Healthcare Improvement Scotland | ihub

Improving care and support for people living with frailty in Scotland

90 day learning cycle

Final report

Publication date: 11 May 2022

Supporting better quality health and social care for everyone in Scotland

Introduction

Background to the report

The Improvement Hub (ihub) is part of Healthcare Improvement Scotland and supports those delivering health and social care across Scotland to redesign and continuously improve services to ensure they meet the changing needs of people in Scotland.
For information on our work, visit www.healthcareimprovementscotland.org.

Frailty is a key area of focus for the ihub and improvement support has previously included quality improvement collaboratives involving NHS boards and health and social care partnerships.

Purpose of the report

The 90 day learning cycle was carried out in Summer - Winter 2021 during the COVID-19 pandemic whilst frailty services remained operational. This learning cycle report presents findings, and the further support systems needed, to redesign services that will have greatest impact and meet people's needs.

Who this report is for

- Practitioners and stakeholders in both health and social care who are delivering frailty services.
- National stakeholders who are responsible for policy, strategy, performance, education and improvement in frailty services.

Why this learning cycle has been undertaken

With the emergence of COVID-19 and hibernation of specific improvement programmes, the ihub wanted to take the opportunity to evaluate the needs of the system to inform the support the ihub should be providing moving forwards.

The impact of COVID-19 has enabled teams to adopt new ways of working, with greater multidisciplinary team working to blur the traditional boundaries of roles and ensure timely person centred care. The challenges and variation in experience of the frailty journey across the country has given the ihub the opportunity to identify areas of focus in health and social care by establishing how integrated working can improve people's outcomes.

Summary of report

The aim of the learning cycle

How can the ihub support the health and social care system to better understand their integrated approach to the delivery of frailty services.

- Explore frailty services in Scotland.
- Identify the common components that enable successful integrated working.
- Highlight examples of practice of integrated multidisciplinary working.

Background

Why this learning cycle has been undertaken.

Method

A learning system was undertaken informed by the 90 day cycle process. This explored what currently exists in Scotland by speaking with experts in the field, people with lived experience and looking at published academic and grey literature.

Findings

Summary of **key messages**.

- The **current integrated frailty landscape** and how services are delivered.
- The **key components of an integrated frailty service**, with **key points** and **implications for practice** under each component .
- **A driver diagram** supporting these components for integration.

Next steps

Identify opportunities for local and national quality improvement support.

Page navigation

Please note: *this is an interactive report, use the hyperlinks and buttons to navigate through it (for example click to return to this homepage, to view the key components of an integrated frailty service, to view the previous page, and to view the next page).*

Learning cycle engagement

The learning cycle was informed by speaking with a wide range of people and a scan and analysis of published literature. The information gathered helped to build an understanding of the current integrated frailty landscape in Scotland, and what an integrated frailty service looks like.

35
Interviews conducted

*includes front line staff, clinical and professional leaders and managers across health, social care and the third sector.

Interviews and conversations were held with national stakeholders and people from 11 out of the 14 regional health board areas.

6
third sector organisations contributed

33
articles and reports reviewed

10
frailty survey responses

6
detailed conversations held with teams to understand more about their work

Key messages

The need to focus on frailty

Frailty can affect people as young as 50 years old and 10% of people over 65 live with frailty. With a projected 50% increase in those aged over 60 years by 2033, there is a need to plan for a consequent increase in the frail older population[1] and the legacy of COVID-19.
Analysis on the cost of frailty was carried out in 2018, the data describes the average cost per annum of an unplanned admission.
The cost identified for people in the following frailty categories: mild £1,119, moderate £3,175 and severe £5,800 per annum, as the severity of frailty increases so can the associated costs. For further information please see why focus on frailty.

Why focus on an integrated frailty service

Teams who work in a more integrated way to deliver frailty care across health, community and social care services, optimise opportunities to provide effective person centred care. This helps to slow deterioration in people and avoids potential for admission to hospital.

Realistic medicine recognises the need to involve all healthcare providers to maximise the network of support around every person with frailty, to ensure that they have the right support to improve their health, manage their condition and maintain their independence and help keep more people in their own homes or in a homely setting as far as reasonably practicable. Read more from the Royal College of General Practitioners.

The current integrated landscape in Scotland

We identified variation in services to support people living with frailty in Scotland through the learning cycle. These services vary by: scope of service, referral criteria, tools for frailty assessment, pathways, and the structure and function of frailty focused teams. Currently, integrated frailty care varies in pace, scale and degree of integration across Scotland.

Whilst there is no standard way for an integrated service to be set up, there are mechanisms that support better integrated working.

This is set out in the integrated components jigsaw graphic which describes what has been identified as the seven factors that enable and support integrated frailty working.

Implications for practice

Local service delivery: Local teams responsible for delivery of frailty services in health and social care have the opportunity to consider how they can deliver more integrated services across boundaries based on the needs of the individual, their carers and families.
National leadership: Senior leaders to consider national strategy, shared vison, standardised frailty education for staff and increasing public awareness of frailty.

