The Dunhill Medical Trust

Picker

Exploring education and training in relation to older people's health and social care

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Picker

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- Empower those working in health and social care to improve experiences by effectively measuring, and acting upon, people's feedback.

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Executive Summary

Executive Summary

The rapid transformation of the United Kingdom's demographic mix and the resulting increasing demand on health services for the older population means that the health and social care system has to increasingly support vulnerable people with complex needs. Consequently, the models of care and the skill sets necessary to care for older patients must adapt to meet these needs. Several major reports and studies have noted the sluggishness of policy and practice to respond to the growing demand, including the need for education and training to correspond with the needs of health and social care staff in order to prepare them for providing care to the population they serve. The extent to which knowledge, skill mix, and attitudes of those who work in health and social care, and the culture within which staff operate are adapting speedily enough to this transformation, is unclear.

To gain a deeper understanding of the extent to which health and social care staff are equipped to provide high quality care to older people, Dunhill Medical Trust commissioned Picker, a not-for-profit healthcare research organisation, to conduct research focussing on the education and training of health and social care staff, and the impact on older people's care.

Aims & Methodology

The overarching aim of this study was to investigate the extent to which the health and social care workforce is equipped to manage the demographic transition and to identify potential deficiencies in education or training, and the impact on the care of older people. The key research questions were:

- What does the training landscape for older people's care currently look like, and what guidelines and standards exist for training and education of health and social care staff?
- What do health and social care staff believe are the barriers and facilitators to providing high quality care for older people?
- What are the views of health and social care staff on the training and education they have received?
- Is there a link between the quality of staff education and training and the patient experience of older people; as well as clinical outcomes for older people?

The methodology involved three components: a knowledge audit involving desk research and telephone interviews with eight stakeholders; qualitative telephone depth interviews with 41 health and social care staff; and a systematic review. A patient and public involvement (PPI) advisory group was set up and played an important role throughout the project. Interviews with stakeholders and staff shed light on the current education and training landscape, as well as key knowledge and skills that staff require, and that should be incorporated in the planning and designing of education and training programmes. The systematic review consolidated the evidence of education and training programmes that have been implemented with staff, and directly or indirectly measured the impact on older people's care.

Key Findings

Education and training can impact outcomes, however existing research is scarce

The systematic review explored the evidence of the impact of education and training of staff on outcomes for older people's care. Studies that incorporated some element of training staff and measured the outcome on older people's care were included (n=36). The findings revealed that there is a link between education and training, and patient experiences and clinical outcomes, with more evidence for the latter. That said, there was little comparability between studies as they ranged in study design; the manner of training; the staff group trained; and the outcomes measured.

Type of training

Ten of the studies had training as the key intervention. Most had training as either part of a larger initiative (such as working in a new ward designed for older people's care); or the training was directed at teaching staff how to implement a subsequent intervention (such as using a new measure or tool to screen for dementia). The theoretical underpinning to the training provided was not clear in all cases, and some publications made the assumption that provision of training resulted in behavioural change, with consequent patient outcome alterations.

Staff trained

The staff groups trained within the included studies were diverse, with a focus on nurses and carers, in care and nursing homes. Given that many vulnerable elderly people live in and are cared for in these settings by these staff groups, this focus is expected. That said, many of the studies did not provide detail on how many, or which type, of staff were trained.

Impact on older people's care

Nineteen categories of outcomes were measured, including broad metrics of mental health; healthcare use (including admission, length of stay, readmission); a specific measure for depression; and quality of life; processes of care (including complications); functional status (residency changes and activities of daily living); medications use; pain; general health status; and others. In the 36 included publications, 33 showed an impact on any outcome for older people, with conflicting findings for each outcome type. Publications demonstrating these impacts included nine articles where the interventions consisted in training only, 12 where training was to deliver the intervention, and 12 where training was part of a wider initiative.

Variation and inconsistency exists in education and training across geographies and professions

The rapid evidence review, and the interviews with stakeholders and staff revealed the education and training for those working in health and social care is varied and inconsistent. Differences exist between organisations (i.e. between care homes or trusts), and across sectors (i.e. health care and social care): more operational consistency is needed so that sectors are speaking the same language. Despite the increasing demand, care of older people is not felt to be a substantial focus in health care education by stakeholders, for example some undergraduate medical courses include only 5 weeks of 'care for the elderly' in a 5 year curriculum.

For those working in social care, such as care homes or domiciliary care, although a 'Certificate of Fundamental Care' has been a compulsory part of care staff induction since 2015, stakeholders and staff felt this was not sufficient to ensure high quality care. Some staff also expressed concern over the lack of experience and basic skills of those moving into social care.

Continuing education

There were varied accounts from staff about access to continuing education and training. When staff were able to acquire skills and knowledge, it was immensely beneficial and instilled confidence in their ability to perform their duties. However, once core training requirements have been fulfilled, there is a lack of consistency and quality control over continuing education.

> "We have no set programme…we do our 3 year degree and we could then work for the next 40 years in healthcare for the elderly… without any extra training…there is no way of progressing because there is no training scheme…there is no need to do it [extra training]… It has an impact on people's understanding obviously, and their education about what patients need and how to treat patients." (Stakeholder, Interview #1)

Medical staff were far more likely to report they had good access to continued education and training than social care staff. However, this was not always the case, for example, a nurse or allied health professional will undertake their three year degree but then there is no impetus to train further. Care home staff can face a particular dearth of further education options, although this seems largely dependent on the individual care home provider or employer.

There are some positive signs of change though, with some medical schools providing dedicated and more substantial teaching blocks to care of older people.

Traditional models of education and training hinder holistic approach required

Siloed training and working

Staff felt that siloed working still exists between different sectors and professions, which can be particularly problematic in care of older people. As individuals age, their care needs may change, and they may require more support arising from complex physical and mental health conditions. As such, caring for older people is multifaceted and having the skills and knowledge to assess and manage the multi-system nature of 'geriatric syndromes', as well as potential polypharmacy, is essential.

> "We need to look at education initiatives that expose people to the whole spectrum of healthcare…and also harness the potential of the care home sector to be a real educational powerhouse… that's another way that you could get that sort of system overview so that everybody has a better feeling for how the whole thing hangs together." (Stakeholder, Interview #4)

Segregation often begins in the classroom: training is still based on traditional medical models and single-organ based specialisation, resulting in professional and clinical silos, and fragmented service provision. As such, the holistic approach to care that is required for those with multi-morbidities is lacking.

Promoting geriatrics and post-graduate training and specialisation

Older people are and will be part of almost every staff's patient or client population. However, there may still be deficiencies in addressing specific learning outcomes in geriatric medicine. In addition, once specialised, there is a risk that clinicians will stay in professional silos, where care competencies, including knowledge of mental capacity, delirium, and frailty, may be neglected. As such it is important that, regardless of specialty or role, caring for older people and understanding their needs is incorporated in all training and education programmes. For those further along in their careers, having refresher courses or keeping up-to-date with best practice is important. There seems to be a lack of training at postgraduate level in both nursing and medicine: creating more geriatricians may be part of the solution but ensuring that front line workers in specialities, nursing and general practice, are properly trained is equally, if not more so, important.

> "[W]e need to illustrate to students that it doesn't matter what speciality they choose, a large proportion of their work will be care of the elderly because that's the reality of medicine in this day and age, hospital is largely full of older people…" (Stakeholder, Interview #3)

Geriatrics in itself, has also not been seen as a preferred or valued pathway. This was the view of the senior clinical staff interviewed, particularly when reflecting on their own education and training. Although junior staff were more positive about the education they had received, and the extent to which care for older people was a focus in their training.

> "I think the recruitment crisis in geriatrics is because it's not seen as a sexy topic or something that's exciting and challenging and so people don't choose it as a career path in medicine…we need to show that it is really exciting and challenging" (Stakeholder, Interview #3)

Suggested methods of education and training emerged quite strongly from the interviews. Practical experience was highlighted as being particularly necessary to equip staff to provide care to older people. Learning how to work in, and learn from multidisciplinary teams, as well as interdisciplinary teaching, shadowing, and mentoring could also expand staff's skills, knowledge, and their approach to providing care. Furthermore, embedding caring for older people in all education and training programmes, regardless of specialty or role was viewed as incredibly important, as older people are and will be part of almost every staff's patient or client population. This also includes staff further along in their careers or those in acute specialties, having refresher courses.

Systemic issues hinder education and training

Resources and organisational culture

Organisational culture and environment seems as varied as the levels of education, and is impacted by, and impacts access to training. Similarly, restricted resources was a significant barrier for many to gain access to training. Lack of funding results in staff shortages, which creates a culture where 'getting the job done' is prioritised over the upskilling and development of staff. This was reflected in the organisational culture which would not, or could not, support further training, and staff feeling pressure or guilty when leaving their colleagues to continue working while they were away. In social care, in addition to these cultural and resourcing issues, staff reported marked discrepancies between providers' commitment to requiring continued education for both junior and more experienced staff.

The pressures of increased demand without the necessary resources in place to support staff has a significant impact on their ability to provide high quality care to older people, who receive sub-optimal care as a result. Lack of time not only impacts staff's ability to afford patients and service users the time required to understand their views and needs, and provide holistic and person-centred care, it also hinders communication between staff, and services.

> "We never get offered it. We never get told "we can do this". Nor, do we get encouraged, to be honest, maybe that's just the care home we're in because it's so busy. Maybe it's because they don't want the staff obviously going out on day courses so to speak, which is a shame really. And sometimes you feel frowned upon if you do ask to go on a course because it's like, well why would you need that, we could show you that here". (Junior carer, private, #27)

Lack of incentive and motivation

With little formal educational requirement to care for older people in place, there is often no incentive for staff to receive or seek out additional training. There is often no compensation or financial incentive for the physically and emotionally draining work, consequently skilled and motivated staff are not attracted to these roles. In some instances, care home staff are expected to pay for their own additional training with their time, money and travel. The lack of encouragement and motivation, as well as the lack of any perceived personal benefit was seen to lead to complacency, as such, staff were not driven to acquire or seek out training. For example, no perceived career progression or pay rise

This absence of investment in staff training can make them feel undervalued. Such a culture can often foster discontent amongst the workforce, and this, coupled with little to no compensation or reward, and long hours can culminate in a level of disengagement that can be difficult to reverse, leading to high staff turnover and a depleted workforce. Many felt that low staff morale and motivation could also impact attitudes towards older people. Those working in social care and community settings in particular highlighted the impact that this can also have on recruitment i.e. quality of applicants, and staff turnover.

There is a demand for information and training on: 'who does what'

How professionals access information about other resources and, or specialties that might be beneficial to older patients emerged as a central theme. This is closely linked to the idea of working in siloes and the lack of knowledge and information sharing that occurs all too often. Because older people's conditions can be complex, they often need a number of different services (both health and social care). However, few staff felt they had a good understanding or knowledge of services outside their immediate remit including: their responsibilities; capability; or even their existence. This reportedly impacts the continuity as well as the quality of care they can provide, as staff are unaware of their patients' full care pathway, or any other services they are accessing. Having better knowledge of available services and their roles would facilitate safe and coordinated care pathways for older people, as well as equip staff with additional resources to call upon when this is required, ultimately resulting in holistic care.

> "I would say my weakest point in my practice, even 25 years on, is that I say to people, oh 'I'll find out for you', and then I just don't know where to go or how to get it. It'd be nice to have it there to hand so you can just say, 'I don't know, but this person is the one to contact'." (Senior AHP, #22)

There is a need for education and training to go beyond clinical care

Person-centered care

Staff reflected on what they felt the key needs of older people are which included physical, mental, social, and emotional needs, and how these are inextricable. As such, caring for older people is complex and requires a holistic and person-centred approach. It necessitates services and staff to work together efficiently to provide continuity and comprehensive care. The need for integrated services, and inter- and multidisciplinary working and learning is crucial to provide high quality care. As noted above, a key challenge to providing holistic care raised in the research, is the siloed working that exists between different sectors and professions. Immense lack of time owing to staff numbers and work volume also severely impedes their ability to afford patients and service users the time required to provide person-centred care.

> "When you talk to people about what they find challenging about the work… it's about the training that we need to work in a different way, working in a person-centred way, an integrated way. So it's the sort of skills and behaviours and attitudes that we need for that way of working as much as it is about the content…" (Stakeholder, Interview #5)

Community care

The social needs of older people were highlighted: ensuring people are able to stay independent and in the comfort and safety of their own home was recognised as crucial. However, this should not be to the detriment of social interaction, resulting in isolation and loneliness which was a particular concern for those interviewed. Again, knowledge of the available services in the community was viewed as important to ensure older people can receive safe care in their home. This included knowledge of 'step-up' services so as to avoid, for example relying on accident and emergency or patients being admitted to secondary care unnecessarily, where they are at risk of infections or becoming 'a body in a bed', without any context. Similarly, staff in secondary care should have better knowledge of 'step-down' services, so that patients can be safely and appropriately discharged with the necessary support. Therefore, greater support for, and value of social care is needed to ensure sufficient and appropriate resources are available to care for older people. Yet many felt that multiple constraints on staff and the system is a significant hindrance to this which has a great impact on older people.

Compassionate care

Another central theme was the need for compassionate care. This was highlighted by members of the PPI group, stakeholders, and staff. Positive values and attitudes were viewed as core qualities that staff should have to ensure older people are afforded respect and dignity, as well as having their views and preferences incorporated in their care. Although for the most part these values were seen as connected to personal motivations, experiences and demeanour, many felt that it can be instilled through training, including mentoring and role modelling.

> "Older people's views are generally not that people should be better trained…it's that they should …behave well, be friendly, be kind, be compassionate and whether or not that's a matter of values and characteristics and the culture of the institution…it's difficult to say that you can train people to be kind." (Stakeholder, Interview #6)

Areas for focus in training

There is a general consensus about some of the key things that potentially impact outcomes in older people's care, and therefore should be encompassed in training and education. These include:

- Person-centred or relationship-centred care
- Multi- or interdisciplinary working and learning
- Integration of health and social care services
- Care co-ordination and planning
- Complex health education
- Practical (rather than virtual or didactic) learning initiatives
- Continuing professional development and education for community carers
- Comprehensive Geriatric Assessment (CGA)

Comprehensive geriatric assessment (CGA), is a multidimensional and interdisciplinary diagnostic process, which enables holistic focus on an older person (medical conditions, social situation, mental health and so forth). It is a very helpful tool for clinicians, particularly as there are not enough Geriatricians to cope with the population, but the key is how this tool is used in practice, and how well it is understood.

Conclusion

The global population is ageing, and the increased demand from this populace is, and will have a significant impact on the provision of health and social care. The issue of providing high quality care to older people is complex and multifaceted. Consequently, the models of care and the skillsets necessary to care for older patients must adapt in order to meet their needs. Yet, several major reports and studies have noted the sluggishness of policy and practice to respond to growing need. Included in this is the need for education and training of health and social care staff to correspond and reflect the needs of staff in order to prepare them to provide for the actual population they are and will serve.

Using a combination of methods this report set out to explore the current education and training landscape of health and social care staff as well as exploring how well professionals think the education and training they receive is equipping them to deal with the increasingly complex needs of an ageing population. Interviews with stakeholders and staff shed light on the current education and training landscape, as well as key knowledge and skills that staff require and should be incorporated in the planning and designing of education and training programmes. The Systematic Review consolidated the evidence of education and training programmes that have been implemented with staff and directly or indirectly measured the impact on older people's care. It is hoped that the findings in this report will serve as a first step in understanding how the health and social care workforce can be equipped to provide high quality care to older people, and that continued conversations and debates will lead to further exploration.

CHAPTER 1

Introduction

Introduction

The global population is ageing, with the number of people aged over 60 projected to rise from an estimated 962 million to 2.1 billion worldwide by 2050.[1] This demographic transition has significant implications for the provision of health and social care. As individuals age, they are increasingly likely to suffer from complex co-morbidities and associated 'geriatric syndromes', including delirium, falls, and urinary incontinence.[2] These conditions can result in multiple drug treatments, with the potential for associated interactions and side effects. In addition, older patients often require palliative and end-of-life care.[3]

Consequently, the models of care and skillsets necessary for the care of older patients are distinct from those for the care of younger patients. The chronic and complex conditions that many older people suffer from means that specific training is required to sufficiently meet care needs.[4]

The purpose of this research is to investigate the extent to which the health and social care workforce is equipped to manage the demographic transition and to identify potential deficiencies in education or training that impact on the care of older people.

Health and social care for older people

The quality of health and social care for older people has been the subject of several major reports.[5–8] In particular, the Francis Report, following the Mid-Staffordshire NHS inquiry, highlighted serious failings in the provision of care for older adults.[9] The report made 209 recommendations, including improved education and training for healthcare staff, with a particular emphasis on safety.[9] The failings outlined in these reports suggest that the health and social care workforce are inadequately equipped to meet the care needs of older patients.

In a 2015 review of more than 130 countries, the World Health Organization (WHO) noted that "there is low priority within health policy to the challenge of the demographic transition" and "there are low levels of training in geriatrics and gerontology within the health professions, despite increasing numbers of older persons".[10] They identified training and education of healthcare staff as one of the key components of a global health-policy response to ageing populations.[10] Whilst the National Institute for Health and Clinical Excellence (NICE), the Royal College of Physicians (RCP), and the Royal College of Nursing (RCN) have guidelines for the provision of care, guidelines and standards for the provision of education vary by professional group.

Care Staff

The current training and education landscape in the UK, in relation to older people's care, is varied and inconsistent: the lack of mandatory training or registration for the 1.3 million non-clinical healthcare assistants and care workers in the public and private sector has been subject to particular scrutiny.[11] Despite the fact that these staff are providing hands-on physical and emotional care for older people, there have historically been no compulsory or consistent training requirements for care workers.[12–14]

In the wake of the Mid-Staffordshire inquiry, the government commissioned a review of the recruitment, training, supervision, and support, of non-clinical care staff,[11] which suggested that common competencies and training requirements should be implemented across health and social care. Specifically, it proposed a 'Certificate of Fundamental Care' that all care staff will be required to achieve before working unsupervised. The Care Certificate has been a compulsory part of care staff induction since 2015.[15]

The introduction of mandatory certification, however, is not sufficient to ensure quality care for older patients. Care staff often experience poor working conditions, low pay, low status, and

associated low morale.[16] It has been suggested that there is a mutually reinforcing relationship between high turnover rates and perception of low competency in core skills in care home staff.[16] These factors need to be holistically addressed to train and retain a long-term care workforce.

Nurses, Medics, allied health professionals

The training and education requirements for clinical staff, including doctors, nurses, and allied health professionals, are similarly varied and inconsistent. In the UK, all clinical staff are required to achieve professional qualifications to complete their registration. However, despite the fact that care of older people involves specialist skills, including knowledge of dementia care, safeguarding, assessment of mental capacity, falls training, and general competencies in compassionate and person-centred care, there is no specific qualification in nursing care for older adults.[12]

Similarly, whilst junior doctors undertake rotations through different specialities throughout their training, there is no guarantee that they will receive specialist training in geriatrics.[4] For example, a global survey of 36 countries found that 27% of medical schools did not provide training in geriatric medicine.[10,17] A UK survey of undergraduate teaching in medical schools highlighted deficiencies in addressing specific learning outcomes in geriatric medicine.[18] In addition, once specialised, there is a risk that clinicians will stay in professional silos, where care competencies, including knowledge of mental capacity, delirium, and frailty, may be neglected.[19]

The WHO suggests that whilst "the needs of older people will be best met if all professionals receive adequate training in geriatrics, this cannot be achieved without a critical mass of specialist geriatric expertise or the availability of geriatricians to see and treat complex cases".[10] However, historically, geriatrics has been viewed as a specialism with low earning potential and low prestige, impacting on recruitment of trainees and consultant geriatricians.[4,12]

Models of care

Improving clinical geriatric education and training may be a necessary but not sufficient condition for providing high quality care for older patients.[13] Currently, the healthcare system is oriented towards single-organ disease models, resulting in professional and clinical silos, and fragmented service provision. The multi-system nature of 'geriatric syndromes', requires a multidisciplinary and holistic approach to care. Consequently, the provision of high-quality care depends on the coordination and collaboration of multiple health and social care professionals.

Further, the WHO suggests that healthcare professionals should be trained in non-medical processes and models, including shared decision-making, multidisciplinary care, and prevention of ageism, to provide holistic geriatric care.[10]

Impact on Older People – sub-optimal outcomes

The existing literature on education and training in the context of older people's care is wide-ranging and heterogeneous, with a particular focus on care homes.[13,20] Studies address a broad range of specific interventions, including training in polypharmacy,[21] dementia,[22] falls prevention,[23] and end-of-life/palliative care.[24] Assessments of educational and training interventions are often discussed in conjunction with other interventions; for example, organisational, including multidisciplinary working and coordinated care, or technological, such as clinical decision support systems.[25]

The heterogeneity of education and training interventions, healthcare professionals, and settings, has resulted in variable measurement and evidence of impact. However, there remain concerns that deficiencies in education and training impact negatively on the quality of care for older people.[13]

Given the recognised importance of provision of care to older people, and the acknowledged shortfalls in quality, Dunhill Medical Trust commissioned Picker to conduct research to further investigate the provision of staff training, and the impact thereof, on older people's care.

Research Aims

The overarching aim of this study was to investigate the extent to which the health and social care workforce is equipped to manage the demographic transition and to identify potential deficiencies in education or training that impact on the care of older people. The evidence for or against associations between educational training and care quality is currently unclear. Employing a combination of research methods, we aimed to explore the following key research questions:

1. What does the training landscape for older people's care currently look like, and what guidelines and standards exist for training and education of health and social care staff?
2. What do health and social care staff believe are the barriers and facilitators to providing high quality care for older people?
3. What are the views of health and social care staff on the training and education they have received?
4. Is there a link between the quality of staff education and training and the patient experience of older people; as well as clinical outcomes for older people?

CHAPTER 2

Methodology

Methodology

To explore the questions set out for this study, the research involved three components: a knowledge audit involving desk research and stakeholder interviews; qualitative in-depth telephone interviews with health and social care staff; and a systematic review. A patient and public involvement (PPI) advisory group was set up and played an important role throughout the project.

Table 1: Methods

Research question	Method
Explore the current landscape of education & training for health & social care staff	Interviews with stakeholders
Explore staff's views of education & training, & providing high quality care to older people	Interviews with frontline staff
Link between education and training and older people's care	Systematic review

Patient and public involvement (PPI) advisory group

To support the development and enrich the insights of the study, a Patient and Public advisory group was established to work with the research team throughout the project. By including an advisory group of people with a lived experience, a different type of knowledge and a greater understanding of the issues being explored were realised, resulting in a more meaningful research project.

Four older people/patients (60+) were recruited via social media channels, using a brief 'job description' which outlined the purpose of the research and the input required from members. Panel members were offered payment for their time (£20 per hour) and reimbursement of any travel costs. The four members were from various locations across England: London, East Sussex, Birmingham, and Chester. They all had a particular interest in the topic from personal experiences and working or volunteering with older people. One member was a retired dentist who had experience training junior staff. Another worked in local council and had experience of commissioning and overseeing training and education needs of social care staff, as well as having personal experience of an elderly family member who was receiving care from a variety of health and social care services. The remaining two had extensive experience volunteering in care homes, and one had a family member who worked in care homes as a nurse.

The members' knowledge and experience provided invaluable insight into the landscape of older peoples' care, and augmented the research by providing background and context to the various sectors; sharing what they see as important to older people, particularly around their care; and reflecting on the health and social care staff that work with older people. The in-depth discussions that researchers had with the PPI group members shaped the sampling strategy for the stakeholder and staff interviews. They considered what questions would be important to ask staff in the interviews and what contextual factors may impact their views.

The PPI group will assist with planning dissemination activities at the end of the project.

Knowledge audit

The first phase of this research aimed to consolidate existing knowledge around older people's care quality and health and social care staff training and education. The knowledge audit entailed a scoping review and interviews with stakeholders.

Scoping review

The scoping review served as a rapid assessment of evidence, and the purpose was two-fold. Firstly, for the researchers to familiarise themselves with the key themes and issues around this topic, including any existing guidance or standards. This assisted with defining and developing the tools used in the study, such as the interview topic guides, and to identify stakeholders to approach. Secondly, the scoping review was used to define and assess the appropriateness of the inclusion and exclusion criteria for the full systematic review, and to determine if there was sufficient evidence to address whether education and training for staff impacts older people's quality of care. The scoping review is not separately reported as its outputs are part of the interview and systematic review methods, and described in those sections.

Stakeholder interviews

Telephone interviews of 45 to 90 minutes were conducted with eight stakeholders in various roles and across sectors, outlined in Table 2 below. They were each involved in education and training for those who care for older people. The aim was to gain a top level understanding of the current education and training landscape, what existing initiatives were in place, and what, if anything, was lacking in this area.

The interviews were conducted using a predetermined interview topic guide developed by Picker and followed a semi structured format allowing the interviewer flexibility to ask follow-up questions based on the emerging discussions and those relevant to their expertise. This broadly covered the following areas:

- What the current landscape of education and training for staff looks like to equip them to work with older people (including any policies or guidelines) and how it is delivered?
- Whether, in their view, there is an impact of education and training on outcomes for older people's care, or conversely whether deficiencies in education and training lead to poor outcomes?
- What the key areas are that education and training should focus on to ensure high quality care for older people?
- Whether they feel there are any particular gaps in education or training for specific staff groups?
- Are there any good practice or initiatives that they are aware of?

All interviews were voice recorded and subsequently transcribed, to enable ease of analysis of key themes. Consent was sought to report stakeholder's role or position, as such they are not anonymised.

It is worth noting, that the sample size is conservative and although the findings contain some rich and interesting data, they represent the opinions of a small number of people and should not be taken as representative for the population as a whole.

Table 2 outlines the job titles of the stakeholder interviewed.

