Frailty Improvement and Implementation Programme

Change Package

October 2022

Improvement Hub

Enabling health and
social care improvement

Introduction

Welcome to the Frailty Improvement and Implementation Programme change package

This change package is for teams in health and social care partnerships (HSCPs), GP practices, and acute care settings interested in frailty improvement work. It is designed to support teams to improve the experience of access to person centered, coordinated health and social care, for people living with or at the risk of frailty.

The change package consists of a number of high-level outcomes supported by activities that when tested and implemented, bring about improvement. It brings together what is known about good practice and processes based on evidence from literature, research, and the experiences of others.

How was the change package developed?

This change package was co-designed virtually with two Expert Reference Groups of professionals from across Scotland with expertise in frailty between May and August 2022. The Expert Reference Groups had wide membership including diverse representation across disciplines, sectors, and regions. We have also engaged with third sector and advocacy organisations on the most meaningful ways to involve people living with frailty as we progress the work.

Contents and how to use the package

What is included in this change package?

- driver diagram
- change ideas
- examples of tools, resources, supporting evidence, and guidelines, and
- guidance to support measurement

Guidance on using this change package

This change package is a resource to support teams to use quality improvement methods to improve access to person centred, coordinated health and social care for people living with or at risk of frailty. Teams are encouraged to identify areas for improvement relevant to their local context. It is not expected that teams will work simultaneously on all aspects of the driver diagram. The change ideas and measures are not exhaustive. We would recommend teams develop change ideas to fit their context and seek local quality improvement support, if available, in the development of additional measures as required.

Using this package

We have made this an interactive document, if you click on the primary/secondary driver it will take you to additional information including tools and resources relating to that driver. At the top of each page of the secondary drivers, there is an arrow and home button. The arrow button will take you back to the primary driver page and the home button will take you to the main driver diagram page.

Project aim

Setting a project aim

All quality improvement projects should have an aim that is **S**pecific, **T**ime bound, **A**ligned to objectives and **N**umeric (STAN).

The national aim for ihub Frailty Improvement and Implementation Programme:

People living with or at risk of frailty have improved experience of and access to person centred, co-ordinated health and social care

By [*Insert Locally Agreed Date]*:

- **More people over 65 are identified earlier as living with frailty**
- **People living with frailty, carers and family members report positive experiences of health and social care services**
- **Health and social care teams report improved integrated working**

Driver diagram and change ideas

What is a driver diagram?

A driver diagram visually presents an organisation or teams' theory of how an improvement goal will be achieved. It articulates which parts of the system need to change, in which way and includes ideas of how to make this happen. It is used to help plan improvement projects and ensure team engagement.

The primary drivers are the key components of the system that need to change to deliver the aim. The secondary drivers are the processes that influence the primary drivers. Changing the processes outlined in the secondary drivers should change the primary drivers and deliver the aim.

Change ideas

Change ideas are specific practical changes the project team can make to alter the processes in the secondary drivers. The following pages provide a list of change ideas. They are grouped by the primary driver that they influence. Teams should select change ideas to test and implement based on their understanding of the local system.

Teams can generate their own change ideas that will help drive change in the secondary drivers. One way of generating ideas is to use the question "How might we?" For example, "How might we engage with people and their families to improve the experience of care?"

Driver diagram 2022

What are we trying to achieve	We need to ensure…	Which requires…
People living with or at risk of frailty have improved experience of and access to person centred, co-ordinated health and social care By [*Insert Locally Agreed Date]*: • More people over 65 are identified earlier as living with frailty • People living with frailty, carers and family members report positive experiences of health and social care services • Health and social care teams report improved integrated working	Early identification and assessment of frailty	• Use of reliable tools and shared language to identify frailty and those at risk of frailty • Timely delivery of Comprehensive Geriatric Assessment • Proactive reassessment and responsive multidisciplinary and multi-agency intervention
	People living with frailty, carers and family members access person-centred health and social care services	• Resources, services, and community assets which support prevention and empower people to self-manage • Proactive person-centred care planning, management and end of life care • Timely and equitable access to clearly defined care pathways • Effective care co-ordination to improve experience of care • Health and social care services are responsive to changes in an individual's level of frailty
	Leadership and culture to support integrated working	• Strategic leadership which supports integrated working • Integrated multidisciplinary and multi-agency working • Co-producing services with people, families and carers with lived experience • Compassionate leadership to promote psychological safety and staff wellbeing • System for learning