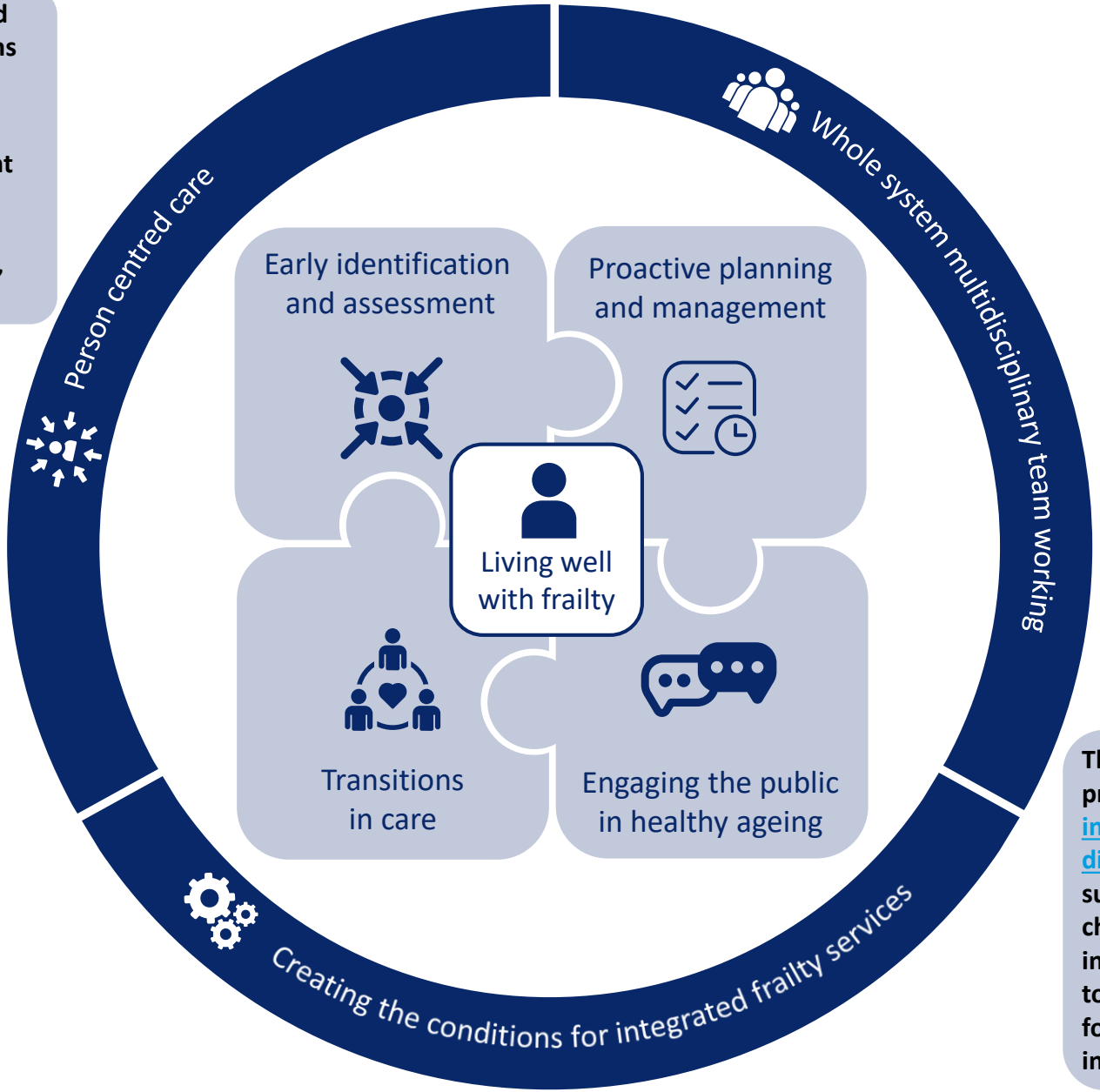
Key components of an integrated frailty service

Key components constructed from a range of conversations and a scan of published literature.

Identified in each component slide are:

- **high level points,**
- **established best practice,**
- **examples of practice.**

For further information about each component, click on the icons to navigate the report



These seven components are primary drivers, forming the integrated frailty driver diagram. The driver diagram supports the theory of change for progressing integrated service provision, to improve care and support for people living with frailty in Scotland.

Next steps

Next steps will be to co-design and launch the new ihub frailty improvement and implementation programme, underpinned by the ihub frailty learning system.

Creating the conditions for integrated frailty services

Community Care

Review current processes across care in the community and third and independent sector patient pathways to identify how integrated working across boundaries can be improved.

Secondary Care

Review identification of frailty pathways across secondary care to identify how integrated working across boundaries can be improved.

Integrated frailty service
The analysis, review and identification of integrated service design components which interlink across all service dimensions and systems.

Work with stakeholders to develop a national change package with high impact changes and design an improvement offer to support implementation.

Person centred care

Whole system multidisciplinary team (MDT) working

Proactive planning and management

Transitions in care

National

Agree and co-design with key stakeholders a national integrated frailty quality improvement programme.

Primary Care

Proactively work with health and social care services to ensure early identification and intervention to slow decline of frailty and avoid hospital admission.

Engaging the public in healthy ageing

Early identification and assessment

High level driver diagram - integrated frailty

Aim

To improve the care and support for people living with frailty in Scotland

who are supported by the health and social care system

through

an integrated approach to the delivery of frailty services.

[Read more about the change concepts related to these drivers]

Primary drivers	Secondary drivers
Person centred care	• Person centred assessment • Designing systems and processes with and around the person • Responding to personal outcomes and what matters • Involving the person and carers/families in decision making and management - positive and outcomes focused.
Creating the conditions for integrated frailty services	• Leading national strategy across health, social care and third sector, providing sustainable resource and commissioning • Upskilled workforce • Access to frailty resources and aids
Whole system multidisciplinary team working	• Professional teams that span professional and organisational boundaries and coordinated approach to frailty care • Personalised outcomes focused care • MDT professional team composition • Collaboration and trusting relationships
Early identification and assessment	• Early assessment and diagnosis • Person centered assessment • Involving the person and carers/families in early identification • Ongoing holistic shared assessment • Reliable infrastructure, common tools and approaches
Proactive planning and management	• Support to anticipate changes in health and support requirements • Proactive planning in support of progression of frailty • Proactive individualised support in right setting
Transitions in care	• Improving transitions through integration • Equitable access to services (for example Hospital at home) • Timely sharing of information • Minimal movement across services
Engaging the public in healthy ageing	• Increasing public awareness • Framing frailty using language that articulates possibilities • Encouraging self management • Multisector health ageing model

Integrated frailty – change concepts

These change concepts are suggested approaches related to the high level driver diagram on integrated frailty

Read more about the driver diagram these change concepts relate to

Possible change concepts to test and measure

- Comprehensive Geriatric Assessment in secondary care and community
- Experienced based co-design toolkit
- What matters to you conversation
- Realistic Medicine, personal goal setting and care planning
- Essentials of Safe Care

- National Frailty Strategy
- New National Frailty Network
- Advocacy for frailty
- Standardised frailty education
- Frailty educational resources
- Tool for self assessment (e.g. SCIROCCO)

- Multidisciplinary team working
- Creating common purpose and integrated team working
- Team huddles
- Case coordinators
- Coordination of care across health, social, third and independent sectors
- National dashboard concept (akin to developments in NHS Grampian)

- Systematic identification of frailty
- Comprehensive Geriatric Assessment – acute and community
- Shared assessment tools and shared language
- eFI and frailty scoring
- Responsive intervention
- Reassessment to meet changes in care planning

- Structured education on comprehensive geriatric assessment, clinical frailty scoring and person centred care planning
- Manage risks in partnership with families and carers
- Right place, time care to avoid hospital admission
- Community Out of Hours service response
- Anticipatory Care Planning conversations

- Continuity of care and minimal movement between services
- Network of services to access
- Mapped services and resources
- Integrated to provide right place, timely care
- Referral process and access to information
- Digital developments for patient records

