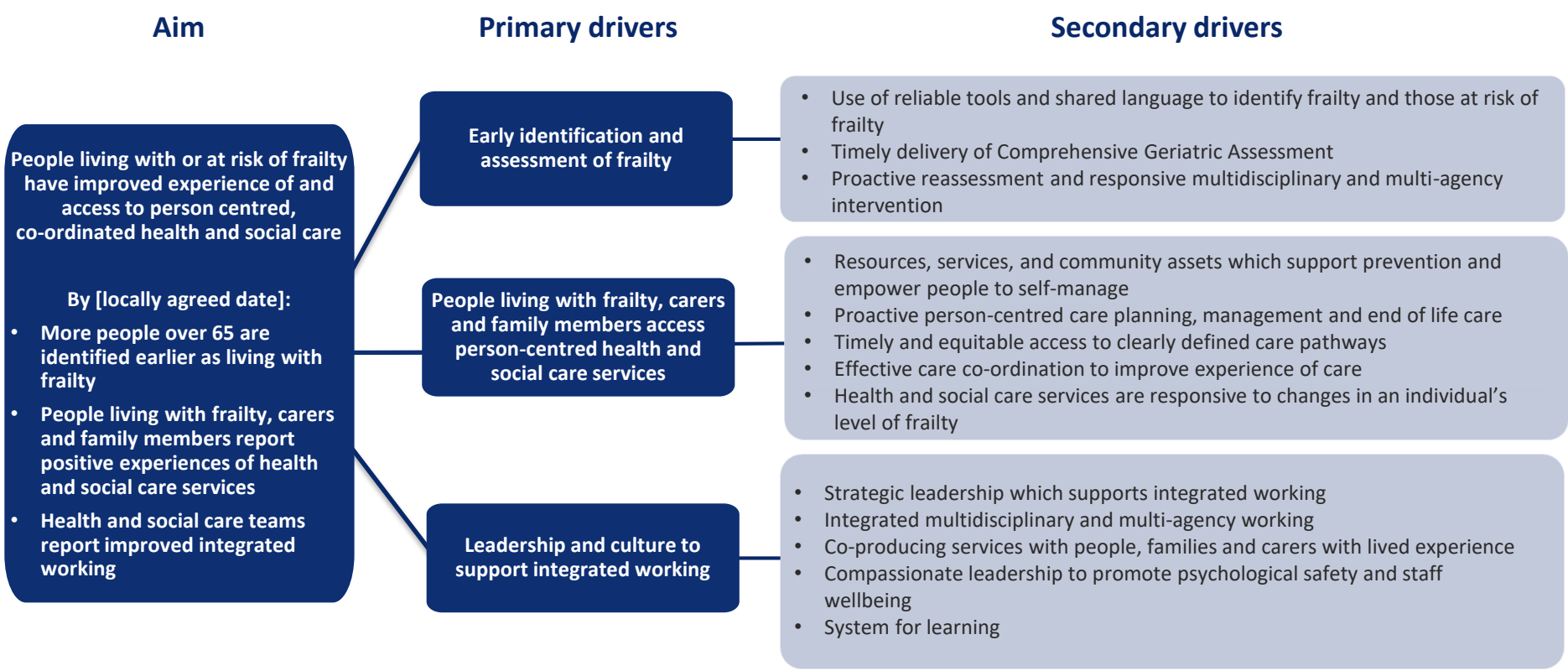
ihub Frailty Improvement and Implementation Programme Driver Diagram



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	

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 centred 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: Leadership and culture to support integrated working

Secondary driver	Change ideas			
Strategic leadership which supports integrated working	Leadership walkrounds 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