Healthcare Improvement Scotland

Focus on Frailty end of programme celebration event

Wednesday 20 November 2024

Leading quality health and care for Scotland

NHS SCOTLAND

Introduction

Dr Lara Mitchell

Strategic National Clinical Lead (Acute)

Healthcare Improvement Scotland

Agenda

Time	Topic	Speaker
09:15	Registration opens	
10:00	Chair's welcome	Dr Lara Mitchell, Strategic National Clinical Lead (Acute), Healthcare Improvement Scotland
10:10	Team presentations	All
11:10	Networking and refreshments	
11:20	Team presentations	All
12:20	Thank you and summary	Dr Lara Mitchell
12:30	Lunch and networking	
13:20	Afternoon keynote: Creating the conditions for spread, scale and sustainability	Professor Trish Greenhalgh, Professor of Primary Care Health Sciences and Fellow of Green Templeton College at the University of Oxford
14:20	Next steps for your frailty improvement work	Focus on Frailty team, Healthcare Improvement Scotland
15:00	Refreshments	
15:10	Panel session: Improving health and social care for people living with frailty – where next?	Belinda Robertson, Associate Director of Improvement, Healthcare Improvement Scotland
15:50	Closing remarks	Dr Lara Mitchell
16:00	Close	

Aims

An opportunity for attendees to celebrate their progress as part of the Focus on Frailty programme and consider next steps for their improvement work by:

- Sharing their key achievements and learning
- Connecting with colleagues
- Developing plans for sustaining and spreading improvement

36 stage wins - best sprinter of all time

2008 4 stage wins
2009 6 stage wins
2010 5 stage wins
2011 5 stage wins
2012 3 stage wins
2013 2 stage wins
2015 1 stage win
2016 4 stage wins
2017 0 stage wins
2018 0 stage wins
2019 0 stage wins
2020 dropped
2021 4 stage wins
2022 0 stage wins
2023 crashed out
2024 1 stage win

Frailty

Could this be your sliding doors moment?

Frailty

Frailty

Review

Aim

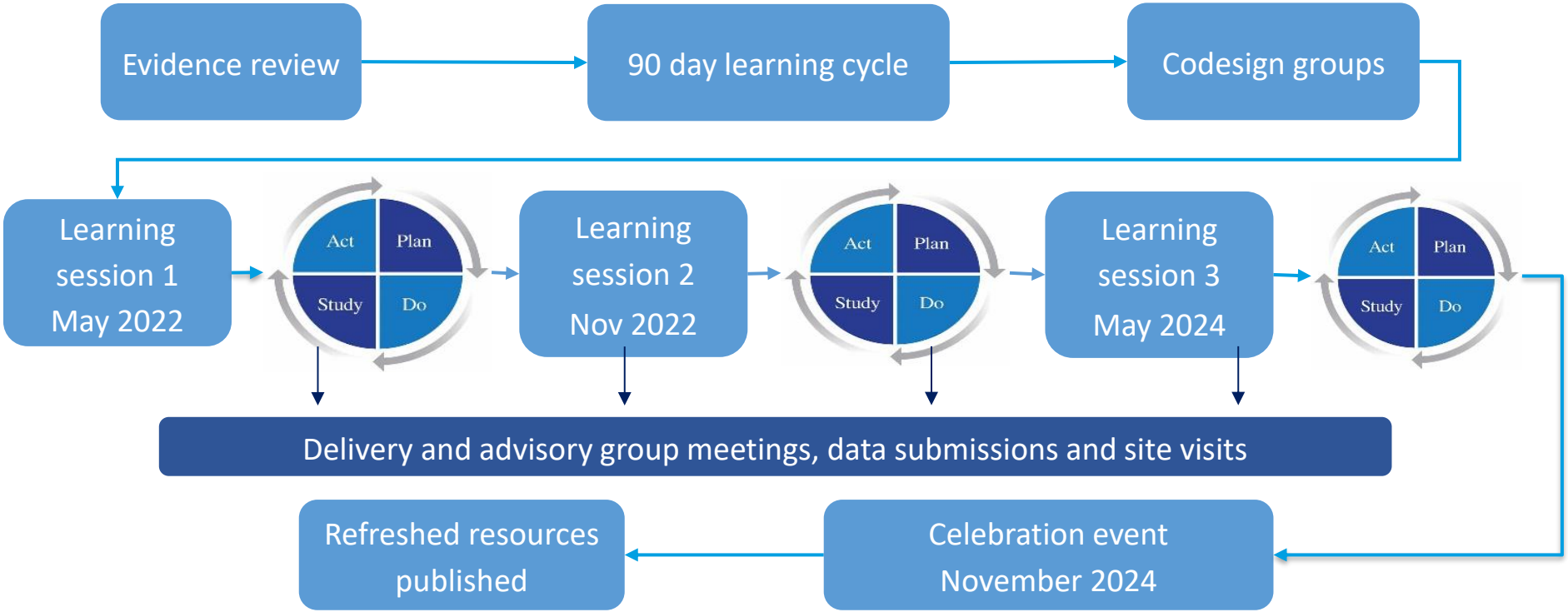
Integration

Leadership

Teams

Yomp

Frailty



[Healthcare Improvement Scotland: programme updates]

Review

90 day learning cycle on frailty, Healthcare Improvement Scotland, 2022

Focus on Frailty programme Healthcare Improvement Scotland

Joining the dots: A blueprint for preventing and managing frailty in older people, British Geriatrics Society, 2023