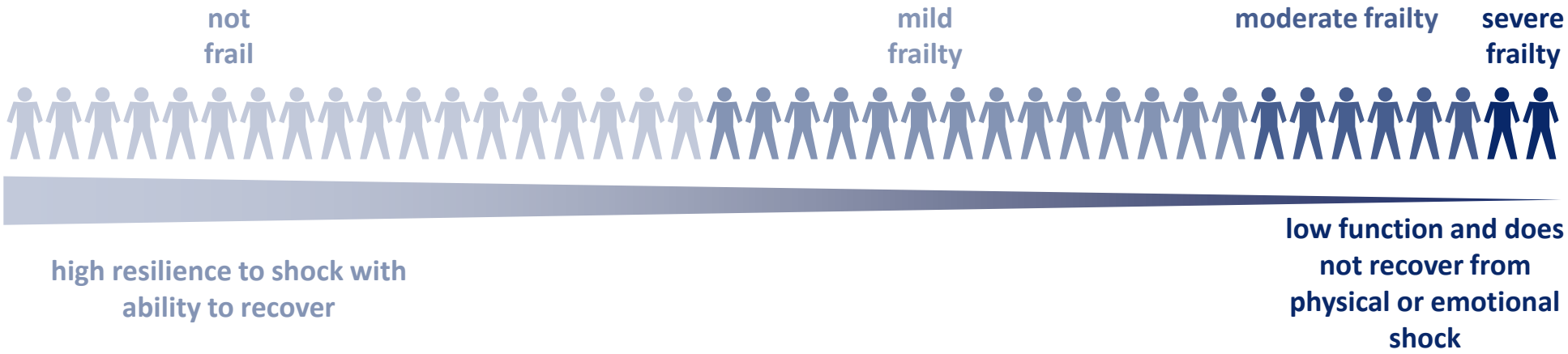
- Health Promotion for frailty
- Articulating frailty positively
- Self management of prevention and slowing decline
- Holistic model of care
- Public engagement
- Access to information

Why focus on frailty

'Frailty' is a term that is used a lot but is often misunderstood. When used appropriately, it refers to a person's mental and physical resilience, or their ability to bounce back and recover from events like illness and injury.[2]

Frailty can affect people as young as 50 years old. There is a projected 50% increase in those aged over 60 years living with frailty by 2033, there is a need to plan for a consequent increase in the frail older population.[1]

Frailty is progressive, negatively impacting independence and quality of life and is linked to an increased use of health and social care resource. The frailty trajectory is, however, modifiable with the right support.



Outcomes for people living with frailty

It's important that people living with frailty have access to proactive, joined-up care to maximise health and wellbeing and prevent problems arising in the first place. Equally important is access to rapid, specialist services in the event of a health or social care crisis.
There is evidence to support working with people living with frailty and their families to put in place care and support plans tailored to meet individual needs, based around people's own goals and preferences[3].

Engaging people in healthy ageing supports them to maintain quality of life, independence and abilities to meet basic needs; learn, grow and make decisions; be mobile; build and maintain relationships; and contribute to society[2].

Why focus on frailty

Extrapolated cost data

Previous analysis carried out in 2018 has shown that as the severity of frailty increases that costs of care also increase. Midlothian Health and Social Care Partnership (HSCP) applied the electronic frailty index to their population aged 65 and over to identify their frailty cohort. The frailty cohort data was then connected to their service use data to calculate the services used and the cost per year. The estimated national cost of frailty was extrapolated based on these figures, assuming that similar resources would be applied to individuals aged 65 and over with mild, moderate and severe frailty. Annual costs are demonstrated below.

Extrapolated costs over 12 months for people aged 65 and over with frailty, based on pre COVID-19 data from Midlothian health and social care partnership (HSCP), 2018

	mild frailty	moderate frailty	severe frailty
Average cost of unplanned admissions per person per year	£1,119	£3,175	£5,800
Unplanned bed days	£396m	£482m	£293m
Community prescribing	£231m	£137m	£62m
Outpatient appointments	£240m	£118m	£54m
GP appointments	£212m	£127m	£55m
Community nursing	£84m	£44m	£10m

HIS frailty improvement and implementation

The focus and timeline of national frailty support

2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022

Living Well in Communities (now known as Community Care) prototyping programme

Tested improvements within the community and care home settings with a focus on the identification, early intervention and care coordination for people with frailty

2016 – April 2019

Living and dying well with frailty collaborative

Using learning from the prototyping programme
Further information can be found on the ihub website

August 2019 – hibernated March 2020

Frailty at the front door collaborative: phase 1

Tested approaches to improving care coordination for people living with frailty who presented to unscheduled acute care services.
The full impact report for phase 1 of the collaborative can be accessed via this document

December 2017 – May 2019

Frailty at the front door collaborative: phase 2

Using learning from phase 1
Further information can be found on the ihub website

August 2019 – hibernated March 2020

COVID-19 resilience support

- Consolidating the tools and resources from across the ihub into one place
- Developing and delivering a national frailty learning system
- Undertaking a learning cycle to understand the opportunities for future frailty programmes of work.

This timeline is specific to Healthcare Improvement Scotland, respecting that many organisations led and facilitated improvements during this period.

The impact of COVID-19 and new ways of working

The restrictions imposed by COVID-19 encouraged many teams to consider new ways of working, adopt greater collaborative multidisciplinary working across the health and social care boundaries, to ensure more person centred care in a timely fashion. Following the hibernation of both quality improvement frailty collaboratives, the ihub developed the national frailty learning system (link to MS Teams) which brings together acute, community and social care to support this more integrated working.

The aim of this frailty learning system is to accelerate sharing of learning and improvement work via an MS Teams channel. This includes a series of monthly webinars and development of case studies for all staff from health, social care, third and independent sector organisations in Scotland interested in improving the quality of lives for people living with frailty.

HIS frailty quality improvement

Focus on Dementia

Frailty as a risk factor for dementia has been widely investigated. Evidence from the identified studies suggests that frailty is prevalent in dementia and that frailty can increase the risk of developing dementia in older adults. The relationship between frailty and dementia in the context of frailty being a risk factor for dementia has been extensively explored the published literature.

Given that frailty has been found to increase the risk of dementia and the value of multidimensional approaches to the assessment of frailty, this evidence supports current recommendations for integrated approaches to the prevention, assessment and management of dementia with other long-term conditions. Alzheimer Scotland's 5 pillars, 8 pillars and advanced model for dementia care and support are also helpful models. For further information see the ihub evidence summary.