Primary Driver: Early identification and assessment of frailty

Secondary driver	Change ideas			
Use of reliable tools and shared language to identify frailty and those at risk of frailty	Frailty screening at interactions with key services	Standardised use of reliable tools such as Clinical Frailty Scale and Think Frailty	Population screening for frailty using eFI	Electronic recording of frailty (e.g. frailty coding)
Timely delivery of Comprehensive Geriatric Assessment (CGA)	Timely CGA across all settings	Use of integrated multidisciplinary and multi-agency team huddles	Adopt 7 steps to appropriate polypharmacy reviews	Development of systems to record and share the assessment of frailty
Proactive reassessment and responsive multidisciplinary and multi-agency intervention	Services designed to enable self-referral as circumstances change	Use of multidisciplinary and multi-agency team meetings in primary care	Reliable process for sharing information between health, social care, third and independent sector	

Primary Driver: Early identification and assessment of frailty

Secondary driver	Change ideas			
Use of reliable tools and shared language to identify frailty and those at risk of frailty	Frailty screening at interactions with key services	Standardised use of reliable tools such as Clinical Frailty Scale and Think Frailty	Population screening for frailty using eFI	Electronic recording of frailty (e.g. frailty coding)

Evidence and Guidelines:

Clegg, A, Bates C, Young J, Ryan R, Nichols L, Teale EA, et al. Development and validation of an electronic frailty index using routine primary care electronic health record data. Age and Ageing. 2016;45(3):353-360

Rockwood K, Song X, MacKnight C, Bergman H, Hogan DB, McDowell I, et al. A global clinical measure of fitness and frailty in elderly people. CMAJ. 2005;173(5):489-495

Tools and Resources:

Geriatric Medicine Research. Clinical Frailty Scale. [online] 2005

Healthcare Improvement Scotland. HIS THINK Frailty tool. [online] 2018

Healthcare Improvement Scotland. eFI in NHS Forth Valley. [online] [Video] 2019

Healthcare Improvement Scotland. University Hospital Monklands case study. [online] 2019

Newcastle University. LifeCurve™ Improving independence (and reducing costs) at scale presentation. [online] 2019

Scottish Primary Care Information Resource. eFI User Guide for GP practices. [online] 2019

Primary Driver: Early identification and assessment of frailty

Secondary driver	Change ideas			
Timely delivery of Comprehensive Geriatric Assessment in acute and community care settings	Timely CGA across all settings	Use of integrated multidisciplinary and multi-agency team huddles	Adopt 7 steps to appropriate polypharmacy reviews	Development of systems to record and share the assessment of frailty

Evidence and Guidelines:

British Geriatrics Society. Silver Book II [online]. 2021

British Geriatrics Society. CGA in Primary Care Settings [online]. 2019

Ellis G, Gardner M, Tsiachristas A, Langhorne P, Burke O, Harwood RH, et al. Comprehensive Geriatric Assessment for Older Adults Admitted to Hospital Cochrane Database of Syst. Rev. 2017; 9

Gutierrez-Valencia M, Izquierdo M, Cesari M, Casas-Herrero A, Inzitari M, Martinez-Velilla N. The relationship between Frailty and Polypharmacy in older people: a Systematic Review. Br. J. of Clin. Pharm. 2018; 84:1432-1444

Sum G, Nicholas SO, Nai ZL, Ding YY, Tan WS. Health outcomes and implementation barriers and facilitators of comprehensive geriatric assessment in community settings: a systematic integrative review. BMC Geriatrics. 2022;22(1):379.