Table 2: List of stakeholders interviewed

Stakeholder job title
Professor of Rehabilitation Research and Occupational Therapist, University of Nottingham
Consultant in elderly care medicine, Senior Lecturer and Training Programme Director for Geriatric Medicine in the North East., Health Education England
Academic GP and Joint Academic Lead for Medicine for Older People, Bristol Medical School
Clinical Associate Professor in Medicine of Older People - University of Nottingham, Visiting Professor - City University London, Consultant Geriatrician - Derby Teaching Hospitals NHS Foundation Trust
GP with special interest in the care of older people, Associate National Clinical Director for older people and integrated person-centred care, NHSE
Professor of social work King's College London & Director -Social Care Workforce Research Unit - visiting Professor University of Melbourne & Ulster University
Professor of nursing care for the older adult, City University, Executive Director 'My Home life'
Honorary (Consultant) Assistant Professor, Division of Rehabilitation and Ageing, University of Nottingham

Staff interviews

Researchers at Picker conducted 41 telephone interviews with staff in the various roles outlined in the 'Sample' section. The interviews lasted between 45 minutes and an hour. Telephone interviews were deemed the most effective way of accessing this population as staff are often stretched for time, which would have made it logistically difficult to schedule focus groups. Further, this method was appropriate as individuals worked in different settings, specialties, and had differing levels of experience therefore the interviewer had more flexibility to ask follow-up questions based on the emerging discussion.

The staff interviews, including the questions and the sample of staff interviewed, were shaped and informed by the findings from the knowledge audit and input from the PPI group. For example, given the importance placed on care for older people in this setting by stakeholders and the PPI group, a greater focus was placed on social care and the number of staff interviewed who work in social care was increased.

Interviews were conducted using a semi-structured topic guide developed by Picker. Although the same topic guide was used for all staff, there was some flexibility to vary the emphasis depending on the role of the staff member, with questions covering:

- Background of their role, including how often they provide care to older people, and how they came to work in their role?
- Whether the health and social care sectors are equipped to work with older people, particularly as demand increases?
- What the key care needs for older people are, in their view?

- What do they find particularly challenging, or facilitates them to provide care for older people specifically?
- If and how education and training could or should assist them to feel more confident in providing care for older people? Including, what education they have received, and what they would like more training in.
- What the impact on older people's care is when education and training are lacking?

Sample

The purpose of this phase was to include the views of as broad a range of staff as possible, in terms of the sector they work in, their level of experience working with older people, and their years in practice such as junior nurses and doctors, to senior consultants. We included:

- Community care givers – including allied health professionals, those providing domiciliary care, and care to older people in care homes (nurses and non-clinical carers).
- Primary healthcare professionals – GPs and practice nurses.
- Secondary healthcare professionals – consultant geriatricians, 'other' consultant specialists, geriatric nurses, and nurses working in other acute care settings.

A detailed description of the requirements for each staff category can be found in the recruitment specification (see Appendix A), which defines sectors including what was viewed as 'council' or 'private' for care staff.

Given the range of staff included in this phase, a professional recruiter supported the recruitment. Picker provided a detailed Recruitment Specification, outlining the key demographics and requirements for each staff group and an information sheet to be shared with potential participants. Participants were provided with information about the research and asked to give their informed consent. Once eligibility was established, an interview was scheduled at a mutually suitable time. Participants were asked to provide informed consent and were assured that all their information would remain confidential and anonymously reported. Interviewees were remunerated for their time as a thank you. All interviews were digitally recorded and transcribed with consent from participants. Table 3 provides full details of the sample of staff interviewed.

Table 3 Sample of staff interviewed

Cohort Requirements	Number interviewed	Sector
Junior Allied Health Professional	n=2	Community
Senior Allied Health Professional	n=4	Community
Junior non-clinical Carer - Private	n=2	Social care: care home & domiciliary care
Junior non-clinical Carer - Council	n=2	Social care: care home & domiciliary care
Senior non-clinical Carer - Private	n=3	Social care: care home & domiciliary care
Senior non-clinical Carer - Council	n=2	Social care: care home & domiciliary care
*Junior care home nurse - private	n=0	-
*Junior care home nurse - council	n=0	-
Senior care home nurse - private	n=1	Social care: care home
Senior care home nurse - council	n=2	Social care: care home
Junior GP	n=3	Primary care
Senior GP	n=3	Primary care
Medical School Doctor	n=2	General training
Junior Doctor	n=2	Secondary care
Trainee Nurse	n=3	General training
Senior Geriatric Nurse	n=2	Community; Secondary care
Senior Nurse - secondary care	n=2	Secondary care
Geriatrician	n=2	Secondary care
Senior Consultant (non-geriatric)	n=4	Secondary care
Total	**41**	

**We were unable to recruit any junior nurses working in care homes. We used various methods to access this group: our external recruiter; contacting senior nurses and care home carers for recommendations; and social media platforms. That said, we have fair representation from the care home and social care sector to mitigate this.*

Analysis and reporting of interview results

Audio-recordings from the stakeholder interviews and interviews with staff were transcribed, and for staff interviews the personal details anonymised. Researchers initially followed inductive analysis whereby they familiarised themselves with the transcripts and conferred to identify initial themes emerging from the data. Following this, a framework was developed in which data from the transcripts were coded and synthesised allowing researchers to look both across and within individual cases to explore themes. The framework was dynamic and fluid, allowing for subsequent themes to emerge as researchers coded the data.

Findings from the thematic analysis were used to identify key concepts and patterns for each staff group. Verbatim quotes are presented throughout the report in *purple italics.* Direct quotes from stakeholders are distinguished by an interviewee code (see Table 4, located in Chapter 3). For staff, direct quotes are followed by their role and a number to distinguish between participants. The quotes are to illustrate certain viewpoints, particularly where there was broad agreement about an issue. Where there are differing views, these are presented. It is important to remember that the views expressed do not always represent those of all participants.

Systematic review

To explore the evidence of the impact of education and training on the quality of care for older people, specifically clinical outcomes and patient experiences, a systematic review was conducted, following best practice guidelines. The systematic review is presented as a whole with detailed methods, results, and discussion (Chapter 5).

Ethics

All fieldwork complied with the Market Research Society Code of Conduct (2014). The proposed project was submitted to Picker's internal ethical review and was peer reviewed. Ethical approval was not required for this project in line with the Health Research Authority guidelines, as the project was deemed a service evaluation. Participants were not randomised and there was no intervention that changed patient treatment or care pathways. The project has been recorded on the organisation's research register database.

CHAPTER 3

Stakeholder interviews

Stakeholder interviews: Results

The eight stakeholder interviews provided an overarching insight into the current education and training landscape. Stakeholders came from a variety of settings and backgrounds. The aim was to gain a top level understanding of this area, what existing initiatives were in place, and what, if anything, was lacking.

Throughout the interviews, direct quotes are followed by an interviewee code (see Table 4). Findings are presented by theme.

Table 4: List of stakeholders interviewed

Stakeholder job title	Interviewee Code
Professor of Rehabilitation Research and Occupational Therapist, University of Nottingham	Interview 1
Consultant in elderly care medicine, Senior Lecturer and Training Programme Director for Geriatric Medicine in the North East., Health Education England	Interview 2
Academic GP and Joint Academic Lead for Medicine for Older People in the Bristol Medical School	Interview 3
Clinical Associate Professor in Medicine of Older People - University of Nottingham, Visiting Professor - City University London, Consultant Geriatrician - Derby Teaching Hospitals NHS Foundation Trust	Interview 4
GP with special interest in the care of older people, Associate National Clinical Director for older people and integrated person-centred care, NHSE	Interview 5
Professor of social work King's College London & Director -Social Care Workforce Research Unit - visiting Professor University of Melbourne & Ulster University	Interview 6
Professor of nursing care for the older adult, City University, Executive Director 'My Home life'	Interview 7
Honorary (Consultant) Assistant Professor, Division of Rehabilitation and Ageing, University of Nottingham	Interview 8

Current education and training landscape overview

Generally speaking, education and training provision for those working in care of older people is varied, inconsistent and difficult to gauge (particularly within the care home sector).

> *"…every home you go into is different, the way it's run is different, the leadership is different, so it's very hard to come out with a generalised statement of within the care home sector this is what training or learning and development looks like because it's different everywhere." (Interview 8)*

Differences exist at an organisational level (i.e. between care homes and between trusts) and across sectors (i.e. health care versus social care). These differences can depend on a number of factors, aside from job roles and organisational remit, such as how training is regulated in a particular field and the engagement of management:

> *"I'm working with a trust…they wanted a level of frailty awareness across their organisation so they've decided to put in an e-learning brief frailty awareness module that everyone has to do and will sit alongside other things like fire safety…that's something they've chosen to do themselves because they think it's important…not because anybody's said, 'everybody's got to'." (Interview 5)*

Those staff working with older people often receive general training, but despite the increasingly elderly population accessing health and social care services, care of older people seems not to receive substantial focus in education. For example, in a 5 year curriculum of a medical undergraduate, 'care of older people' might be covered in a total of 1 or 2 weeks (5 weeks maximum). Training is still very much based on traditional models and single-organ based specialties. In nursing, although the RCN states on its website that "care for older people represents the largest area of adult nursing in the UK," there is a lack of technical training dedicated to older populations, within undergraduate curricula:

> *"I was involved when the National Service Framework for Older People came out…I remember pulling together the literature on best practice in acute hospitals in caring for older people, and what struck me was there was nothing new to write about, the same issues had been written about for decades….the only new bit is that we've not yet acted on it, so that tells us that it's not embedded in our education and training enough…" (Interview 7)*

For some professions, such as those working in allied health, an undergraduate degree is all the training that a member of staff might receive in their career:

> *"For the nurses and Allied Health Professional, we have no set programme…we do our 3 year degree and we could then work for the next 40 years in healthcare for the elderly… without any extra training…there is no way of progressing because there is no training scheme…there is no need to do it [extra training]… It has an impact on people's understanding obviously, and their education about what patients need and how to treat patients." (Interview 1)*

This training is still more than some other staff receive though, for example, staff working in care homes can have fragmented and poorly defined training. This appears to be largely down to the individual care home and is not necessarily a reflection on whether they are NHS, local authority, or privately funded:

> *"There is accredited training…but it will be down to care home owners and managers as to whatever way they want to and I don't get the impression from the staff that there's a national requirement that they do that, because as long as they can say yes every year*

you have had moving and handling training, or fire training, there doesn't seem to be much recourse as to where that's been accessed from, it could be another member of staff delivering as cascade training - great if it works, but I'm not sure where the quality control is..." (Interview 8)

However, there are some signs of change - albeit slow moving - and increasingly more specific training in care of older people is being offered. This tends to focus either on a particular area (e.g. falls prevention or dementia) or a specific setting (e.g. postgraduate level training for registered nurses working in care homes (see Table 4 for examples)). Education of doctors within care of older people is starting to concentrate more on management and application of knowledge, rather than clinical skills. There is still some way to go in terms of content: end of life care often largely focuses on a palliative care model – a useful framework (and appropriate in some cases) – nevertheless, this does not reflect the fact that some people simply die of old age. Many staff are ill equipped to manage complexity in care of older people.

Impact of education and training on care

It is difficult to measure the direct impact that training has on care of older people, within the scope of this study, because it is hard to disentangle from any other factor or intervention.

"There's a lot of evidence that if people are trained, that improves not only their wellbeing and job satisfaction but also retention and recruitment…there are obvious patient benefits to that but it's an indirect line to actually measuring a patient outcome, so I don't know if there's much evidence for that at the moment." (Interview 5)

There is a general consensus (from stakeholders and the PPI group) about some of the key things that potentially impact outcomes in older people's care, and therefore should be a focus in education.

These include:

- Person-centred or relationship-centred care
- Multi or interdisciplinary learning
- Integration of health & social care services
- Care coordination and planning
- Comprehensive geriatric assessment
- Complex health education
- Practical learning initiatives
- Community care

Comprehensive geriatric assessment (CGA), is a multidimensional and interdisciplinary diagnostic process, which enables holistic focus on an older person (medical conditions, social situation, mental health and so forth). It is a very helpful tool for clinicians, particularly as there are not enough Geriatricians to cope with the population, but the key is how this tool is used in practice, and how well understood it is:

"I'm involved in a project that's about comprehensive geriatric assessment and what's come out of that for me is that nobody can really define properly what it is… you have to really be able to coordinate care to be able to deliver that assessment… those sorts of approaches that will help us break down the siloed working… how do they make this happen in the real world, and it's not just about going in and assessing, it's about how do we coordinate care to then deliver it, and that requires all sorts of skills…" (Interview 7)

There are signs that a multidisciplinary approach is infiltrating training, which allows staff to gain a broader understanding of the complexity of caring for older patients. This helps ingrain the idea of integration of services, to dissolve silos that exist between different sectors and organisations, smoothing the way for more cohesive care across the board. But this training could be significantly better and staff need access to a range of different specialties to hone their skills and be competent in caring for an older population:

"We've started broadening our net a little bit…when I trained, most of it was hospital-based, if I went to a GP I sat with the GP, I certainly never saw an allied health professional, a

district nurse, a carer or a voluntary organisation…I was never exposed to any of that, and actually all of those areas can provide experience for medical students to see also the non-medical side of the elderly…not just the fact that they've got something wrong with them but actually that holistic care, they can get that much more by exposure to other staff that aren't just doctors." (Interview 2)

It is important that training includes a practical and 'hands on' element, to enable staff to be more confident in using their skills and instincts, and to 'personalise' care. Staff need to have the aptitude to know when to refer a patient on and an awareness of what they *don't* know. This taps into the more relational aspects of care, which can be difficult to teach. These are not small issues to address or measure but cultivating a more solution-focussed, empowered and united work force, could lead to better outcomes for older people. After all, training in clinical skills is not necessarily what older people might cite as having the greatest bearing on their care – it is relationships that are important:

"Older people's views are generally not that people should be better trained…it's that they should …behave well, be friendly, be kind, be compassionate and whether or not that's a matter of values and characteristics and the culture of the institution…it's difficult to say that you can train people to be kind." (Interview 6)

Education focus: what should education and training include?

There are many areas that are important in education and training, ranging from the physiology of older people and dealing with multiple conditions, to the more interpersonal elements of care. Stakeholders discussed the anxiety around legal and ethical aspects and how this can impact the way in which staff deal with older patients. Alongside interdisciplinary and community approaches to care, other issues were raised such as training structure and delivery, issues of recruitment, retention and organisation culture.

"I think older people are on the map but I don't think it's recognised enough as a specialism and I think that's because you need to make a specialism out of a generalism really…we need to be more thoughtful about how we integrate it into our education and training and that's around issues of understanding the ageing processes, how to manage complexity, not just thinking about health but also social care and being able to wrap services around individuals and around the leadership required to help people to be able to do that." (Interview 7)

Person-centred care

"The biggest and most important thing is truly understanding what person-centred care is all about …because that's still a really difficult thing for us to do…it conflicts with a lot of the other things that we're taught to do…we can get finely tuned in how we understand and deal with a specific condition, but what we're not good at and what very few of us have had formal training in is how do you best support a person who's got five of those conditions all at once when all the treatments conflict with each other?" (Interview 5)

At the core of what should be included in education and training in care of older people, is what is important to *them*: being treated with compassion, respect and dignity, having their views and opinions heard and the concept of being afforded a 'good death'.

There can be a fine line between managing risk and supporting independence. Older people must be allowed to make decisions about what is appropriate for them, because what staff may perceive to be priorities, may not be important to the patient at all. Again, this is something that needs to be a central theme in education and may feel counter intuitive to some students because they are being taught primarily to provide a cure or make someone 'better'.

> *"How do we overcome our professional drive to want to make people safe, control their conditions as much as we can, but actually that may not be what the person wants…they now want to do things that may make their fall risk higher but actually their quality of life depends on being able to go out into the garden to feed the birds…" Interview 5*

Community care, integration of services & co-ordination of care

The majority of stakeholders felt that the services available are not being used effectively enough, particularly in the training arena. Care homes offer real opportunity for people to learn about caring for older people but this does not seem to happen because the sectors do not always display this level of cooperation.

"We need to look at education initiatives that expose people to the whole spectrum of healthcare…and also harness the potential of the care home sector to be a real educational powerhouse… that's another way that you could get that sort of system overview so that everybody has a better feeling for how the whole thing hangs together." (Interview 4)

There is a momentum to work force behaviours: people are very used to working in silos and part of the problem is that the services an older person might require, are not necessarily all part of the same organisation. Even when there is the desire to work together, this can be very difficult, due to differences in how organisations function:

> *"Operationally clinicians, care workers and all the different people involved are really, really keen to work together but the system often doesn't let them do that very easily. Because, for example, people have got completely different approaches in different sectors about managing risk, managing risk is a massive issue in this sort of care…there's not really any kind of training, let alone any consistent training or alignment about how people from different sectors would think about managing risk or supporting patients to make decisions…" (Interview 5)*

So structure and access to services needs to adapt; this involves interdisciplinary working, learning, utilising community services, and involving a person's own family, carers or support network. This is important because it means teaching staff to educate relatives, carers, or the patient themselves, none of whom might have clinical training:

> *"The hospital location isn't always optimal…that doesn't mean that you should be left abandoned in your own home, particularly if you're living alone, but there should be greater resource around locally for care to come into people's home …a lot of this is teaching and less clinical interaction…it's more about having skills to communicate to other people how to spot infections or something going wrong…it's more I suppose really talking to family carers and to the older person themselves about that." (Interview 6)*

Empowerment (for both staff and older patients)

Staff were often said to be overwhelmed by their work load and the fact that resources are tight. Therefore it becomes crucial that staff are knowledgeable about all available resources - and this might include the patient themselves. This can benefit the patient who is wishing to have some sense of autonomy:

> *"I suppose it's getting people to understand how important this is in maintaining their independence, and I've actually said to somebody who was very bolshy in the past who said, 'I know what I'm doing, I've just got loads of work to do', I said, 'Actually, if you enable people to do what they can and to make some choices, you might find you have less tasks to do'." (Interview 8)*

It is important to remember that whilst some older people will wish to maintain their independence, *interdependence* might be more important to those who are very frail, in which case, greater value might be placed on relationships.

Valuing staff and empowering them to make decisions is key. In particular, this includes ensuring that non-medical staff feel confident communicating with clinical staff:

> *"From a GP perspective, out-of-hours, you get called to a nursing home, often the staff haven't got the training to know how to handover… nobody can tell you what's wrong with that patient or nothing in the notes or they're are patchy…if somebody's made a plan they don't want to go into hospital and it's been decided by their GP and their family members that they're not for admission, the staff need to be empowered to be able to follow that plan through and not ring an ambulance in the middle of the night - a lot of admissions from care homes are what happens." (Interview 3)*

One stakeholder had carried out research into medical schools and whether there was adequate coverage of geriatric medicine education. The conclusion was that, it takes up a very small proportion of the curriculum and this tends to manifest in the work force:

> *"I think we've got part of the way there in that people now recognise that there are syndromes of frailty, multiple morbidity and polypharmacy, common syndromes that cause problems in later life… they've got an evidence based approach to those but they haven't yet got to the point where they feel sufficiently skilled themselves to deliver that care, and that's a potential problem for doctors because there's not enough geriatricians to go around." (Interview 4)*

Table 5: Key areas to be included in education and training (care of older people)

Area	Sub-specialty	Comment
Legal/ethical issues	End of life	Not just focussing on palliative care, understanding a patient's wishes in advance. The opportunity to have a 'good death' and to be pain free
	Consent	Legalities and complexities around consent and power of attorney, guardianship
	Maintaining liberty and autonomy	Supporting older patients to make important decisions about themselves, for as long as possible; promoting independence in the community
	Definition and assessment measures	Ensuring that key definitions (such as 'frailty' and 'old age') and assessments are consistent
Physiological	Comorbidities	High probability of treating more than one condition; polypharmacy
	Falls	Falls education, prevention and treatment; readmissions
	Frailty	Defining and measuring frailty
	Incontinence	Not just the physiological aspects, and the social and emotional impact
	Physical ability	Assessing a person holistically, not making assumptions based on age; knowledge of social/personal set up
	Physiology of older people	Comprehensive geriatric assessment; Not just focussing on palliative care models; helping older people manage transitions in terms of their health
Social care	Housing	Impact of housing issues and using local support networks (both personal and professional); helping older people transition in terms of housing arrangements
Old age psychiatry	Dementia	Insuring understanding of dementia and its impact, effective communication
	Cognitive capacity	Having a clear understanding of an individual's capacity
	Depression and anxiety	Not just the practical side of things such as falls prevention, but helping a patient with the anxiety they might feel around this happening, for example
	Finances	Ensuring access to appropriate financial services/advice
	Loneliness	Older people can be more at risk of developing loneliness as support and community networks diminish
Relational aspects	Capacity building	As part of training, staff need to be able to 'upskill' others, potentially family members or patients themselves
	Communication	General communication and having the skills, understanding and confidence to have sensitive conversations (such as end of life or a diagnosis of dementia); communication across sectors
	Empowerment of patients	Empowerment of older patients, enabling them to make decisions about their care and treatment by making sure they are informed and supported in their own care
	Empowerment of staff and students	Valuing and investing in those already in the workforce with training, attracting in new recruits, ensuring that they are comfortable making small and large decisions, know their limits and possibilities

Area	Sub-specialty	Comment
Relational aspects (continued)	Knowledge building about other caregivers/sectors	Having an understanding of how other sectors work and the operational differences that could potentially complicate or obstruct good quality care; terminology knowledge
	Person-centred/ relationship-centred care	Personalised care, with care planning; relationship building (see below)
	Respect	Taking into account what an older patient wants, not just what caregivers think they need
	Relationship building	Between caregivers and older patients; between caregivers and organisations or professionals; more focus on older carers of older people.

Barriers to learning

There are a number of obstacles to and within education and training. These include:

- Training delivery, access and regulation
- Cultural issues embedded in organisations (empowerment, staff value etc.)
- Attitudes and perceptions:
  - Ageism and how older people services are viewed
  - Recruitment and retention issues
  - No career progression
- Language and cultural differences
- Finances (of the sector)

Training delivery and access

Training needs to be readily accessible. Sometimes it is available but there can be a number of obstacles to attending. Staff can be required to pay for courses with their own time, money and travel.

> *"One recurrent theme is that very often care home staff aren't paid to attend the training, so they have to attend on their day off and they don't get their travel paid for, so if you're providing training that's away from the care home you don't have a particular motivated attendee when they've had to pay their own travel and they're doing this on their day off." (Interview 8)*

To counteract this, training is sometimes provided online. However, this can have its own issues: some staff (particularly within care homes) have no access to a computer or the internet, or do not have the computer skills to support learning in this manner. Sometimes the problem lies beyond the initial education. Staff can receive training but are subsequently not given the opportunity to use their skills, which impacts patient care and confidence, and puts further pressure on other services (e.g. calling an ambulance or out of hours GP or a GP not having the skills to manage complexity), which potentially might not be needed:

> *"Sometimes homes are very committed to providing training and you have a good attendance, and then the staff are saying, 'Well this is all very well and good but…I'm not allowed to write in the care plan, I'm not allowed to do this,' …you sometimes feel that it's almost like you're there because it looks good in a brochure that you're providing training, but it doesn't actually change practice on the ground, because there isn't that high level commitment to allowing the staff to put into practice some of the things you're trying to get over…" (Interview 8)*

Training needs to be an ongoing investment: to value staff and ensure they have the appropriate skills and support to carry out their jobs. This can be particularly remiss (e.g. the idea of a training supervisor) in the care home sector.

This raises the issue of accountability: staff can be fearful of complex areas - such as end of life care and consent – and sometimes smaller decisions, such as whether to call an ambulance or not. More comprehensive and relatable training could mitigate these issues, and encourage more personal and organisational responsibility, fostering a reduction of 'blame cultures'.

Attitudes to and perceptions of older people services & recruitment and retention

A number of stakeholders referred to caring for older people and Geriatrics as a 'Cinderella service', that is to say, an area that is not given as much attention as is warranted and a 'resistance' to putting older people's care into core curriculae:

> *"We see that older people are everywhere but people don't like to think that they are working with older people." (Interview 7)*

Care of older people needs to be viewed as part of 'core business', rather than something that should always require a referral: a shift in how care of older people is viewed must be made, therefore, if the right people are to be attracted and retained in the field:

> "There's potential for education to be quite transformative…but you'd have to work on the assertion that education can change behaviours and that's challenging, we know that it can change knowledge, we know that it probably can change behaviours, although we're not sure how it does that in a sustainable way. There's probably something about how it also changes attitudes as well, and if you actually start to look for good evidence of educational initiatives that really can change and modify attitudes to older people so that we become less ageist as a system, I think that's quite lacking you know, so I've got a hunch that they probably can but I've got no real empirical scientific evidence that we can." (Interview 4)

> *"I think the recruitment crisis in geriatrics is…because it's not seen as a sexy topic or something that's exciting and challenging and so people don't choose it as a career path in medicine…we need to show that it is really exciting and challenging… we need to illustrate to students that it doesn't matter what speciality they choose, a large proportion of their work will be care of the elderly because that's the reality of medicine in this day and age, hospital is largely full of older people…" (Interview 3)*

Recruitment affects training because staff turnover can be so high, particularly in the care home sector: sometimes the jobs are simply not in place and others' workloads are so great that staff burn out or leave or both. Turnover often hinges on the management:

> *"Every two or three weeks staffing is changing...the biggest challenge to providing opportunities within a care home environment is the turnover of staff, you can't just do a one-off, you can't provide something annually… and without a doubt, and this is from years of experience, if the manager or one of the senior leaders or people who have a real influence on the culture of the home don't attend the training, you're wasting your time." (Interview 8)*

Language and cultural differences

"I was talking with a lady… I can't think where she was from and she hadn't been in the UK very long, she said, 'In my culture to expect somebody to do something for themselves when they're very elderly would be seen as disrespectful...' so the fact that you might be encouraging people to retain some of their independence was so alien to her, because older people are to be revered and you wouldn't expect them to do that." (Interview 8)

Staff are often required to attend training in English, which might be their third or fourth language. Sometimes important points can be lost in translation, and it can make communication with an older person, who might have hearing or cognitive issues, difficult. In addition, some staff members come from countries that are culturally very different: what may be appropriate and expected in the UK, might be quite the opposite in their native country and staff feel disrespectful and uncomfortable carrying them out, without sufficient explanation.

However, there were examples of extremely high levels of care coming from carers where English was not the first language: when there were problems, this tended to be endemic to the organisation, and a reflection of the management and leadership in general.