12 critical success factors and models of care co-ordination

Focus on Dementia worked with one HSCP who were regarded as an exemplar of dementia care co-ordination to better understand what their critical success factors were and if they led to better outcomes for people. 12 critical success factors were extrapolated from the work which reinforced what was found in the wider literature. Although these 12 critical success factors were extrapolated for dementia care co-ordination, the principles are transferable to any long term condition. Alzheimer Scotland's 5 pillars, 8 pillars and advanced model for dementia care and support are helpful models when considering care co-ordination for people with dementia and also have transferability to other long term conditions. Read more on the Alzheimer Scotland website and Focus on Dementia webpages.

The World Health Organisation reports that care co-ordination can improve patient and carer experience and outcomes, reduce hospital admissions and emergency department attendances and reduce lower medical costs[4].

Hospital at Home

Hospital at Home (H@H) provides a level of acute hospital care in an individual's own home, or homely setting that is equivalent to that provided within a hospital through short-term, targeted intervention.

In mid-2020, the ihub within Healthcare Improvement Scotland began working with a number of NHS boards and HSCPs to support the implementation of H@H services across Scotland.

This programme of work is now being further expanded across Scotland. To find out more about the H@H programme please visit the ihub website.

Why focus on integrated services

The intention is to ascertain ways to improve care and support for people living with frailty who use services, by a network of coordinated care provision and an integrated approach to delivery of care. By putting a greater emphasis on joining up services and focusing on anticipatory and preventative care involving the person, carer and family in co-designing services.

Integrated care is a system across health and social care services, commissioned and provided to support holistic approaches to the care of people with frailty that are sustainable in the face of rising demand. Integrated care can support improved frailty outcomes by decreasing demand on acute services, reducing accident and emergency attendances, admissions and hospital bed days.

By working with individuals and local communities, integrated services will support people to achieve the following outcomes:

Benefits to the individual

- People who use health and social care services have positive experiences of services, and have their dignity respected.
- People are able to look after and improve their own health and wellbeing and live in good health for longer.
- People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.

Benefits to the system

- Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.
- Health and social care services contribute to reducing health inequalities.
- Resources are used effectively and efficiently in the provision of health and social care.
- People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.

Resources: Anticipatory Care Planning (ACP) toolkit
A new collection of case studies demonstrating good practice within health and social care can be found on the Health and Social Care Alliance Scotland webpages.

Current frailty service landscape

The learning cycle heard from individuals and teams from across Scotland about a range of frailty focused services being delivered whilst also responding to the COVID-19 pandemic, including: frailty units in acute hospitals, community frailty beds, hospital at home, and multidisciplinary teams delivering integrated services.

Examples of practice and frailty improvement

Edinburgh Health and Social Care Partnership
A single approach to identify, record, code and share information on frailty using the Rockwood clinical frailty scale and SPIRE electronic frailty index tools.

NHS Fife: The community health and wellbeing hub model
Multidisciplinary assessment which previously required multiple appointments and months of waiting. 35% of referrals received a more specific and coordinated service provision as a result.

NHS Forth Valley
A GP Practice use of the electronic frailty index (eFI) to prioritise patients in order to have proactive conversations regarding ageing well, frailty prevention and self-management.

NHS GGC: Augmenting Front Door Frailty in Queen Elizabeth University Hospital
Increased number of frail older adults discharged from unscheduled care within 48hrs - 15% to 33%. Increased frailty identification and initiation of comprehensive geriatric assessment by enhancing the frailty team.

NHS Tayside
Acute Medicine for the Elderly Assessment Unit, a short stay assessment unit has reduced hospital induced dependency and delirium.

What the learning cycle found

The work identified that there is variation in services to support people living with frailty in Scotland. These services vary by:

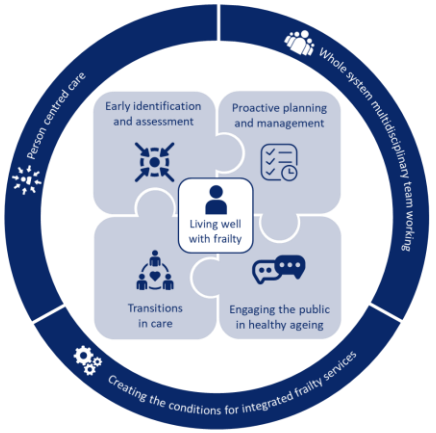
- Scope of service,
- referral criteria,
- tools for frailty assessment,
- pathways, and
- the structure and function of frailty focused teams.

Currently, integrated frailty care varies in pace, scale and degree of integration.

Discussions with a range of interviewees identified that some teams are increasing their awareness and knowledge of frailty using a structured method for identification, coding and implementing evidence based interventions.

What integrated frailty care looks like

The need for, and challenges in providing integrated frailty care was described both in the literature and by interviewees. It was also noted that there is a wide variation in the delivery of frailty services across Scotland and that there is no one way for an integrated service to be set up.



Analysis of the findings identified the common components required for what a successful integrated frailty service could look like. To support the health and social care system to better understand their integrated approach to frailty services, these components are presented in this interactive report.

The components are interdependent and should be viewed as a whole and can be viewed on the key components of an integrated frailty service page.

The links below guide through the report – click to view the details of each integrated care component in any sequence.

Person centred care | Creating the conditions | Whole system multidisciplinary team working | Early identification and assessment | Proactive planning and management | Transitions in care | Engaging the public

Person centred care

Key points: Care planning should be centred around the needs of the individual living with frailty, their family and their carers.

Designing systems and processes around the person

- Person centred care is not yet reliably delivered across health and social care.
- Integrated care requires connected services, designed to offer personalised care.
- Coordinating care and support provided by multiple services to improve continuity of care and better identification of people living with frailty, dementia and other conditions
- Designing person centred integrated services requires consistent, meaningful engagement with people who access services and communities.

Responding to people's personal outcomes and what matters to them

- Support should be tailored to fulfil people's personal outcomes rather than only their functional needs.
- Prioritising what matters to people with frailty creates a personalised approach to care. This can enable people to live well, and, as one interviewee said: "*be all they can be".*

Involvement of carers and families in early recognition, assessment, planning and shared decision making

- Living with frailty affects the whole household.
- Incorporating the expertise of carers and families is crucial to effective person centred support.
- Health and social care teams should engage with carers and families to enable effective planning, with shared decision making and appropriate consent.