Front door frailty: Advice on setting up services, British Geriatrics Society, 2023

Developing hospital front door frailty services webinar, Healthcare Improvement Scotland, 2024

Urgent and unscheduled care healthcare standards, Scottish Government

Frailty in Older Adults, Dae Hyun Kim,nd Kenneth Rockwood, M.D.K. Rockwood et al, New England Journal of Medicine, 2024

FRAIL strategy – a strategy for the development and/or improvement of acute frailty same day emergency care services, NHS England, 2024

Ageing and Frailty standards, Healthcare Improvement Scotland, 2024

Scottish care of older people project (Scoop) report, March 2025

Aim

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

By December 2024

Early identification and assessment of frailty

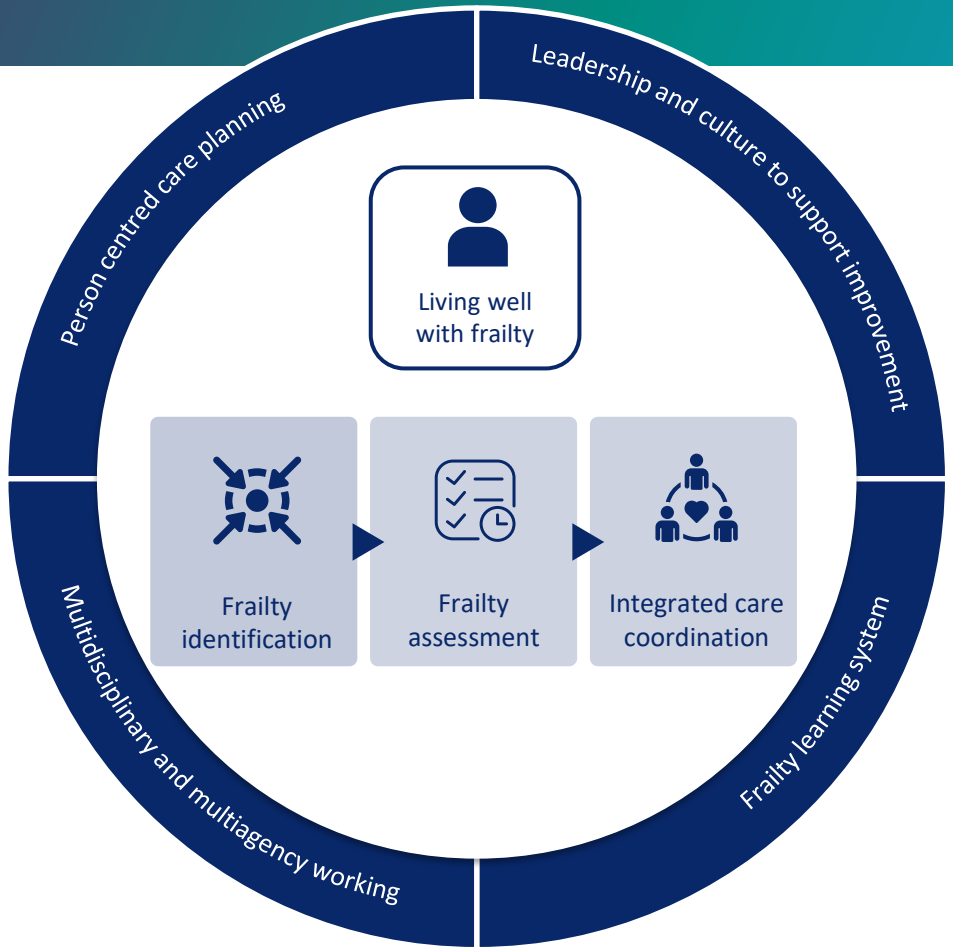
People living with frailty, carers and family members access person-centred health and social care services

Leadership and culture to support integrated working

Healthcare Improvement Scotland: Frailty change package

Aspirational

Integration



Please describe the most important leadership quality in health and social care at the moment?

Listening

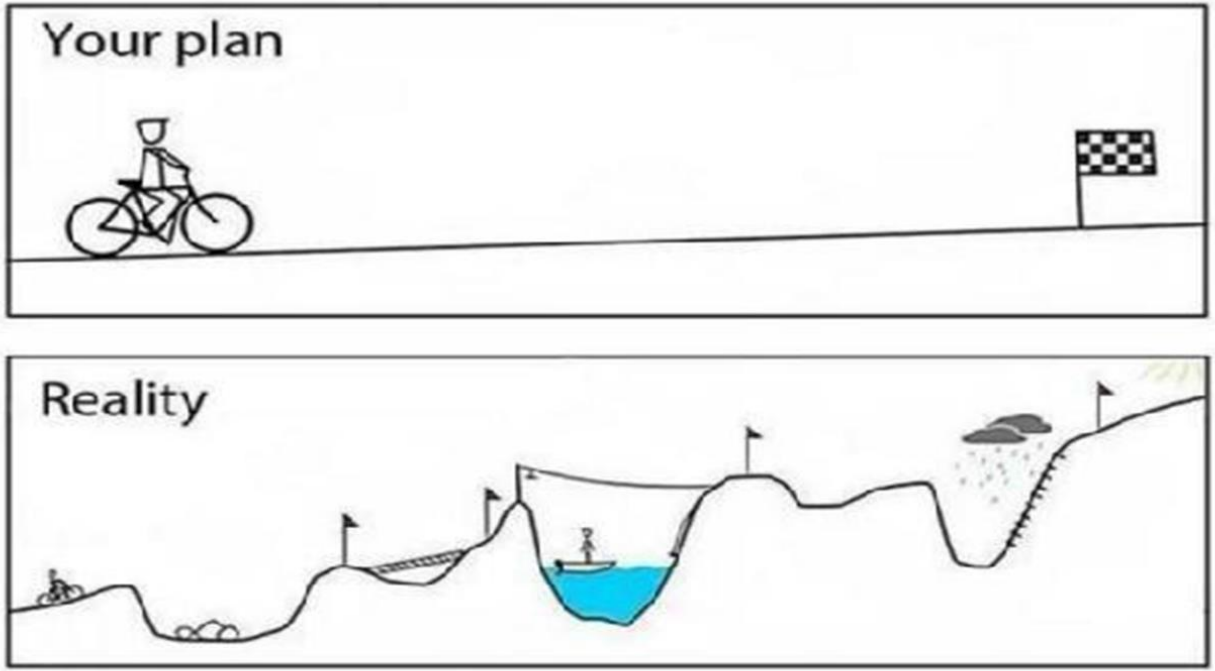
"Listening is probably the most important leadership skill and compassionate leaders take time to listen to the challenges, obstacles, frustrations and harms colleagues experience as well as listening to accounts of their successes and joys."

