Healthcare Improvement Scotland

Focus on Frailty programme

Measurement framework

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1 How to use this measurement framework

Measurement is an essential part of improvement. It helps teams understand if the changes they are making are leading to improved care. This document contains an overview of the three types of measurement used in improvement. It also sets out the data that participating teams are required to submit as part of the Focus on Frailty programme. It is designed to be used in conjunction with the frailty change package.

To learn more about measurement click on the link: The Improvement Journey – Measurement (NHS Education for Scotland)

1.1 Why measure

This measurement framework is intended to measure the impact of key changes that you want to make.

Measurement helps you to:

- Recognise the variation that exists within your system and processes.
- Work out whether your changes are making an improvement.
- Help tell your improvement story.

To learn more about measurement click on the link: Introduction to measurement for improvement (NHS Education for Scotland)

1.2 Choosing measures

An improvement project should have a small family of measures that track the progress of the project over time. These should include:

- Outcome measures: to tell an NHS board, health and social care partnership, site or team whether the changes it is making are helping to achieve the stated aim. For example, number of people identified as living with frailty.

- Process measures: to tell the team whether things that have to be carried out to achieve the desired outcomes are happening reliably. For example, the percentage of people living with frailty who attend appointments made in connection with referrals.
- Balancing measures: to check for possible consequences elsewhere in the system. For example, staff wellbeing.

To learn more about measures click on the link: Developing your measures (NHS Education for Scotland)

1.3 How to measure

When planning your data collection you will need to consider:

Collecting your data	Displaying your data
• Who will collect the data? • What data will you collect? • When will you collect the data? • How will you collect/record the data?	• What chart type you will use? • How will you share and use your data?

To learn more about data collection click on the link: Data collection (NHS Education for Scotland)

1.4 Sampling

Measuring for improvement relies on small sample sizes, often referred to as 'just enough' data to learn from. When it is not possible to access a larger amount of data, it is suggested that a random selection of 5 records per week, giving 20 records per month will gather enough data.

1.5 Presenting data

Run charts are an excellent way to present your data to help you to understand what is happening in your service. They are used to distinguish between random variation (variation that affects all processes, people and outcomes equally) and non-random variation, which could be due to the changes you have introduced.

The Focus on Frailty team will issue a toolkit for outcome measures and for process measures to participating teams.

To learn more about presenting your data in a run chart click on the link: Presenting your data (NHS Education for Scotland)

2 Focus on Frailty measures

2.1 Outcome measures

Outcome measures help you understand if the changes are resulting in improvements towards the aim. There are essential and desirable outcome measures for the Focus on Frailty programme. All participating teams are required to submit data on the essential outcome measures. Participating teams can also collect and submit data on the desirable outcome measures. Which of the desirable outcome measures teams select will depend on the focus of their improvement work.

Essential outcomes measures

Each quarter teams must submit data to Healthcare Improvement Scotland on the following programme measures:

- Frailty identification
- Frailty assessment

Desirable outcome measures

Teams may also collect and submit data that describe:

- the experiences of people living with frailty, carers and family members, and integrated team working.

Essential outcome measures: data for quarterly submission

Measure name	What/ How to measure	Data source	Frequency	Chart type
Frailty identification	Community setting Number of people aged 65 or older identified as living with frailty. Count of the number of people aged 65 or older identified as living with frailty. Teams should use a reliable tool, such as the eFrailty Index or the Clinical Frailty Scale.	Data should be collected from electronic systems if available	Monthly data submitted quarterly	Run chart or extract of whole population risk stratification report
	Hospital setting Percentage of people aged over 75 years screened for frailty at front door of the hospital. Teams will define their own front door. Numerator: number of people screened for frailty at front door. Denominator: total number of people over 75 arriving at front door. Calculate the percentage by dividing the numerator by the denominator then multiplying by 100.	Data should be collected from electronic systems if available. If data are collected from case notes a sample of arrivals may be used (minimum 5 cases per week). If sampling the denominator is the sample size.	Monthly data submitted quarterly	Run chart
Frailty assessment	Community setting: Percentage of people identified as living with frailty who are discussed and/or assessed by the multidisciplinary	Data should be collected from electronic systems if available.	Monthly data submitted quarterly	Run chart