Guidance and best practice

- The British Geriatrics Society. Integrated care for older people with frailty. (webpage)

"…too often we build services around an individual without asking them what it is that they want …we make too many assumptions"

(Interviewee, third sector)

"…life was good, I was retired… I was going to the gym 3 mornings a week for 20 years…[then] I had a broken hip… and ended up in here for 12 weeks… Just [want] to get home and go back to the old way of things…"

(Person with frailty)

Examples of practice and resources

- People led care webpage.
- ACP toolkit. (webpage)
- Colleagues in Fife have shared their success with setting up an Assessment and Rehabilitation Centre (ARC). (case study)

Implications for practice: Services co-designed and produced alongside people with lived experience, focusing on the needs of the individual rather than the current system structure.

Creating the conditions for integrated frailty services

Key points: Investment in strategy, leadership and sustainable funding of services combined with standardised frailty education.

Leading national strategy across health, social care and third sector care

- The strategic direction of frailty care in Scotland is led by those who maintain commitment to, and accept accountability for transforming services in partnership with each other.
- Advocacy for frailty at national level supported by development of a leadership network.

Resource and commissioning – good practice

- Strategic direction of person centred connected services requires resources, commissioning and shared vision to deliver flexible local services. This requires joint governance structures, clear and accountable, which include all partners at all levels.
- Long term financial planning is essential when commissioning integrated frailty services.
- Investment and longer term funding is required in a patients journey, starting from their homely setting, before they access or enter services.
- Funding will allow local bodies to develop new care models they can sustain in future.

Upskilling the workforce

- Frailty focused education in further and higher education institutions considering standardised and expanded generic frailty competence.
- Best practice suggests all staff have access to frailty training and educational resources that are wider reaching rather than role specific.

Guidance and best practice

- Kings Fund. Making our health and care systems fit for an ageing population. (PDF)

"the block is finance and commissioning …we have seen an exorbitant rise in 15 minute commissioned social care visits and you're not going to get anything other than a transactional functionalist… commissioners are doing it for fiscal pressure. It's very short term. It's very personally damaging to the individual… I think is only potentially achievable with a whole system change …" (Interviewee, third sector)

Examples of practice and resources

- ihub and nesta. Community health and wellbeing. (PDF)
- ihub. Community led models: innovation in health and social care. (PDF)
- SCIROCOO Self-assessment tool. (webpage)
- Ihub. Strategic planning: good practice framework. (PDF)

Implications for practice: Consider local and national strategies for shared vision, effective use of resources and staff education.

Whole system multidisciplinary team working

Key points: Flexible team membership and ways of working, to build common purpose and trusting relationships are critical to integrated care.

Flexible teams that span professional and organisational boundaries

- Composition of teams varies widely across Scotland.
- Decisions are made by the multidisciplinary team and with ability to adapt to circumstances.
- Teams with flexible membership enables care to be responsive to local context and provide individualised care.
- For better integration, interaction with acute, primary and social care as well as third and independent sector organisations is advocated.

Provide personalised outcomes focused care by blurring of roles and responsibilities

- A care coordination approach may enhance care when led by the most appropriate professional for the person, rather than a pre-designated individual or profession.
- If all MDT members have core frailty knowledge, this enables each professional to work across traditional boundaries. Read an example from NHS Fife.

Trusting relationships are critical to care

- Developing a shared vision and coalescing around a common purpose is key to building trust and understanding of individual disciplinary perspectives.
- Trusting relationships and blurring of roles between disciplines, teams and services enables teams to operate and draw on expertise from their membership, to provide continuity of care as well as effective decision making.

Guidance and best practice

- The British Geriatrics Society. Integrated care for older people with frailty. (webpage)

"the advantage of that … [multidisciplinary] approach means that we stick with you till it solved. You have one person who's helping you... We're [multidisciplinary team] bringing in solutions, and …that's probably what's needed … rather than passing you from person to person."

(Interviewee, acute care)

Examples of Practice

- Following a fall, not requiring hospitalisation, Scottish Ambulance Service connect the person/their carers with the community alarms and falls team to ensure they have post-fall support.

Implications for practice: Fostering trusting relationships to collaborate on decisions and shape the delivery of individualised coordinated care.

Early identification and assessment

Key points: Early identification, shared information and tools for continuous assessment impacts health and independence.

Early assessment and diagnosis

- Early identification of frailty matters for preventing avoidable decline in health and independence.
- Presentation of frailty may not be straightforward.
- Knowledge, shared language and tools for frailty contribute to actively recognising frailty during encounters with service users.
- To reliably identify frailty earlier, more people need to be skilled in frailty identification.

Ongoing and holistic shared assessment

- Regularly occurring holistic assessment to support care planning for frailty which evolves with the persons condition.
- A proactive response to changes in care requirements over time and place of care requires multidimensional assessment and reliable infrastructure for sharing information.

Common tools and approaches across contexts of care

- Opportunity to develop a shared understanding of the role of systematic identification of frailty and score through coding and implementing evidence based interventions.
- Reduced variation in adoption of electronic frailty assessment can be achieved using a structured method for identification.
- Appropriate context for different frailty tools including the use of the clinical frailty scale after formal clinical assessment[8].
- Benefits of shared assessment tools and understanding appropriate tools to use.

Guidance and best practice

- British Geriatrics Society. Fit for Frailty part 1 - consensus best practice guidance for the care of older people living in community and outpatient settings. (PDF)

"If there is a real team …around an individual at an early enough stage…,we make huge benefits both financially and economically…to the personal outcomes of the individual." *(Interviewee, third sector)*

"So not only do we need to identify it, we also need to sell the importance of identifying it…then you will have an electronic assessment for frailty available on the GP's system. That's not the case for every person…" *(Interviewee, acute care)*

Examples of practice and resources

- The University of Edinburgh. SCARF project. (webpage)
- Healthwatch Liverpool. Community-based care pilot project. (PDF)
- NHS Tayside set up an Acute Medicine for the Elderly Assessment Unit, a short stay assessment unit which reduced hospital induced dependency and delirium. (PDF)

Implications for practice: Develop shared understanding of principles and processes to support early identification, responsive intervention, reassessment using standardised tools.

Proactive planning and management

Key points: To anticipate and delay deterioration in health, provide a person centred and coordinated service approach to care.

Support to anticipate changes in health

- Proactively support people in the community in order to anticipate and prevent avoidable deterioration with third and independent sector support.
- Establish continuity of care through building relationships and sharing information across the team in order to recognise and respond to changes in a person's condition.
- Develop and maintain advanced care plans, including for multiple eventualities.
- Progression of frailty varies by individual. Incorporating 'what matters to you' in personalised care plans may help people access evidence based interventions to prevent or slow the progression of frailty.
- A coordinated service approach to proactive planning and management enables teams to support people by getting it right, first time.