Michael West

Source: What is compassionate leadership, Kings Fund, 2022

Teams

Yomp



“Difficulties are just small things to overcome after all”
Ernest Shackleton

Storytelling

Storytelling

People

Staff

Health and social care system

Tell us about your experience

- How valuable have the site visits been to progressing your improvement work?
- How valuable have opportunities to connect with other teams been to progressing your improvement work?
- Is there anything you feel was missing from the programme?
- What improvement support would you like to see going forwards?

Healthcare Improvement Scotland

NHS Lanarkshire

NHS Lanarkshire and North Lanarkshire HSCP

Frailty in Lanarkshire - 2023

What were our goals?

Statement aim

Whole system leadership approach resulting in early identification and assessment of frailty and allowing people living with frailty and their carers and family members to have access to relevant person-centred health and social care services.

- Increased identification of frail patients across whole system.
- Increase frailty at the front door (access to CGA).
- Increased access to wider MDT.
- Increased collaboration between 3 acute sites.
- Short term aims were mainly acute focused.

Frailty in Lanarkshire - 2023

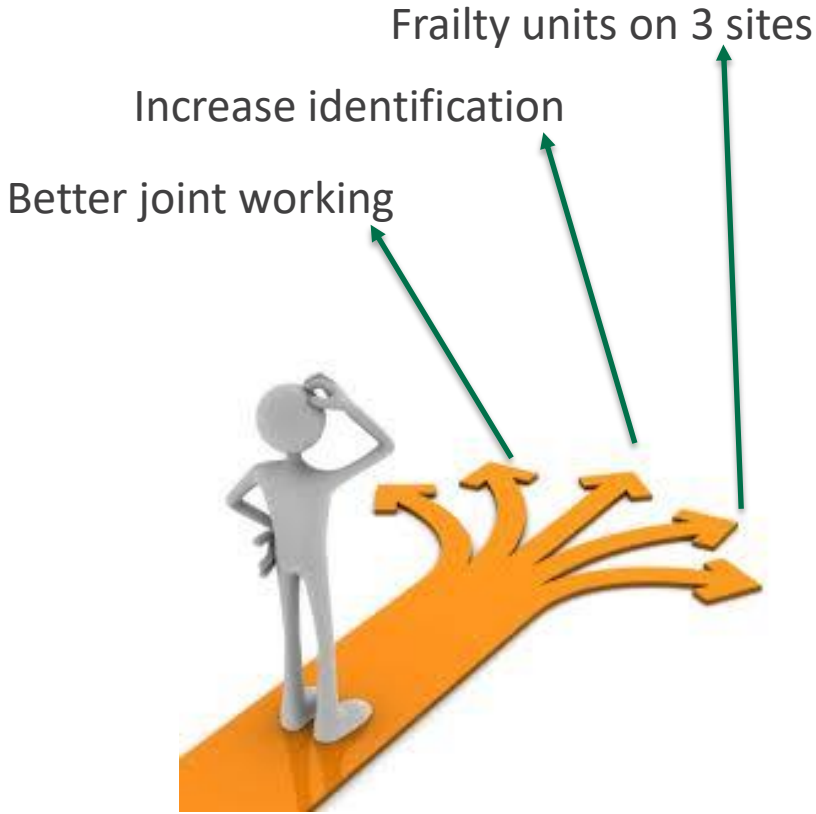
- UHM had established frailty unit.
- UHH and UHW did not have frailty unit (patient admitted into general receiving areas with CGA in reach).
- Limited understanding of what was happening in Lanarkshire and limited data available.
- Multiple areas of good working around Lanarkshire.
- Little joint working.
- No clear understanding of frailty as a whole system.

What happened?

NHSL took a whole system approach to frailty

<u>Understanding our systems</u>

- Frailty network was established.
- UHM focused on improving flow and early CGA within frailty unit and measurements.
- UHH focused on establishing frailty unit and measurements.
- UHW focused on establishing frailty unit and measurements.
- All 3 sites focusing on increased identification.
- Frailty strategy 2023-2028 was created.



Challenges and enablers

Challenges – 

- Different resources and staffing between 3 acute areas.
- Communicating between different groups.
- Different appetite for change and risk taking.
- Electronic systems.
- 3 acute sites, 2 HSCP – different process.
- Resource and time constraints.
- Varying expectations.