Tools and Resources:

NHS Scotland. 7 steps to appropriate polypharmacy [online]. 2022

Royal College of Physicians. Modern Ward Rounds [online]. 2021

Primary Driver: Early identification and assessment of frailty

Secondary driver	Change ideas		
Proactive reassessment and responsive multidisciplinary and multi-agency intervention	Services designed to enable self-referral as circumstances change	Use of multidisciplinary and multi-agency team meetings in primary care	Reliable process for sharing information between health, social care, third and independent sector

Evidence and Guidelines:

Healthcare Improvement Scotland. Multidisciplinary team meeting (MDT) Guidance. [online] 2019

Healthwatch Liverpool. Community-based care pilot project. 2019

World Health Organisation. Framework for countries to achieve an integrated continuum of long-term care. [online] 2021

Travers J, Romero-Ortuno R, Bailey J, Cooney MT. Delaying and reversing frailty: a systematic review of primary care interventions. British Journal of General Practice. 2019;69(678):e61-e9.

Tools and Resources:

Healthcare Improvement Scotland. Fife health and Social Care Partnership: The community health and wellbeing hub model in Fife case study. [online] 2022

Dorset Clinical Commissioning Group. Dorset Frailty Toolkit; A model for the identification, assessment and care planning of frail patients. 2017

Social Care Institute For Excellence. Delivering integrated care: the role of the multidisciplinary team. [online] 2018

Primary Driver: People living with frailty, carers and family members access person-centred health and social care services

Secondary driver	Change ideas			
Resources, services and community assets which support prevention and empower people to self-manage	Access to community based activity to improve physical and mental health e.g. walking and befriending	Community link worker to signpost and navigate access to community support	Timely access to screening and lifestyle modification groups e.g. nutrition and smoking cessation	Access to housing advice and support
Proactive person-centred care planning, management and end of life care	Ensuring individuals have a recently updated Key Information Summary	Anticipatory Care Planning included in person centered care planning and review at transitions of care	Teams use a recognised tool to support people to set and achieve personal goals	Process for shared decision making with individual, family, carers and MDT, including at the end of life
Timely and equitable access to clearly defined care pathways	Pathways to enable direct admission to frailty specific clinical areas from the community	Development of pathways which prevent hospital admission	Development of pathways which promote hospital discharge within 48 hours	Creation and promotion of local map of services and community assets
Effective care coordination to improve experience of care	Single access point to health and social care services for people living with frailty	Process to support transitions between teams and services	Use of integrated multidisciplinary and multi-agency team huddles	Process to share information between teams and services
Health and social care services are responsive to changes in an individual's level of frailty	Use of reliable tools to recognise deterioration in health to prompt holistic assessment	Services designed to enable self-referral as circumstances change	Development of workforce and work patterns to enable responsive support	Process in place for regular case reviews

Primary Driver: People living with frailty, carers and family members access person-centred health and social care services

Secondary driver	Change ideas			
Resources, services and community assets which support prevention and empower people to self-manage	Access to community based activity to improve physical and mental health e.g. walking and befriending	Community link worker to signpost and navigate access to community support	Timely access to screening and lifestyle modification groups e.g. nutrition and smoking cessation	Access to housing advice and support

Evidence and Guidelines:

Hendry A, Vanhecke E, Carriazo AM, López-Samaniego L, Espinosa JM, Sezgin D, et al. Integrated Care Models for Managing and Preventing Frailty: A Systematic Review for the European Joint Action on Frailty Prevention (ADVANTAGE JA). Transl Med UniSa. 2019;19:5-10

Lafortune L, Martin S, Kelly S, Kuhn I, Remes O, Cowan A, et al. Behavioural Risk Factors in Mid-Life Associated with Successful Ageing, Disability, Dementia and Frailty in Later Life: A Rapid Systematic Review PLoS ONE. 2016; 11(2): e0144405

Tools and Resources:

British Geriatrics Society & Greenbrook S. Healthier for longer: How healthcare professionals can support older people. 2019

Healthcare Improvement Scotland. Community led models: innovation in health and social care report. [online] 2021

Healthcare Improvement Scotland. People led care Portfolio. [online] 2022

The King's Fund. Age UK Care co-ordinator roles. [online] 2022

University of the West of Scotland & Health and Social Care Alliance. Frailty Matters. [online] 2021

Primary Driver: People living with frailty, carers and family members access person-centred health and social care services