Provision of care

- To avoid unnecessary hospital admissions and help people stay at home, responsive community based services should be accessible out of hours.
- Teams assess and manage risks in partnership with people, and their families, in order to provide the right care in the right place.

Guidance and best practice

- British Geriatrics Society. End of life care in frailty: advance care planning . (PDF)
- NICE. Advance care planning quick guide. (PDF)
- ACP guidance. (webpage)
- Hospital@Home tool kit. (webpage)

"I think that for GPs to access preventative services is so much more complicated... for the GP who's seen somebody at home... it's a lot faster to just admit to hospital and get full MDT assessment..."

(Interviewee, primary care)

Examples of practice and resources

- Age UK care co-ordinator roles. (webpage)
- Use of the Electronic Frailty Index (eFI). (webpage)
- Comprehensive Geriatric Assessment (CGA) as described in the ihub frailty at the front door collaborative impact report. (PDF)
- ACP toolkit. (webpage)

Implications for practice: Proactive and individualised support in the community, working in partnership with families and carers to avoid unnecessary hospital admissions.

Transitions in care

Key points: Integrated working, access to services and sharing information across boundaries enables greater continuity of care in transitions.

Improving transitions through integration

- Integrated services need to adapt to provide care in the appropriate setting as a person's frailty changes. Reducing the need for movement between services provides greater continuity of patient care and consistency in support.
- Integration of services across different organisations is challenging at a system level. Team level integration was more frequently described.

Access to services

- Some people are not receiving or accessing appropriately placed care where the range of local services available and system of referral is unclear.
- Improving access for people with health and social inequalities, who are more likely to develop frailty and have worse access to healthcare, is particularly important[5].
- A visible and accessible network of local services makes it easier for people to access frailty care. Ideas to achieve this include: service mapping, care coordination and single point of access.

Information sharing enables transitions in care

- People with frailty engage with a range of services. Timely sharing of information between services enables teams to work with people to make informed decisions about what matters to them. Connecting digital information systems can also reduce how often people have to repeat their story and improve safety and continuity of care.

Guidance and best practice

- NICE Guidance. Transition between inpatient hospital settings and community or care home settings for adults with social care needs. (webpage)

"IT systems don't talk to each other, …that is such a barrier to good communication … and it can sometimes make the wrong decisions being made when people can't see the information on the patient... and so for me that is a major challenge"
(Interviewee, acute care)

Examples of practice and resources

- Age UK care co-ordinator roles. (webpage)
- Use of the Electronic Frailty Index (eFI). (webpage)
- Comprehensive Geriatric Assessment (CGA) as described in the ihub frailty at the front door collaborative impact report. (PDF)
- Community Treatment And Care (CTAC). (webpage)

Implications for practice: Service design and access to services, with integrated working, information sharing and focus on reduced movement between services for continuity of personalised care.

Engaging the public in healthy ageing

Key points: Greater public awareness with education of frailty focusing on capability promotes self management.

Frailty: Language matters

- Engaging the public, third and independent sector and carer organisations in prevention should focus on what is relevant to them communicated in an easy to understand way.
- Frailty can be a problematic term which people may consider stigmatising or not relevant to them[6]. Using language which focuses on a person's capabilities, rather than deficits, could enhance public engagement[7].
- While the findings focus on people aged 65 and older, there is a recognition that frailty can be experienced earlier and that the system will need to reflect that to ensure equal access to identification and support.

A healthy ageing model

- Health promotion and self management can contribute to delaying or preventing frailty. Meaningful communication about prevention using a model like healthy ageing[8] can support peoples capacity for self management.
- Healthy ageing can provide a holistic model for a multisector approach to supporting people to live better lives as they age[8].

The voice of the public

- We recognised a desire for knowledge regarding both treatment options and preventative measures.
- Listening to people tell their own stories, incorporating their input, opinions and understanding of frailty services to improve integrated care delivery.

Guidance and best practice

- British Geriatrics Society. Healthier for longer: How healthcare professionals can support older people. (webpage)

> *"Intervene much earlier, ... and the point that we get our bus pass...to say... so you've had a whole lifetime of public health messages ...but now really, is your window of opportunity to actually start ... doing the stuff that's going to help you to age well and keep you fit and keep you independent for as long as possible."*
>
> *(Interviewee, primary care)*

Examples of practice and resources

- North Lanarkshire Making Life Easier Case Study. (webpage)
- Alliance Scotland. STILL Going Project. (webpage)
- Alliance Scotland. Frailty matters research project. (webpage)

Implications for practice: Improving public awareness and articulating frailty in positive terms to enable self management, delaying or preventing frailty.