Finances

A major challenge in the care home sector is who takes responsibility for funding (whether this relates to training, or something else), particularly when the majority of organisations (local authorities and the NHS) do not have the money to spend. Possible solutions include financially incentivised regulation i.e. commissioning at a slightly higher cost band. What was clear from discussions, was that all sectors need to be working together to provide answers:

> *"I think those are some of the dilemmas for me around implementation is just you know, you need a really big push from the centre you know, that gives people in the middle, at the regional level, the moral authority to move pots of money around to really make this happen, a recognition that this has got to be a shared initiative between health and social care, and then you know, I think that if that happen then the private providers will engage with it, but you know, you that's a big ask I would think." (Interview 4)*

Current initiatives

What initiatives and best practice models are there out there?

There are a number of training and education initiatives described by the stakeholders (Table 6), that have either started being rolled out or are in the pipeline. Successful training programmes – as measured by markers such as feedback and uptake – might include:

- **Open access**: multi-sectoral application and availability
- **Designed** with the help of **both experts and users/patients**
- **Specific outcomes** and **goals** to the training
- **Innovative forms** of access to and delivery of **resources** (apps, virtual reality, animation, infographics)
- **National frameworks:** these help ensure consistency

Stakeholders returned to the idea frequently that although content is clearly very important in training, it is delivery, access to and the way in which teams work, that needs to change, a fundamental shift in attitude:

> *"When you talk to people about what they find challenging about the work […] it's about the training that we need to work in a different way…working in a person-centred way, an integrated way…so it's the sort of skills and behaviours and attitudes that we need for that way of working as much as it is about the content…" (Interview 5)*

Table 6: Current training initiatives mentioned by Stakeholders

Organisation	Curriculum/training	Details
Bristol Medical School	'Complex Medicine'. New curriculum (Sept 2017)	18 week training block for 4th year medical students looking at care of older people. Based on the British Geriatric Society's guidance (a curriculum they've developed), focus on the holistic and social side of care of older people (dignity, autonomy, etc.) as well as the 'geriatric giants' (stroke, incontinence, etc.). Shared learning with pharmacy students
Keele University (now entering 2nd cohort)	Frailty and integrated care modules within the Med Sci Programme at Keele.	Although originally for GPs, now a multidisciplinary cohort of people (GPs, Acute older people's nurses, primary care nurses, community matrons. Contains a module around ethics and law: consent and capacity, decision making, and ceilings of care.
King's College London and the King's Health Partners Academic Health Science Centre, sponsored by HEE	The Older Persons Fellowship for Nurses and AHPS	Aims to drive clinical excellence, innovation and quality improvement. Open to Senior Nurses or Senior Allied Health Professionals
University of Northumbria	Focus on providing experience to clinical staff within care homes	Giving undergraduate nurses experience within care homes, Focus on trying to bring more Registrars into geriatric medicine through community geriatrics
Nottinghamshire Frailty & Supported Self-Care programme - HEE, Fusion48, UFI grant	FrailtySIM Virtual reality programme	To enable consistent training in frailty across the board. Helps develop understanding and empathy.
Commissioned by DH, developed by HEE and Skills for Health	The core skills and education frameworks for End of Life Care and for Dementia care	Launched in 2015 for the workforce supporting and caring for people living with dementia.
The Gold Standards Framework	Primary Care Clinical Skills Domiciliary Care Dementia Care Care Homes	Package that provides training for various populations, to help patients at the end of life. The GSF Care Homes Training programme, for example, is the most widely used training programme for all care homes in the UK, supporting all residents as they near the end of their lives. Since 2004, over 2600 care homes have been trained.

(Table 6 continued)

Organisation	Curriculum/training area	Details
Health Education England have commissioned from Skills for Health	Core capabilities framework for frailty	The framework aims to describe core capabilities i.e. knowledge, skills and behaviours which are common and transferable across different types of service provision – including health, social care, local government and housing sectors. The framework will be applicable to employees, patients, carers, the community, the public and to educational organisations, which train students who will subsequently be employed in the workforce. (was due to launch beginning of November 2017)
My Home Life Initiated in 2006 by the National Care Forum, UK wide	Meeting the needs of older people: resources, advice and guidelines	Works with care homes, statutory bodies, community organisations and others to co-create new ways of working to better meet the needs of older people, relatives and staff. Provides resources for the above as well as older people and their relatives and good practice guidelines.
Health Education East Midlands, Nottinghamshire	Frailty and self-care	Toolkit and training programme for anyone working in health and social care to support older people who are living with frailty in self-care. Designed with input from expert advisers as well as users. Includes an animation about what frailty is, a virtual reality frailty simulation experience to help develop empathy and observational skills and a frailty toolkit app to access resources, including case studies
Sheffield University (Mike Nolan)	Relationship –centred care and the Senses Framework, guidelines and best practice	Mike Nolan and a team at Sheffield University identified six dimensions that underpin 'relationship-centred care' in the Six Senses Framework (2006). These six 'senses' acknowledge the subjective and perceptual nature of the key determinants of care for the three groups of people in the care setting: older people, families and staff
Admiral Nurses, nationwide	Dementia support	Provide specialist dementia support that families need. Largely working in the community for the NHS, but others work in care homes, hospitals and hospices. The training and support is highlighted as being a very good model (peer education, support, supervision)
Lewisham and Greenwich NHS Trust	Frailty training in acute settings	Frailty training for consultants, doctors, nurses, therapists, porters, receptionists, radiographers: anyone who might come into contact with patients that are older.
Dementia Care mapping™	University of Bradford	Dementia Care Mapping™ is an established approach to achieving and embedding person-centred care for people with dementia, recognised by the National Institute for Health and Clinical Excellence.
Dementia Care matters	David Sheard/Butterfly	An evidence based approach to developing dementia care in organisations. Trains using a model consisting of 12 core beliefs and achieving 36 outcomes in dementia care.

There are lots of smaller scale projects and studies running in various institutions. One stakeholder told us about her involvement in several such studies, which included research with homeless older people, the directly employed care workforce (this is a growing area, and refers to those employed by older people themselves, rather than an organisation) and hospital discharge for older people.

Other studies or training initiatives that were mentioned by stakeholders included:

- 'Optimal' Study, Hertfordshire and Nottingham universities (and 5 other universities): The study found a narrow focus by NHS decision makers on care homes as a drain on resources, rather than as a solution, can result in short-term interventions that compromise relationships between NHS and care home staff, and affect care home staff confidence in being able to meet residents' health needs. High quality healthcare provision to care homes can only be achieved nationwide if close collaboration between the NHS and care homes becomes part of the 'landscape of care'. This means ensuring, through targeted investment, that visiting healthcare professionals and care home staff are given the opportunity to work closely together to identify, plan and implement care protocols.
- University of York (Karen Stillsbury): Delphi exercise to narrow down broad domains for skill and competency
- University of Nottingham (Sarah Goldberg and Miriam Stanyon): Delphi exercise to develop a list of core competences for registered nurses in nursing homes - this is work in progress
- A number of frailty training initiatives:
    - With the fire service in Nottinghamshire
    - North West Ambulance Service community paramedic training in frailty (frailty champion) from North West Ambulance Service as a sort of frailty champion /cascade training
    - Cheshire (an NHS trust) online frailty awareness training

Some positive steps are being made as a result of some of these studies:

> *"The Masters level courses that are starting to appear in response to some of these papers from Karen Stillsbury and Sarah Goldberg and others, and they're saying […] if there's a gap in the market for registered nurses in nursing homes to develop core competencies then that's the place where nursing schools and universities ought to be operating… I'm aware that there's one in our locality which has been developed by the University of Lincoln, but there are other Masters starting to crop up elsewhere around the country to try to bridge this gap, they're developing their own curricula based around some of this early speculative work that we've been doing you know, academically." (Interview 4)*

Conclusion

The aim of this part of the study was to gain a broad understanding from stakeholders about the current landscape of education and training for those working with older people in health and social care.

Overall, changes are happening in some areas, although not necessarily quickly enough. Some of the key points highlighted were:

- Multidisciplinary training and working is needed: integration of staff and services should begin in the training room
- More operational consistency, so that sectors are talking the same language and dealing with issues in the same way (e.g. frailty training)
- Funding for training and who is responsible for this
- Management: the need to tackle ingrained cultural issues, alongside recruitment and retention of staff (particularly within care home settings)
- Perceptions of older people and working with older people

In addition to greater knowledge of conditions and circumstances that can affect older people (dementia, falls, loneliness), there is a fear around some aspects such as ethics and end of life, for example, and how to have these conversations and make important and sometimes difficult decisions. Empowering staff and trainees to do these things is as important as the knowledge that they gain, and the benefits are likely to positively impact on patients and colleagues.

There is a need to be better at measuring some of these outcomes and the impact that training has:

> *"We're not very good at measuring those outcomes…we might think that we're doing quite a good job because somebody hasn't had, because somebody has not had say a hospital admission or A&E attendance because they're things we measure and count a lot but we haven't looked at those individual sort of quality of life, patient recorded outcome measures, so we're not necessarily measuring the right thing to know what the outcomes are of what we're doing." (Interview 5)*

Although the sample size of stakeholders was small and we would have liked to have spoken to more (including those within care homes), we were very fortunate to be able to involve these eight professionals in the study.

To explore frontline staff's views of education and training and providing high quality care to older people, we next interviewed frontline staff.

CHAPTER 4

Staff Interviews

Staff Interviews: Results

To understand the extent to which the health and social care workforce is equipped to provide high quality care to older people, it was important to gain insights from staff who are on the frontline of providing care. Staff interviews facilitated this, they provided rich data from a range of staff about their experiences of working with older people: be this as their primary role (such as care home staff), or where providing care to older people is part of their role (such as general practitioners). Staff had diverse backgrounds and levels of experience, and were from a variety of care settings. Whilst this allowed for a broad understanding of health and social care staffs' views, generalisations about specific staff groups cannot be made, with these results facilitating further exploration.

To examine staff's perceptions, the interviews explored their experiences of working with older people. It sought to understand: what, in their view, some of the key needs of older people are and the challenges staff face, as well enablers to providing high quality care. In addition, researchers asked staff for their views on what education or training is important to have to support them in providing high quality care, whether this is currently sufficient and importantly, what the impact on older people is if this is lacking.

Setting the scene: Staff background

"I really love what I do, I absolutely love what I do." (Junior carer, council, #42)

The patient and public advisory group (PPI) were invaluable in planning for, and shaping the staff interviews. They helped inform who we should speak to; what we should explore with staff; and how to reflect on influential factors, or personal experiences that staff may bring to the interviews that would shape their views. For example, members of the PPI group deliberated the impact of personal experiences on staff's decisions to move into their chosen field, and the quality of care they provide to older people. To contextualise their views, we explored staff's personal backgrounds to understand how they came to work in their specific area to assist with interpreting the findings.

Almost all the staff interviewed either had a specific interest in the care of older people, or had personal experience of caring for a loved one. Furthermore, most staff expressed a passion for the work they do:

> *"Working with the elderly it gives me so much joy giving something back…I just really enjoy it, I know it's not for everybody, like my sister started at, you know, a job there, but she couldn't, you know, with the cleaning of patients and she couldn't handle it, but to me now it's just… I just love working with the elderly, I just get something from it, to see them happy and make a difference to their life." (Senior carer, council, #20).*

> *"I personally love elderly care because I would happily sit and chat to someone, sit and chat to their family members, you know, have a really good conversation with the physiotherapists and the occupational therapists, you know, really thinking about how to make this person safe so they could go home safely." (Junior doctor, #30)*

Staff's personal backgrounds, experiences, and motivations permeated throughout the conversations and as such should be considered when interpreting the findings. For example, a number of staff reflected on personal experiences of caring for loved-ones as motivation to work in their given field. This was particularly true of care home staff, and junior doctors and nurses reported similar influences that they felt assisted them in caring for older people.

"I've always been interested in dementia, I've always worked with the elderly but I wanted to make a difference, if I could, because it's very satisfying work to work with the elderly." (Senior geriatric nurse, #11)

"Well when my Nana passed away it just made me want to care for the elderly and that's just what I wanted to do." (Junior carer, private, #15)

"I looked after my mum when she was terminally ill and then my dad…ended up going into a nursing home…previous to that I had an old next door neighbour and he was on his own…I used to just pop in and make sure he was okay…and I really like working with older people and I really enjoy it." (Senior carer, council, #43)

Providing care to older people: Being prepared for an aging population

"I feel that the health and social care provide the best care that they are taught to, or the best care that they are able to, within their own limitations, time constraints, and staff turnover..." (Junior AHP, #37)

All staff agreed that caring for older people is complex and requires a holistic approach. It necessitates services and staff to work together efficiently to provide continuity and comprehensive care, with particular emphasis on the social care requirements of older people. To solicit an initial, spontaneous response, staff were asked at the start of the interview whether they felt that the health and social care workforce are equipped to provide high quality care for older people. This prompted varied reactions and replies.

Staff in clinical roles and working in secondary care mostly felt that advances in healthcare has had a positive impact. A few staff felt that the care that is being provided is of a very high quality: "*I think that they're more equipped and savvy than they ever have been" (Senior GP, #10).* Particularly *"compared to, say 10, 12 years ago, the level of training and education for both health and social workers for older people has increased leaps and bounds" (Consultant geriatrician, #7).* That said, social care for older people was highlighted as a key issue by almost all. Being able to provide care for older people in their homes or in the community should be a priority, and is currently at a tipping point.

> *"We're amazing in hospital in regards to how the NHS is, so we're really, really good inside the hospital, outside the hospital we're horrible. There's not much support out of the hospital, the cuts that we've got… all this has had a huge impact on the elderly population." (Consultant orthopaedic trauma surgeon, #8)*

Staff raised concerns about the system being prepared to cope with the growing demands of the elderly population. These included:

- Staff levels
- Time constraints
- The need for integrated services
- Greater support and value for social care services
- Basic training, particularly for social care staff

For the system as a whole, staff levels and time constraints were most frequently cited by all staff groups as serious concerns for the future as the demand from this population increases.

> *"First things first, in terms of just the limited number of GPs at the moment, I think the NHS are facing a lot of pressures and there's just not simply the numbers required of doctors and healthcare professionals to treat an increasingly elderly population." (Junior GP, #24)*

The complexity, increased attention, and time patients that are older may require cannot be met within the current constraints.

> *"I think the problem with elderly people is the majority of them need more time in terms of care and it's something that I've seen on my GP placements as well, their consultations always take longer, just because they've got more health problems, as the older you get you're more likely to have the long conversations, and a lot of the times GPs do not have the time to give those people that amount of care that they need, so I'd say probably no, they don't get the care that they… and mostly because it's time and funding really." (Medical school doctor, #14)*

The need for integrated services, and greater support and value for social care was viewed as important to ensure sufficient and appropriate resources are available to provide care for older people.

> *"The aging population is going up, people are living longer, they're getting lots of comorbidities so the focus of the social care is, at the moment, is to keep the patients at home, you know, they don't want people to be going to any places so with the result that people are on their own and, and I think the care is, and you can't reach each and every person, it is very difficult to reach every, to cater for the needs of each and every person. So I don't think …there is enough staff or enough adequate provision for the care that needs to be provided." (Senior GP, #4)*

Many felt that social care is a crucial need for older people and yet "s*ocial care is seen as a [sighs] rather menial task I think, that you don't need to be particularly skilled or trained for, so it has low funds I think." (Senior care home nurse, council, #36).*

In spite of the constraints though, staff felt that "*people who are in the NHS are trying really really hard, everyone's trying really hard, I think the government's trying hard, and I think Social Services are trying hard, the health service is trying hard." (Secondary care nurse, #39)*

Key needs of older people

"Well elderly people are vulnerable, you know, and they need a lot of reassurance." (Senior carer, council, #20)

The success of longer lifespans owing to the innovations and advancements in health care means there are more people with care and support needs. As individuals age, their care needs may change, and they may require more support arising from complex physical health and mental health conditions. To understand whether the health and social care workforce are prepared to cope with an aging population and whether education and training is sufficient, staff reflected on what they feel, the key needs of older people are. These spanned physical, social, and emotional needs (summarised in Table 7).

Complex needs

The complexity and prevalence of co- and multi-morbidities amongst older people was highlighted as a significant factor. Correspondingly, the occurrence of polypharmacy is more prevalent in this

population and needs to be taken into consideration and incorporated into care decisions and management. This requires sufficient time to review and plan their care, as well as access to various specialities and resources. Providing holistic care, was considered key to ensure high quality.

> *"Well, the older you get the more other diseases and conditions you're likely to get, the more tablets you're on, the more tablets you're on the more side-effects you get. We always look at trying reducing or cutting back on medications and controlling their other comorbid conditions." (Consultant geriatrician, #9)*

> *"So the problem with an elderly population is the patient tends to be a bit more complex, tends to have sort of various co-morbidities, whilst they kind of get a bit older they kind of require more care and sort of time spent with the patients." (Junior GP, #24)*

> *"Usually when you're older, you seem to not just losing your cognition, you become physically frail and then you seem to depend more on medication and, you know, different agencies, you need input from dieticians, speech and language, possible psychiatry input". (Senior geriatric nurse, #11)*

Physical needs

Other physical aspects such as mobility, frailty, and falls were noted as factors that may be prevalent among older people.

> *"Also things like getting to appointments, mobilising on the ward, driving, all things like that which kind of most people, most younger people would take for granted is slightly, needs to be considered differently in an older population." (Junior doctor, #29)*

> *"One that stands out in my mind would be falls. You do tend to see quite a frequent number of patients, elderly patients being admitted with either fall or syncope, which is passing out or loss of consciousness, be it explained or unexplained, or being found on the floor with a suspected fall. There's a lot of comorbidity associated with falls bringing patients into hospital, which requires them to have a lot of investigative work to get to the bottom of what's happened and also get the appropriate treatment, and that's before we even venture into the sort of associated pathology with falls such as hip fractures which can keep patients in for months before they eventually get discharged. So falls and syncope is quite a major one." (Consultant cardiologist, #41)*

There are also physical changes that occur purely because it is an aging body: the physiology of older patients. For example, more brittle bones, less muscle mass and so forth. These changes can be significant, putting patients at greater risk. Basic activities, or lack thereof, can have a far larger impact.

> *"You can go from the really basic: everybody knows that if you are coming into hospital in your 80s and you've broken your hip, that you are very likely to die in hospital, not because of the broken hip, but because you're lying in bed. There's a nervousness about getting them out of bed, there might be a worry about giving them too many fluids or too little fluids, their nutrition drops because we might need to start feeding them. There's all the myriad issues around just because of their age rather than their diagnosis, they're at a much higher risk, and they may have come into hospital completely mobile, but then we treat them like an old person once they pass through the doors without even consciously being aware of it. If they come in on a Friday and they don't get out of bed till Monday, those three days for an old person, for an 80 year old is, you know, it's the difference between a life and death, because if you're not getting them out of bed in the first few days then their muscles have wasted anyway and their muscle waste has gone, and then it becomes a whole different issue about getting them out." (Senior geriatric nurse, #31)*

Cognitive needs

Numerous staff noted deteriorating cognitive ability of some older people, including the onset of Dementia or Alzheimer's disease.

> *"Mental health is increasing because, like I said, if the patients are aging, the dementia is on the rise so dementia, depression, they both are on the rise. The majority of my patients in care homes have dementia." (Senior GP, #4)*

> *"What is expected is that significant increase in the percent of people becoming elderly and for example regarding Alzheimer's disease in particular, you may think that the incidence increase will be 2-3% per year, so this will be very big numbers, so in a decade in ten years' time probably we may double the prevalence of Alzheimer disease and primarily dementias in elderly people in United Kingdom." (Consultant Neurologist, #2)*

Depression was highlighted as an issue that staff came across frequently among older people and often is overlooked or not recognised.

> *"So I think depression is increasing in the elderly population but I don't think that it's something that is necessarily recognised, and people kind of just look over it because you expect older people to be lonely because they're on their own, they see it as okay, but I think that that is something that does happen." (Medical school doctor, #14)*

> *"The impact of depression in most of neurological disorders. For example in a stroke patient I would say, the most important factor that may affect quality of life and even the rehabilitation success, is in depression. Post-stroke depression is something very common but that not all doctors are aware of this and it's easily recognised and treatable. Depression is an important determinant of quality of life also in chronic epilepsy, in dementia and in Parkinson disease, so mood disorders are an important issue." (Consultant neurologist, #2)*

Communication needs

Communication difficulties such as where older people may have hearing or sight impairments was noted as a factor influencing care.

> *"So the problem is usually if they're a bit elderly they might have difficulties in terms of, say, visual or hearing problems, so you have to look at alternative ways to communicate to the patient." (Junior GP, #24)*

> *"They could have had a stroke and they've lost all forms of communication verbally, and it's being able to get them to understand what you're asking them to do, and being able to understand that they themselves are frustrated, as much as you may be. They knew that they were able to talk once and now they can't even tell you that they want a piece of toast." (Trainee nurse, #21)*

Social needs and care

The strongest theme was the social needs of older people. Social isolation and loneliness were raised by almost all staff as a key concern for older people. Ensuring people can stay independent and in the comfort of their own home where they feel safe was recognised as crucial. However, support and social interaction for older people who may become isolated and lonely still goes unaddressed in many cases.

"It's quite sad, a lot of people will say, "You'll probably be the only person I'll see today," and you think, oh, and that's only because I'm here to do a job in essence." (Junior AHP, #37)

"I would say the social issue of loneliness and isolation and a lack of a supportive social, an integrated social package of care that these patients need in order to go home safely but also to enable them to stay at home and without becoming a failed discharge and ending up coming back to hospital within, just a matter of a month. People are living longer, people tend to want to keep their independence for as long as they can, but it's important that we support elderly people in giving them the ability to maintain their independence where they can but also be appropriately supportive and appropriately funded to move out of the hospital system and move into the appropriate residential or social care needs that they require for them to progress and not basically languish in hospital for weeks on end waiting for social packages to be put in place." (Consultant cardiologist, #41)

"There is huge evidence to say that there is a stronger recovery in the community, and I'd definitely agree with that. But there's also the social implication of sending someone home that doesn't have any support, and that isolation can actually have a huge detrimental effect the implications of our mental health to our physical health." (Senior AHP, #26)

"I think investing in kind of more social inclusion, and to not isolate people so much. You know, you've got an older person who is living on their own, they're socially isolated, they lose their appetite and, their mental health deteriorates and they lose their confidence… I'm sure all of us would if we stayed at home for a couple of weeks and didn't see anyone or talk to anyone, they become quite fearful of the outside world. And it all just has huge implications on the health. And so social inclusion is a massive factor, engaging them in community activities." (Senior AHP, #26)

Compassion and staff values

Staff of all levels and roles felt that providing compassionate care, and emulating positive values and attitudes is central to providing high quality care to older people. Many felt that these are core qualities that are fundamental for all staff to have. Although for the most part, these values were seen as connected to personal motivations and staff demeanour, many felt that it can be instilled through training, including mentoring or role modelling.

Need for compassion

"You've got to be a caring person and you've got to have empathy! Not that you can have empathy of that situation because you haven't got to that stage yet, but if you can try to put yourself in those shoes, that one day you may be like it and you'd want to be treated in a certain way, you wouldn't want to be treated badly, that's how I would try to look at it. That people that haven't got a family this is where they're going to die, and they know that, do you know what I mean, and it's sad to have carers or people that are caring for them that are not the best, that's not good quality of life for their last days, you know." (Senior carer, private, #16)

"I guess I saw it most I would have said on my nursing day, I could generally just see how much the nurses actually cared and how hard they worked when caring for the elderly patients. How they spoke to them in a non-medical way, they're just talking about general day-to-day life, which made the patients more comfortable." (Medical school doctor, #12)

"I think we really have to have a really empathetic attitude. Where people don't have the patience, who talk to someone with dementia and they think because they can't understand them that they just can't be bothered or they just move on and we should give them extra time in my opinion. I think because I've had family members that have had dementia, and then I've seen nurses, I've seen doctors inappropriately treat patients, like I have a particular maybe biased view, but I think that's a massive part of geriatrics, is just having that having that empathy and patience." (Medical school doctor, #14)

Instilling and teaching compassion

"Starting off being friendly and approachable is really important and that's partly due to your training, partly due to your personality and partly due to what you learn from other people." (Junior doctor, #29)

"I don't know, yeah, something you either have or you don't, I do believe that sometimes it is something that you can acquire along the way, like you're not going to care for someone knowing that they're not able to care for themselves, or knowing that they're on their last few days or few months and just do the role you… it's still going to pull at your heartstrings." (Trainee nurse, #21)

"I think it can be taught, because a couple of the healthcare assistants from my unit went to a dementia study day and they were given things like glasses they were to put on and they'd given them headphones that disorientates them, and they were put in a position of an elderly. It really had quite an impact on them. A couple of the healthcare assistants, one of whom was particularly a "get the job done" [attitude], you know, I think it had quite an impact on her." (Senior care nurse, council, #36)

Table 7: Summary of care needs for older people

Key Need	Staff Quote
Basic care needs	"…[E]lderly population they've got transport needs, a lot of them need transport, [they] need help in feeding, dressing at home, certainly they need it postoperative period." (Consultant orthopaedic trauma surgeon, #8) "The thing for me is things like, it is the basics really, you know, ensuring people have good nutrition, are hydrated, warmth, shelter, all of those sort of very, very basic things that some people perhaps can take for granted that that's happening and maybe it's not." (Senior secondary care nurse, #32)
Complexity & comorbidity	"So the problem with an elderly population is the patient tends to be a bit more complex, tends to have sort of various co-morbidities, whilst they get a bit older they require more care and time spent with the patients." (Junior GP, #24)
Polypharmacy	"[T]hey're more likely to be on lots of medications, they probably don't know why they're on them, and they just say yes because their doctor's said yes." (Medical school doctor, #12)
Frailty & mobility	"Frailty is obviously another problem because the more frail you are the more likely you are to suffer from ongoing complications: you're more likely to fall and then that in itself can give you problems." (Medical school doctor, #14).
Communication	"I think it can be hard for, I mean, the physical communication, hearing or their sight might not be as good so you perhaps can't use the same methods that you would." (Senior community nurse, #34)
Mental Health	"There are so many types of dementia and people can be dual-diagnosed with dementia, you can have people who've got mental health issues coinciding with the dementia." (Consultant neurologist, #2)
Social needs	"So definitely loneliness is a factor and I find myself often visiting some patients and there may not be anything medically wrong, often you find it's just that they've been alone or they don't want to interact, or they have the fear of going outside alone specifically, they don't have the confidence." (Junior GP, #5)

Challenges to providing high quality care

The staff interviewed raised a number of challenges they face in providing high quality care to older people, including system or organisational barriers; resourcing challenges; and challenges within the workforce (Table 8). The two most prevalent themes that almost all staff reported as a barrier to providing high quality care were the lack of resources, and the lack of knowledge or awareness of other services.