Measure name	What/ How to measure	Data source	Frequency	Chart type
	team. Numerator: number of people identified as living with frailty who have been discussed and/or assessed by the multidisciplinary team. This should be evidenced by a written summary of the discussion and/or assessment on local systems. Denominator: number of people identified as living with frailty within the population. Calculate the percentage by dividing the numerator by the denominator then multiplying by 100.	If data are collected from case notes a sample of arrivals may be used (minimum 5 cases per week). If sampling the denominator is the sample size.		
	<u>Hospital setting:</u> Percentage of people who meet criteria for comprehensive geriatric assessment (CGA) with evidence of timely initiation of assessment after frailty identification. Teams will define their local aim for time to assessment, for example in acute care this may be 24hrs from identification. Clock starts: frailty identified using validated tool. Clock stops: assessment commenced. Criteria to identify initiation of assessment can be locally defined based on acute processes. It is likely to include first contact with multidisciplinary team responsible for	Data should be collected from electronic systems if available. If data are collected from case notes a sample of arrivals may be used (minimum 5 cases per week). If sampling the denominator is the sample size.	Monthly data submitted quarterly	Run chart

Measure name	What/ How to measure	Data source	Frequency	Chart type
	frailty assessment e.g. written entry of discussion or outcome of comprehensive geriatric assessment huddle. Numerator: total number of people who met the criteria for CGA have evidence of assessment being initiated within the locally defined timeframe. Denominator: total number of people identified as meeting criteria for CGA. Calculate the percentage by dividing the numerator by the denominator then multiplying by 100. Tools and resources to support this include: • Urgent care for older people | British Geriatrics Society (bgs.org.uk) [online]			

Desirable outcome measures

Measure Name	What/ How to measure	Data source	Frequency	Chart type
Experience of health and social care services for people living with frailty, carers and family members	Qualitative and quantitative data regarding the care experience of people living with frailty, carers and family members. Teams should have a process in place for capturing the experience of people living with frailty who use health and social care services. This should be utilised to identify improvements. Locally defined definitions based on current context and capacity. Tools and resources to support this include: • Healthcare Improvement Scotland. Experience based co-design [online] • Healthcare Improvement Scotland, Care experience improvement model for health and social care [online] • NHS Scotland, What Matters to You? [online] • Care Opinion [online] • Local processes in place to gather people's experience of health and social care services.	Local systems	Quarterly	Narrative report; Pareto chart
Integrated team working	Qualitative and quantitative data regarding the views of staff members on integrated working and evidence that	Local systems	Quarterly	Narrative report

Measure Name	What/ How to measure	Data source	Frequency	Chart type
	organisational processes are in place that support high quality integrated care. Locally defined definitions based on current context and capacity. Tools and resources to support this include: • Social Care Institute for Excellence, How to understand and measure impact of integrated care [online]			
People whose frailty score has changed	Community setting: Number of people aged 65 or older whose frailty score has changed in the past six months. Count of the number of people aged 65 or older whose frailty score has changed in the past six months. Teams should use a reliable tool to detect changes in frailty levels, such as the eFrailty Index or the Clinical Frailty Scale.	Data should be collected from electronic systems if available	Monthly data submitted quarterly	Run chart or extract of whole population risk stratification report

2.2 Process measures

Process measures demonstrate that change ideas are improving the underlying processes that contribute towards your aim. Below are a set of example process measures that teams can consider for inclusion in their own measurement plan. These are not exhaustive and teams are not required to collect data against each of these process measures, only those which relate to their own aim.

Measure Name	What/ How to measure	Data source	Frequency	Chart type
Person centred care planning for people living with frailty	Community setting: Percentage of people identified as living with frailty who have a person-centred care plan in place. Numerator: number of people living with frailty who have a person centred care plan in place. Denominator: number of people identified as living with frailty. Calculate the percentage by dividing the numerator by the denominator then multiplying by 100. Local teams can define their own essential criteria for person centred care planning. This could include the percentage of identified individuals where an Anticipatory Care Planning conversation has taken place and the percentage of identified individuals with an Anticipatory Care Plan summary recorded on the Key Information Summary (KIS). Tools and resources to support this include: • Healthcare Improvement Scotland, Anticipatory Care Planning toolkit [online]	Local systems and monthly KIS extract from Public Health Scotland. If data are collected from case notes a sample of people identified and assessed as living with frailty may be used (minimum 5 cases per week). If sampling the denominator is the sample size.	To be decided locally	Run chart