Enablers – 

- Passion for change.
- Leadership.
- Allocated network focused on wider NHSL.
- Patient-focused.
- Good understanding of our systems.
- Learning from already established areas.
- Determination.
- Great teams!

UHM

Focus on Frailty @ UHM

MOA Ward Admissions

MOA Ward Admissions By Age

MOA Ward Admissions By Location

Frailty Ward Admissions

Frailty Ward LoS

Frailty Ward Discharges

Measures

Ward Discharge Week:
LoS <24 Hrs
LoS 24-48 hrs
LoS >72 Hrs
Total Patients
% Patients LoS <24 Hrs
% Patients LoS 24-48 Hrs
% Patients LoS >72 Hrs
Average LoS (Days)

Flow in (and out) Frailty Assessment Unit (FAU)

Measures:
- LoS in FAU and MOA
- Ward% of patients up and sitting at 10am in FAU
- Ward beat
- Feedback

Time to CGA in and out with FAU

Measures:
- Time to CGA (admission to FAU)
- Time from referral to CGA team to being seen (outwith FAU)

Frailty identification

Measures:
- No of eFrailty ' icons'

Feedback from our service users in FAU

Flow in (and out) Frailty Assessment Unit (FAU)

We asked –

How was your stay?

What did we do well?

July 2024 FAU UHM

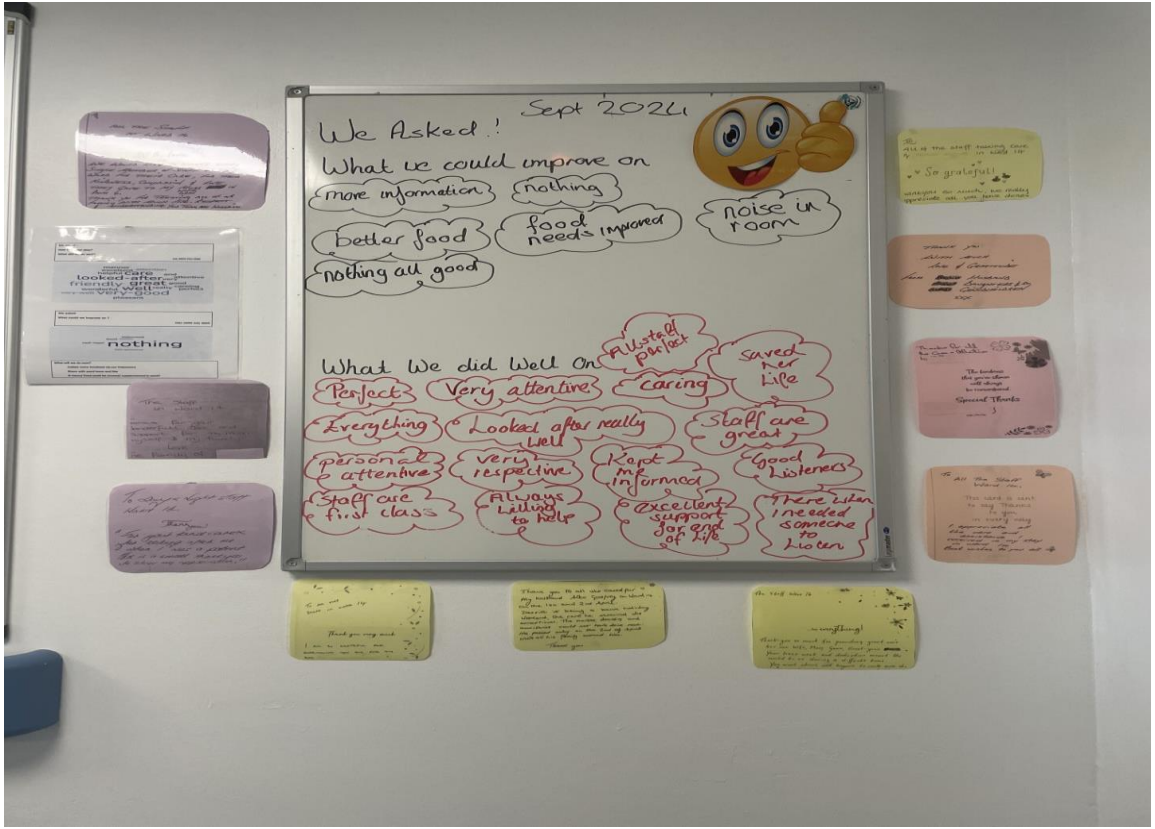
We asked-

What could we improve on ?

FAU UHM July 2024

What will we do next?