Resources: time, staff levels, and funding

With the potentially complex clinical, physical, and social needs that older people may have, a holistic, person-centred approach to their care is essential. Yet staff highlighted numerous factors that hinder this holism. Immense lack of time, low staff levels, and restricted funding severely impedes their ability to provide appropriate care to older people.

> *"I think obviously time is an issue there. When you've got such heavy workloads at the front door, when you're faced with trying to assess a 96 year old in a hospital corridor without even so much as a proper room to be able to assess them, both time and resources can be pushed." (Consultant cardiologist, #41)*

> "We need more doctors, more nurses to provide high quality care. If you want a doctor or a nurse to show empathy, compassion, just give them time to show it. You can't show empathy or compassion in 5 minutes or 10 minutes, you need at least to sit with the patient for longer, get to know them, know their story, and then you can come across as a compassionate doctor or a nurse. It boils down to time. More staff will aid us in providing high quality care." (Consultant orthopaedic trauma surgeon, #8)

Staff in the community, primary care, and social care sectors reported feeling (or perceived this of colleagues and other staff) the pressures of increased demand without the necessary resources in place to support them. Staff recognised the impact on staff morale, and on patients and service-users who they felt are receiving sub-optimal care as a result. Having insufficient funding results in fewer staff, which leads to greater workload, less time for each individual patient or service-user, and ultimately poorer care.

> *"I think the way we can improve it is by having more time, which obviously links to budget and everything. If we had a bigger budget to be able to have more nurses so the nurses have got more time, I think that would drastically increase sort of the level of care, just because, giving somebody attention, sitting down and talking with someone is, I think really valuable. I get quite sad when I can't do that in the day and I do feel really guilty when I just don't have the time to give somebody that attention and sit down and take it slow and just sit down with them and make them a cup of tea. It does make me really sad that you can't always do that." (Trainee nurse, #23)*

> *"I think a lot of the time… because of the pressures that are put on staff at the moment, I think quality of care is not as good as it could be because there's just so much time pressure. So you have to do the bare minimum and it's a hard, it's tricky because…as a health professional you want to help people, you want to help people get better but generally if you have a massive list and you have that pressure then you'll literally do the bare minimum and then you'll move on. So to answer the question: [the care] is going to be affected because you can't do what you need to do to get the best quality and get the best result for that patient." (Senior care home nurse, council, #33)*

The impact of under resourcing on staff could result in situations where staff are left without the necessary support.

> *"You can't expect three staff to run a 36 floor on a dementia unit, when you've got people that are fighting and kicking off. If you're sending one carer to look at… to sit in the lounge with two people that they don't like each other kicking off, you've only got two people to watch that floor, if I'm behind my desk doing my work, or if I've got doctors to see, you can't expect two people to run a floor." (Senior carer, council, #20)*

One junior carer described how in her first few days working she was required to assist a patient in palliative care even though she was not prepared, as there were not enough senior staff available, which had a great impact on her:

> *"When I first started I was working with a lady who was in palliative care, End of Life care, I had no experience whatsoever in that area, I did my absolute best, however, I knew I was way out of my boat. I think a lot of people, we are understaffed, you are thrown in at the deep end and you could be in a situation where you don't know what to do and there is nobody to ask… Emotionally I definitely wasn't ready for it. The lady passed away I had to have some time off because it was just to... And it was my first, they call it RIP, it's my first one in that care home and I think it was just a bit of a shock to me." (Junior carer, private, #27)*

Many saw how the time pressures and increased demands, without sufficient support or financial compensation affects staff morale and attitudes toward older people.

"There is a lot of judgment, there's a lot of, I guess, impatience I think is probably a better word. Having worked in the nursing homes for a long time I would say that the majority of staff who've worked a long time, I see a lot of impatience and a lot of intolerance. It's probably because it's a hard, hard job, you know." (Senior AHP, #22)

> *"I know they're stretched and I know they're tired, and I know they're underpaid and overworked, but it is just, I personally just feel it's really just slapdash and it's just rough… there's just no individualised care… a lot of the nurses are older nurses and they've been doing it for a while so it could just be that they're so used to it and it's just almost become mundane so they just get on with it." (Trainee nurse, #21)*

The lack of resources, particularly time, inhibited the relationships that staff could build with their patients or clients, which was upsetting for some older people.

> *"When you've got deadlines on your back and everything, like it is, you could see the nurses were stressed out, it stressed me out. They do want to communicate and build relationships with you, but it is again just the time pressure really. (Trainee nurse, #38)*

> *"A lot of really angry, it's the comments from some of the older people, 'oh she does this', or 'she just runs in and does that', so it can make them really upset and bitter. I'm thinking: God, it really destroys the relationship." (Senior AHP, #22)*

The impact of time constraints on older people's care:

Case1: Patient disempowered and dignity

"I remember this lady once, every time I went in she was sat on the edge of her bed with her back to me, you know, she was naked from the back down, because she'd been trying to have her back washed. But someone would come in, wash her back, and then gone…And then she had to dress herself, and all the rest of it, and there wasn't much. It was like, you know, hang on now, this lady, she's been disempowered. You know, she should be more in control of the situation. She should be able to say, you know, 'When I… when I hear the doorbell, I will open it, and then I'll go and get ready', whereas she'd left the front door open, and she just sat by the door, because the person coming in only had five minutes, and all this sort of thing. So people can get disempowered." (Senior community nurse, #6)

Case 2: Patient lonely

"I look at some times and the resources of the NHS is being severely wasted, I know when my client is sick, I know when my client is just feeling lonely and just want to take a trip to the hospital because they want to. I feel that's really a severe a hindrance on NHS. I know that that client can stay in the house, but the problem is, the hours that we as carers are giving to cater for these clients, is absolutely ridiculous, you get 30 minutes to wash and dress and give a client breakfast, sometimes that maximum you get is an hour, you get 30 minutes to give them lunch, you get 45 minutes for somebody who does not mobilise, and then you might have like six different clients only in that morning, and you are hopping from place to place, and as a result you're getting frustrated as a carer because there's not enough time to do anything, your client is frustrated because not everything they want is being given to them in the short space of time that you're given and allocated in the mornings, and it's a knock-on effect." (Junior carer, council, #42)

Case 3: Unmet needs

"I think that I've come to like a stage where I do often, on a Friday afternoon I'm an on-call doctor at a practice and I'll have a few patients that are like elderly patients that definitely the reason that they're calling is not because… I mean often it is something medical, but other times it's mostly because they're lonely or they're worried, there's something that you have to probe out of them and a lot of them do have mental health needs, but I don't think in the short time we have as GPs for appointments we cover adequately." (Junior GP, #5)

Knowledge of available services and pathways for continuity of care

The siloed working that exists between different sectors and lack of integrated services was immensely frustrating and challenging for staff. This was exacerbated by the fact that staff acknowledged they had little knowledge or understanding of other services: their remit; capability; or even their existence.

> *"I find it quite difficult to know like what fell under the OT remit, what fell under the Social Worker's remit and what fell under the physiotherapist's remit. And knowing, you know, who to approach essentially for, you know, advice on xyz, because obviously they all kind of interlink but something like going out and looking at the home could come under physio, it could also come under the OT. Making sure they can get in and out the bath, that's a very OT thing but actually the movement might come from the physio. So knowing who you approach for the right help, which I think would be really useful and I found definitely lacking." (Junior doctor, #30)*

"I would say my weakest point in my practice, even 25 years on, is that I say to people, oh 'I'll find out for you', and then I just don't know where to go or how to get it. It'd be nice to have it there to hand so you can just say, 'I don't know, but this person is the one to contact'." (Senior AHP, #22)

> *"I need to know better about rehab, what happens exactly in the community in rehab, I need to know exactly about the packages of care. If I know exactly what package of care A versus package of care B, then I'd have a better understanding of the patient's needs. Well maybe when I see them in clinic then I know which package of care he's been under, how many carers come every day, it's just the training to teach me the lingo of the OT, teach me about the available care that we have in our area. So that, we don't have a clue." (Consultant orthopaedic trauma surgeon, #8)*

Being unaware of the services available and the full care pathway of their patients could result in disjointed service provision and lack of continuity of care. This was particularly true between secondary care, and primary or community care services.

> *"When I worked… in hospitals you have, a lot of people have no idea what's happening in the real world… and then I moved into primary care, it was such an eye-opener, because it was kind of like, the buck stops at the door in primary care. [When you're working in hospitals] you can give people sort of a can of drink to go off with, but in fact these people need a bit of a social care programme, you should be referring to a social worker, you should be referring to an occupational therapist to do a home check, you know, there's a lot more involved with sending somebody home." (Senior AHP, #22)*

> *"I think what we need to know and we need to be training is to identify how to work in the healthcare model in the communities, what are the type of people involved in these teams, what they are there doing their roles, how you can get access to them and what are the pathways of care? So I think this is quite important because you may aware that the diagnosis of a condition or you can study in a book but the practice and the management of a clinical complex elderly patient you need the support of more people, however you need to get this information so you need to understand to whom you are going to talk, who is responsible for what, where is this colleague or what is their responsibilities, how could you refer on." (Consultant neurologist, #2)*

The complex health and social needs that older people may face, requires better interaction between health and social care services and yet many staff felt even a basic understanding was lacking.

> *"I don't have much understanding of social care, and I've never really worked with Social Services, so we normally used to pass them on and once they were with Social Services*

it was sort of done, so having a better understanding of how social care and healthcare link together and overlap would be quite useful. I think the future is going to be a much more integrated service, I'm guessing that healthcare doesn't have a clue what Social Services do and sometimes vice-versa." (Senior geriatric nurse, #31)

"How they all work together and where the holes are. We have whole lots of services in the community and a huge amount of services in acute care, but no-one's really sitting down and thinking, 'okay, this is the pathway for an old person through those services, and where are they falling down'." (Senior geriatric nurse, #31)

Knowledge of the wide ranging services available, would assist with patients moving between services, and accessing more appropriate and safe care. This was viewed as important for both primary care providers who require knowledge of 'step-up' services so as to avoid, for example relying on accident and emergency or patients being admitted to secondary care unnecessarily.

"I think one of the main issues is being able to quickly provide what we would term, step-up care. You know, if someone has an acute illness, they don't necessarily need to go into hospital, but you know they're going to really struggle to manage on their own. Historically we would always have sent people into hospital…it's often the case that a hospital isn't appropriate for these people, I know that if you go into hospital the risk of actually having someone's confusion, deteriorating mobility, picking up secondary infections is far greater." (Senior GP, #10)

Secondary care providers need an understanding of 'step-down' services in the community.

"There's like step down services in the community, so linking in kind of early discharge with kind of very advanced skilled nurses that are going to see these patients that has had a positive impact. But again I see the problem is that the staff on the wards don't know about these services, so you know, they could be discharged if the services were available in the community, but they might not know about those services." (Senior AHP, #26)

Having better knowledge of the available services and their roles would facilitate coordinated care pathways for older people, as well as equip staff with additional resources to call upon when this is required, ultimately resulting in holistic care.

Table 8 details the main challenges outlined by staff.

Table 8: Challenges to providing high quality care

Challenge	Description
Management & red-tape	Organisational restrictions and demands were seen as barriers by some staff working in social care. Specifically, management being unwilling to resource properly because of financial constraints. Similarly, not investing in adequate training of new staff owing to the cost involved. Time is money: staff reported getting pressure from their organisations to work under strict time constraints which meant they couldn't provide the care required without being reprimanded. Fear of criticism from senior managers, as well as external inspections meant staff are unwilling to take initiative which may assist their patient. GPs and carers reported that there is a lot of red-tape which means basic procedures that could be done by care home staff is not allowed (such as taking blood pressure). This results in additional staff being required to perform the procedure causing delays and inefficient use of resources.
Communication between staff & services	Communication between staff or services was viewed as a challenge. This was reflected in poor handover of patient notes between individual staff or teams, as well as communication between different services caring for the same individual. A dietician described visiting patients in their home and drawing up a care plan for the patient: "I just have to write it down, it's really hard, that's where the communication gets to be a problem. Sometimes I'll write out the sheet and leave it for them, or I try and contact the care agency, but [you don't know what happens]. And sometimes, [when the carer is there] they're in such a bloody rush they don't really listen anyway." (Senior AHP, #22).
Cross-team working	Similar to poor communication between services, many staff noted that working across disciplines, specialities, or services was challenging. Getting different specialities to work together efficiently and subsequently avoiding delays in for example, getting an older patient discharged quickly and safely is challenging. Staff recognised that a greater deal of respect of what each specialist or role contributes is sometimes lacking. This was noted between specialties: "improving attitudes and behaviours towards each other, respecting the professional boundaries and respecting the value the specialists bring into these teams". (Consultant geriatrician, #7). As well as between healthcare and social care services: "carers are really not respected in the healthcare world, and the carers are the ones who are totally the next port of call to the clients. I think there should be a deeper relationship between carers and the NHS, that is lacking totally." (Junior carer, council, #42).
Access to geriatric / geriatric specialists	Clinical staff working in secondary care felt there was a need to have greater access to geriatric care specialists, be it consultant geriatricians or specialist nurses. "We need to have them, with us when we do our ward round we need them to see them with us from a medical point of view because usually the elderly population don't just come with a broken bone, a broken bone in an elderly population patient signify a huge change in their normal physiology which means that they might have a lot of other things going wrong with them that a care of the elderly physician would be able to detect.." (Consultant orthopaedic trauma surgeon, #8)

"If you spend that extra minute doing something for somebody else, it could mean that somebody else is waiting, then [management] start panicking, they start having seizures, it is a never-ending circle." (Junior carer, council, #28)

"If we work as a team, I'd like to think there wouldn't be a problem: they listen to us, we listen to them. We're all good at the one thing we do, rather than learn other people's skills." (Consultant geriatrician, #9).

"What we also need is a shift in our records…we're still not interlinked with everything, so I can't access the mental health community records, even though I'm dealing with someone that has both physical and mental problems." (Senior AHP, #26)

(Table 8 continued)

Challenge	Description
Continuity of care between services	A number of staff spoke of a disconnect between different services, particularly between primary and secondary care. An example included: older patients being discharged from hospital and moving into social care or having their care be managed by primary care services and neither being aware, or having an understanding of what the other can or has provided. A number of GPs as well as staff working in the community felt that secondary care providers work in isolation and do not consider social implications when discharging older patients back into the community. Conversely, those working in secondary care felt a lack of control or influence over the care their patients receive when they are discharged. "I need to know better what happens exactly in the community in rehab, I need to know exactly about the packages of care and I need to know whether I can modulate and change the packages of care. Rather than just the secondary care journey of the patient and then bye-bye. All I'd be able to do, I'll write a letter to their GP, this patient needs more package of care. Honestly! I have no control. The GP controls the finances, yeah? The GP has to authorise it and the patient, poor patient has to wait for a prolonged period of time to get that extra package of care." (Consultant orthopaedic trauma surgeon, #8).
Experience & expectations	Staff felt strongly that insufficient life experience was a challenge for many junior staff members to assist them with working with older people. In care home and community settings, many staff felt that junior members are not fully aware of the expectations of the role and are quickly overwhelmed or unwilling to do the tasks required of them. "My key thing is I think they're setting on too many young carers that hasn't had much life experience, some of them don't get me wrong come in and they're really good carers, they've just got the knack, but we've got some that are coming in that have left school and haven't got a clue about obviously care work or what it involves, and how hard it is, and I think some of them are just there for like, it's a job, the money, and it's not like that at all." (Senior carer, council, #20).
Trained staff	Similarly, many carers felt the lack of basic training or requirements expected of certain staff groups is problematic. "I think [many] are very untrained and a lot of the jobs I see advertised, even in backs of papers and our home, it will always say experience not necessary, which I think in a way is good because it's giving everybody a chance because everyone's got to start somewhere, right? But at the same time I do sometimes think it doesn't quite tally up: giving it to somebody who has to have quite a strict routine care. To send someone in there who's not experienced can be quite upsetting, quite traumatic for the patient." (Junior carer, private, #27)

"If you're a junior and you started at 17, 18, you don't have much experience. I think when you're a mum and you've looked after your parents or your siblings, you do get a lot of experience but it still doesn't prepare you for what it's like in a care home at all." (Junior carer, private, #27).

"Some of the agency staff that we get in, they haven't got a clue, so, no, I don't think so, they're not trained properly at all, even in the most basic things." (Senior carer, private, #16).

(Table 8 continued)

Challenge	Description

Staff turnover	High staff turnover in care homes was viewed as a significant challenge. Many staff leave owing to the working conditions, demands, and low pay. Retaining staff is a concern and impacts both staff and the residents. Continuously having new staff requires others to do additional tasks until they are more experienced. Staff recognised the impact on residents who feel uncomfortable or afraid as a result of constantly having different people care for them.
Feeling valued	Many staff felt there is no compensation or financial incentive for the physically, and sometimes emotionally draining work, particularly for those working in care homes or providing domiciliary care. Consequently, skilled and motivated staff are not attracted to these roles. Similarly, those working in this field can be unmotivated and feel unvalued. "Not everybody is enthusiastic are they, because the pay's terrible at the end of the day for some people it's a motivator .Unfortunately who will you attract to join us when you know the pay is not so good as a support worker? So there needs to be some attraction doesn't there in terms of recruiting the right type of person." (Senior secondary care nurse, #32)
Staff empowerment	Another demotivating factor for care staff in particular is that, although on many occasions they are on the frontline, providing the day-to-day care to an older person, they are often disregarded or excluded in decisions, or their knowledge and opinions are not taken into consideration. "I think sometimes people need to listen, I mean we get a lot of people coming in from different agencies, and sometimes they overrule us…we're with these residents 24 hours a day, and sometimes we'll tell them something, overlook us. We know our patients, we know our individuals." (Senior carer, council, #20).
Staff attitudes & ageism	Staff noted the attitudes and values that colleagues might hold about older people was challenging for them, as well as the care they saw older people were receiving as a result. "Attitudes of other doctors is definite barrier. Doctors who don't work in elderly care tend to have a different attitude to the patients and tend to make assumptions about patients." (Junior doctor, #30).
Relatives	Staff acknowledged the importance involving family in providing high quality care, but occasionally managing their expectations was viewed as difficult by some staff. "I always feel that it's difficult. You can deal with a situation quite well with the patient, but then a relative will come in, and have a different… You know like that helicopter mum. You can have helicopter children who only zip in from London for two hours, and then they've got to get back on the motorway, and they feel they've got to do the right thing by their parent, by saying all this stuff…which you want to listen to, but you might think, 'hang on, they don't really know what's going on here'." (Senior community nurse, #6)

"A lot of people are not going to see looking after elderly people as a career because it's not well paid". (Senior carer, private, #16).

"Some of the nurses who worked there, you could just tell that they were just doing everything automatically and robotically and there was no care in with it. No compassion in their care. I was a bit scarred with that experience." (Trainee nurse, #38)

Aids to providing high quality care

"Treating people as people, being aware of that, that makes the job easier." (Junior doctor, #29)

Staff outlined a number of factors and qualities that assist them with providing high quality care for older people. These included, receiving the necessary education, having practical experience of working with older people, and as such, having confidence in their abilities. Having adequate support and positive working relationships with colleagues (including multidisciplinary teams), and with their organisation as well as knowing their patients, was highlighted as beneficial. Staff's personal background and experiences surfaced as a strong theme and, as described before, compassion and values permeated throughout the discussions. These were viewed as fundamental. In contrast, many challenges outlined by staff, when absent or managed effectively were viewed as positives. Table 9 presents the key enablers highlighted by staff.

Education and training

Staff felt that good education and training and access to resources for continual improvement was immensely valuable and gave them the tools to provide high quality care to older people. [This is explored in subsequent sections of the report].

> *"Because I've been involved with plenty of End of Life patients, we've had the extra support from places like Marie Curie, and from the continuing health under the NHS. It is something that I was very, very interested in and I just want to be able to support the clients. Because it helps you, once you understand things you work without fear. Many people can hear death and get scared and think, "Oh". But with what I've been studying it takes away the myths, the mystery and the stigma around it." (Junior carer, council, #42)*

> *"I've always thought to myself, whatever I do, I do it properly. I just thought to myself, studying the course will give me a basic understanding of how to deal with people [with mental ill health], because there is also a stigma around mental health. So for me it's to facilitate what my role is, and for me to be able to meet the needs of these people and to be able to provide a positive input in their care." (Junior carer, council, #42)*

> *"I think being on ward, like just being, having time on the wards to speak to people has really helped me. I think I had a placement in medical school but obviously you see elderly patients all the way through, so GP surgery, you know, everywhere you go you see elderly patients and you have to communicate with them, so I really think that helped me. And I think definitely kind of appropriate training and teaching from consultant geriatricians and nurse specialists in things like Parkinson's disease and dementia really, really helpful." (Junior doctor, #30)*

Relationships & support: with peers, organisation

The relationship with, and the support staff received from their organisation, as well as from their peers and colleagues was viewed as instrumental. It heightened job satisfaction, feeling valued, and increased resilience when the demands of the job were difficult.

> *"I got this new job and this new company I have, I was very, very happy, I think that's what really made me want to do the jobs more in the beginning, because of the training, I was so happy with what training they provided, I just thought this is a good company, and when you think you're working for a good company it's much better. If you don't have a good relationship with your company, if they're not a good company then you're just going to have nothing but problems". (Junior carer, council, #42)*

"There's quite a lot of satisfaction from doing direct caring work in a good environment, in a good caring environment you know? A positive one where working as a team. Obviously it can be quite stressful as well you know with the demands that there are so, and I know some people do burn out, so I think you've got to be aware of that and quite supportive with each other." (Senior carer, private, #17)

Good leadership and supportive team leaders or senior staff made for a positive working environment that allowed staff to flourish and enjoy their work.

"We have got good team leaders. If I need any help or if I am struggling with some paperwork and I need to go anywhere, I can ring my team leader, she'll come, or she'll say, "Well I'll do the care review, you carry on with your paperwork". Or if we've had a crash call, somebody's fallen, and there's that many of us, she'll say, "Well we only need two, you can all go". So in that respect our team leaders are really good, and we all work really well as a team." (Senior carer, council, #20)

"Support from senior staff: if they see you've done something it's nice to hear, 'oh, well done', like a pat on the back. We do that with all staff, and it gives them a higher morale at the end of the day." (Senior care home nurse, council, #33)

Relationships within the team and having constructive ways of working together and sharing learnings made for a positive environment in which staff felt confident to do their work.

"Now we've got a really good team in and we work, we've worked together a long time and some of them would have always been friends a long time, we work well as a team now. We're not one of these, 'Oh, so and so did that'. If you need help we say 'ask, don't be afraid to ask', we say that to our carers as well. If you've done something wrong let us know, don't push it under the carpet, 'Tell us and we can help, if you don't tell us we can't help you'." (Senior carer, council, #20)

"If you're part of a team that does work well together and supports one another, that is [good]. To get together and come up with ideas and discuss things, then people are more motivated to learn and educate and provide good care, if you know what I mean, rather than people feel they're not valued within the team. So I think, yeah, having a good team is it's a part of the education." (Senior care home nurse, council, #36)

"I think because I've been really fortunate and had really good support on my jobs I've never found, particularly time to be a problem as much as with other things. I definitely felt like I was quite confident working in the team and talking to the different people, a lot of whom had a lot more experience than I did and I guess as I've become more senior also helping people who I then have more experience than." (Junior doctor, #29)

"I find team meetings really helpful and discussing clients with staff you know in a group, I find that really helpful, and sharing ideas of how best to support individuals, that's what seems to be helpful. Every environment's quite specific isn't it, so it's everybody talking about the care they offer within that home, and to those individuals, so I think that has been really helpful." (Senior carer, private, #17)

Table 9: Enablers to providing high quality care

Enablers	Description
Experience	Almost all the staff mentioned experience as incredibly beneficial. Some felt this was life experience; others felt it was having the right expectations of what the job entails; and some felt it was experience of doing the job itself (practicing the skills hands on). "Experience! I think being on ward, like just being, having time on the wards to speak to people has really helped me." (Junior doctor, #30)
Knowing your patient	Knowing the individual patient or client, as well as taking the time to understand their needs and wishes was viewed as invaluable to staff. "Actually speaking to the patients. A lot of the time if you meet with just a nurse they give you one picture, whereas actually if you speak to the patient direct, quite often it's a different answer" (Junior AHP, #37).
Personal experience & background	Many staff spoke of experiences in their own lives and how these influenced them, not only to work in their chosen profession, but drawing on those experiences to improve their work. "I also have a very elderly grandfather who is still very with it, who I live next door to, so see daily, and just through some of the things that he says I think I pick up on and then sort of apply that to my work." (Junior AHP, #37) "I looked after my nanna when I was little, and then it's like my granddad as well, it's just something that I just felt suited me." (Senior carer, council, #20)
Job satisfaction	Having job satisfaction and being passionate about their work, is a positive driver for staff working with older people. "I'm very passionate about my job and I guess the outcomes and I want job satisfaction and I want to see improvement, not just on an individual level but on a society level." (Senior AHP, #26) "I've been kicked, I've been punched, I've been spat at, you know, but it's rewarding for me, I just, I come home at the end of the night and I think I've made a difference to somebody's life." (Senior carer, council, #20) "It's a personal thing I think really. I feel so much better when I actually do take the time to get to know somebody than just trying to get the job done and rushing through it." (Trainee nurse, #38)
Resources	When resources were appropriately available, it afforded staff the opportunity to focus on the important elements of caring for older people, giving them time to provide personalised care and improved the quality of care staff were able to provide. It cultivated a positive working environment where staff felt motivated and supported to do their work. "Where I work I would put any of my family there, that's how good a standard it is. There's good training, there's good support, sufficient staffing, if we don't have our own staff, we can also go to bank, and it's more regular staff and as part of working for NHS they pay for all your training and updates and mandatory updates, so that's quite positive." (Senior care home nurse, council, #33) When time was afforded, staff were able to build a relationship and rapport with their patients and clients. "Within the community we have a lot more time, I plan my own diary, I can say if I'm seeing somebody, 10, 11, two, three, whereas in fact in a clinic setting it'd be 20 minutes to review someone, or 40 minutes for a new appointment, which when you've got quite a lot of material to get through it's hard. (Junior AHP, #37)

"Working in the same practice, knowing your patients." (Junior GP, #5)

"Just a relative coming up to say, 'oh, thank you for this', it really made a difference, that sort of helps you want to give more care, good care!" (Senior care home nurse, council, #33)

(Table 9 continued)

Enablers	Description
Teamwork	There was consensus from staff that working together as an effective and supportive team was crucial. This entailed trusting each other, as well as having strong supportive leadership. "I think really it needs to be always work as a team, I think that's the key for everything, work as a team. If you see that one of the team members is going to the wrong direction, you need to support them, you need to guide them and I think that's the key, to give a person-centred care to the residents." (Senior care home nurse, private, #35)
Multidisciplinary teams	Multidisciplinary team working, having access to other specialist, and sharing in the decision making to provide holistic care was invaluable to staff. "So my experience with that was actually really quite good we had a good MDT. We had MDT meetings weekly and if there needed to be then we had a family meeting, and obviously the most important person in this is the patient and everyone was aware of their specific role." (Senior AHP, #25)
Guidelines & updates	Having formal guidelines, such as the NICE guidelines Gold Standard Framework as well as receiving regular updates and alerts via email was viewed as positive and helped staff keep up-to-date.