Secondary driver	Change ideas			
Proactive person-centred care planning, management and end of life care	Ensuring individuals have a recently updated Key Information Summary	Anticipatory Care Planning included in person centered care planning and review at transitions of care	Teams use a recognised tool to support people to set and achieve personal goals	Process for shared decision making with individual, family, carers and MDT, including at the end of life

Evidence and Guidelines:

Agoristsas T, Heen AF, Brandt L, Alonso-Coello P, Kristiansen A, Akl EA, et al. Decision Aids that Really Promote Shared Decision Making: The Pace Quickens. BMJ, 2015; 350:g7624

Scottish Government. Shared Decision Making in Realistic Medicine: What Works. [online] 2019

Huntley AL, Chalder M, Shaw ARG, Hollingworth W, Metcalfe C, Benger JR, et al. A systematic review to identify and assess the effectiveness of alternatives for people over the age of 65 who are at risk of potentially avoidable hospital admission. BMJ Open. 2017;7(7):e016236.

Tools and Resources:

Boyd, K. REDMAP framework. [online] 2021

NHS England. Always Events®. [online] 2016

Healthcare Improvement Scotland. Anticipatory Care Planning including My Anticipatory Care Plan. [online] 2018

Healthcare Improvement Scotland. Principles of Structured Response to Deterioration. [online] 2022

University of Edinburgh. Supportive and Palliative Care Indicators Tool (SPICT™). [online] 2019

Primary Driver: People living with frailty, carers and family members access person-centred health and social care services

Secondary driver	Change ideas			
Timely and equitable access to clearly defined care pathways	Pathways to enable direct admission to frailty specific clinical areas from the community	Development of pathways which prevent hospital admission	Development of pathways which promote hospital discharge within 48 hours	Creation and promotion of local map of services and community assets

Evidence and Guidelines:

Gonçalves-Bradley DC, Iliffe S, Doll HA, Broad J, Gladman J, Langhorne P, et al. Early discharge hospital at home. Cochrane Database of Syst. Rev. 2017(6).

Looman WM, Huijsman R, Fabbricotti IN. The (cost-)effectiveness of preventive, integrated care for community-dwelling frail older people: A systematic review. Health Soc Care Community. 2019;27(1):1-30.

Tools and Resources:

Healthcare Improvement Scotland. Improving planned care pathways toolkit. [online] 2022

Healthcare Improvement Scotland. Hospital at Home toolkit. [online] 2021

Healthcare Improvement Scotland. NHS GGC: Augmenting Front Door Frailty in Queen Elizabeth University Hospital case study.

Healthcare Improvement Scotland. NHS Tayside Improvement Team Workplan 2021-2022.

Healthcare Improvement Scotland. The Frailty at the Front Door Collaborative Impact Report. 2019

Primary Driver: People living with frailty, carers and family members access person-centred health and social care services

Secondary driver	Change ideas			
Effective care coordination to improve experience of care	Single access point to health and social care services for people living with frailty	Process to support transitions between teams and services	Use of integrated multidisciplinary and multi-agency team huddles	Process to share information between teams and services

Evidence and Guidelines:

Healthcare Improvement Scotland. SIGN Guideline 128: The SIGN Discharge Document. [online] 2012

NICE Guideline [NG27] Transition between inpatient hospital settings and community or care home settings for adults with social care needs. [online] 2015

Ran L, JaiweiG, Jibin L, Wang G, Hesketh T, Effectiveness of integrating primary healthcare in aftercare for older patients after discharge from tertiary hospitals – a systematic review and meta-analysis. Age and Ageing. 2022; 51(6)

Tools and Resources:

Healthcare Improvement Scotland. Care Co-ordination. [online] 2022

Healthcare Improvement Scotland. Improving planned care pathways toolkit. [online] 2022

Healthcare Improvement Scotland. Frailty and falls assessment and intervention tool. [online] 2020

Primary Driver: People living with frailty, carers and family members access person-centred health and social care services

Secondary driver	Change ideas			
Health and social care services are responsive to changes in an individual's level of frailty	Use of reliable tools to recognise deterioration in health to prompt holistic assessment	Services designed to enable self-referral as circumstances change	Development of workforce and work patterns to enable responsive support	Process in place for regular case reviews