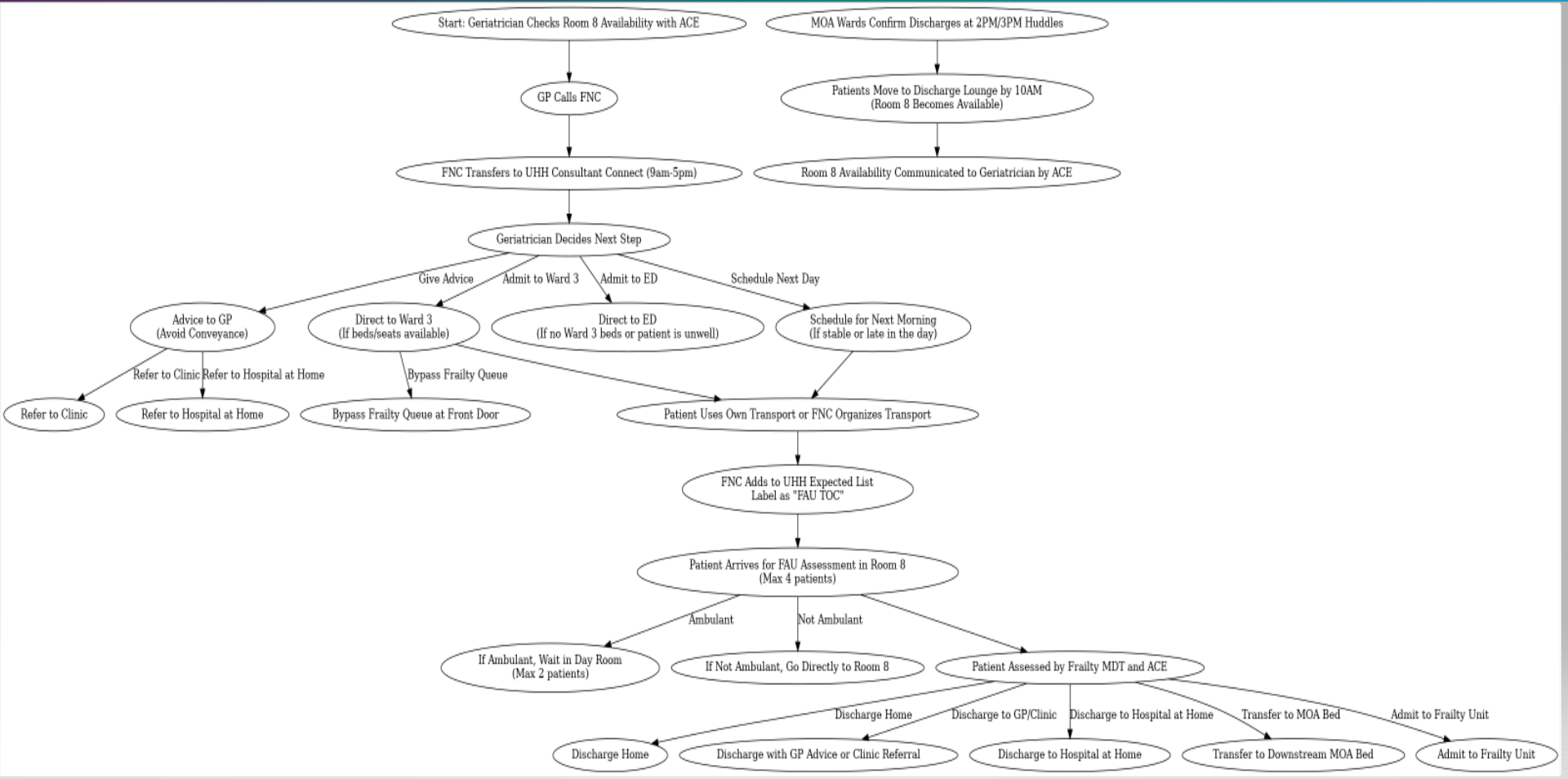
- Collate more feedback via our Volunteers
- Share with ward team and Site
- If menu/ food could be revised/ supplemented in ward?



UHH - Frailty unit opened - November 2023

- Similar measurements as UHM to understand flow and functionality of unit.
- Staff education sessions.
- Frailty leaflet.
- Focus on early mobilisation and up to sit/active wards.
- TOC with FNC+ to take direct admits into frailty unit.

Test of change with FNC+ during firebreak



Results – 10 days

Calls

- 16 throughout Firebreak.
- 8 to FAU
  - H@H could not take 1 pt due to capacity on 23/9/24, otherwise would have been appropriate.
- 1 to EAU DVT pathway.
- 3 to H@H.
- 4 went to front door
  - 2 could have gone to frailty unit if beds available.
  - 2 went to ED, chest pain and heart condition and GG advised needed ED stabilisation.

Lots of learning (positive)

- Porter availability.
- Transport availability.
- Prof to Prof/ Consultant Connect.

Could be improved

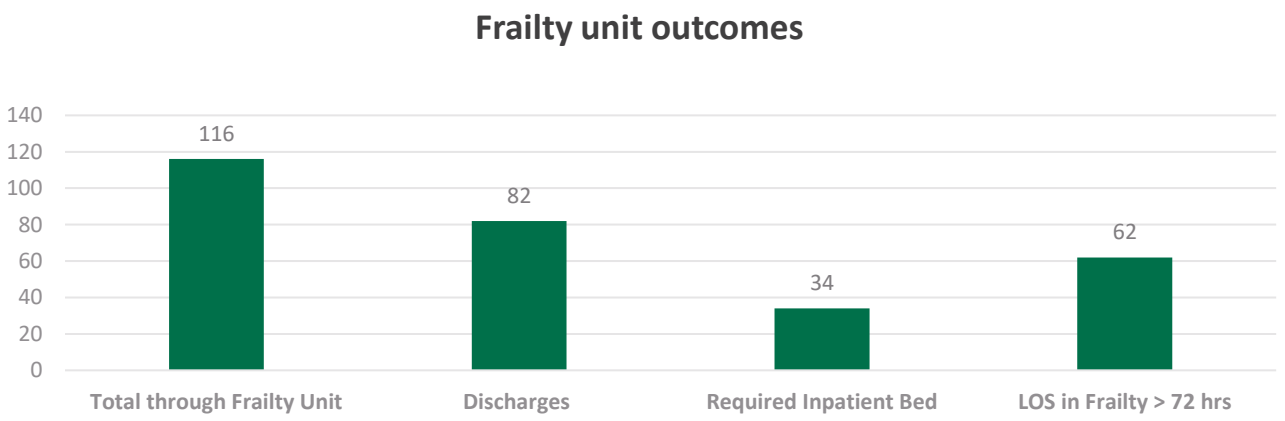
- Ability to move downstream (barriers of internal transport, investigations). Positive was quick response from ACE/consultant/ coordinator to add downstream wards.
- Too many people involved.
- Streamlining FNC process (couple of hiccups with CC.)
- Process for arriving in ED when no available FAU beds.
- Not blocking beds overnight.