Access to education and training

"I've just joined a new company who to me have been the best company by far, and just because of the training, that's what made me think, 'yeah, I really would like to work for this company'." (Junior carer, council, #28)

Access to education and training was a theme that came out strongly in the interviews, and viewed as immensely beneficial when this was afforded. Staff recognised the benefit to their practice, instilling confidence, and ensuring they were up-to-date with the latest evidence.

> *[Education and training is] very important, because it just gives you guidelines doesn't it. If you have guidelines, you know when something's going wrong or when something's going good so you know when to speak up. If you don't have guidelines and you don't know when a problem might arise or if a problem is happening, how to recognise certain things because you know people these days, there's lots of things that elderly people are going through with their family, with strangers, even with carers you know." (Junior carer, private, #27)*

> *"I think the training course I'd done the other month…was the best training I've received in all these years of being a carer for. I was very happy with it and I learned things that I had done right, learned things I had done wrong and just like my views on being a carer and for my new role I just feel really like 100% confident that this was going to work out..." (Junior carer, council, #28)*

"There's emphasis on repeating some of those areas so I do think it is quite good, because you need to constantly be having training, it's not something you're trained to do and then you know it for the rest of your life." (Senior carer, private, #17)

Beyond attending formal training courses or conferences, having access to experienced colleagues or senior staff who they could learn from and observe was seen an instrumental resource.

> *"Appropriate training and teaching from consultant geriatricians and nurse specialists in things like Parkinson's disease and dementia really, really helpful because these people are with them all day every day seeing them, and can really teach you more about how to approach these patients in a respectful and a sensitive way on very sensitive topics. Having it led by someone who is there with the patients, someone who understands patients and not just someone who has been out of clinical practice for 25 years." (Junior doctor, #30)*

Clinical staff, such as GPs, or those working in secondary care mostly felt that they had relatively good access to training, including online courses or opportunities to attend refresher courses and conferences.

"Yes, to be fair, my work are quite good, they do put on courses with dieticians and speech and language therapy and skin integrity as well. And we also have the medication training every so often to keep our skills up-to-date. So we do have quite a few clinical training but I think the nurses get more training than the care staff do. (Geriatric nurse, #11)

> *"I think the second thing is how easy it is to keep up-to-date, to update your knowledge. So, online CPD and things that you can research. Just the other day I was researching new treatment options for dementia, so although it's not something that I would initiate, it's something that I can explain to the patient and say 'look, when I refer you to the Memory Clinic, these are the treatment options that, you know, they may consider doing', and I think that's really, really changed things actually, having that knowledge available is really good." (Junior GP, #24)*

> *"I think I've been quite lucky I've recently gone to an international conference overseas where I was able to hear some of the best speakers and all about the new technology…So I think I've been quite lucky in being kept up-to-date and I think that is a real privilege to be able to hear some of the most prominent speakers in the care of the elderly world about the progress that's being made and different hospitals, how they try different things." (Junior doctor, #29)*

For staff in the community and social care sectors, some reported they have ample access to training: not only the mandatory training that their organisation require to ensure the upkeep of certifications; but other opportunities to develop as well. Having a supportive and encouraging organisation that valued training was seen as key to ensuring access to opportunities for development.

> *"Yes they do, update your training any time, if there's anything that you want to do, as long as your company are able to provide it there is a chance to do that as well. So this company that I'm working for right now actually offer a lot of opportunities which I think are very good." (Junior carer, council, #28)*

> *"I'm just going with my company and I think maybe because the owner is an ex-nurse, and an ex-Social Worker, so that's possibly different, so she's rounded, and so that the support she gives us, I mean it's phenomenal, it really is, and it makes you very confident doing your job." (Junior carer, council, #42)*

Required certifications and appraisals were viewed as positive ways of ensuring staff were able to access education and training. This manifests at the individual level, ensuring skills and knowledge are kept up-to-date personally, and at the organisational level, ensuring personnel are current.

> *"We have allocated, well we should allocate ourselves time out of the working hours for constantly appraising ourselves and doing self-directed learning, keeping up-to-date with guidance, that's all part of sort of our yearly assessment as GPs making sure we're keeping up-to-date." (Junior GP, #5)*

"While working in the care homes, then obviously I've got to do my medication update every year." (Senior carer, council, #20)

> *"They're mandatory, most of them, the ones within the nursing home, like I was saying, we've got to do audits and things like that, so you all get a shot doing different things." (Senior carer, council, #43)*

> *"Every year we have certain aspects of patient care that is now an online training course…it is part of our mandatory training that all sort of nursing staff have to do each year. It's an online training package that's been developed… and you have to get 100% to be able to pass it and get your certificate. So they do take it very seriously within the Trust that I work in." (Secondary care nurse, #32)*

Barriers to accessing training

There were varied accounts from staff as to their ability to attend training and development opportunities. Although access to education and training was viewed as invaluable to assist staff, the interviews revealed many challenges to gaining this access. Organisational culture, standards, and administrative constraints were particular barriers to staff having access to training. This influenced the level of training or certification required to be employed, as well as the ongoing training and upskilling too. Analysis of the data, and direct reports from staff, revealed potential discrepancies between the private and non-private sectors, and between carers and nursing staff working in social care settings. However, the sample is too small to make conclusive generalisations.

"I think the mentoring side and how well staff are supervised is really up to the different organisations, so I think that there's probably quite a lot more variety in how well staff are supported and how much training people have once they've had the basic training." (Senior carer, private, #17)

> *"A lot of our people I think are very untrained and a lot of the jobs I see advertised, even in backs of papers and our home, it will always say "experience not necessary"... which doesn't quite tally up… [Also] a lot of the courses come across now like brush-up skills, which is fine for somebody with a lot of experience, but I think somebody coming in head first needs a bit more of a thing, you know." (Junior carer, private, #27)*

"Well it depends really as in which company, and their rules and regulations, but you have to have some kind of experience and you have to go on a training course which now is for five days, so yes you do need some level of like experience, but like I said it does depend on the company you work for, and that's the problem." (Junior carer, council, #28)

As noted, organisational culture, time and financial constraints were barriers to accessing additional training.

"[If I wanted to go on some courses] they're [the organisation] a bit more like "you have to do it in your own time", or "pay for it yourself". They're not really good at funding it for you, and obviously you don't get paid very well in my job, so it's not something that I'd be able to really fund myself." (Senior carer, private, #16)

Some staff felt pressure from management to prioritise being at work, and that requesting additional training was frowned upon.

"We never get offered it. We never get told "we can do this". Nor, do we get encouraged, to be honest, maybe that's just the care home we're in because it's so busy. Maybe it's because they don't want the staff obviously going out on day courses so to speak, which is a shame really. And sometimes you feel frowned upon if you do ask to go on a course because it's like, well why would you need that, we could show you that here. Maybe that's just my care home but I do think it's not encouraged enough". (Junior carer, private, #27)

Similarly, staff felt guilty leaving colleagues to cover for them while they attended a course, as management were not willing or able to provide additional resources.

"This is where the problem is. I mean there was a course I did, it was End of Life Palliative Care, I did feel like I was an inconvenience… you feel bad because if you work inside a care home they don't bring in somebody else to cover, it literally means that the care home loses another member of staff for a few hours which you then feel guilty about…and I shouldn't really because I'm just bettering myself and bettering the care I can give." (Junior carer, private, #27)

The lack of time and resources was problematic for those working in secondary care.

"There's such a short staff problem isn't there, everywhere in terms of the NHS and in social care. [So] the opportunities to be able to go and get training is extremely difficult. It's not through lack of willingness I don't think on people's parts, I think people acknowledge that they need specialist training in certain areas but being able to give them time away from their day-to-day work to be able to go and get that skills it's less and less." (Senior secondary care nurse, #32).

Organisational and resourcing barriers were seen as having both a direct impact on staff's ability to access training and education (as described above), as well as an indirect impact. The lack of encouragement and motivation, as well as any perceived personal benefit was seen to lead to complacency, as such, staff were not driven to acquire or seek out training. For example, no perceived career progression or pay rise. (It must be noted that none of the staff interviewed saw this in themselves, instead recognised this in some of their colleagues).

"Lot of people who are moving to elderly care, I don't think they get paid as much and it's a thankless task. So it can be difficult to get them engaged in things like projects and more information and so they're a bit jaded sometimes." (Senior AHP. #22)

"I think sometimes people are just set in their ways and don't want to learn more, they're quite happy in doing what they're doing because I mean "I could do more two more courses, my pay's not going to increase". I like going on these things so I'm happy to do

that, but I think a lot of people are like, 'well I'm just getting by, I've been in this job for 5, 10 years, I don't really need another course do I?'." (Junior carer, private, #27)

"I think people become very complacent because, you know, I mean that staff don't have pay rises, you know, that it's a very cut throat system, you know, that if you've got a government who are leading our country and wanting to invest in healthcare, but they're not really investing in their staff, so people become very complacent and people lose their passion about their job and people cut corners because of time constraints, because there's not enough time and [sighs], you know, you invest in your staff and you're investing in the whole system." (Senior AHP, #26)

Education and training needs

"Having a good basis in it is very important I think. Unless you do paediatrics really, any specialty in medicine you're going to be involving older people so it's a really important thing to know about." (Junior doctor, #29)

Current education and training

As discussed in the section 'Setting the scene: Staff background', almost all the staff interviewed described their passion for their work, and caring older people. Similarly, it must be noted that a number of the staff we spoke to were broadly positive about the education they had received and were confident in their own skills and knowledge.

There were mixed accounts as to whether the level of education and training of the health and social care workforce is sufficient. Junior staff were positive about the education they had received, and the extent to which care for older people was a focus in their training.

> *"I think I've had very good training in care of the elderly. I don't know if it's the same for everyone but I think having a good medical foundation and then kind of practising and supplementing that specifically for older people. Knowing what needs to be focused on and what people's limitations are can be taught to a certain extent, but also needs to be experienced. I think I've had good teaching before my placement, during my placement and I've continued to learn after it so it's been useful." (Junior doctor, #29)*

> *"Actually I've done it [elderly medicine], even on an elective module, through acute care and research and development in the care of the elderly and that's what I chose instead and it was a lot more interesting exploring about the person, the patients and the individual like who were speaking to you." (Trainee nurse, #38)*

> *"So in the first few years when it was more lecture based we had a session every week, every morning, where we would discuss like more personal issues and care of elderly people came up, or the care of people with long-term conditions which most of the time is elderly people because they're the people who get long-term conditions. Then in the clinical years at [my university], in fifth year you have a module called Care of the Elderly, where you spend a month pretty much just learning about like conditions that are prominent in elderly people such as frailty, as in Parkinson's, we've already learnt in neuro and stuff but it's just emphasised particularly among elderly people. And then in final year, this year, we get assigned a ward, and mine was palliative care, and so that was quite a lot of elderly teaching, and then also in final year we have a month on geriatrics, so Yeah, there's quite a lot of training." (Medical school doctor, #14)*

"So obviously everyone gets taught elderly care medicine at medical school." (Junior doctor, #30)

Reflecting on their own education, the more senior staff members that were interviewed did not feel their training programmes and curricula incorporated care for older people as much as the junior members' accounts. Indicating a potential shift in the focus and design of educational and training programmes in recent years.

> *"I mean certainly at medical school, which for me was a long time now, but there wasn't a specific focus there. When you go through your junior doctor's training there's never any sort of specific requirement to do anything particularly around specific requirements of elderly people. I think you know as a doctor whether it's sort of dealing with mental health, or pharmacology, or problems around operations and surgery, rehab for elderly people, all these things have various factors that you need to understand. So that certainly wasn't really part of your training at any point." (Senior GP, #10)*

"As a trainee registrar in rheumatology, and general medicine, I don't remember a single event where I had the focused training based on the elderly care. It is mostly by self-learning, and I think it is some area which is hugely neglected in other specialities. Care of the Elderly obviously concentrates on various causes and its effects, which we have no idea. I share the office with the Care of the Elderly, and I sometimes sit in the MDT meeting and they are covering the terminology and the codes they use are totally alien to me. Come think of it, as a registrar, I think we never had any focused training on the elderly, which is a shame. I mean, it applies in is a speciality, let alone, rheumatology, if you take up a surgical speciality, they don't concentrate on the care of the elderly aspect, which I think is very, limiting." (Consultant rheumatologist, #3)

In the community and social care settings in particular, both junior and senior staff raised concerns about the adequacy and quantity of the education and training that certain staff groups receive, or are required to have prior to starting work with older people. Some felt the minimum training or certification requirements should be raised, and staff should receive on-going training and supervision for longer than is currently the standard.

"I think training should be a big issue, it's paramount to delivering care for the elderly. I don't think that a lot of companies offer enough training, especially because our population's growing so much, the elderly, they're living longer and it's not just basic care that you have to give now. I think that some companies don't counter this, into the vacancies when they advertise them. I do think they should do a lot more training, the NHS, private companies." (Senior geriatric nurse, #11)

"I think everybody should have a minimum Level 3 in care before you can even be accepted in the job role. I think it should be made a mandatory requirement, nobody should be allowed to do care without having that basic level of training, health and social care." (Junior carer, council, #42)

"I know you have to have Health and Social Care Level 2, but that doesn't really consist of much. Anybody can do it, I'm not like being horrible, but you don't have to be a genius to do that course. [I definitely don't think it's sufficient] because it doesn't give you nothing in terms of the reality of what you're going to be dealing with." (Senior carer, private, #16)

"I think that they [junior care staff] need ongoing training. Not like, a week's induction training, and then go and get on with it, for somebody who's never worked in a care home. All this NVQ stuff, they should be watched, ongoing, for at least six months. Sort of, paired-up working with somebody with experience, or a senior carer. But ongoing training, not just that one week, or two weeks induction training. That's not good enough." (Senior carer, private, #13)

The quantity of education and training focussing on older people's care was seen to be lacking. Similarly, the move to a more academic curriculum for nurses, results in a lack of experiential learning which staff viewed as important for working with older people in particular.

"I don't think it's just the nursing and residential, I think it's across the board for healthcare professionals. I know that even with say for example dieticians, I'd do a one-hour lecture for the university here on elderly care and I speak to them, they go into, their practicals and if they don't do any elderly care in that, then it's not something they learn on the job. So yeah, I'd say there is a big lack." (Senior AHP, #22)

"The actual training programme that nurses have to become qualified now, I'm just not 100% sure that they've got that right. The level of understanding that they had by the time they'd finished their training with them registered nurses, it was just a bit scary .It's become more academic and in some ways that's a very good thing but you know, I just worry that sometimes the basic stuff is missed out." (Senior secondary care nurse, #32)

Approach to training

Practical experience

There are many core areas or topics that could and should be included in education and training, from clinical knowledge that is specific to older people, having the skills to examine and manage multiple conditions, as well as having an aptitude for the relational aspects of care. Whilst staff recognised that a lot of this is and can be taught, there is little substitute for practical experience. As such, numerous staff spoke of the need for practical placements or opportunities to receive hands-on experience.

"I don't know if it's the same for everyone but I think having a good medical foundation and then kind of practising and supplementing that specifically for older people, kind of knowing what needs to be focused on, what people's limitations are, can be taught to a certain extent but also needs to be experienced, like lots of jobs, you know, if you're actually experiencing and doing something you learn it." (Junior doctor, #29)

"We do get advice on how to talk to people and how to go about caring for people but it's very difficult because we learn that in university, it's very difficult to actually, until you're there caring for someone, you can't quite simulate that with your mate at uni who's doing the role-play exercise with you. In terms of actually real world and applying it, you can't quite simulate that until you're working with someone who is elderly." (Trainee nurse, #23)

"First-hand experience is the best way to learn. In my training I didn't do any community work, so it was a complete shock to the system going to a nursing home. I think it's always been you learn quicker doing it." (Junior AHP, #27)

"When we trained we did a lot of hands-on placements. Our basic training started with doing a twelve-week stint on a ward to learn the basics. So it's become more academic and in some ways that's a very good thing but I worry that sometimes the basic stuff is missed out." (Senior secondary care nurse, #32)

Multi and interdisciplinary learning

Multidisciplinary and interdisciplinary learning and working was viewed as incredibly important tool for gaining knowledge and skills required for providing high quality care to older people. This in turn would enable staff to gain a better understanding of the services available, as noted before many staff felt the silo-working exists between different sectors, and coupled with the lack of knowledge of other services resulted in challenges. Thus teaching staff the skills to work in partnership and utilise the expertise of colleagues is crucial.

"I mean that would be a really good sort of opportunity for us to get together as different professions, all part of a multidisciplinary team if we were able to have a session like that I think that would be really, really useful. It would also make everyone aware of what kind of services we'd be able to offer patients, because often when you're just seeing patients you don't really know what's out there and how we can be offering the best services to patients." (Senior GP, #5)

"I think what we need to know and we need to be training, is how to work in the healthcare model in the communities, what are the type of people involved in these teams, what they are there doing their roles, how you can get access to them and what are the pathways of care?" (Consultant neurologist, #2)

"When I see them in clinic then I know which package of care he's been under, how many carers come every day, it's just the training to teach me the lingo of the OT, teach me about the available care that we have in our area. So that… we don't have a clue." (Consultant orthopaedic trauma surgeon, #8)

One junior general practitioner felt there was a need for a more holistic approach to training, to strengthen staff's knowledge and understanding of how the different sectors work together as well as the type of care that patients may receive from various services.

> *"You do three years GP training and this is in a mixture of a GP and a hospital setting. But rather than just working in a hospital and just doing whatever they do in a hospital, there needs to be more training available delivered probably by GPs in the hospital: explaining, how we can improve communication between Primary and Secondary Care; what the sort of things you should look out for; the sort of benefits. When I did my Elderly Care job in the GP training, I was just literally on the wards as a ward monkey basically, just seeing the patients etc but not really getting the Primary Care slant of things, and I would have really appreciated it if somebody could explain to me that whole." (Junior GP, #24)*

"I definitely think they should be teaching about the biopsychosocial model. I think it's a really important model and it basically shows how medicine should work and how it overlaps into everything. It's not just looking at the patient in front of you [it's taking everything into account]." (Junior doctor, #30)

This extended to providing older patients with the holistic care they may require. For example, another junior doctor had a positive experience of working in a geriatric ward where a holistic and multidisciplinary approach had been taken to caring for the older person.

> *"I think there is definitely medical schools I've heard of that do more kind of holistic training. So I did an extra degree in public health and primary care and a lot of my work in that was about the biopsychosocial model, which is a very well-known model with a rainbow and how kind of, shows how everything interacts. So that's how, that's definitely influenced my approach to patients. I think again definitely you pick it up on the geriatric wards, like when you have your ward rounds and your board, you know, your meeting in the morning you'll have a Social Worker there, you'll have an occupational therapist there, you really listen to the physiotherapists and the whole team much more than when you are on say a gastroenterology ward…*
>
> *…We did anatomy so we did a lot of kind of dissecting bodies and seeing the processes and things like that. But then when you're on the ward you have more kind of condition-based teaching, so if you were on a heart ward you'd have more heart-based teaching, when I was on geriatric wards I had dementia teaching, things that are more applicable to what you're doing at that moment. So I definitely found [holistic care training] more with the geriatric doctors, much, much more than any other specialty. I definitely had some but I, you know, I don't think it was enough. You get a little bit in psychiatry as well but a lot of the other specialties unfortunately don't take in that holistic model or adhere to the holistic model as much." (Junior doctor, #30)*

Mentoring and shadowing

Staff noted that for more junior members of staff, including trainee nurses and carers, mentoring and shadowing is an excellent way to learn: not only physical skills such as moving and handling, or feeding; but also behaviours and attitudes toward older people, emulated by positive role models.

> *"I think it's good to sit and have time to think about the theory in a training course and ask questions you know that you might not be able to do in another environment, but I think mentoring the staff is really important and having role models of how best to provide care, or different strategies that carers might have for dealing with different situations to get a better outcome really so that the client doesn't feel isolated, doesn't feel like they're not being listened to and that there is the communication there, and perhaps a bit of reflection. So supervision's quite important for that as well." (Senior carer, private, #17)*

"We had our general lectures and tutorials on compassionate care but I didn't feel like it related because it was so much more complex when you're actually on the ward. Just talk about it in a classroom based environment, it's very different. It would have been nice to have somebody maybe on placement talking to me about it, so that was a mentor's role I guess but they never brought it up, they never spoke about it." (Trainee nurse, #38)

Incorporating care of older people throughout

Older people are and will be part of almost every staff's patient or client population. As such it is important that, regardless of specialty or role, caring for older people and understanding their needs is incorporated in all training and education programmes. For those further along in their careers, having refresher courses or keeping up-to-date with the best practice is important. One senior consultant felt it would be beneficial that all trainee doctors, irrespective of their chosen specialty, should do a substantial placement in geriatrics.

"I think it doesn't matter, even if you end up not doing medicine and going into another speciality, say you did orthopaedics, the vast majority of your inpatients will still be elderly patients, this age people dominate the inpatient basis. If you're going to end up working in a hospital, certainly from my perspective in secondary care, there is a minimum level of knowledge and skills that we should have to be able for you to look after your elderly patients no matter which type of specialty you end up in." (Consultant cardiologist, #41)

"So from doctors' point of view I think all junior doctors have to have a training in general medicine, so they have to have six months or eight months in general medicine before they come and work for a trauma and orthopaedic unit. I would prefer they have four months in general medicine and four months in care of the elderly so that they will be able to see and detect early on any pathology or any problems that might be arising in the elderly population." (Consultant orthopaedic trauma surgeon, #8)

"A lot of the staff obviously will only be basing themselves within secondary care and I think, unless you're very junior and you've recently done a rotation of primary care and ended up shadowing GPs or perhaps done domiciliary visits to patients, you won't have had experience or recent experience. So refreshing yourself as to seeing that aspect of the patient in their home when they do eventually leave the hospital. So that aspect of care can be forgotten." (Consultant cardiologist, #41)

Holistic, person-centred care

To address the potentially complex needs presented by older people, a holistic and person-centred approach is required. This entails assessing all the potential needs of the person, physical, psychological, and sociological, and subsequently, connecting the appropriate resources and services. Furthermore, involving the person in decisions about their care, and listening to their needs and wants is crucial.

Assessing all needs:

"So you really have to look holistically, so at everything. So whilst, you know, a nice 30 year old guy who comes in with tummy pain, you can kind of know, life for them is generally, obviously not for everyone but generally going okay and you don't really have to think about …they shouldn't have too much of a past medical history…Whilst when you're thinking of an elderly person you're really thinking about their home environment, so are they safe to go home? Can they walk? Can they see? Can they hear? If they fell would they be able to get themselves up? Who might find them? Are they alone most of the day? Can they go and get a glass of water? Can they get to the toilet? Are they safe to walk? Are their slippers appropriate? Have they got heating and things like that?

But also generally a lot of elderly people are on a lot of medication so when you prescribe medication you're thinking is this interacting with a different medication? Is this something that's going to cause a side-effect which is dangerous for them? If you're putting them on something like a blood thinner, are they someone who falls over a lot so actually putting them on the blood thinner means every time they fall and they bleed a lot they're going to have to come into hospital, which is going to happen every two weeks.

And generally physiology of elderly patients, they have less muscle mass, they're generally thinner, their bones are thinner, I kept saying to a lot of my patients, "thank God you've got a heart but your heart has been beating for seventy years compared to mine beating for twenty-five years", so actually, things get weaker, things get less efficient unfortunately. Also understanding that they might need different diet, they might need more advice, they might need a flu jab, they might need vitamins if they're someone who continues to drink, elderly people don't eat as well so do they need protein, not protein shakes but kind of nutrition shakes that give them a lot of energy if they don't eat their meals? So yeah, there's a lot of consideration, which is why I really like it." (Junior doctor, #30)

Incorporating the correct services and specialities:

"I think as a doctor you definitely have to involve other healthcare systems, like occupational therapists, occupational health, physiotherapy because a lot of them like have, they're frail and then they have a hip replacement or something, obviously nurses are such a critical part of their care and they're the people to see the patients. You have to involve the GPs if you're working with the hospital, you know, so yeah, I don't think it's just one doctor's job, I think it's a massive multidisciplinary issue." (Medical school doctor, #14)

Taking a person-centred approach

"So people maybe I guess vulnerable as in for example somebody may not be able to make their own meal, but that doesn't mean they don't have the right to say what they want the meal to be or when they might want it and how much they might want of it you know, the kind of, I think we can get a bit prescriptive about, 'Oh, somebody needs 'X', 'Y' and 'Z', without there being sort of a two-way consultation with the individual of what they actually want." (Senior secondary care nurse, #25)

What education and training should include

Many of the key needs older people may have, the challenges that staff highlighted, and those factors that assist staff in providing high quality care, can be addressed through education and training. This can be provided by formal didactic education, experiential learning, informal observation, and mentoring.