Evidence and Guidelines:

International Foundation for Integrated Care. Report of Round Table on Healthy Ageing in Scotland. [online] 2020

Healthcare Improvement Scotland. Living well in communities with frailty: Interventions evidence summary. [online] 2018

O'Caoimh R, Galluzzo L, Rodriguez-Laso A, Van der Heyden J, Ranhoff AH, Carcaillon-Bentata L, et al. Transitions and trajectories in frailty states over time: a systematic review of the European Joint Action ADVANTAGE. Annali Dell'Istituto Superiore di Sanita. 2018;54(3):246-52.

Tools and Resources:

Healthcare Improvement Scotland. Midlothian Health and Social Care Partnership: An HSCP approach to using data to improve the care of people with frailty. [online] 2018

Healthcare Improvement Scotland. Frailty and the Electronic Frailty Index. [online] 2018

Primary Driver: Leadership and culture to support integrated working

Secondary driver	Change ideas			
Strategic leadership which supports integrated working	Leadership walk-rounds at team, locality and strategic levels	Strategic frailty leadership network	Mechanism to encourage staff feedback	Development of a shared vision
Integrated multidisciplinary and multi-agency working	Processes to enable teams to work together and build trusting relationships	Use tool to assess readiness for integration	Integrated huddles across health, social care, third and independent sectors	Process to share information between teams and services
Co-producing services with people families and carers	Involvement of people with lived experience, families and carers in service improvement	Use of recognised frameworks to support lived experience engagement	Use of feedback to inform service improvement	
Compassionate leadership to promote psychological safety and staff wellbeing	Celebrating success	Structured debrief opportunities and 1:1 time	Clear link to local wellbeing strategies	Learning and development opportunities for health and social care staff
System for learning	Opportunities to share learning locally and nationally	Sharing learning through HIS Frailty Learning System	Quality improvement education for teams	Frailty specific education for MDT and wider team

Primary Driver: Leadership and culture to support integrated working

Secondary driver	Change ideas			
Strategic leadership which supports integrated working	Leadership walk-rounds at team, locality and strategic levels	Strategic frailty leadership network	Mechanism to encourage staff feedback	Development of a shared vision

Evidence and Guidelines:

Hendry A, Carriazo AM, Vanhecke E, Liew A, Hammar T, Albaina O. European Guide for integrated models of care for frailty. 2019

Sexton JB, Adair KC, Profit J, Bae J, Rehder KJ, Gosselin T, et al. Safety Culture and Workforce Well-being Associations with Positive Leadership WalkRounds. The Joint Commission Journal on Quality and Patient Safety. 2021. 47(7):403-411

The Kings Fund. Making our health and care systems fit for an ageing population. [online] 2014

Threapleton DE, Chung RY, Wong SYS, Wong E, Chau P, Woo J, et al. Integrated care for older populations and its implementation facilitators and barriers: A rapid scoping review. Int J Qual Health Care. 2017;29(3):327-34.

Tools and Resources:

Healthcare Improvement Scotland. Leadership walk-rounds and safety conversations. [online] 2021

Institute for Healthcare Improvement. Patient safety leadership walk-rounds. [online] 2022 (note requires IHI login)

Healthcare Improvement Scotland. Strategic planning: good practice framework. 2019

Primary Driver: Leadership and culture to support integrated working

Secondary driver	Change ideas			
Integrated multidisciplinary and multi-agency working	Processes to enable teams to work together and build trusting relationships	Use tool to assess readiness for integration	Integrated huddles across health, social care, third and independent sectors	Process to share information between teams and services

Evidence and Guidelines:

The British Geriatric Society, Integrated care for older people with frailty. [online] 2016

Franklin BJ, Gandhi TK, Bates DW, Huancahuari N, Morris CA, Pearson M, Bass MB, Goralnick E. Impact of multidisciplinary team huddles on patient safety: a systematic review and proposed taxonomy. BMJ Quality & Safety. 2020;29:1-2.

Sempe L, Billings J, Lloyd-Sherlock P. Multidisciplinary interventions for reducing the avoidable displacement from home of frail older people: a systematic review. BMJ Open. 2019;9(11):e030687.