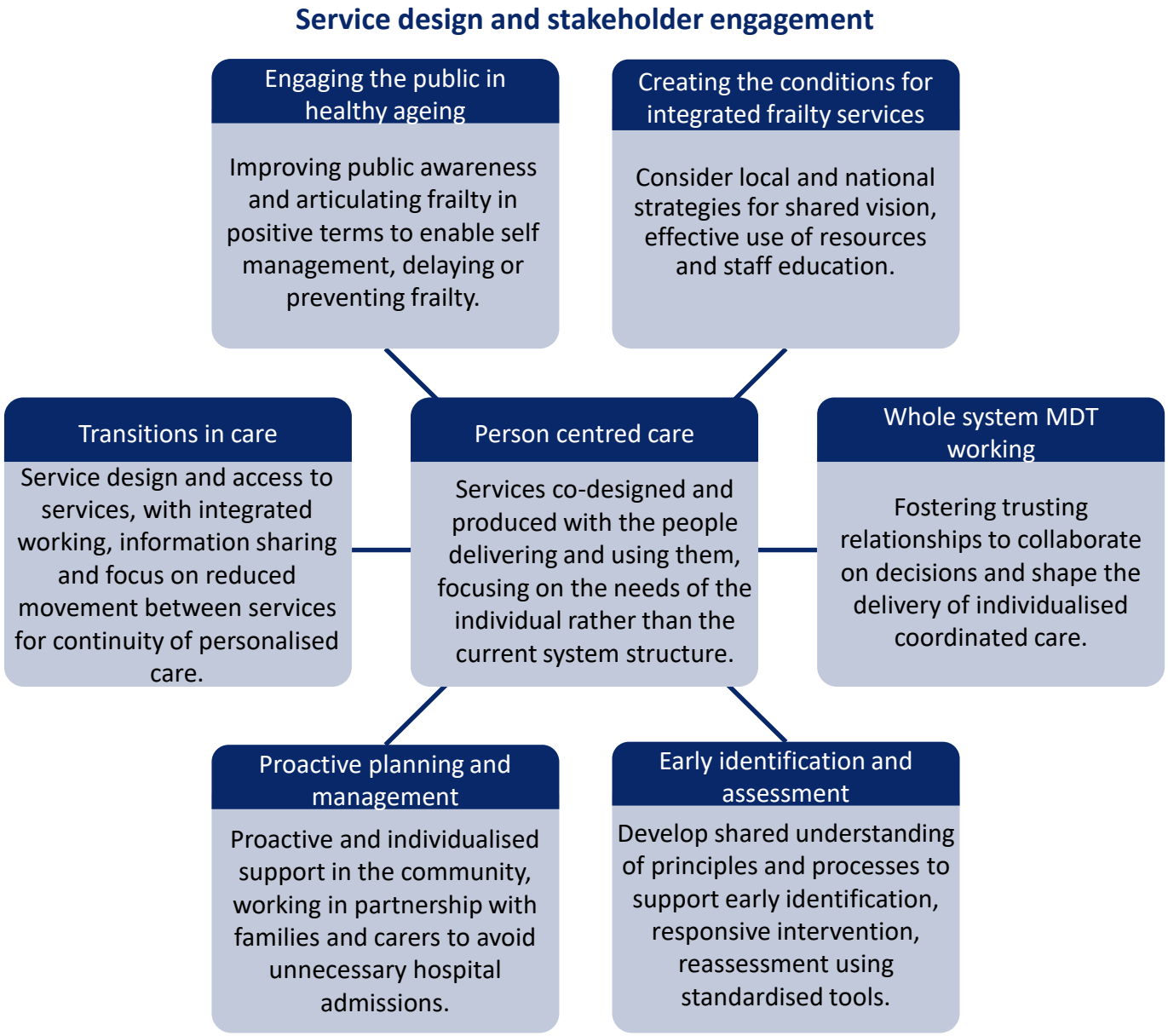
Summary of implications for practice

Linking key messages and components that support better integrated working

This learning cycle has focused on and identified

"How can the ihub support the health and social care system to better understand their integrated approach to the delivery of frailty services?"

The next stage will be focused on engagement based on the 90 day learning cycle.



Next steps: new improvement and implementation offer

The findings from this report will be used to inform a new national improvement offer: the **ihub frailty improvement and implementation programme, which will launch in 2022. This programme will be underpinned by the ihub frailty national learning system (link to MS Teams)**. The programme will work with health and social care teams and organisations together with people with lived experience of frailty including unpaid carers **to improve the experience, care and support for people living with frailty in Scotland**. A frailty improvement and implementation driver diagram for the programme with the key priorities for this work follows on the next page.

2022 → 2024

Stage 1
Programme initiation

- Develop programme infrastructure including evaluation framework.
- Establish national advisory group.
- Publish national change package including high impact changes and measurement framework.
- Publish nomination and application process.
- Confirmation of participating frailty teams.

Stage 2
Improvement and implementation

- Frailty team engagement.
- Quality improvement and implementation support to implement high impact changes.
- Data collection and analysis.
- Share practice and innovation via the ihub frailty learning system and case study development.

Stage 3
Analysis, evaluation and reporting

- Analyse data to inform evaluation findings.
- Prepare final report with recommendations.
- Share final outputs and learning.

ihub Frailty Learning system

ihub frailty improvement and implementation programme

Aim

To improve the experience, care and support for people living with frailty in Scotland

Primary drivers

- **Early identification and assessment of frailty**
- **Supporting people to live well with frailty**
- **Leadership and Culture to support integrated whole system working**

Secondary drivers

Early identification and assessment of frailty

- Case find people at risk of frailty
- Consistent identification of frailty and scoring through validated tool and shared language
- Deliver comprehensive geriatric assessment in acute and community care settings
- Proactive reassessment and responsive multidisciplinary intervention

Supporting people to live well with frailty

- Proactive person-centred care planning and management including anticipatory care planning
- Timely access to clearly defined care pathways
- Care co-ordination across health and social care systems, and third and independent sectors
- Responsive intervention including prehabilitation and rehabilitation
- Engaging people with lived experience, families and carers in co-design of pathways and services

Leadership and Culture to support integrated whole system working

- Strategic and engaged leadership to support whole system working
- Integrated multidisciplinary working
- Visible map for accessing support for individuals living with frailty
- Psychological safety
- Staff wellbeing
- System for learning

Glossary

Description of the terminology used in relation to this report

90 day cycle	A disciplined and structured form of inquiry designed to produce and test knowledge syntheses, prototyped processes, or products in support of improvement work.[5]
Anticipatory care planning (ACP)	A person centred, proactive approach to help people consider what is important to them and plan for their future care. ACP involves conversations between individuals, their families, carers, and professionals.
Care coordination	Organising care activities and sharing of information between all of those involved in a person's care.
Co-design	A design approach that actively involves users and stakeholders from the beginning of a project, right through to roll-out.
Collaborative (breakthrough series collaborative)	An improvement method that relies on spreading and adapting highly effective changes to multiple settings. Usually brings together 20 to 100+ teams working on improving a process, practice, or system in health care and run for 12 to 24 months. Collaboratives operate on adult learning principles, require focused work by each team to adapt effective changes to their setting, use methods for accelerating improvement, and capitalise on shared learning and collaboration.
Comprehensive Geriatric Assessment (CGA)	A multidimensional, interdisciplinary diagnostic process to determine the medical, psychological, and functional capabilities of a frail older person in order to develop a coordinated and integrated plan for treatment and long-term follow-up.[2]
Clinical Frailty Scale (CFS)	The Dalhousie University / Rockwood clinical frailty scale is a judgement-based tool to screen for frailty and to broadly stratify degrees of fitness and frailty.
Electronic frailty index (eFI)	A clinically validated tool that uses existing electronic health record data to detect and assess the severity of frailty. It uses a cumulative deficit model of frailty, in which frailty is defined through the accumulation of deficits, which can be clinical signs, symptoms, diseases and disability.
Frailty	A form of complexity, associated with developing multiple long-term conditions over time leading to low resilience to physical and emotional crisis and functional loss leading to gradual dependence on care.
Holistic	The assessment and treatment of the whole person, taking into account mental and social factors, rather than just the symptoms of a disease.