It should be noted that most of the staff interviewed were broadly positive about the training they had received (or had sought out), and were confident in their own knowledge and skills. Staff highlighted some areas they felt less equipped to deal with personally, or could benefit from additional training, but on the whole felt assured in their ability to care for older people. Therefore, the broad areas noted by staff as essential knowledge or skills to have are not necessarily lacking in training at present. Rather, these include elements that staff felt are important for everyone, or specific groups to have to equip them to work with older people in general. The list of skills and training is drawn from staff's accounts, particularly what they felt strongly about, as such is not exhaustive (Tables 10, 11, and 12).

Table 10: Clinical / physical care skills

Subject	Description
Basic Care	General moving, handling, and feeding were examples of the basic care needs that older people may require and is important for all staff to have a basic knowledge of. Knowing how to physically and practically implement these tasks to ensure the older person is safe, and doing it with compassion and dignity.
Physiology of ageing	Understanding the physiological changes that occur as the body grows older and how this impacts and should be incorporated in care decisions.
Frailty	A clear definition and understanding of frailty is required, as well as information on the range of tools available to assess frailty.
Dementia / Alzheimer's disease	All staff should have a basic knowledge of dementia and Alzheimer's disease to detect it, and understand the impact (physically and on relationships), and how to communicate appropriately.
Mental health (including depression)	Mental ill health, including depression, anxiety, and loneliness is a risk factor in older people. Having basic skills to identify socioeconomic problems and a lack of social support in older people is important.
Managing co-multi-morbidity & complexity	Older people are more at risk of having a myriad of issues, as such managing and understanding complex patients with multi-morbidities is required.
Nutrition	Staff felt that basic knowledge in nutrition is important. Knowing what older require and understanding how to measure and manage their nutrition, particularly staff responsible for care home or domiciliary care.
Polypharmacy	Recognising and managing medications is crucial. If not an in-depth knowledge of the particular medications and their interactions and side-effects, at the very least identifying when someone may be on multiple medications and knowing to seek assistance to manage these.

Table 11: Relational and soft skills

Subject	Description
Ageism & attitudes	Ageism and attitudes to older people not only impacts on the relational aspects of care, such as showing compassion or communicating kindly and respectfully. It can impact assumptions about older people and decisions about their care. This is an important topic to include in the education and training of all staff.
Empathy, compassion, respect & dignity	Values-based education was seen as crucial for all staff. Although many felt this was difficult to teach, empathy training for example, is important and should be included in basic training and continued education.
Communication with patients & family (including EOL)	General communication skills is important, but should include: a focus on how to share information with patients in layman's terms; communicating with persons who may have impaired cognition; and having sensitive or difficult conversations with older people and their family.
Consent	Staff should have thorough understanding of consent, including legal complexities around issues such as power of attorney, and Deprivation of Liberty.
Person-centred care	Providing personalised care and care planning. Understanding how to incorporate the older person's needs and views into the care provided.
End of life & palliative care	Providing support and comfort, and understanding a person's wishes. Coping strategies should be provided to support staff.
Safeguarding	Safeguard training should be mandatory for all staff.
Preventative care	Staff should be equipped to provide preventative care. This includes empowering older people to care for themselves: educating them to manage their own health or condition. As well as early detection.

Table 12: Organisational & collegial knowledge and skills

Subject	Description
Knowledge of services & pathways	There was strong consensus that staff need to have better knowledge of available services and the care pathways of their patients or service-users. Furthermore, having a better understanding of the remit and capabilities of other specialities and services is important.
Communication with colleagues & other members of staff	Communication between individual staff, specialties, and across sectors is required. As above, understanding the remit and capabilities of others would facilitate communication and respect, and ultimately, more effective utilisation of resources.
Team work & multidisciplinary working skills	Having the skills and knowledge to work effectively in a team are key competencies that all staff should be trained in.

The impact of lack of training

Staff described the impact that lack of basic education and training can have on older people's quality of care. These are some of the examples highlighted by staff:

Physical harm

"I've seen that and I've seen serious safeguarding issues. A lot of it is due to lack of awareness, what they didn't know, and because they didn't know they haven't been able to act accordingly and as a result clients have had to rush back to hospital, clients have been left in their home vulnerable due to the lack of knowledge of the carer. It's always come up, 'oh, I didn't know we had to do that', and of course you wouldn't know because you haven't been taught or shown." (Junior carer, council, #42)

"Well I think the consequence could be quite serious really. I had a situation where I had put someone in the bath because I knew that the person hadn't had a wash for a very long time so I was just concerned about washing them, but I didn't actually think about actually getting the person back out of the bath you know. I mean I'd done it and everything worked out very well but I just think that maybe if I was not as experienced as I am, I should have known better really in this situation that could have been very dangerous. She could have slipped over, she could have banged her head and then I would have been in trouble for one, obviously causing that harm, and for actually even putting her in the bath you know?" (Junior non-clinical carer, #28)

"Well just even things like getting the right… from taking their history, then the doctors may not even get the right kind of diagnosis, or like if they can't communicate with them, they can't get the patient to tell them what actually happened, or even just getting trust, so like some patients may not actually want to tell the full story, or they forget the story or so on, so like it may actually affect diagnoses." (Medical school doctor, #12)

Feeling vulnerable

If staff aren't trained to be caring:

"Well, it makes them really sad, it makes them depressed, yeah, it makes them uncomfortable or anxious and all that stuff if they know so and so's on shift. For somebody to come and put them into bed and get them ready, to think that somebody not caring is coming that night, is going to upset their whole day." (Senior carer, private, #16)

"I think on the resident probably they feel insecure, they might feel scared, they've come into a new home, they're being brought out of their home that where they might have lived 60, 70 years. It's different faces, they probably feel intimidated, scared, afraid. So it's, you know, we've got to give them that reassurance, get to gain their trust." (Senior carer, council, #20)

Inappropriate or outdated care

"No-one wants to live in hospital and as much as people go like "oh yeah, it's very nice to get three meals a day and you're looked after", even old people who don't have anyone to speak to, they don't want to be in hospital. So I think it's, you just won't ever care for your patient fully if you don't have the right skill set or the right understanding of elderly care medicine, which is to make your patients comfortable and to not be in hospital again hopefully." (Junior doctor, #30)

"Well the impact is they're just getting the same old same old aren't they, they're not getting any sort of improvements that they could, they're being denied potential improvements in their day-to-day sort of care and management." (Senior secondary care nurse, #32)

"The team could make a mistake if it is lack of learning because they're thinking that they're doing right but actually it's wrong and it would impact to the residents, maybe it would be risk for their lives." (Senior care home nurse, private, #35)

Conclusion

"I'd never really understood the impact of good nursing until I'd realised the impact of bad nursing." (Senior care home nurse, council, #36)

To understand the extent to which the health and social care workforce is equipped to provide high quality care to older people, it was important to gain insights from staff who are on the frontline of providing care. The interviews provided rich data from a range of staff about their experiences of working with older people and allowed researchers to explore: what, in their view, are some of the key needs of older people; the challenges staff face, as well enablers to providing high quality care; and staff views on what education or training is important to have to support them in providing high quality, whether this is currently sufficient and importantly, what the impact on older people is if this is lacking.

Staff recognised that providing care to older people is complex and requires a holistic approach. Besides the clinical or medical complexities of older people, the social and social care needs of older people were highlighted as significant by staff, and many questioned whether this was being properly managed and addressed.

Some of the biggest challenges staff face in providing high quality care to older people include the lack of resources: time, staff levels, and funding. This has a significant impact on their ability to access the appropriate education and training, to upskill and stay up-to-date. Furthermore, for those working in social care environments and in community settings, the immense pressure and lack of support owing to decreased staffing levels, organisational cultures, and simply having limited time, coupled with little to no compensation or reward, can culminate in a downtrodden and depleted workforce, ultimately impacting on the care and even quality of life of those they serve. Furthermore, integrated service provision and continuity of care is problematic. Staff reported having little understanding or knowledge of services and professions beyond their immediate working environment, which resulted in disjointed service provision, and meant staff could not provide holistic care.

Despite the challenges, the staff interviewed were passionate about their work and motivated to provide high quality care for older people. This, coupled with personal experiences or backgrounds, as well as emulating compassion and care was noted as advantageous. Similarly, having strong relationships with peers and the organisation they are employed by, as well as the organisational culture as a whole made for a positive and motivating working environment in which staff could flourish, and subsequently their patients or clients could too.

Access to education and training was a particularly strong theme throughout the interviews, and there were varied accounts from staff about this. When staff were able to acquire skills and knowledge, it was immensely beneficial and instilled confidence in their ability to perform their duties. However, as mentioned before, resources were a big barrier for many to gain access to training. Lack of funding results in staff shortages, which creates a culture where 'getting the job done' is prioritised over the upskilling and development of staff. This was reflected in the organisational culture which would not support further training, and staff feeling pressure or guilty when leaving their colleagues to continue working while they were away.

Staff reflected on areas or topics that they felt would be beneficial to include in education and training programmes, summarised in Tables 10, 11 & 12. Some of these areas are already well covered in training programmes, while others should be made mandatory for all staff who work with older people. Furthermore, methods of education and training emerged quite strongly from the interviews. Practical experience was highlighted as being particularly necessary to equip staff

to provide care to older people. Learning how to work in and learn from multidisciplinary teams, as well as interdisciplinary teaching, shadowing, and mentoring could also expand staff's knowledge and their approach to providing care.

Overall, the staff interviewed were passionate and confident in their abilities, but did raise questions about the skill-level and commitment of some of their peers, as well as the preparedness of the system as a whole to cope with increasing demands from on an increasing older population.

CHAPTER 5

Systematic Review

Systematic Review

Introduction

Rationale

Following failings in the care of older vulnerable adults outlined in the Francis Report,[26] the Dunhill Medical Trust has developed a work stream committed to improving older people's care. As part of this work, Dunhill Medical Trust wishes to understand whether there is a link between educational training and older people's care quality and health outcomes in the UK.

Aims

The aim of this systematic review was to explore whether there is an association between care staffs' training and education and patients' outcomes, looking specifically at the evidence in care for older people, to answer the research questions:

A. Is there a link between education and training of staff and older people's experiences of care?

B. Is there a link between education and training of staff and the clinical outcomes of older people?

Methods

This systematic review followed the methods recommended in the Cochrane Handbook for Systematic Reviews of Interventions v5.1.0.[27]

Eligibility of publications

The final publication list was established using inclusion and exclusion criteria set in advance of starting the search:

Inclusion criteria

Publications were included if they:

- Included outcomes specifically for older people, regardless of where the care was provided. Any outcome was permitted, including clinical, self-reported or externally measured, quality of life, and access to care. Older people were defined as being 60 years or older
- Reported results from an education or training intervention for paid staff
- Compared patient outcomes before and after training
- Were written in English in the full text
- Were peer-reviewed journal articles, or nationally commissioned research reports (e.g. Health Technology Assessments from the National Institute of Health Research)

Exclusion criteria

Publications were excluded if they:

- Were conference abstracts, articles describing care pathways, or non-research items such as policy documents or guidelines
- Assessed staff knowledge alone
- Reported outcomes for older patients in conjunction with other age groups without distinguishing between ages
- Did not report outcomes (for instance, they only described a model of care)
- Did not provide data at all (for instance, research protocols)
- Did not have full text available from a Legal Deposit library

We did not exclude based on study design. This incorporates the realities of care provision outside of the restraints imposed by randomised control trials (RCTs), thereby providing insight on the impact of training in everyday practice.

Search strategy

We implemented a search strategy using the multi-database search platform Ovid®,[28] with search terms around training, education, different healthcare staff groups, older patients care settings, and health outcomes (Appendix B).

Databases searched

A number of databases were searched to ensure a broad variety of sources were covered. We carried out a multi-database search via Ovid®:

A. AMED (Allied and Complementary Medicine Database): 1985 to September 2017.

B. Embase® (*Excerpta Medica* database): 1987 to September 2017.

C. Ovid MEDLINE® Epub Ahead of Print, In-Process & Other Non-Indexed Citations, Ovid MEDLINE®Daily: 1988 to September 2017.

D. Ovid MEDLINE and Versions®: 1988 to September 2017.

E. PsycINFO®: 1987 to September 2017.

Study selection

The candidate records were de-duplicated and abstracts retrieved automatically by Ovid Online®. A subsequent manual inspection was made for unmatched duplicates arising through differences in the database structures; any records so identified were de-duplicated.

After receiving formal instructions, abstracts and titles were assessed by a team of 9 screeners working at Picker. One screener sense-checked 5% of the other screeners' decisions. Where screeners indicated they were unclear if the record met criteria, the inclusion of the record for full text review was discussed by two screeners to determine eligibility for the second phase, in which the full texts were obtained and assessed for inclusion, by double review.

Data extraction

After piloting a standardised data extraction form with three publications, one reviewer extracted information from the included publications, and two reviewers crosschecked the extraction. Data items extracted included fields such as study design; number of patient participants; number of staff participants; setting; age groups of participants; country; description of training intervention; staff groups trained; outcomes; total sample size; and key conclusions from a 43 item set (Appendix C). These fields determined article characteristics and allowed assessment of quality. Outcomes described in the publications were grouped into broad categories for presentation (Appendix D).

Intervention categories

Given the remit of this study, it was expected that there would be a range of training and education types. To aid in organisation and analysis, we set three categories of intervention:

- **Training only** – training was the intervention and could take the form of a series of workshops, the provision of a care guide, or lectures with phone support, with expectation of behaviour change.
- **Training to do intervention** – training of this sort would involve education as in the previous category and a consequent action, for instance being trained to make referrals, or to use a new surgical technique, with the behaviour change being the tested intervention.
- **Part of wider initiative** – training of this sort would involve education as part of wider changes, that could include pathway or unit redesign, such as new referral processes, new team dynamics, and quality improvement approaches.

Quality of publications included in this review

The quality of the publications was assessed independently by three team members using a bespoke tool adapted from the Scottish Intercollegiate Guidelines Network (SIGN) suggested Critical Appraisal notes and Checklists,[29] so that it could be used with all study types (Appendix E). All publications are presented with their assessment status described.

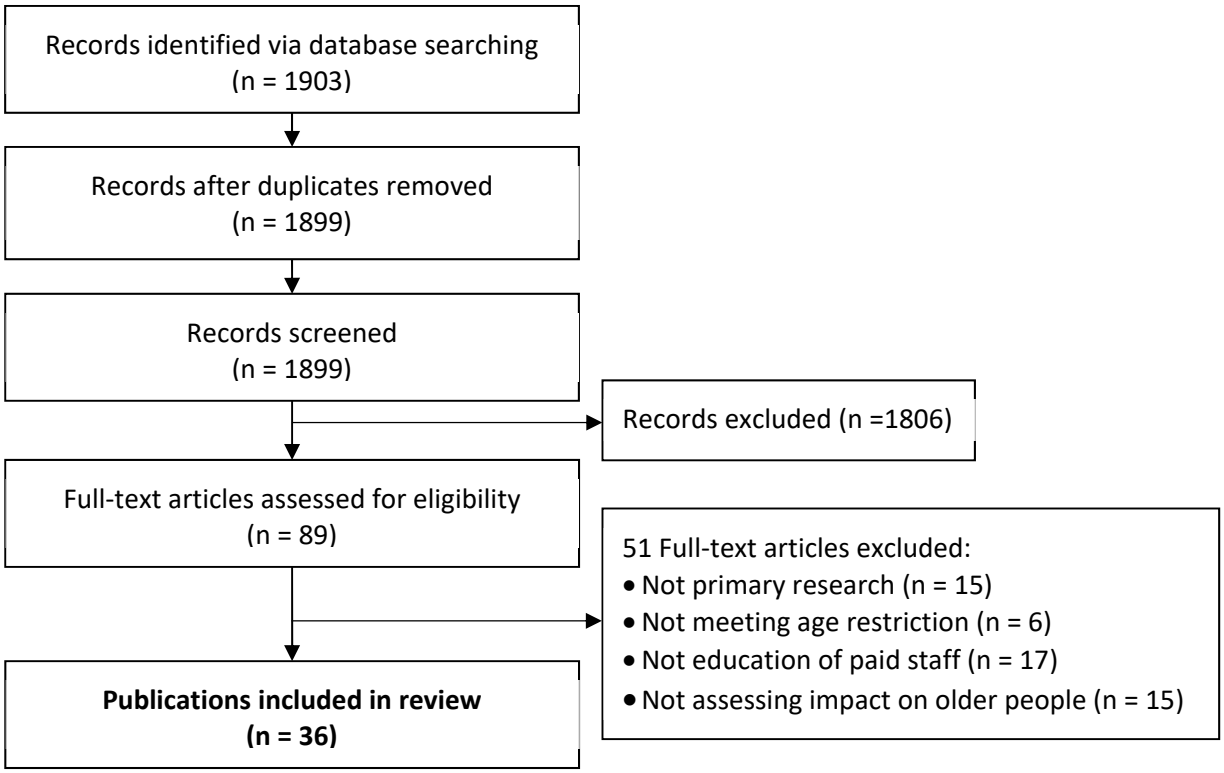
The risk of bias across studies was examined by comparing reported outcomes with protocols, where present, for RCT designs. Publication bias was indicated by proportion of publications reporting any impact.

Results

Study selection

After de-duplication, we identified 1899 records from the multi-database search. Following title and abstract screening, 89 records were potentially eligible. Reviewing the full text provided 67% (60/89) of the assessments matching (Krippendorff's alpha = 0.469). The largest number of mismatches were due to the use of a "check" category, indicating discussion with the group being desired. Mismatches were resolved by consensus amongst three researchers, until a final study set of 36 publications was established (Figure 1).

Figure 1. Selection of studies in review of the impact of staff education on the outcomes of older people



Study Characteristics

The 36 publications included in this review comprised a range of study designs, including 11 RCTs (9 clustered, cRCTs); six quasi-experimental; three pre-post designs; two time series; and 6 other designs (including qualitative, case control and audit); six publications did not state their design (Table 13). Twelve were from the USA, six from UK and six Australia; with other studies conducted in Europe, Hong Kong, China, Japan, and Canada (Table 13).

Publications varied in the reporting of the number of participants and staff involved (reporting encounters, or beds, or not indicating at all). As such, the number of older people enrolled in the publications was a minimum of 23,139, with a minimum of 7,141 staff trained or educated (Table 13). Thirteen publications examined training that enabled an intervention, 13 examined training as part of a wider initiative, and 10 training only.

Nineteen categories of outcomes were measured by the 36 publications (Table 13 and Appendix D), including broad metrics of functional status (residency changes and activities of daily living); processes of care (e.g. complications, screening use of restraints); healthcare use (including admission, length of stay, readmission); mental health; a specific measure for depression; and quality of life (including Quality Adjusted Life Years – QALYs - and EQ-5D[30]). Other outcomes include pain; social activity (including isolation); satisfaction; dental health (Table 13 and Appendix D).

Table 13: Characteristics of included studies.

Author, Year (country of study)	Title	Staff groups trained	Setting	Ages	Training type	Classified Outcome type
Bank et al. 2002 (USA) [31]	More than meets the eye: how examiner training affects the reliability of the MacNeill-Lichtenberg decision tree in geriatric rehabilitation patients.	Physicians	Neuropsychology rehabilitation service of a large, freestanding, urban hospital	60+	Training enabled intervention	Processes of care
Bartsch et al. 2009 (USA)[32]	Senior reach outcomes in comparison with the Spokane Gatekeeper program.	Primary care physicians, Adult Protective Services, County Human Services, other programs serving seniors; and non-traditional community partners	Two community mental health centres and one senior resources organization	60+	Training enabled intervention	Depression, Mental health, Social activity
Beck et al. 2009 (USA)[33]	House calls for seniors: building and sustaining a model of care for homebound seniors.	Medics	House calls	65+	Part of initiative	Depression, Functional status, Healthcare use, Mental health, Mortality, Processes of care, Satisfaction,
Beer et al. 2011 (Australia)[34]	A Cluster-Randomised Trial of Staff Education to Improve the Quality of Life of People with Dementia -Living in Residential Care: The DIRECT Study	General Practitioners (GPs) and Residential Aged Care Facility (RACF) staff	Residential Aged Care Facilities	65+	Training only	Dementia, Pain, Processes of care, Quality of life
Beernaert et al. 2017 (Belgium)[35]	Improving comfort around dying in elderly people: A cluster randomised controlled trial.	Nurses and family carers	Acute geriatric wards in 10 hospitals	Mean age: 83	Training only	Processes of care, Satisfaction

Blinkhorn et al. 2012 (Australia)[36]	An intervention to improve the oral health of residents in an aged care facility led by nurses	Nurses	Ward at hospital caring for elderly residents with mental health problems	implied 65+	Training enabled intervention	Dental health
Bradley and Kozakl. 1995 (Canada)[37]	Nursing care and management of the elderly hip fractured patient.	Nurses	Four acute care orthopaedic units in a large tertiary care hospital	65+	Training enabled intervention	Functional status, Healthcare use, Processes of care
Bruce et al. 2007 (USA)[38]	A randomized trial of depression assessment intervention in home health care	Nurses (medical and surgical) working more than 20 hours per week	Three certified home healthcare agencies	65+	Training enabled intervention	Depression, Mental health, Processes of care
Chenoweth et al. 2009 (Australia)[39]	Caring for Aged Dementia Care Resident Study (CADRES) of person-centred care, dementia-care mapping, and usual care in dementia: A cluster-randomised trial.	Care Staff	Residential care sites	60+	Training enabled intervention	Cost, Falls, Mental health, Quality of life
Cuijpers & van Lammeren 2001 (Netherlands)[40]	Secondary prevention of depressive symptoms in elderly inhabitants of residential homes.	Care givers	Residential homes	70+	Training enabled intervention	Depression, Quality of Life
de Souto Barreto et al. 2016 (France)[41]	Effects of a geriatric intervention aiming to improve quality care in nursing homes on benzodiazepine use and discontinuation.	Nursing Home staff	Nursing Homes	Mean: 85.5y intervention 84.6y control	Training only	Medication use
Flaherty et al. 1998 (USA)[42]	Decreasing hospitalization rates for older home care patients with symptoms of depression.	Care Home staff and nurses	Home care organization	65+	Part of initiative	Healthcare use
Garcia-Gollarte et al. 2014 (Spain)[43]	An educational intervention on drug use in nursing homes improves health outcomes resource utilization and reduces inappropriate drug prescription.	Physicians	Nursing Homes	65+	Training only	Health status, Healthcare use, Medication use

Goldberg et al. 2013 (UK)[44]	Care in specialist medical and mental health unit compared with standard care for older people with cognitive impairment admitted to general hospital	Nurses; Health Care Assistants; Junior doctors	Hospital (acute general)	65+	Part of initiative	Functional Status, Healthcare use, Mental Health, Processes of care, Quality of life
Gordon et al. 2016 (USA)[45]	Impact of a Videoconference Educational Intervention on Physical Restraint and Antipsychotic Use in Nursing Homes: Results From the ECHO-AGE Pilot Study	Participants typically included a nurse and a certified nurse assistant, with an occasional nurse manager, activities director, or social worker.	Nursing homes	In pilot paper mean age 82y	Training only	Functional status, Health status, Processes of care, Social activity
Grudzen et al. 2015 (USA)[46]	Redesigned geriatric emergency care may have helped reduce admissions of older adults to intensive care units.	Emergency Department (ED) staff - Emergency Physicians, Physician Assistants, Advance Practice Nurses, Social workers, and Pharmacists	ED hospital	65+	Part of Initiative	Healthcare use
Hullick et al. 2016 (Australia)[47]	Emergency department transfers and hospital admissions from residential aged care facilities: a controlled pre-post design study.	Clinical Staff	Residential Aged Care Facility	75+	Part of initiative	Healthcare use
Keene et al. 2016 (UK)[48]	The ankle injury management (AIM) trial: A pragmatic, multicentre, equivalence randomised controlled trial and economic evaluation comparing close contact casting with open surgical reduction and internal	Surgeons	24 Hospitals	60+	Training enabled intervention	Clinical function, Quality of life, Satisfaction

	fixation in the treatment of unstable ankle fractures in patients aged over 60 years					
Lyne et al. 2006 (UK)[49]	Analysis of a care planning intervention for reducing depression in older people in residential care.	Care staff	14 care homes	65+	Training enabled intervention	Depression
MacDonald & Walton 2007 (USA)[50]	E-learning education solutions for caregivers in long-term care (LTC) facilities: New possibilities	Nurses and Care givers	Patients in long-term care facilities	Geriatric	Training only	Processes of care
Makoutonina et al. 2010 (Australia)[51]	Optimizing care of residents with Parkinsonism in supervised facilities.	Staff	Residential care facilities	60+	Training only	Falls, Functional status, Quality of life, Staff knowledge
Proctor et al. 1999 (UK)[52]	Behavioural management in nursing and residential homes: a randomised controlled trial.	Staff	Nursing homes and residential homes	Mean 83.4y intervention, 82.7y control	Training enabled intervention	Depression, Functional status, Healthcare use, Mental health
Quijano et al. 2007 (USA)[53]	Healthy IDEAS: A depression intervention delivered by community-based case managers serving older adults	3 agency supervisors and 15 case managers	Community based	60+	Training enabled intervention	Depression, Functional status, Healthcare use, Quality of life, Social activity, Staff knowledge
Rolland et al. 2016 (France)[54]	Improving the Quality of Care of Long-Stay Nursing Home Residents in France.	Nursing home staff; and hospital doctors trained to deliver coaching	Nursing homes	Mean 86.5y intervention, 85.5y control	Training only	Functional status, Healthcare use, Processes of care,
Skelly et al. 2014 (UK)[55]	Does a specialist unit improve outcomes for hospitalized patients with Parkinson's disease?	All ward Multi-Disciplinary Team (MDT)	Elderly care ward and specialist unit in a hospital	median 81 (IQR 73-84)	Part of initiative	Healthcare use, Medications use
Sloane et al. 2013 (USA)[56]	Effect of a person-centered mouth care intervention on care processes and outcomes in three nursing homes	Certified Nursing Assistants	Nursing Homes	mean 79y	Training only	Dental health, Processes of care

Spijker et al. 2011 (Netherlands)[57]	Systematic care for caregivers of patients with dementia: A multicenter, cluster-randomized, controlled trial	Mental health professionals	7 community mental health services	mean 80.1y intervention, 80.1y control	Training enabled intervention	Functional status
Stevens et al. 2015 (USA)[58]	Enhancing the Quality of Prescribing Practices for Older Veterans Discharged from the Emergency Department (EQUiPPED): Preliminary Results from Enhancing Quality of Prescribing Practices for Older Veterans Discharged from the Emergency Department, a Novel Multicomponent Interdisciplinary Quality Improvement Initiative.	ED Providers received training	Veterans Affairs Medical Centre ED	65+	Part of initiative	Medications use
Tang et al. 2015 (China)[59]	Advantages and challenges of a village doctor-based cognitive behavioral therapy for late-life depression in rural China: A qualitative study	Village doctors	Rural community	60+	Training enabled intervention	Processes of care
Tse & Ho. 2013 (Hong Kong, China)[60]	Pain management for older persons living in nursing homes: a pilot study.	Nursing staff	Nursing Homes	60+	Part of initiative	Functional status, Mental health, Pain
Tse et al. 2012 (Hong Kong, China)[61]	The effectiveness of an integrated pain management program for older persons and staff in nursing homes.	Registered nurse; Enrolled nurse; Personal care worker; Health worker; others	Nursing Homes	60+	Part of initiative	Functional status, Mental health, Pain, Staff knowledge
Underwood et al. 2013 (UK)[62]	Exercise for depression in care home residents: a randomised controlled trial with cost-effectiveness analysis (OPERA).	Staff	Nursing Homes	65+	Part of initiative	Depression, Functional status, Healthcare use, Mental health, Pain, Quality of life, Social activity
Vidan et al. 2009 (Spain)[63]	An intervention integrated into daily clinical practice reduces the incidence	Geriatricians, (medical)	Hospital	70+	Part of initiative	Delirium, Functional status

	of delirium during hospitalization in elderly patients.	Residents, nurses in the geriatric ward				
Wong et al. 2009 (Australia)[64]	Innovations in aged care: Delirium unit: Our experience.	All regular staff including medical, nursing and allied health staff	Hospital	65+	Part of initiative	Cost, Delirium, Health status, Healthcare use, Processes of care
Yasuda & Sakakibara 2017 (Japan)[65]	Care staff training based on person-centered care and dementia care mapping, and its effects on the quality of life of nursing home residents with dementia.	Care staff and Nurses	Nursing Homes	mean 87.4y	Training only	Mental health
Yeo et al. 1987 (USA)[66]	Effects of a geriatric clinic on functional health and well-being of elders.	Two internists trained in geriatrics, Two medical geriatric fellows, one geriatric nurse practitioner (later a geriatric nurse specialist), and a social worker with special training in gerontology and geriatrics	Outpatient Primary Care	65+	Part of initiative	Functional status, Mental health

Quality of publications included

Amongst the included publications, 16 were assessed as high quality, scoring 11 or 12 on the bespoke tool; and 1 was low quality, scoring 7 or less on the tool. For the 11 RCT designs, there were five protocols or registrations available; two publications reported all outcomes per protocol,[34,48] three had minor variations in reporting of secondary measures.[35,39,44] Thus, a risk of bias for selective reporting cannot be discounted. Any publications without a protocol may have selective reporting of outcomes. Publication bias cannot be ruled out for all study types, with the majority of publications finding impacts: 92% (33/36) showed an impact on any outcome for older people.