UHW – Frailty unit opened - September 2024

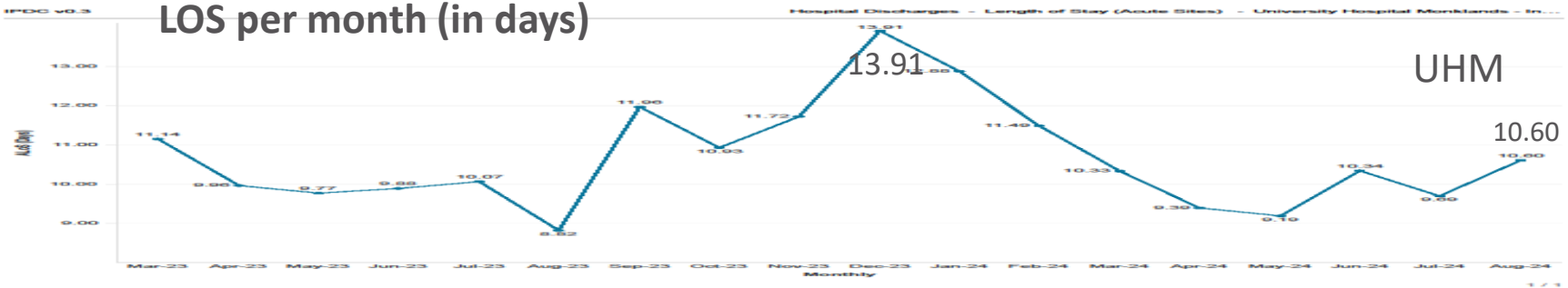
- Ambition to open a frailty unit for many years.
- Multidisciplinary working group from across the site – eager for the change.
- Tested a number of options and important learning and feedback – essential steps to get it right
  - Ward 12 via ED
  - Ward 12 via receiving unit
  - Roving team
  - RAFT
- Number of challenges
  - Workforce
  - Additional receiving unit in downstream ward
  - Ongoing financial challenges associated with additional nursing and medical resource

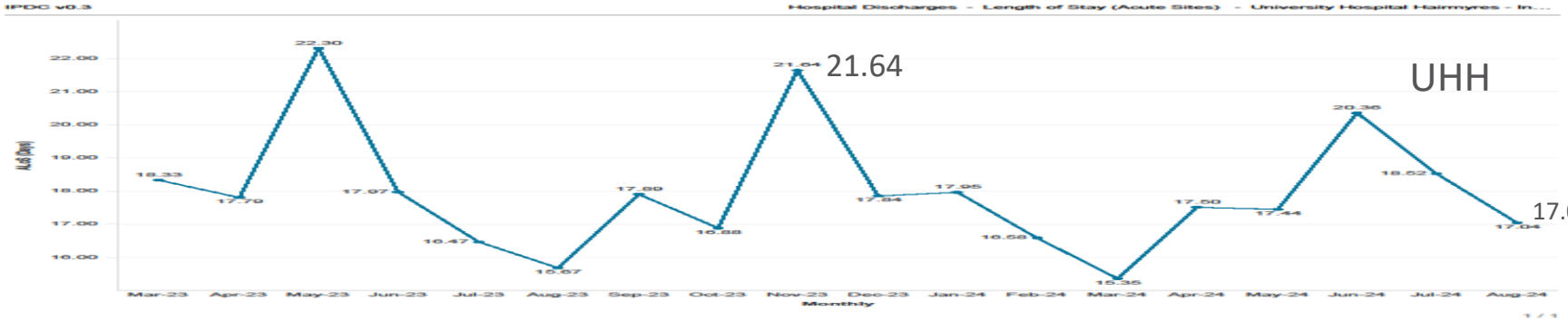
UHW – Frailty unit outcomes from 18 September 2024

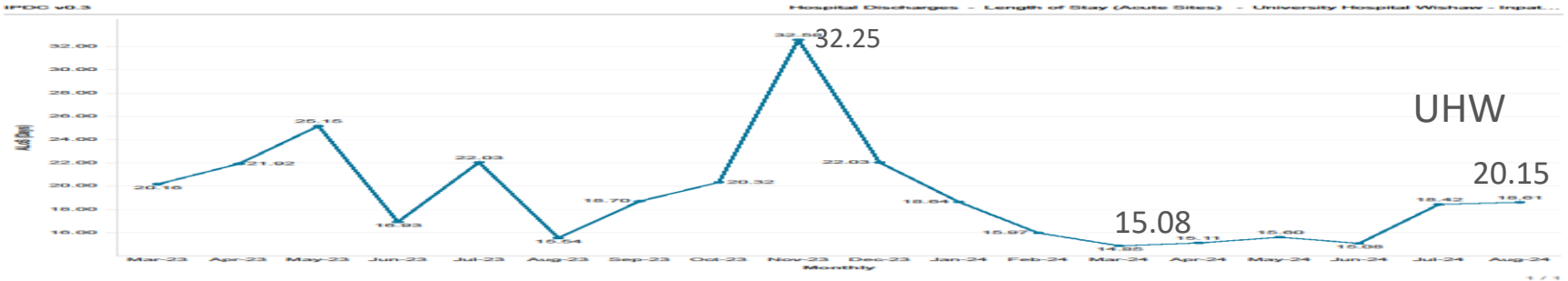
- Total of 116 patients since started.
- 82 patients were discharged from frailty unit **(71%)**.
- 34 patients were moved to inpatient MOA beds for ongoing assessment and treatment.
- 62 of these patients remained within the frailty unit for over 72 hours. This was due to a variety of factors including awaiting social care provisions, IPC, or awaiting a downstream bed to become available for ongoing treatment.