Tools and Resources:

Scaling Integrated Care in Context. SCIROCCO self assessment tool. [online] 2016

Healthcare Improvement Scotland. Fife health and Social Care Partnership: The community health and wellbeing hub model in Fife case study. [online] 2022

Healthcare Improvement Scotland. Multidisciplinary team meeting (MDT) Guidance. [online] 2019

Primary Driver: Leadership and culture to support integrated working

Secondary driver	Change ideas		
Co-producing services with people families and carers	Involvement of people with lived experience, families and carers in service improvement	Use of recognised frameworks to support lived experience engagement	Use of feedback to inform service improvement

Evidence and Guidelines:

O'Donnell D, Ní Shé E, McCarthy, Thornton S, Doran T, Smith F, et al. Enabling public, patient and practitioner involvement in co-designing frailty pathways in the acute care setting. BMC Health Services Research. 2019. 19:797

Sadler E, Potterton V, Anderson R, Khadjesari Z, Sheehan K, Butt F, et al. Service user, carer and provider perspectives on integrated care for older people with frailty, and factors perceived to facilitate and hinder implementation: A systematic review and narrative synthesis. PLoS One. 2019;14(5):e0216488.

Tools and Resources:

Care Opinion. [online]

Healthcare Improvement Scotland. Community led models: innovation in health and social care report. [online] 2021

Healthcare Improvement Scotland. Care Experience Improvement Model (CEIM). [online] 2021

Healthcare Improvement Scotland. Experienced Based Co-design. [online] 2021

Healthcare Improvement Scotland. Person-centred Design and Improvement Programme. [online] 2021

Primary Driver: Leadership and culture to support integrated working

Secondary driver	Change ideas			
Compassionate leadership to promote psychological safety and staff wellbeing	Celebrating success	Structured debrief opportunities and 1:1 time	Clear link to local wellbeing strategies	Learning and development opportunities for health and social care staff

Evidence and Guidelines:

Edmondson A. The importance of psychological safety [online] [video] 2021;

Edmondson A. Three ways to create psychological safety. [online] [video] 2022; IHI

O'Donovan R, McAuliffe E. A systematic review of factors that enable psychological safety in healthcare teams. Int. J for Qual. In Health Care. 2020. (4):240-250

Tools and Resources:

Institute for Healthcare Improvement. IHI Framework for Improving Joy in Work. [online] 2017 (IHI log in required)

Scottish Government. National Wellbeing Hub. [online]

NHS Education for Scotland. National Trauma Training Programme. [online] no date

NHS Education for Scotland and ihub. Ready to Lead: Lesson 7 – Celebrating Success. [online] [video] 2021

NHS Education for Scotland: TURAS | Learn. Values Based Reflective Practice. [online] 2022 (TURAS log in required)

Psychological Safety. Psychological Safety Tool Kit. 2020.

Primary Driver: Leadership and culture to support integrated working

Secondary driver	Change ideas			
System for learning	Opportunities to share learning locally and nationally	Sharing learning through HIS Frailty Learning System	Quality improvement education for teams	Frailty specific education for MDT and wider team

Evidence and Guidelines:

Centre for Public Impact, Healthcare Improvement Scotland, Iriss. Human Learning Systems: A practical guide for the curious. 2022.

Davies S, Herbert P, Wales A, Ritchie K, Wilson S, Dobie L. Knowledge into action – supporting the implementation of evidence into practice in Scotland. Health Information and Libraries Journal. 2017. 34(1)74-85

Viggars RJ, Finney A, Panayiotou B. Educational programmes for frail older people, their families, carers and healthcare professionals : A systematic review. Wien Klin Wochenschr. 2022;134(5-6):227-36.

Tools and Resources:

British Geriatric Society. Frailty Hub: Education and Training. [online] 2020

Healthcare Improvement Scotland. HIS Frailty Learning System Microsoft Teams Channel

Healthcare Improvement Scotland. Learning Systems. [online] 2021

Learning from Excellence [online]

NHS Education for Scotland: TURAS | Learn Quality Improvement Zone. [online] (TURAS log in required)

Measurement

Measurement is an essential part of improvement as it helps the project team understand if the changes they are making are leading to improved care. Below you will see an outline of three types of measures used in improvement and a link to the measurement framework.