Measure Name	What/ How to measure	Data source	Frequency	Chart type
	Hospital setting: Percentage of people identified as living with frailty who have a person-centred care plan in place. Numerator: number of people identified as living with frailty who have a person centred care plan in place. Denominator: number of people identified as living with frailty. Calculate the percentage by dividing the numerator by the denominator then multiplying by 100. Local teams can define their own essential criteria for person centred care planning. It may include locally agreed requirements for Treatment and Escalation Planning. Tools and resources to support this include: • Healthcare Improvement Scotland, SIGN 167 Care of deteriorating patients [online] • Healthcare Improvement Scotland, SPSP Acute Adult Deteriorating Patient Change Package [online] • NHS Scotland, What Matters to You? [online]	Local systems If data are collected from case notes a sample of people identified and assessed as frail may be used (minimum 5 cases per week). If sampling the denominator is the sample size.	Monthly	Run chart
Uptake of referrals to service offering preventative interventions	Community setting Percentage of individuals who attended service referral. Numerator: no. of individuals with service referral uptake	Local systems	To be decided locally	Run chart

Measure Name	What/ How to measure	Data source	Frequency	Chart type
	Denominator: no. of individuals referred to services.			
e-medicines reconciliation	<u>Hospital setting:</u> Percentage of people identified as living with frailty who have timely e-medicines reconciliation completed on admission to hospital. Numerator: number of people identified as living with frailty who have timely e-medicines reconciliation completed on admission to hospital. Denominator: number of people identified as living with frailty. Calculate the percentage by dividing the numerator by the denominator then multiplying by 100. Teams will define their local aim for time to reconciliation; for example in acute care this may be 24hrs from identification. Clock starts: frailty identified using validated tool. Clock stops: e-medicines reconciliation complete.	Data should be collected from electronic systems if available. If data are collected from case notes a sample of arrivals may be used (minimum 5 cases per week). If sampling the denominator is the sample size.	Monthly	Run chart
Polypharmacy review	<u>Community setting</u> Number of medication reviews carried out monthly for people identified as living with frailty. Count of medical reviews per month.	Local systems	To be decided locally	Run chart

Measure Name	What/ How to measure	Data source	Frequency	Chart type
	<u>Community setting</u> Percentage of individuals with a review whose medication was adjusted as a result of a medication review. Numerator: no. of individuals where medication was adjusted. Denominator: no. of individuals with a medication review.	Local systems	To be decided locally	Run chart
	<u>Hospital setting:</u> Percentage of people identified as living with frailty who have a polypharmacy review as a component of CGA. Numerator: number of people identified as living with frailty who have a polypharmacy review as a component of CGA. Denominator: number of people identified as living with frailty. Calculate the percentage by dividing the numerator by the denominator then multiplying by 100. Teams will define their local criteria for polypharmacy review as a component of CGA Tool and resources to support polypharmacy review: • NHS Scotland. 7 steps to appropriate polypharmacy [online]	Local systems If data are collected from case notes a sample of arrivals may be used (minimum 5 cases per week). If sampling the denominator is the sample size.	Monthly	Run chart

Measure Name	What/ How to measure	Data source	Frequency	Chart type
Occurrence of multidisciplinary team meetings	Locally agreed frequency. This process measure supports the integrated team working outcome measure.	Local systems	To be decided locally	Run chart
Percentage of multidisciplinary team meetings with relevant team members	Locally agreed attendees. This process measure supports the integrated team working outcome measure.	Local systems	To be decided locally	Run chart

2.3 Balancing measures

Balancing measures determine if the changes are affecting things elsewhere in the system, highlighting any unintended consequences. Below you will find a list of example balancing measures. Teams should develop balancing measures that relate to their planned improvement work.

Measure Name	What/ How to measure	Data source	Frequency	Chart type
Readmissions	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	Data should be collected from electronic systems if available.	To be decided locally	Run chart

Measure Name	What/ How to measure	Data source	Frequency	Chart type
	people's medicine per calendar month Calculate the percentage by dividing the numerator by the denominator then multiplying by 100.			
Staff capacity	Quantitative and qualitative data on staff capacity.	Local systems	To be decided locally	Narrative report; Pareto chart
Staff wellbeing	Quantitative and qualitative data on staff wellbeing. This can include staff surveys and iMatter reports.	Local systems	To be decided locally	Narrative report; Pareto chart

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