8: Outcome card (blank)

Introducing frailty with care and support planning

Practice ID:	
Staff name:	
Date:	
Outcomes of CSP conversation	
Self-management: advice given **Y/N**	Details: (e.g. postural hypertension advice, leaflet, optician review)
Referred/signposted to exercise group **Y/N**	Details: (e.g. staying steady, strength and balance group)
Referred to GP **Y/N**	Details: (e.g. medication review, syncope, further assessment)

Appendix 9: Training observation checklist

- Who is present?
- Who is doing parts of the CSP? Links together in process? Training needs of different people/roles?
- Content covered
- How are the desired outcomes presented? Rationale/reasons for change (what are the intended benefits, how (if) are these communicated to staff (building 'coherence' and 'participation')
- Atmosphere/mood in the room
- Questions/feedback
- Anticipated problems/challenge/resistance
- Think – attitudinal, practical, skills/knowledge, confidence, time, resources etc.

Appendix 10: Participant information sheet

Northumbria University NEWCASTLE

NHS North of England Commissioning Support Unit

Participant Information Sheet

Title - Falls, frailty and care and support planning: Qualitative evaluation of pilot feasibility project

Background to falls, frailty and care and support planning
Falls are a leading cause of illness and death in people over the age of 75 and closely associated with frailty. Prevention, early assessment and appropriate management of frailty are strategic priorities for the Academic Health Sciences Network (AHSN) and Newcastle and Gateshead CCG (NGCCG). Care and Support Planning (CSP) may improve the management of frailty, offering patients a holistic approach to support. CSP is an approach to providing the space for a 'better conversation' between a prepared person and a trained practitioner which brings together all the issues a person may live with including prevention. CSP (using the Year of Care (YOC) approach) has been successfully introduced as routine care within general practice for people living with multi-morbidity (2 or more of 6 named conditions) across NGCCG. However, relatively little is known about how to introduce CSP to support the management of frailty in primary care. This study aims to fill this gap, starting by testing the feasibility of introducing prevention, assessment and early management of falls within the context of frailty.

What is the purpose of the evaluation?
Newcastle and Gateshead CCG have commissioned a pilot project to develop and evaluate the inclusion of falls assessment and prevention in the context of frailty within CSP in general practice. An evaluation team has been assembled, including researchers from Northumbria University, NHS North of England Commissioning Support (NECS) and an independent research consultant. The purpose of this evaluation is to understand the impact of this pilot to inform an incentive scheme and share learning across the region. Interviews with healthcare professionals will look to understand their views, context and barriers to this approach.

Why have I been invited?
You have been approached because you are a health care assistant, practice nurse, nurse practitioner or general practitioner, working for a member practice of Newcastle and Gateshead CCG, who have volunteered to take part in this pilot implementing falls assessment within CSP. In total, we are hoping to interview up to 24 healthcare professionals, and your contribution would be much appreciated.

Do I have to take part?
It is entirely your decision whether to take part. This is voluntary and you are welcome to ask further questions before making your decision. If you are happy to take part, you will be asked to sign a consent form. However, you are free to change your mind at any time, withdrawing from the study without giving a reason. This will not affect your legal rights.

What will I have to do?
You will be asked to participate in a maximum of two audio-recorded interviews, either individually or as part of a group, with a member of the evaluation team, who will ask you open questions to gain an understanding of your experiences of the training session and implementation of introducing CSP for falls and frailty, including the perceived impact on

patients and reflection on what has worked well or could be improved. Participation in an initial interview does not mean you are obliged take part in a second interview. Each interview should take no longer than 45 minutes, at a convenient time and venue for you, and may take part within other meetings.

Will my taking part in the evaluation be kept confidential?
The interview will be audio recorded. This lets us type up and capture accurately what you have said so we can analyse the information. However, this will be done without identifying you; your responses will be treated in strict confidence and will be completely anonymous. In group interviews, all participants will be asked to respect participants' anonymity and not share information from the discussion with others. Access to information will be restricted to the evaluation team. Data will be stored securely on password protected files on password protected computers, and any paper work will be stored in locked filing cabinets.

Benefits of taking part
The interview will give you the opportunity to talk about your experiences and express your opinions on the introduction of falls assessment and prevention within CSP to an independent listener. Your contribution to the evaluation will help Newcastle and Gateshead CCG to gain a greater knowledge of the introduction of this pathway and its impact on GPs practices and their staff, frailty services and the perceived impact on the health and wellbeing of patients.

