

ihub Frailty Improvement and Implementation Programme

Change Package

October 2022

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**Published Month Year**

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# 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 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 best practices 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
* Guides, tools, and signposts to the supporting evidence and examples of good practice, 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 centered, 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.

# Project aim

## Setting a project aim

All quality improvement projects should have an aim that is Specific, Time bound, Aligned to objectives, and Numeric, the acronym known as STAN.

### The national aim for the ihub Frailty Improvement and Implementation Programme is:

People living with or at risk of frailty have improved experience of, and access to person centered, coordinated 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 team’s 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?”

# Frailty Improvement and Implementation Programme Driver Diagram 2022

# Aim:

People living with or at risk of frailty have improved experience of and access to person centered, coordinated health and social care

Measures to support the aim include:

* 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

Primary Driver: Early identification and assessment of frailty

### Secondary drivers:

* 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

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

### Secondary drivers:

* Resources, services, and community assets which support prevention and empower people to self-manage
* Proactive person-centered 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

Primary Driver: Leadership and culture to support integrated working

### Secondary drivers:

* 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: Use of reliable tools and shared language to identify frailty and those at risk of frailty

### Change Ideas:

* 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)

## Secondary driver: Timely delivery of Comprehensive Geriatric Assessment (CGA)

### Change Ideas:

* 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

## Secondary driver: Proactive reassessment and responsive multidisciplinary and multi-agency intervention

### Change Ideas:

* 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: Use of reliable tools and shared language to identify frailty and those at risk of frailty

### Change Ideas:

* 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](https://academic.oup.com/ageing/article/45/3/353/1739750)

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### Tools and Resources:

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# Primary Driver: Early identification and assessment of frailty

## Secondary driver: Timely delivery of Comprehensive Geriatric Assessment (CGA)

### Change Ideas:

* 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](file:///\\hislfspri01\share\ihub\Frailty\01%20Programme%20Management\Change%20package\01%20Frailty%20Programme%20draft%20change%20package\British%20Geriatrics%20Society.%20Silver%20Book%20II%20%5bonline%5d.%202021;%20Available%20from:%20https:\www.bgs.org.uk\policy-and-media\leading-experts-in-frailty-launch-the-silver-book-ii-in-collaboration-with-the)

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# Primary Driver: Early identification and assessment of frailty

## Secondary driver: Proactive reassessment and responsive multidisciplinary and multi-agency intervention

### Change Ideas:

* 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:

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

## Secondary driver: Resources, services and community assets which support prevention and empower people to self-manage

### Change Ideas:

* 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

## Secondary driver: Proactive person-centered care planning, management and end of life care

### Change Ideas:

* 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 end of life

## Secondary driver: Timely and equitable access to clearly defined care pathways

### Change Ideas:

* 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

## Secondary driver: Effective care coordination to improve experience of care

### Change Ideas:

* 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

## Secondary driver: Health and social care services are responsive to changes in an individual’s level of frailty

### Change Ideas:

* 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

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### Evidence and Guidelines:

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[University of the West of Scotland & Health and Social Care Alliance. Frailty Matters. [online] 2021](https://www.alliance-scotland.org.uk/people-and-networks/frailty-matters-research-project/)

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## Secondary driver: Proactive person-centered care planning, management and end of life care

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* 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 end of life

### Evidence and Guidelines:

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

## Secondary driver: Timely and equitable access to clearly defined care pathways

### Change Ideas:

* 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 Systematic Reviews. 2017(6).](https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD000356.pub4/full)

[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.](https://onlinelibrary.wiley.com/doi/full/10.1111/hsc.12571)

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[Healthcare Improvement Scotland. The Frailty at the Front Door Collaborative impact report. 2019](https://ihub.scot/media/6870/201912-frailty-at-the-front-door-collaborative-impact-report-v10.pdf)

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

## Secondary driver: Effective care coordination to improve experience of care

### Change Ideas:

* 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](file:///\\hislfspri01\share\ihub\Frailty\01%20Programme%20Management\Change%20package\01%20Frailty%20Programme%20draft%20change%20package\Healthcare%20Improvement%20Scotland.%20SIGN%20Guideline%20128:%20%20The%20SIGN%20Discharge%20Document.%20%5bonline%5d%202012;%20Available%20from:%20https:\www.sign.ac.uk\media\1066\sign128.pdf)

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

## Secondary driver: Health and social care services are responsive to changes in an individual’s level of frailty

### Change Ideas:

* 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:

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[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](https://ihub.scot/media/6481/midlothian-hscp-case-study-v30.pdf)

[Healthcare Improvement Scotland. Frailty and the Electronic Frailty Index. [online] 2018](https://ihub.scot/media/6106/frailty-and-the-electronic-frailty-index.pdf)

# Primary Driver: Leadership and culture to support integrated working

Secondary driver: Strategic leadership which supports integrated working

### Change Ideas:

* Leadership walk-rounds at team, locality and strategic levels
* Strategic frailty leadership network
* Mechanism to encourage staff feedback
* Development of a shared vision

Secondary driver: Integrated multidisciplinary and multi-agency working

### Change Ideas:

* Processes to enable teams to work together and build trusting relationships
* Use tools to assess readiness for integration
* Integrated huddles across health, social care, third and independent sectors
* Process to share information between teams and services

Secondary driver: Co-producing services with people, families and carers

### Change Ideas:

* 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

Secondary driver: Compassionate leadership to promote psychological safety and staff wellbeing

### Change Ideas:

* Celebrate success
* Structured debrief opportunities and 1:1 time
* Clear link to local wellbeing strategies
* Learning and development opportunities for health and social care staff

Secondary driver: System for learning

### Change Ideas:

* 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: Strategic leadership which supports integrated working

### Change Ideas:

* 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](https://advantageja.eu/images/D7.2_EuropeanGuide_models.pdf)

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# Primary Driver: Leadership and culture to support integrated working

Secondary driver: Integrated multidisciplinary and multi-agency working

### Change Ideas:

* Processes to enable teams to work together and build trusting relationships
* Use tools 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](https://www.bgs.org.uk/sites/default/files/content/resources/files/2018-10-09/RCGP-Integrated-care-for-older-people-with-frailty-2016.pdf)

[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](https://qualitysafety.bmj.com/content/29/10/1.2)

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### Tools and Resources:

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[Healthcare Improvement Scotland. Fife health and Social Care Partnership: The community health and wellbeing hub model in Fife case study. [online] 2022](https://ihub.scot/media/9171/nhs-fife-case-study.pdf)

[Healthcare Improvement Scotland. Multidisciplinary team meeting (MDT) Guidance. [online] 2019](https://ihub.scot/media/6101/20180827-mdt-guidance-document-v20.pdf)

# Primary Driver: Leadership and culture to support integrated working

Secondary driver: Co-producing services with people, families and carers

### Change Ideas:

* 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](https://link.springer.com/article/10.1186/s12913-019-4626-8)

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### Tools and Resources:

[Healthcare Improvement Scotland. Community led models: innovation in health and social care report. [online] 2021](https://ihub.scot/media/8107/20210305-community-led-approaches-report-v20.pdf)

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[Healthcare Improvement Scotland. Experienced Based Co-design webpage. [online] 2021](https://ihub.scot/improvement-programmes/people-led-care/person-centred-design-and-improvement/experience-based-co-design)

[Healthcare Improvement Scotland. Person-centered Design and Improvement Programme webpage. [online] 2021](https://ihub.scot/improvement-programmes/people-led-care/person-centred-design-and-improvement/experience-based-co-design)

# Primary Driver: Leadership and culture to support integrated working

Secondary driver: Compassionate leadership to promote psychological safety and staff wellbeing

### Change Ideas:

* Celebrate 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:

[Healthcare Improvement Scotland. The importance of psychological safety by Amy Edmondson, Novartis Professor of Leadership and Management, Harvard Business School. [online] [video] 2021](https://www.youtube.com/watch?v=eP6guvRt0U0)

[Institute of Healthcare Improvement. Three ways to create psychological safety by Amy Edmondson. [online] [video] 2022](file:///\\hislfspri01\share\ihub\Frailty\01%20Programme%20Management\Change%20package\01%20Frailty%20Programme%20draft%20change%20package\03%20Change%20package%20accessible%20version\Institute%20of%20Healthcare%20Improvement.%20Three%20ways%20to%20create%20psychological%20safety%20by%20Amy%20Edmondson.%20%5bonline%5d%20%5bvideo%5d%202022;%20%20Available%20from:%20https:\www.ihi.org\education\IHIOpenSchool\resources\Pages\AudioandVideo\Amy-Edmonson-Three-Ways-to-Create-Psychological-Safety-in-Health-Care.aspx)

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### Tools and Resources:

[Institute for Healthcare Improvement. IHI Framework for Improving Joy in Work webpage. [online] 2022](https://www.ihi.org/resources/Pages/IHIWhitePapers/Framework-Improving-Joy-in-Work.aspx)

[Scottish Government. National Wellbeing Hub webpage. [online] no date](https://wellbeinghub.scot/)

[NHS Education for Scotland. National Trauma Training Programme webpage. [online] no date](https://transformingpsychologicaltrauma.scot/)

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[NHS Education for Scotland: TURAS | Learn. Values Based Reflective Practice. [online] 2022 (TURAS log in required)](https://learn.nes.nhs.scot/21027/person-centred-care-zone/spiritual-care-and-healthcare-chaplaincy/values-based-reflective-practice-vbrp)

# Primary Driver: Leadership and culture to support integrated working

Secondary driver: System for learning

### Change Ideas:

* 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.](https://www.centreforpublicimpact.org/assets/pdfs/hls-practical-guide.pdf)

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[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.](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8245918/)

### Tools and Resources:

[British Geriatric Society. Frailty Hub: Education and Training. [online] 2020](https://www.bgs.org.uk/resources/frailty-hub-education-and-training)

[Healthcare Improvement Scotland. HIS Frailty Learning System Microsoft Teams Channel](https://teams.microsoft.com/dl/launcher/launcher.html?url=%2F_%23%2Fl%2Fteam%2F19%3A694f22ec978a436ea701d4e82e725ff0%40thread.tacv2%2Fconversations%3FgroupId%3D3bee3d91-af9e-4daf-9bee-83b0fc3b75e3%26tenantId%3D10efe0bd-a030-4bca-809c-b5e6745e499a&type=team&deeplinkId=4ba43f0d-15f0-4f91-a4a6-72344b7eac42&directDl=true&msLaunch=true&enableMobilePage=true&suppressPrompt=true)

[Healthcare Improvement Scotland. Learning Systems webpage. [online] 2021](https://ihub.scot/improvement-programmes/quality-management-system/learning-systems/)

[Learning from Excellence webpages [online] no date](https://learningfromexcellence.com/)

[NHS Education for Scotland: TURAS | Learn Quality Improvement Zone. [online] 2022 (TURAS log in required)](https://learn.nes.nhs.scot/741)

# 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

Number of people over 65 are identified as living with frailty

## What/How to measure

Number of people over 65 identified as living with frailty using a reliable tool. Local teams can agree which tool, such as [Think Frailty!](https://ihub.scot/media/1430/20180523-think-frailty-screening-tool-v35.pdf) or the [Clinical Frailty Scale](https://www.dal.ca/sites/gmr/our-tools/clinical-frailty-scale.html), is most appropriate for them.

## Concept/Name

People living with frailty, carers and family members report positive experiences of health and social care services

## What/How to measure

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](https://ihub.scot/improvement-programmes/focus-on-dementia/improving-diagnosis-and-post-diagnostic-support/evaluating-post-diagnostic-support-a-single-quality-question/):

Overall how helpful or unhelpful has the support 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.”

## Concept/Name

Health and social care teams report improved integrated working

## What/How to measure

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

Percentage of people screened for frailty at the front door of the hospital or GP practice

## What/How to measure

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.

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

## Concept/Name

People over 65 identified as at risk of living with frailty using a population screening tool

## What/How to measure

Number of people aged 65 or older identified as at risk of living with frailty using a population screening tool such as eFI.

## Concept/Name

Time to initiation of Comprehensive Geriatric Assessment (CGA)

## What/How to measure

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.

## Concept/Name

Number of people living with frailty with a person centered care plan in place

## What/How to measure

Number of people identified as living with frailty who have a person centered care plan in place.

Local teams can define their own essential criteria for person centered care planning which should include a conversation with the person and Anticipatory Care Planning as appropriate.

# Measurement: Balancing measures

## Balancing measure

## Concept/Name

Readmissions

## What/How to measure

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

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

MS Teams: Joining the [Frailty Learning system](https://teams.microsoft.com/l/team/19%3a694f22ec978a436ea701d4e82e725ff0%40thread.tacv2/conversations?groupId=3bee3d91-af9e-4daf-9bee-83b0fc3b75e3&tenantId=10efe0bd-a030-4bca-809c-b5e6745e499a) MS Teams Channel

Email: [his.frailty@nhs.scot](mailto:his.frailty@nhs.scot)

Twitter: @ihubscot

To find out more visit https://ihub.scot/project-toolkits/frailty-improvement-programme/frailty-resources/

# END

Published October 2022

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