Results of individual studies

Publications demonstrating impacts included nine (of 10) where the interventions were training only, 12 (of 13) where training was to do the intervention, and 12 (of 13) where training was part of an initiative. Not all of the studies adequately described the number of staff trained, nor their eligibility. Two-thirds of the publications (24/36) provided an evidence base (literature, or scoping studies) for the training given, and 16/36 made an explicit hypothesis about the effect of training. Some of the publications make an assumption that training will result in outcomes without explicating the rationale.

Summary of outcome measures

Within the 19 broad outcomes categories, there are a large number of measure concepts and definitions (Appendix D). Additionally, the manner in which the measures varied between: staff or carer reporting using direct observation or interviewing tool; data available from diagnostic testing or administration systems (e.g. blood test results, or number of GP visits; or patient reported (Table 13)); each of these may look at an aspect of clinical care or the experience of that care. In this review, we found few examples of experiential self-reported measures: end of life care in dementia,[35] and “satisfaction”.[33,48]

Summary of training setting, staff group and approach

The theoretical underpinning to the training provided was not clear in all cases, and most publications made an implicit assumption that provision of training resulted in behavioural change, with consequent patient outcome alterations. The settings of intervention, staff groups trained, and approach to training varied:

- Nursing homes and residential homes (by several names), and hospitals were the most common settings – Figure 2
- Nurses were the most commonly trained group – Figure 3
- Lectures were commonly used, and several studies did not define the education – Table 14

Table 14. Categories of outcome and their measurement.

Category of Outcome	Measure by staff or carer	Administrative or diagnostic source	Patient reported	Unclear *
Clinical Function		Yes[48]	Yes[48]	
Cost		Yes[39,64]		
Delirium	Yes[64]	Yes[64]		
Dementia	Yes[34]			
Dental Health	Yes[36,56]	Yes[36]		
Depression	Yes[32,49,52]		Yes[32,33,38,40,53,62]	
Falls		Yes[39,62]		
Functional status	Yes[33,54,60–62]	Yes[37,44,51,57,63,64]	Yes[66]	Yes[33,45,52,53]
Health status		Yes[43,45,64]		
Healthcare use		Yes[33,37,42,43,45–47,52–55,62,64]		
Medications use	Yes[41]	Yes[41,45,55,58,62]		
Mental health	Yes		Yes[44,62,65]	
Mortality		Yes[33]		
Pain	Yes[60]		Yes[34,48,60–62]	
Processes of care	Yes[33,35,45,56,59]	Yes[37,38,50,54]		
Quality of life	Yes[34]		Yes[34,39,40,48,62]	Yes[44,51,53,60,61]
Satisfaction	Yes[35]		Yes[33,35,48]	
Social activities	Yes[32]		Yes[62]	
Staff knowledge	Yes[51,53,60,61]			

** Activities of Daily Living and Quality of Life were not always clearly described and can be assessed in several ways*

Figure 2. Settings of interventions, showing number of publications in each.

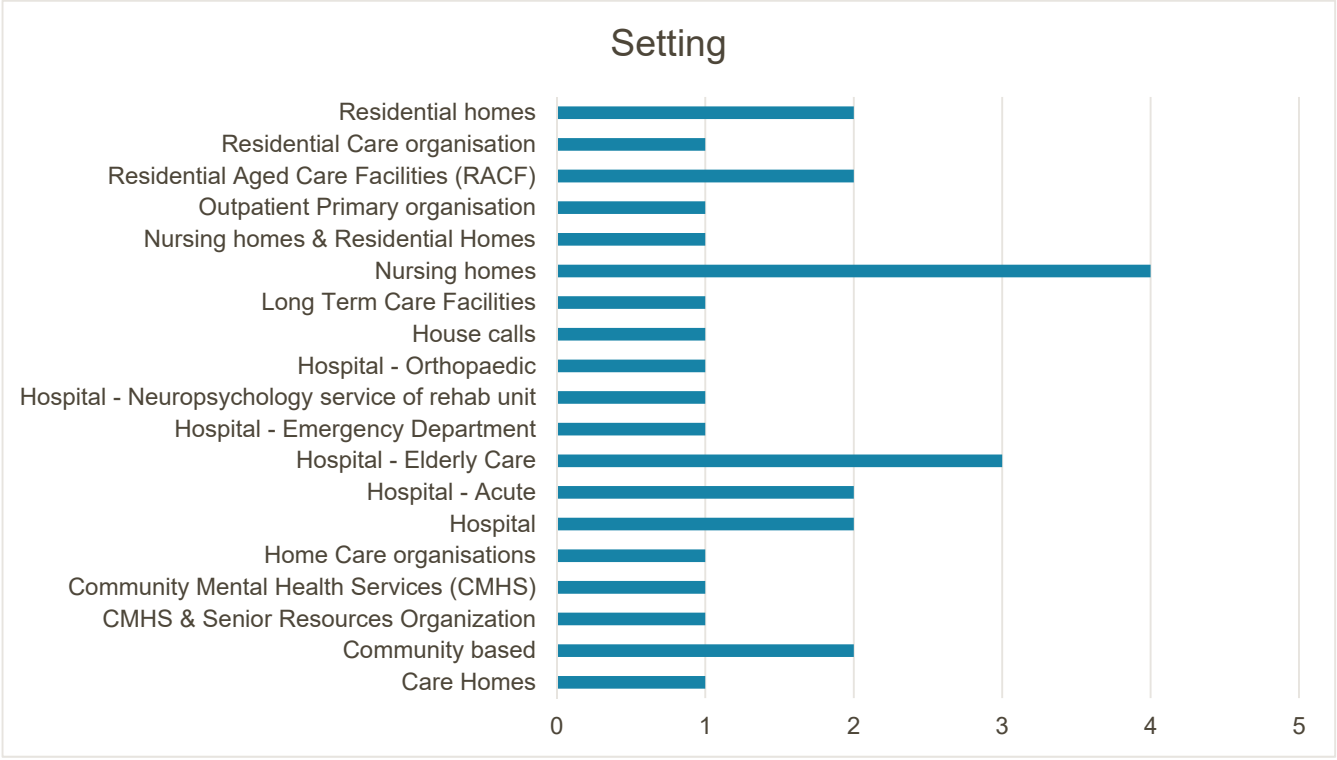


Figure 3. Staff trained, showing number of publications training each group

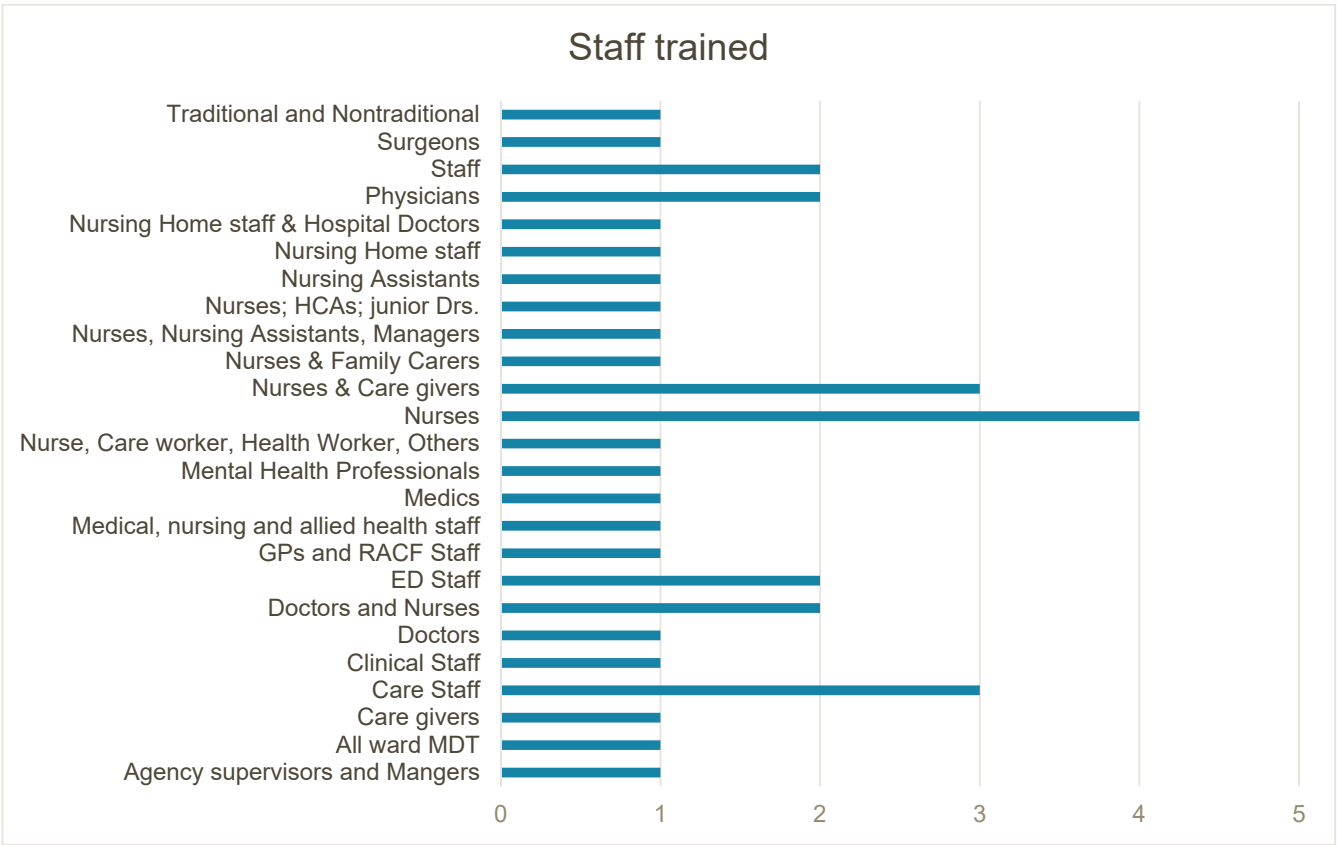


Table 15. Summarised training approaches

Training approaches
15 minute training session and manual
"Trained" to recognise and refer various distress
Half day work shadowing
“Flexible” program delivered in 30minute blocks
"Training" and a support guide
“Oral health education programme”
Day-long educational workshop.
The training totalled 4.5 hours divided into two sessions
Two-day training sessions
Three training sessions, feedback
Two half-day visits from specialist
An educational seminar about depression in older people was held for home care staff.
A structured educational intervention; two 1-hour workshops; on-demand advice
Staff were trained in recognition and management
Biweekly online video case discussions and brief didactic sessions
Educational programs that focused on palliative care and were discipline appropriate
The program constituted two hours of presentation with ongoing education
“Training”
Four 3h weekly sessions
Eight module eLearning
Three 1.5h lectures to staff members
Seven 1h seminars
Three half-day group training session; program manual ; assigned a “coach” ; group “booster training” sessions occurred semi-annually
Two half-day visits
Four one-hour training sessions
Training and supervision were provided daily for 2 weeks
Three sessions of 2 hours each
Lecture during three shifts over the course of a month; journal club; reminder cards
Six full days (three consecutive weekends); supported interactions
Eight lectures
Eight lectures
“Training”; twice-weekly physiotherapist-led exercise class
"An educational program "
"Specialised training"
Staff-training sessions were conducted in three rounds
Weekly post-clinic case conferences and seminars.

Intervention was training only

For publications where any impact was found, there were three cRCTs;[34,35,43] two publications used a pre-post analysis;[56,65] the remaining four designs were a matched cohort study,[45] a time series analysis,[51] a non-randomised control trial,[54] and unstated.[50] Five publications were in nursing homes,[43,45,54,56,65] two in residential care facilities,[34,51] one in long term care,[50] and one in hospital wards.[35]

The outcomes improved are processes of care,[34,35,45,50,54] satisfaction,[35] dental health,[56] depression,[45,54] falls,[51] functional status,[51] health status,[43] healthcare resources use,[43,54] medications use,[43,45] mental health,[51,65] pain,[34,54] quality of life,[51] and staff knowledge.[51]

Within these publications, no impacts were noted in functional status,[45,54] quality of Life,[34] and social activity.[45] An additional publication found no impacts on any outcomes included,[41] a nursing home based quasi-experiment that examined for impact on Medications use.

Five publications are considered high quality;[34,35,41,43,54] four medium quality;[45,51,56,65] and one low quality.[50]

Impacts where training was to do the intervention

For publications where any impact was found, there were four RCTs (3 cRCTs),[38,39,48,52] three were quasi-experimental,[37,40,49] one qualitative study,[59] one pilot study,[36] three did not state the design.[31,32,53] Four publications were in hospital wards,[31,36,37,48] two were community based,[53,59] three were in residential or care homes,[39,40,49] and the remaining three were in nursing homes,[52] community mental health services,[32] or home care agency.[32]

The outcomes improved included: processes of care;[59] clinical function;[48] cost; [39,48] dementia;[39] dental health;[36] depression;[32,38,40,49,52,53] functional status;[37] healthcare resource use;[37,52] mental health;[31,32,39,52,53] pain;[53] and quality of life.[40,53] Where the intervention compares surgical interventions,[48] a lack of impact on clinical function, satisfaction, and quality of life was found, in this case meaning that the use of a new technique is not detrimental to the patients.

Within these publications, no impacts were noted in processes of care,[37] functional status,[52] healthcare resource use,[53] quality of life,[39], and social activity.[53] An additional publication found no impacts on any outcomes included,[57] a community mental health based cRCT that examined for impact in functional status.[57]

Four publications are considered high quality,[37–39,48] and nine are medium.[31,32,36,40,49,52,53,57,59]

Impacts where training was part of initiative

For publications where any impact was found, there were two RCTs (one clustered),[44,61] one non-randomised control trial,[63] one randomised experiment,[66] two quasi-experiments,[47,60] one time-series,[58] one audit,[64] one pre-post,[55] one case control,[42] and two did not state their design.[33,46] Six publications were hospital based,[44,46,55,58,63,64] four were nursing home, residential home or home care based;[42,47,60,61] the remaining two were at outpatient clinics,[66] and house calls.[33]

Improvements were found in processes of care,[33] carer satisfaction,[44] cost,[64] delirium,[63] functional status,[61,63,66] health status,[44] healthcare resource use,[42,46,47,55,64] medications use,[55,58] mental health,[44,60,61] pain, [60,61] satisfaction,[33] quality of life,[61] and staff knowledge.[61]

Within these publications, no impacts were noted in processes of care,[64] functional status,[64] healthcare resource use,[47] and mental health.[66] The Australian publications in Residential care facilities determined a reduction in hospital admission but no alterations to ED presentation, ED length of stay, hospital length of stay, nor readmissions within 28 days.[47] An additional publication

found no impact on any outcomes included,[62] a nursing home based cRCT that examined for impact in Depression; Healthcare resource use; Medications use; Mental health; Pain; Quality of life; and Social activity.

Six publications were considered to be high quality,[47,58,60–62,66] and seven medium.[33,42,44,46,55,63,64]

Discussion

Summary of evidence

This review set out to answer two questions:

A. Is there a link between education and training of staff and the patient experience of older people?

B. Is there a link between education and training of staff and the clinical outcomes of older people?

The findings from this systematic review of literature indicate that there are links between the education or training of staff and the outcomes (clinical or experiential) of patients. However, consideration should be given to the outcomes studied, the staff groups trained, and the training approach when interpreting the results.

There are a large number of individual measure concepts examined by the included publications (a minimum of 152, as several outcomes are briefly described or grouped together as components of others; e.g. where quality is said to include several elements). Of all the measures, around one sixth are patient reported measures and very few are direct experiential measures (i.e. measures of satisfaction). For the direct experiential measures, each was increased or not adversely affected by the use of a new technique in which the staff have been trained. Thus, there seems to be a link between staff education and patient experience, but the strength of this link is unclear. That the studies measuring satisfaction in this review are from different settings, training approaches, and conditions is suggestive that the effect is not constrained to particular contexts. Additional studies in differing settings will be valuable in determining whether any constraints do exist. Given that patient experience is positively associated with clinical effectiveness and patient safety,[67] the determination of staff training as a way to positively impact patient experience could provide a way to alter clinical effectiveness and patient safety. Of the other self-reported measures, such as mental health and pain, the picture provided by the literature is somewhat blurry, as publications found both ‘no impact’ and ‘impact’, while using differing measures. The use of standardised tools to provide assessments would help to focus the image.

All 19 broad categories of outcomes are covered by measures provided through querying administrative or diagnostic data, or making use of staff (or carer) reported measures. The range of settings, and training approaches, for the studies gives insight into the impact that training can have on clinical outcomes. Whilst different definitions in measures does not allow a definitive settlement where disagreement in impact has been found, there is evidence that training does have impact. No publication mentioned co-production or goal setting of outcome measures with the patients; thus, there exists an opportunity to increase person-centred care.

The staff groups trained within the included studies were diverse, with a focus on nurses and carers, in care and nursing homes. Given that many vulnerable older people live in and are cared for in these settings by these staff groups, and there is a desire for hospital avoidance (a USA study noted poor outcomes for around a third of hospitalised over 70 year olds)[68], this focus is expected. However, only a few of the studies used hospitalisation, hospital avoidance (days at

normal place of residence), or readmissions as outcomes. Training that articulates how the interventions are expected to impact these types of measures should be considered.

Care provision is becoming more complicated, through advancements in disease recognition, increased knowledge about the treatment of people with co-morbidities, and use of new technologies, meaning it is difficult for one group to have knowledge of the complete practice of healthcare. Additionally, attempts to reduce silos of care are becoming common, thus education for the multidisciplinary team, and how to make best use of that team, will become useful.[69,70] Not all staff groups have mandatory education in care for older people (for instance, a junior doctor's training rotations may not incorporate this), and so there are possible knowledge gaps that ought to be filled to prevent avoidable detriment.

In this review, the majority of the studies were not conducted in the UK, with the largest number coming from the USA, and so workforce attitudes, knowledge-bases, and structures in the evidence base are unlikely to be the same. Thus, the application of any given interventions from one setting onto another may not produce the same results without some adaptation to local context and funding conditions.

Within the three categories of training, there were several approaches (e.g. seminars, workshops, coaching) with varying degrees and durations of trainer-trainee contact. Interestingly, similar approaches can have different impacts, and different approaches similar impacts. This suggests additional contextual and confounding factors that have not been adequately articulated. Additionally, many of the studies did not provide detail on how many, or which type, of staff were trained, making it hard to determine whether the impact observed is resultant from the intervention. Linked to this, the causal pathways of that impact is not always articulated, and where training is part of a wider initiative the individual contribution of training is not separately analysed for impact on the outcome, and it has been found that training alone is not sufficient for healthcare improvement such that additional changes are important.[71] Yet, the publications in this review where training is the intervention show that impact can be made, and *prima facie* trained individuals are preferred over untrained, especially as task complexity increases. Thus, initiatives should support training with other organisational structures, and could consider the use of factorial designs, and other techniques to increase "causal confidence",[72] to determine the elements of an intervention that are most efficacious on altering outcomes.

Strengths and Limitations

This review had a broad remit, and use of a multi-database search, thus the opportunity for studies to be included was increased, and the use of single tool for quality assessment (which was specifically constructed to allow comparison of different study designs), provides evidence that is pertinent to the realities of care provision in a number of settings. This review followed the methods established by Cochrane, which are considered to be the gold standard in systematic reviews, hence providing rigour. All publications included in the review were assessed by at least two researchers, and any disagreements were discussed among the three researchers in this project.

There are limitations that need to be considered when looking at the findings from this review. There was a high degree of heterogeneity among the included publications, making it difficult to summarise and inappropriate to directly compare measures. There is a risk of biases: publication bias (almost all publications found an impact) and reporting bias (few protocols available, some with deviation in the secondary outcomes). Further, the broad range of interventions, settings and study designs precluded a meta-analysis, therefore only descriptive analysis is provided in this report.

Conclusions

The findings from this systematic review indicate that there is a link between training and patient experiences and clinical outcomes, with a stronger link in the latter. The results highlight gaps in the use of experiential measures; in standardisation of measures; person-centred care (goal setting of important outcomes); describe in detail how impacts are to be brought about by training; and knowledge directly applicable to care settings in the UK.

In light of these findings, we recommend that training and educational programme leads ensure localisation of any new and ongoing initiatives, and make use of careful study design to assess the impact of such interventions. Training can be viewed as mechanism for change, as it is anticipated that increased knowledge shifts attitudes and behaviours. Thus, it might be more suitable to study impact of education and training programmes using approaches designed for use in change management. In such designs, including quality improvement methods, it is important to consider how to determine an intervention works in the setting under examination. Rigour should be maintained, and careful study design should be paramount. Excellent programme logic and use of appropriate controls and comparisons will help to establish causal confidence that a particular intervention has led to the observed outcomes, those outcomes should be set in partnership with staff and patients to ensure important aspects of care are captured.

CHAPTER 6

Conclusion

Conclusion

The global population is undergoing a demographic transition with more people being elderly. The increased demand from this populace is having, and will have, a significant impact on the provision of health and social care. Providing high quality care to older people is complex and multifaceted. Older people have complex needs potentially presenting multi-morbidities and physiological vulnerability. The action of medications and responses to treatments such as surgeries, differs in older people compared to other ages. Furthermore, older people have a higher incidence of cognitive disruption. Consequently, the models of care and the skill sets necessary to care for older patients must adapt to meet their needs. Yet, several major reports and studies have noted the sluggishness of policy and practice to respond to the growing demand, including the need for education and training of health and social care staff to correspond with the needs of staff to prepare them to provide care to the population they serve.

Using a combination of methods this report set out to explore the current education and training landscape of health and social care staff as well as exploring how well professionals think the education and training they receive is equipping them to deal with the increasingly complex needs of an ageing population. Interviews with stakeholders and staff shed light on the current education and training landscape, as well as key knowledge and skills that staff require and should be incorporated in the planning and designing of education and training programmes. The Systematic Review consolidated the evidence of education and training programmes that have been implemented with staff and directly or indirectly measured the impact on older people's care.

The stakeholder group provided insight into the current position. They highlighted a need for consistency across and within the health and social care sectors. This includes training for multidisciplinary working; knowledge of conditions that can affect older people; and empowering staff and trainees to provide high quality care, especially with regards to end of life care. Measurement of outcome was considered to be important. Changes are occurring yet more improvements can be made with greater speed. The stakeholder group was small yet the membership provided expert knowledge on the landscape through long professional work and research in the sectors.

The staff interviews had marked crossover with the stakeholder findings and provided rich data across the care pathways for older people. The complexity of providing care to older people was highlighted, which arises through the medical and social needs of older people, and as a consequence of the settings in which care is provided. Compounding the challenge of addressing complexity is the availability of resources in these settings: in terms of time, money, and people. Additionally staff, societal, and governmental attitudes to the provision of care for older people has effects on that provision. Social care in particular has been seriously impacted by austerity measures, and is under-resourced with a workforce that is often provided little training opportunity and has a low wage with a high turnover. Service provision was acknowledged as requiring better integration to provide continuity of care. Staff reported little knowledge of services and professions beyond their immediate setting. This reduces the opportunity for holism in care provision. Staff were passionate, often with personal experiences motivating them to and in their profession. They noted compassionate and caring attitudes were important, coupled with organisational cultures that provide support to staff and service users; keeping the humanity in care. Access to education and training was strongly desired, but that access was divergent across and within the different groups; some managerial attitudes to staff training were noted as poor. A lack of funding has reduced the opportunities for training as fees cannot be paid, and people's time cannot be released as there is no funding to cover their absence with additional staff. Train the trainer models may mitigate this to some extent. Practical experience was highlighted as particularly necessary, thus simulation approaches to training could be considered.