Outcome measures
Outcome measures are used to understand if the changes are resulting in improvements towards the aim.

Process measures
Process measures demonstrate that change ideas are improving the underlying processes that contribute towards falls prevention.

Balancing measures
Balancing measures are used to determine if the changes are affecting things elsewhere in the system (unintended consequences).

The following measures are for teams to use in their local context and area of focus for frailty improvement. You may identify other concepts and changes that require measurement to further understand your progress towards improved care. Our team's contact details are available at the end of this document should you wish to discuss measurement for improvement.

Measurement: Outcome measures

Concept/ Name	What/ How to measure
Number of people over 65 identified as living with frailty	Number of people over 65 identified as living with frailty using a reliable tool. Local teams can agree which tool, such as Think Frailty! or the Clinical Frailty Scale, is most appropriate for them.
People living with frailty, carers and family members report positive experiences of health and social care services	Qualitative data from local systems and processes which seek feedback on the care experience of people living with frailty, their family, and carers. You may wish to use the Single Quality Question: "Overall how helpful or unhelpful has the support [*from/for…*] been to you - helpful, neither helpful nor unhelpful or helpful? Please tell us a bit more about the option you chose: if the support [*from/for…*] made a difference to you please tell us a bit more. If the support [*from/for…*] did not make a difference, please tell us a bit more."
Health and social care teams report improved integrated working	Qualitative data from local systems and processes about staff member's views on integrated working shared routinely as part of existing management pathways. Locally defined definitions based on current context and capacity.

Measurement: Process measures

Concept/ Name	What/ How to measure
Percentage of people screened for frailty at the front door of the hospital or GP practice	Percentage of people aged 65 or older screened for frailty at front door of the hospital or GP practice. Teams will define their own front door and can define their own age criteria. Numerator: number of people screened for frailty at front door or GP practice. Denominator: total number of people aged 65 or older, arriving at front door or attending GP appointments. Percentage Calculation: (numerator/denominator) x 100
Percentage of people over 65 identified as at risk of living with frailty using a population screening tool	Percentage of people aged 65 or older identified as at risk of living with frailty using a population screening tool Numerator: Number of people aged 65 or older identified as at risk of living with frailty using a population screening tool such as the eFrailty Index (eFI). Denominator: total number of people aged 65 or older screened for frailty using a population screening tool such as eFI Percentage Calculation: (numerator/denominator) x 100

Measurement: Process measures

Concept/ Name	What/ How to measure
Time to initiation of Comprehensive Geriatric Assessment (CGA)	Number of people who meet criteria for CGA with evidence of timely initiation of assessment after frailty identification. Locally defined aim for time to assessment, for example in acute care e.g. 24hrs from identification. Clock starts: frailty identified using validated tool Clock stops: CGA commenced Criteria to identify initiation of assessment can be locally defined based on community or acute processes. It is likely to include first contact with multidisciplinary team responsible for frailty assessment e.g. written entry of discussion or outcome of CGA huddle.
Number of people living with frailty with a person centred care plan in place	Number of people identified as living with frailty who have a person centred care plan in place. Local teams can define their own essential criteria for person centred care planning which should include a conversation with the person and Anticipatory Care Planning as appropriate.

Measurement: Balancing measures

Balancing measure

Concept/ Name	What/ How to measure
Readmissions to acute hospital within 7 days of discharge	Percentage of people discharged from older people's medicine who experience an unscheduled readmission as an inpatient to an acute hospital within seven days of discharge. Numerator: Number of people readmitted to hospital within 7 days of discharge from older people's medicine per calendar month Denominator: Number of people discharged from older people's medicine per calendar month

Contact Us

Get in touch to provide feedback or share your plans for using the Frailty Improvement and Implementation change package by:

- Joining the Frailty Learning system MS Teams Channel
- his.frailty@nhs.scot
- @ihubscot

To find out more visit Frailty resources toolkit (ihub.scot)

Review Date: January 2023