Disadvantages and risks
There are no direct risks associated with being interviewed. Every effort will be made to minimise inconvenience and to ensure your comfort in the interview process. It will be possible to take a break and stop at any point during the interview. If during the interview an issue is raised that you wish to discuss further, the evaluation team will be able to direct you to the most appropriate source of support.

What if I change my mind or there is a problem?
If you decide during the interview you no longer wish to take part you may ask the researcher to stop recording. Your decision will be treated with respect and a decision not to take part in this study will not affect you negatively in any way. If you encounter a problem before, during or after your participation in this evaluation, please contact Professor Tracy Finch (Please see contact details below).

Who has reviewed this study and is funding the evaluation?
This evaluation is funded by the Academic Health Sciences Network (AHSN).

Who do I contact to take part?
If you would like to take part in this evaluation or you have any questions or would like any further information please contact Professor Tracy Finch, at tracy.finch@northumbria.ac.uk, or on 0191 2156477.

Thank you for taking the time to read this information sheet

Appendix 11: Consent form

Northumbria University NEWCASTLE

NHS North of England Commissioning Support Unit

CONSENT FORM

Title of Project:	**Falls, frailty and care and support planning: Qualitative evaluation of pilot feasibility project**
Name of Researcher:	Joanne Smith / Michaela Fay
Participant Identification Number:	

Please initial box

I confirm that I have read the information sheet, dated 01/10/2019 for the above evaluation. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐
I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason.	☐
I understand that the data collected from me will be used within the evaluation, which is being conducted by representatives from the North of England Commissioning Support (NECS) and Northumbria University overseen by Professor Tracy Finch and Dr Shona Haining.	☐
I understand that the goal of this evaluation is to develop an understanding of the inclusion of falls assessment and prevention in the context of frailty within care and support planning (CSP) in general practice	☐
I understand that my interview will be audio recorded and quotes from my interview may be used within the final evaluation report. However, any quotes used in the report will be anonymised and I will not be able to be identified within the report.	☐
I agree to take part in the above study.	☐

Name of Participant	**Date**	**Signature of Participant**

Name of Person taking Consent	**Date**	**Signature of Person taking consent**

Appendix 12: Structured interview guide

Northumbria University NEWCASTLE

NHS North of England Commissioning Support Unit

Linking falls assessment and prevention (as a component of frailty) with care and support planning (CSP)

Interview guide

Introduction Prompts to have present; Flowchart Key resources – 'Get up & go' leaflet, outcomes cards, etc.	• Who we are: explain purpose of study and interview (to introduce falls prevention in a systematic way into general practice/assess impact and usefulness of falls prevention and frailty training/challenges and benefits)? • Consent (recording) • Please describe your role within the practice (i.e. HCA/Nurse/Nurse practitioner) • What is your perception and knowledge of this pilot? • Introducing CSP to prevent falls and manage frail patients (Coherence – explore whether pilot idea makes sense to individuals)

Falls and Frailty Training
 	
Impact assessment
 	
Benefits/ challenges
	• How useful did you find the Falls and Frailty training you received? Why/why not?
	  ○ How it was presented
	  ○ What it covered
	• Has the training changed how you think about and talk about frailty? (Skills and confidence levels)
	• How useful and/or difficult do you find the two key components of the training
	  ○ 'Slips and Trips' conversation
	  ○ Lying and standing BP measurements challenges/examples/required resources

Implementation of process	• What have your experiences been of implementing CSP for falls and frailty? ○ Explore role (HCA versus Nurses) & two different appointments styles (initial data gathering appointment versus 'the conversation' • What have been the main benefits and challenges of this new process (e.g. time, organisational issues)? • How useful have you found the materials you were provided with in the training

	○ 'Get up and Go' booklet, BP card, Care Planning Summary templates? ○ Which ones do you use and how? • What (other) services and resources are available to support you/your patients? Info/referrals. (Especially social isolation). • How do you think your patients benefit from what you have learned from the training/any changes you might have made to your practice? (Prevention/care/ referrals). Examples. Patient-HCP relationship. • What changes have you made to how you identify/talk to/manage/refer patients (personally/as a practice team and clinic infrastructure) since attending the training? Why/why not? Looking to the future… • What would you change about the training to make it more useful to you/your practice? Other practices in the Newcastle/Gateshead area?

Appendix 13: Pilot practices

Our thanks to:

Gateshead area GP practices

Birtley Medical Group

Glenpark Medical Centre

Teams Medical Practice

Whickham Health Centre

Newcastle area GP practices

Cruddas Park Surgery

Holmside Medical Group

The Grove Medical Group

West Road Medical Centre

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