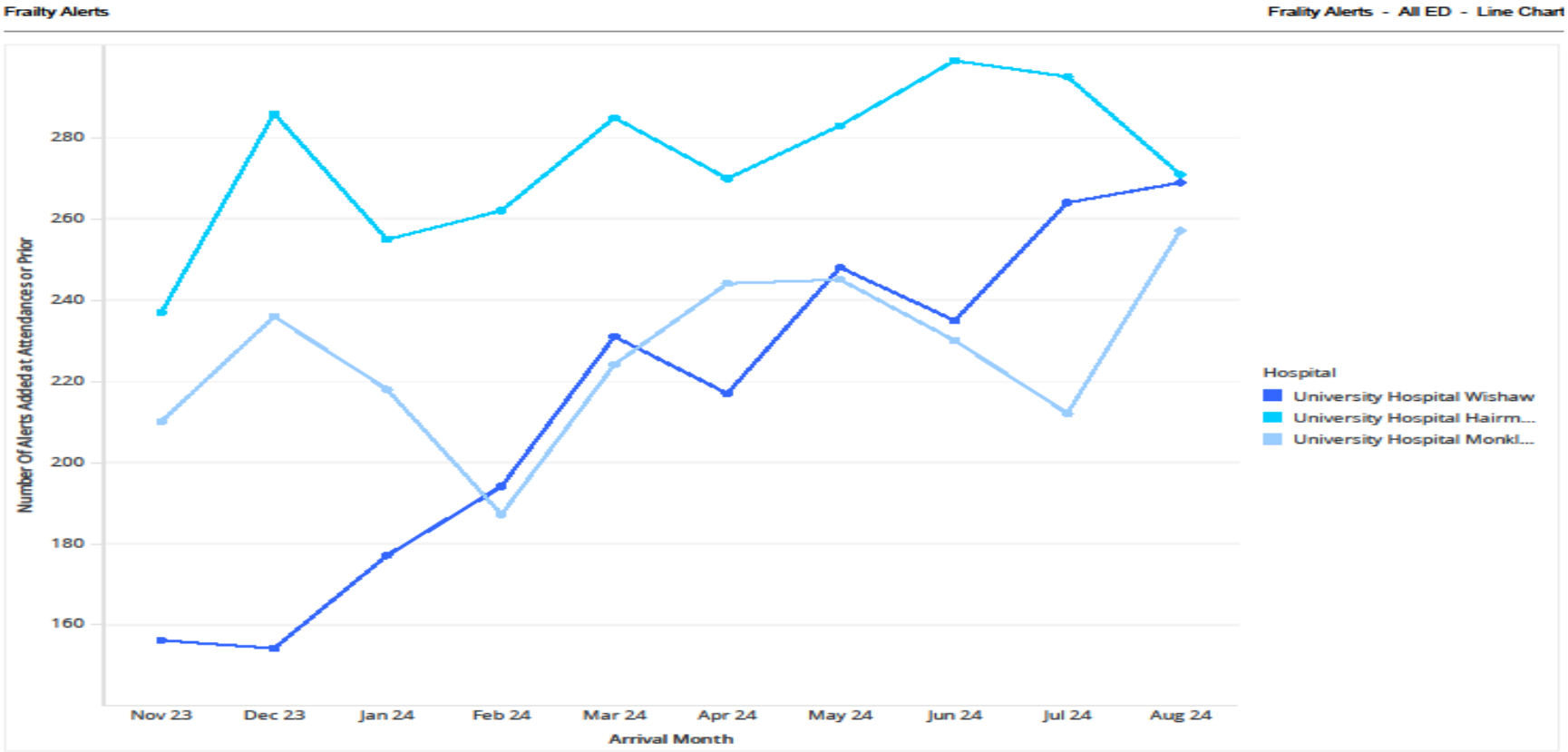
LOS per month (in days)







Frailty alerts added to Trakcare



Other areas of work - ToC ReSPECT

	No of residents
Invited to meeting	103
Declined / uncontactable	5
ReSPECT forms	75
Status Quo	2
Avoid all hospital admission/palliative care only	24
Hospital if adding to care	48
Further meeting planned	1

Other benefits of ReSPECT form TOC

- Specialty referrals to optimise care (Respiratory LTOT, psychiatry for BPSD/distress).
- Medication reviews (stopped statins, anticholingerics, bisphosphonates, anti-anginals, DOACs).
- Ripple effect
  - ❖ CH staff having ACP conversations (ReSPECT completed in absentia).
  - ❖ CHL nursing staff support.

TOC with UHH geriatrician in-reach into care homes, completing ReSPECT forms for many residents.