Glossary continued

Description of terminology used in relation to this report

Integrated care	Integrated care is about improving people's lives, and wellbeing through better joined-up care between health and social care systems, better anticipatory and preventative care and a greater emphasis on community-based care (https://hscscotland.scot/integration/).
Learning cycle	A concept of how people learn from experience. A learning cycle will have a number of stages or phases.
Learning system	Bringing together a range of professionals to share learning and experiences on a particular topic through a variety of engagement and learning opportunities.
Life curve	A graph showing the trajectory most people will follow as they age and begin to lose the ability to carry out activities of daily living (from cutting toenails, going shopping, using steps, through to transferring from bed, washing hands and face and eating independently). https://www.adlsmartcare.com/Home/LifeCurve
Multidisciplinary	Involving people from different professions, or who have different specialities of knowledge, in an approach to a topic.
Person centred care	People are supported to make informed decisions and be involved in their own health and care. Staff will also work with other health and social care professionals to tailor services to the needs of the individual and what matters to them, ensuring care is coordinated, compassionate, personalised and enabling.
Realistic medicine	Puts the person receiving health and social care at the centre of decisions made about their care by encouraging shared decision making and discussion around risks and benefits to treatments. This includes all professionals who use their skills and knowledge to help people maintain health and to prevent and treat illness.
Transitions in care	Movement of people through services and settings as their needs change. Well managed transitions between care settings ensure people receive the support they require in the right place at the right time and provide continuity of care, such as at discharge from hospital to home.

References

1. NHS Health Scotland. Optimising older people's quality of life: an outcomes framework. 2014 [cited 2022]; Available from: http://www.healthscotland.scot/media/1159/optimising-older-people-quality-of-life-strategic-outcomes-model-08-14.pdf
2. Age UK. Understanding frailty [online]. 2020 [cited 2022]; Available from: https://www.ageuk.org.uk/our-impact/policy-research/frailty-in-older-people/understanding-frailty/
3. Akpan A, Roberts C, Bandeen-Roche K. et al. Standard set of health outcome measures for older persons. BMC Geriatr. 2018; 18(36). Available from: https://bmcgeriatr.biomedcentral.com/articles/10.1186/s12877-017-0701-3
4. World Health Organisation. Continuity and coordination of care: a practice brief to support implementation of the WHO Framework on integrated people-centred health services. 2018 [cited 2022]; Available from: https://www.who.int/publications/i/item/9789241514033
5. Friends families and travellers. Reducing health inequalities for people living with frailty, a resource for commissioners, service providers and health, care and support staff. 2020 [cited 2022]; Available from: https://www.collectivevoice.org.uk/wp-content/uploads/2020/10/HWA-frailty-Report-FINAL.pdf
6. Nicholson C, Gordon AL, Tinker A. Changing the way "we" view and talk about frailty… Age and Ageing. 2017; 46(3): 349-351. Available from: https://academic.oup.com/ageing/article/46/3/349/2654238
7. Britain Thinks. Frailty: Language and Perceptions. 2015 [cited 2022]; Available from: https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/health--wellbeing/rb_june15_frailty_language_and_perceptions.pdf
8. World Health Organisation. Framework for countries to achieve an integrated continuum of long-term care. 2021 [cited 2022]. https://www.who.int/publications/i/item/9789240038844

Bibliography

- British Geriatrics Society. Fit for frailty: consensus best practice guidance for the care of older people living with frailty in community and outpatient settings. 2014. Available from: https://www.bgs.org.uk/sites/default/files/content/resources/files/2018-05-23/fff_full.pdfources/resource-series/fit-for-frailty
- British Geriatrics Society. Fit for frailty: part 2: developing, commissioning and managing services for people living with frailty in community settings. 2014. Available from: https://www.bgs.org.uk/sites/default/files/content/resources/files/2018-05-23/fff2_full.pdf
- British Geriatrics Society. Silver Book II. 2021 [cited 2022]; Available from: https://www.bgs.org.uk/policy-and-media/leading-experts-in-frailty-launch-the-silver-book-ii-in-collaboration-with-the
- Carnegie Foundation for the Advancement of Teaching. 90 day cycle handbook. 2013. Available from: https://www.carnegiefoundation.org/wp-content/uploads/2014/09/90DC_Handbook_external_10_8.pdf
- Coker JF, Martin ME, Simpson RM, Lafortune L. Frailty: an in-depth qualitative study exploring the views of community care staff. BMC Geriatr. 2019;19(1):47-.
- Giguere AMC, Farmanova E, Holroyd-Leduc JM, Straus SE, Urquhart R, Carnovale V, et al. Key stakeholders' views on the quality of care and services available to frail seniors in Canada. BMC Geriatr. 2018;18(1):290.
- Hale M, Shah S, Clegg A. Frailty, inequality and resilience. Clin Med (Lond). 2019; 19(3): 219-223. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6542240/
- 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.
- Holroyd-Leduc J, Resin J, Ashley L, Barwich D, Elliott J, Huras P, et al. Giving voice to older adults living with frailty and their family caregivers: engagement of older adults living with frailty in research, health care decision making, and in health policy. Res Involv Engagem. 2016;2:23.
- International Centre for Integrated Care (IFIC). Integrated Care Report of Round Table. 2020. Available from: https://integratedcarefoundation.org/wp-content/uploads/2020/09/Report-of-Round-Table-Aug-28th-1.pdf
- Kennedy F, Galvin R, Horgan NF. Managing frailty in an Irish primary care setting: A qualitative study of perspectives of healthcare professionals and frail older patients. J Frailty Sarcopenia Falls. 2021;6(1):1-8.
- Longobucco Y, Benedetti C, Tagliaferri S, Angileri VV, Adorni E, Pessina M, et al. Proactive interception and care of Frailty and Multimorbidity in older persons: the experience of the European Innovation Partnership on Active and Healthy Ageing and the response of Parma Local Health Trust and Lab through European Projects. Acta Biomed. 2019;90(2):364-74.
- 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.
- Ludwig C, Graham ID, Gifford W, Lavoie J, Stacey D. Partnering with frail or seriously ill patients in research: a systematic review. Res Involv Engagem. 2020;6:52.

Bibliography continued

- Royal College of General Practitioners. Integrated care for older people with frailty. 2016. Available from: https:/www.rcgp.org.uk/-/media/Files/News/2016/RCGP-Integrated-care-for-older-people-with-frailty-2016.ashx?la=en
- 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.
- SCIROCOO self-assessment tool. 2016. Available from: https://www.scirocco-project.eu/maturity-model-in-practice-scirocco-assessment-tool/
- 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.
- Turner G, Clegg A, British Geriatrics Society, Age UK, Royal College of General Practioners. Best practice guidelines for the management of frailty: a British Geriatrics Society, Age UK and Royal College of General Practitioners report. Age Ageing. 2014; 43(6):744-7. Available from: https://pubmed.ncbi.nlm.nih.gov/25336440/

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