The systematic review found many examples of the outcomes of older people being impacted by provision of training to staff, however the effects were not consistent. The reporting of mechanisms for the intended impacts was lacking, and surprisingly the training interventions and staff involved were often not well described. The research included in the review was often not conducted in the UK, and so may not be directly transferable to the UK due to differences in the models of care, demographics, and health status of the populations in different countries. There were few instances of measures for experience of care reported.

This report provides an understanding on how the health and social care workforce can be equipped to provide a high quality of care to older people. The stakeholders' professional and expert views on the need for consistency and multidisciplinary training was recognised by staff, who spoke of a need for organisational cultures to support professional development. The systematic review shows that the impacts of education and training are not yet fully understood, and needs to be investigated through robust methods. Forthcoming investigations need to measure the outcomes well, and define those outcomes in detail with the causal relationships between training and outcomes articulated, recognising that training alone may not be sufficient. Involving staff and service users to highlight what is important to both groups to determine topics and approaches for education and training is important.

It is hoped that the findings in this report will serve as a first step in understanding how the health and social care workforce can be equipped to provide high quality care to older people, and that continued conversations and debates will lead to further exploration.

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Appendix A - Staff Interviews: Recruitment Specification

The following document contains the specifications for recruiting respondents to participate in telephone interviews for the Dunhill Medical Trust: 'Older People's Care and Educational Training' project, conducted by Picker.

Background

Purpose of the study

The aim of this phase of the project is to carry out interviews with a range of staff who provide care to older people. We want to understand views on the usefulness of any training and education they have received. There will be a focus on clinical (where applicable) and compassionate aspects of care delivery, as well as an exploration of the barriers and enablers of delivering high quality care to older people including contextual factors such as resource, time, pressures and support.

We will ask staff about their background; their experience of working with or providing care to older people; how equipped they feel working with this population; any training or education they have received, or would find useful, to work with or provide care to older people specifically; the barriers and enablers to delivering high quality care; and what their views are of the impact on the care they can deliver to older people.

Sample details and incentives

We would like to speak to a range of staff across health and social care who work with older people in some capacity, i.e. some staff groups may work primarily with older people such as care home staff or geriatricians; and others may include providing care to older people such as a general practitioner. We would like to speak to staff at different stages of their career i.e. junior staff members at the start of their careers, as well as senior staff who have substantial experience. Please see the breakdowns and specifications for each group below. Please refer to the Excel spreadsheet for details.

Community:

We would like to speak to allied health professionals such as district nurses, physiotherapists or occupational therapists. They must have some experience of working with older people, and as such should not specialise in for example paediatric care. We would like a range of specialties included in the spread, thus they should not all be from the same specialty.

Number	Staff Specification	Incentive
x 3	Junior allied health professionals (less than 4 years' experience) such as district nurses, physiotherapists, or occupational therapists. One of them must work mostly/primarily with older people i.e. their current job/role entails providing care or working with primarily people over 60 years old. The other two must have some experience of working with older people, but doesn't have to be primary population they assist i.e. has worked with/ provided care to people over 60 years old in their role/job. It must exclude anyone who works primarily in paediatrics or with people younger than 60 years.	£50 each
x 3	Senior allied health professionals (more than 10 years' experience) such as district nurses, physiotherapists, or occupational therapists.	£50 each

	One of them must work mostly/primarily with older people i.e. their current job/role entails providing care or working with primarily people over 60 years old. The other two must have some experience of working with older people, but doesn't have to be primary population they assist i.e. has worked with/ provided care to people over 60 years old in their role/job. It must exclude anyone who works primarily in paediatrics or with people younger than 60 years.	

Care home staff:

We would like to speak to staff who provide care to older people in the care home sector. This includes qualified nurses as well as non-clinical carers. There should be a portion of staff working for private care home providers as well those working for care homes run by local authorities, councils or charities.

For the non-clinical care staff, we would like to speak to staff who work solely in a care home providing care to older people, as well as some who provide domiciliary care i.e. as part of their role or as their entire job role, they are employed to provide care to older people in their own homes (this however excludes anyone who is employed by private individuals, they should be employed by a care home or provider).

Preferably, the staff will come from a range of care homes. I.e. we do not want all of them to come from same care home/ care home provider.

This group excludes anyone who provides care to service-users other than older people, such as children or those with specific disabilities who are younger than 60 years.

Care home nurses working for or in a care home for older people

Number	Staff Specification	Incentive
x 3	Junior care home nurses (less than 4 years' experience / qualified for less than 4 years). Must be qualified nurse. Must work in a care home for older people (over 60 years old). One must be employed by / work for a private care home provider. The other two must be employed by / work for a care home run by a local authority, charity or council.	£50 each
x 3	Senior care home nurses (more than 10 years' experience / qualified for 10 years or more). Must be qualified nurse. Must work in a care home for older people (over 60 years old). One must be employed by / work for a private care home provider. The other two must be employed by / work for a care home run by a local authority, charity or council.	£50 each

Non-clinical carers working for or in a care home for older people

Number	Staff Specification	Incentive
x 4	Junior non-clinical care home carers (less than 4 years' experience). Must work in/for a care home for older people (over 60 years old). Two must be employed by / work for a private care home provider. The other two must be employed by / work for a care home run by a local authority, charity or council. We would like at least one, preferably two of the carers to provide domiciliary care as part of (or entirely) their role. The other two or	£50 each

	three should work solely in a care home providing care for older people.	
x 4	Senior non-clinical care home carers (10 or more years' experience). Must work in/for a care home for older people (over 60 years old). Two must be employed by / work for a private care home provider. The other two must be employed by / work for a care home run by a local authority, charity or council. We would like at least one, preferably two of the carers to provide domiciliary care as part (or entirely) their role. The other two or three should work solely in a care home providing care for older people.	£50 each

Primary care (General Practitioners)

We would like to speak to general practitioners with a range of years of experience.

Number	Staff Specification	Incentive
x 3	Junior GPs qualified for less than 4 years.	£50 each
x 3	Senior GPs qualified for 15 years or more.	£75 each

Secondary care

There are a range of staff we would like to speak to who work in secondary care. All groups should have a focus on adult care. No paediatrics should be included; nor any specialities who do not have contact with service users such as Histopathology. This includes the following groups below.

Medical students/Junior doctors: medical students (doctors in medical school) and junior doctors (those who are in their Foundation Years, or only a few years post Foundation Year training).

Number	Staff Specification	Incentive
x 2	Medical students – doctors in medical school, not yet in post-graduate medical training / education. (Preferably toward the latter years of education i.e. not first or second year).	£50 each
x 2	Junior doctors – we would like to speak to those doctors who are early in their career. That is, they are only a few years post graduating from medical school such as completing Foundation Years 1 or 2; or only a few years post Foundation Year training).	£50 each

Senior consultants: Experienced senior consultants: Geriatricians; as well as consultants in specialties other than geriatrics or palliative care. For the latter we would like a mix of specialist in surgery and medicine. They must work in adult care, rather than paediatric or child health, and must have some patient contact (exclude for example Histopathologists).

Number	Staff Specification	Incentive
x 2	Geriatric Consultants – those who specialise in geriatrics or palliative care. Qualified for more than 10 years	£75 each
x 3	"Other" Consultants – those who do not work in geriatrics or palliative care. We would like a mix of specialists from medicine and surgery. (E.g. surgeons, radiographers, gastroenterologist etc.) Should exclude those who do not work with adults at all (such as paediatrics), or who have minimal or no patient contact (such as histopathology).	£75 each

	Qualified for more than 10 years	

Trainee nurses: This includes trainee nurses currently completing a training course/degree, or with less than 2 years in job training.

Number	Staff Specification	Incentive
x 3	Trainee nurses: currently in training i.e. completing a training course/degree, or with less than 2 years in job training. Must be training in adult nursing (not paediatric, learning difficulties or mental health)	£50 each

Senior nurses working in secondary care: We would like to speak to qualified senior nurses who specialise in geriatrics or palliative care; as well as those who are in areas other than geriatrics or palliative care or provide general care to patients in secondary care. They must however work in adult care, rather than paediatric or child health.

Number	Staff Specification	Incentive
x 2	Senior Geriatric Nurse – those who specialise or work in geriatrics or palliative care. Must work in secondary care (such as NHS hospital). Qualified for more than 10 years / 10 years or more experience	£50 each
x 2	"Other" Senior Nurses – those who do not work in geriatrics or palliative care. Preferably the two nurses will work in different areas/specialties/wards. Should exclude those who do not work with adults. Must work in secondary care (such as NHS hospital). Qualified for more than 10 years / 10 years or more experience	£50 each

Appendix B - Search Strategy

Databases:

- AMED (Allied and Complementary Medicine) (1985 to September 2017)
- Embase (1988 to 2017 Week 39)
- Ovid MEDLINE(R) Epub Ahead of Print, In-Process & Other Non-Indexed Citations, Ovid MEDLINE(R) Daily (1987 to September Week 3 2017)
- Ovid MEDLINE and Versions(R) (1987 to September Week 3 2017)
- PsycINFO (1987 to September Week 3 2017)

To find articles where staff received some education or training that improved the care of older people a search strategy was constructed querying abstract and title fields, using the truncation symbol * as a substitute for any string of characters in the search term:

A. Intervention: Staff *and* education search strings

1. Staff	2. Education
Doctor*	Educat*
Consultant*	Teach*
Surgeon*	Train*
Physician*	Curricul*
Trainee doctor*	Supervis*
Student doctor*	
Medical student*	
Nurse*	
Student nurse*	
Trainee nurse*	
Carer*	
Medical professional*	
Clinician*	
Therapist*	

B. Population search string

Elderly
Older adult*
Aged care*
Geriatric*
Over 65
Over 60

C. Impact *and* outcome search string

Impact	Outcome
Impact*	Patient experience*
Improv*	Quality of care
Increas*	Quality of life
Effect*	Health outcome*
Decreas*	Quality care
Associated	Quality life
	Outcome*

Filters:

Year: None

Language: English Language only

Subject: Humans/Human only

Age Group: Over 65 years

Search Strategy = A & B & C

Returned: 1903 records after automated de-duplication

Manual de-duplication resulted in 1899 records.

Appendix C – Extraction fields

The following information was sourced from eligible studies:

1	Publication Year	extracted
2	Author	extracted
3	Excluded during data extraction	extracted
4	Title	extracted
5	Publication Title	extracted
6	Study design as stated	extracted
7	Study duration	extracted
8	Randomisation process if appropriate	extracted
9	Blinding process if appropriate	extracted
10	Number of patient participants	extracted
11	Number of staff participants	extracted
12	Care setting	extracted
13	Inclusion criteria	extracted
14	Exclusion criteria	extracted
15	Ages	extracted
16	Gender	extracted
17	country	extracted
18	Disease groups	extracted
19	Ethnicity	extracted
20	Date of study	extracted
21	Training/ education intervention description	extracted
22	Training type	extracted
23	Wider intervention description	extracted
24	Number of intervention groups	extracted
25	Staff groups trained	extracted
26	Intervention group description	extracted
27	Comparison / control group description	extracted
28	Outcomes	extracted
29	*Classified outcomes*	*derived*
30	Which outcomes were significant?	extracted
31	*Was there any impact at all?*	*derived*
32	*Classified impacts*	*derived*
33	Times outcomes collected	extracted
34	Outcome definitions	extracted
35	Participants in each group	extracted
36	Total sample size	extracted
37	Missing participants (number and treatment)	extracted
38	Summary data for each intervention group	extracted
39	Funding source	extracted
40	Key conclusions	extracted
41	Rationale for education / training	extracted
42	*Was the study an RCT of any type?*	*derived*
43	*Are outcomes the same as in RCT protocol?*	*derived*

Appendix D – Outcomes Classification

Classification	Publication	Outcome
Clinical function	Keene et al. 2016	Olerud–Molander Ankle Score (OMAS) - a patient-reported assessment of ankle function
Clinical function	Keene et al. 2016	Ankle range of motion and mobility (as measured by the timed up and go test)
Clinical function	Keene et al. 2016	Radiological measures
Cost	Chenoweth et al. 2009	Cost of treatment
Cost	Wong et al. 2009	Costs
Delirium	Vidan et al. 2009	Incidence of delirium during hospitalization
Delirium	Wong et al. 2009	Confusion Assessment Method
Delirium	Wong et al. 2009	Duration of delirium
Dementia	Beer et al. 2011	Behavioural and psychological symptoms of dementia (measured with the Neuropsychiatric Inventory- NH version)
Dental health	Blinkhorn et al. 2012	Plaque score
Dental health	Blinkhorn et al. 2012	Cleanliness (dental)
Dental health	Blinkhorn et al. 2012	Gingivitis
Dental health	Blinkhorn et al. 2012	Pocket depth
Dental health	Blinkhorn et al. 2012	Number of pocket
Dental health	Sloane et al. 2013	Plaque Index for Long-Term Care (PI-LTC,)
Dental health	Sloane et al. 2013	The Gingival Index for Long-Term Care (GI-LTC)
Dental health	Sloane et al. 2013	Denture Plaque Index (DPI)
Depression	Bartsch et al. 2009	Additional outcomes for Senior Reach: short form of Geriatric Depression Scale (GDS) and Colorado Client Assessment Record (CCAR) Excerpt
Depression	Beck et al. 2009	Geriatric Depression Scale (GDS)
Depression	Bruce et al. 2007	Depression severity (24-item Hamilton Depression Rating Scales)
Depression	Cuijpers & van Lammeren 2001	Geriatric Depression Scale (GDS)
Depression	Lyne et al. 2006	Depression Scale of the Geriatric Mental State Schedule (GMS-DS)
Depression	Proctor et al. 1999	Depression
Depression	Quijano et al. 2007	Geriatric Depression Scale-15
Depression	Underwood et al. 2013	Geriatric Depression Scale-15
Falls	Chenoweth et al. 2009	Falls
Falls	Makoutonina et al. 210	Falls reduction
Functional status	Beck et al. 2009	Activities of Daily Living (ADLs)
Functional status	Beck et al. 2009	Increased dependency
Functional status	Bradley et al. 1995	Maintenance of pre-admission residence status

Classification	Publication	Outcome
Functional status	Bradley et al. 1995	Length of time to first ambulation
Functional Status	Goldberg et al. 2013	Number of days spent at home (or in the same care home) in the 90 days after randomisation
Functional status	Gordon et al. 2016	Functional status (IADLs)
Functional status	Makoutonina et al. 2010	Measures of mobility
Functional status	Makoutonina et al. 2010	ADL function
Functional status	Proctor et al. 1999	Functional ability
Functional status	Quijano et al. 2007	Physical activity
Functional status	Rolland et al. 2016	The Katz ADL score
Functional status	Spijker et al. 2011	Patient institutionalization in a long-term care facility during the 12-month follow-up
Functional status	Tse & Ho. 2013	Activities of Daily Living
Functional status	Tse et al. 2012	Physical functions
Functional status	Underwood et al. 2013	Short Physical Performance Battery
Functional status	Vidan et al. 2009	Incidence of functional decline
Functional status	Wong et al. 2009	Discharge destination
Functional status	Yeo et al. 1987	Self-assessed functional health
Health status	Garcia-Gollarte et al. 2014	Incidence of selected geriatric syndromes
Health status	Wong et al. 2009	Comorbidities
Healthcare use	Beck et al. 2009	average Length of Stay (LOS)
Healthcare use	Beck et al. 2009	Quality (preventative, patient satisfaction, geriatric syndrome identification, vaccinations, End of Life (EoL) discussions, healthcare utilisation)
Healthcare use	Bradley et al.1995	LOS on orthopaedic unit
Healthcare use	Flaherty et al. 1998	Whether the patient was hospitalized at the time home care services ended
Healthcare use	Garcia-Gollarte et al. 2014	Health resource utilization (visits to physicians and nursing homes, visits to the emergency room, days of hospitalization)
Healthcare use	Goldberg et al. 2013	Number of days spent at home (or in the same care home) in the 90 days after randomisation
Healthcare use	Grudzen et al. 2015	Intensive Care Unit admission rate from the Emergency Department (ED) for patients ages 65+ during study period
Healthcare use	Grudzen et al. 2015	ED-initiated palliative care consultations
Healthcare use	Grudzen et al. 2015	Hospice referrals
Healthcare use	Hullick et al. 2016	ED presentation
Healthcare use	Hullick et al. 2016	ED LOS in minutes
Healthcare use	Hullick et al. 2016	Hospital admission following ED presentation
Healthcare use	Hullick et al. 2016	Hospital LOS in days
Healthcare use	Hullick et al. 2016	28 day hospital re-admission
Healthcare use	Proctor et al. 1999	Use of resources was measured

Classification	Publication	Outcome
Healthcare use	Quijano et al. 2007	Utilisation
Healthcare use	Rolland et al. 2016	prevalence of residents transferred to the ED of the nearest hospital in the last 12 months
Healthcare use	Skelly et al. 2014	Length of stay
Healthcare use	Underwood et al. 2013	visits by health-care professionals
Healthcare use	Wong et al. 2009	length of stay
Healthcare use	Wong et al. 2009	referral source
Medication use	de Souto Barreto et al. 2016	Benzodiazapide (BZD) use
Medication use	de Souto Barreto et al. 2016	use of long acting BZDs
Medication use	de Souto Barreto et al. 2016	new users of BZD
Medication use	de Souto Barreto et al. 2016	Stopping of BZD medications
Medication use	Garcia-Gollarte et al. 2014	Appropriateness and quality of drug use
Medication use	Gordon et al. 2016	Prescription drugs
Medication use	Skelly et al. 2014	Proportion of PD medication given on time
Medication use	Stevens et al. 2015	The monthly number of potentially inappropriate medications (PIMs) as defined according to the Beers criteria that ED staff providers prescribed to veterans aged 65 and older at the time of discharge from the ED
Medication use	Underwood et al. 213	Care home data on medication use
Mental health	Bartsch et al. 2009	Emotional disturbance
Mental health	Bartsch et al. 2009	Cognitive impairment
Mental health	Beck et al. 2009	Mini Mental State Examination (MMSE)
Mental health	Bruce et al. 2007	Nurse-assessed mood or anhedonia (OASIS) versus research assessments using the Structured Clinical Interview for Axis I Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition Disorders (SCID)
Mental health	Chenoweth et al. 2009	Cohen-Mansfield agitation inventory (CMAI)
Mental health	Chenoweth et al. 2009	Psychiatric symptoms including hallucinations
Mental Health	Chenoweth et al. 2009	Neuropsychological status
Mental Health	Goldberg et al. 2013	MMSE
Mental health	Goldberg et al. 2013	General Health Questionnaire-12
Mental health	Makoutonina et al.2010	Mood
Mental health	Proctor et al. 1999	Cognitive impairment
Mental health	Proctor et al. 1999	Behavioural disturbance
Mental health	Quijano et al. 2007	MMSE
Mental health	Tse & Ho. 2012	Psychologic parameters of the older persons were collected from the two nursing homes before and after the IPMP

Classification	Publication	Outcome
Mental health	Tse et al. 2012	Psychosocial well-being
Mental health	Underwood et al. 2013	Mini Mental State Examination
Mental health	Underwood et al. 2013	Fear of falling
Mental health	Yasuda & Sakakibara 2017	Wellbeing
Mental health	Yeo et al. 1987	Subjective well-being
Mortality	Beck et al. 2009	Mortality
Pain	Beer et al. 2009	Pain (measured using the Brief Pain Inventory modified verbal form and PAIN_AD)
Pain	Keene et al. 216	Pain
Pain	Tse & Ho. 2013	Pain situations (including pain site, severity, use of non-pharmacologic methods for pain relief)
Pain	Tse et al. 2012	Pain intensity
Pain	Underwood et al. 2013	Pain
Processes of care	Bank et al. 2002	The temporal stability of participants' performance on the cognitive and affective components of the MacNeill–Lichtenberg Decision Tree (MLDT)
Processes of care	Beck et al. 2009	Quality (preventative, patient satisfaction, geriatric syndrome identification, vaccinations, End of Life (EoL) discussions, healthcare utilisation)
Processes of care	Beer et al. 2011	Use of physical restraint
Processes of care	Beernaert et al. 2017	Symptom management using a modified version of the End-of-Life in Dementia–Symptom Management (SM-EOLD) assessed by nurses and family carers
Processes of care	Beernaert et al. 2017	Symptoms and care needs in the last 3 days of life assessed by nurses using the validated Palliative Care Outcome Scale (range 0–40)
Processes of care	Beernaert et al. 2017	Symptom burden assessed by nurses using items developed by the study investigators
Processes of care	Bradley et al. 1995	Decrease in clinical risks
Processes of care	Bradley et al. 1995	Preoperative complications
Processes of care	Bruce et al. 2007	Referrals for mental health evaluation (agency records)
Processes of care	Goldberg et al. 2013	Carer strain
Processes of care	Gordon et al. 2016	Nutritional assessment
Processes of care	MacDonald & Walton 2007	Staff turnover
Processes of care	MacDonald & Walton 2007	Quality indicators from USA federal government
Processes of care	Rolland et al. 2016	Prevalence of creatinine clearance estimation (number of residents with creatinine clearance estimated in the last 12 months divided by number of participants in the NH)

Classification	Publication	Outcome
Processes of care	Rolland et al. 2016	Prevalence of residents without standardized cognitive assessment from among those estimated to have cognitive impairment
Processes of care	Rolland et al. 2016	Prevalence of assessment for the risk of pressure ulcers
Processes of care	Rolland et al. 2016	Prevalence of assessment of behavioural and psychological symptoms of dementia (BPSDs) in residents with a formal diagnosis of dementia recorded in the medical charts
Processes of care	Rolland et al. 2016	Prevalence of assessment of depression
Processes of care	Rolland et al. 2016	Prevalence of pain assessment using a standardized scale in the last month in residents complaining of pain or at the end of life
Processes of care	Rolland et al. 2016	Prevalence of residents with three weight measurements in the last 3 months
Processes of care	Rolland et al. 2016	Systematic tracking of falls and annual review
Processes of care	Sloane et al. 213	Each care episode was rated using the Mouth Care Task Completion Form
Processes of care	Sloane et al. 2013	The duration of each mouth care episode
Processes of care	Tang et al. 2015	Facilitators and barriers
Processes of care	Wong et al. 2009	Complications
Quality of life	Beer et al. 2011	Quality of Life - Alzheimer's Disease Scale (QOL-AD)
Quality of life	Beer et al. 2011	Quality of life was measured using the staff and next-of-kin (NOK) rated QOL-AD and the Alzheimer Disease Related QOL Scale (ADRQOL)
Quality of life	Chenoweth et al. 2009	Quality of life in late-stage dementia (QUALID)
Quality of life	Chenoweth et al. 2009	Quality of life
Quality of Life	Cuijpers & van Lammeren. 2001	Health Related Quality of life
Quality of life	Goldberg et al. 213	Quality of life
Quality of life	Keene et al. 2016	Quality of life (as measured by the European Quality of Life 5-Dimensions, Short Form questionnaire-12 items)
Quality of life	Makoutonina et al. 2010	Energy
Quality of life	Makoutonina et al. 2010	Quality of life
Quality of life	Quijano et al. 2007	Quality of life
Quality of life	Tse et al. 2012	Quality of life
Quality of life	Underwood et al. 2013	EQ-5D
Quality of life	Underwood et al. 2013	Proxy EQ-5D
Satisfaction	Beck et al. 2009	Quality (preventative, patient satisfaction, geriatric syndrome identification, vaccinations, End of Life (EoL) discussions, healthcare utilisation)

Classification	Publication	Outcome
Satisfaction	Beernaert et al. 2017	EoL in Dementia–Comfort Assessment in Dying (CAD-EOLD)
Satisfaction	Beernaert et al. 2017	Satisfaction with care during the last 48h of life assessed by the family carer using the validated End-of-Life in Dementia–Satisfaction With Care
Satisfaction	Keene et al. 2016	Patient satisfaction
Social activity	Bartsch et al. 2009	Social isolation
Social activity	Bartsch et al. 2009	Economic disadvantage
Social activity	Underwood et al. 2013	Social Engagement Scale
Staff knowledge	Makoutonina et al. 2010	Determine if the knowledge could be improved
Staff knowledge	Quijano et al. 2007	Depression management knowledge
Staff knowledge	Tse & Ho. 2013	Staff knowledge
Staff knowledge	Tse et al. 2012	Staff knowledge and attitude survey regarding pain

Appendix E – Quality assessment tool

	Item	Score *(please circle)*	Comments
1.	The study addresses and appropriate and clearly focussed question? (The research question is well defined).	Yes = 1 No/ Can't Say = 0	
2.	The study design is clearly stated (or described).	Yes = 1 No/ Can't Say = 0	
3.	The age group of patient population/participants is clearly defined. (60+)	Yes = 1 No/ Can't Say = 0	
4.	The staff group that received education or training is clearly defined.	Yes = 1 No/ Can't Say = 0	
5.	The outcomes of the study are clearly defined.	Yes = 1 No/ Can't Say = 0	
6.	The education or training that was delivered is clearly described.	Yes = 1 No/ Can't Say = 0	
6a.	*If not, is the wider programme or context of the intervention clearly described?*	*Yes = 1* *No/ Can't Say = 0*	
7.	Did the study state the eligibility criteria for the patients?	Yes = 1 No/ Can't Say = 0	
8.	Did the study state the eligibility criteria for the staff who received the training?	Yes = 1 No/ Can't Say = 0	
9.	Were the groups being studied selected from source populations that are comparable in all respects other than the factor under investigation? (Including pre-post studies).	Yes = 1 No/ Can't Say = 0	
9a.	*If above not applicable, does the study design measure appropriate target population?*	*Yes = 1* *No/ Can't Say = 0*	
10.	Overall, outcome data was available for all participants?	Yes = 1 No/ Can't Say = 0	
10a.	*If not, drop-out or missing data are explained.*	*Yes = 1* *No/ Can't Say = 0*	
11.	Has the study taken steps to minimise bias? (E.g. blinding, randomisation, controls, etc.)	Yes = 1 No/ Can't Say = 0	
12.	Did the authors of the study discuss any limitations of the research methodology?	Yes = 1 No/ Can't Say = 0	
Total Score (12 Max)			

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