Other ongoing work currently

Offsite clinical pharmacist

Rehab coordinator/offsite case management support

Active wards

System wide education on CFS – DNs currently

Frailty AHP based within ED

Geriatrician input to FNC+

Areas for celebration ☺

- Frailty network leading on frailty across Lanarkshire.
- All 3 acute sites now have a frailty unit.
- NHSL approach to ‘right care, right place’ with FNC+.
- **Teams have been amazing,** resilient and remained positive during challenging times.
- Monthly frailty network meetings where members of the 3 acute sites, GPs, pharmacy, AHP and localities attend to share learning and communicate information back to their teams.
- Frailty strategy is being launched 28 November 2024.

Original aims:

- **Increased identification of frail patients across whole system.**
- **Increase frailty at the front door (access to CGA).**
- **Increased access to wider MDT.**

Increased collaboration between 3 acute sites.

Reflecting on the year and what's next…

- Trying to keep people in the loop and updated – highlight reports.
- In-depth discovery conversations.
- Intranet frailty information page with information on support, onwards referrals and education for staff.
- Continuing momentum and improving our systems for people living with frailty in Lanarkshire – celebrate achievements.
- Explore direct admissions from FNC+/SAS into frailty units – (further resource required) and role of geriatrician in-reach into FNC.

HIS collaborative has helped gather momentum across the MDT and from Corporate Team

Learning from the teams around Scotland has been invaluable

Healthcare Improvement Scotland

DUMFRIES AND GALLOWAY Health and Social Care

NHS Dumfries and Galloway and Dumfries and Galloway HSCP

Leading quality health and care for Scotland

NHS SCOTLAND

Goals: To deliver

- Focus on frailty and ageing in D&G.
- Deliver integrated pathways.
- Improvement for patients, staff and public.

DUMFRIES AND GALLOWAY
Health and Social Care

Context

- 3rd collaborative.
- Huge volume of change across D&G.
- Conditions for change established.

DUMFRIES AND GALLOWAY
Health and Social Care

Challenges and enablers

- Clear champions and leaders.
- Interest beyond traditional stakeholders.

- Competing priorities.
- Loss of improvement advisor.
- Lack of data.

DUMFRIES AND GALLOWAY
Health and Social Care

Reflections – ‘Good’ and ‘even better if’

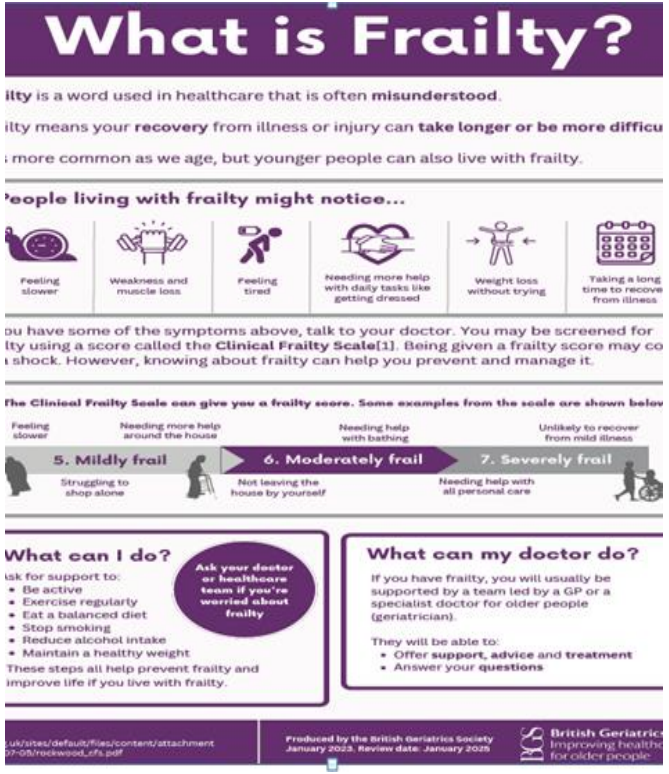
- Provides focus.
- Learning from others.

- Rolling programme.
- National focus on ageing well.

DUMFRIES AND GALLOWAY
Health and Social Care

Tests of change – Early identification and proactive planning

- Rockwood clinical frailty scale training was cascaded to community health and social care partnership staff.
- Links to additional frailty training modules were also included.
- A form and patient information leaflet were also developed for the individual's frailty scores to be recorded on.
- The form is visible under a frailty folder on our clinical portal.



What is Frailty?

ilty is a word used in healthcare that is often **misunderstood**.

ilty means your **recovery** from illness or injury can **take longer or be more difficu**

more common as we age, but younger people can also live with frailty.

eople living with frailty might notice...

Feeling slower | Weakness and muscle loss | Feeling tired | Needing more help with daily tasks like getting dressed | Weight loss without trying | Taking a long time to recove from illness

ou have some of the symptoms above, talk to your doctor. You may be screened for lty using a score called the **Clinical Frailty Scale**[1]. Being given a frailty score may co shock. However, knowing about frailty can help you prevent and manage it.

he Clinical Frailty Scale can give you a frailty score. Some examples from the scale are shown belov

Feeling slower | Needing more help around the house | Needing help with bathing | Unlikely to recover from mild illness

5. Mildly frail — Struggling to shop alone

6. Moderately frail — Not leaving the house by yourself

7. Severely frail — Needing help with all personal care

What can I do?

sk for support to:

- Be active
- Exercise regularly
- Eat a balanced diet
- Stop smoking
- Reduce alcohol intake
- Maintain a healthy weight

Ask your doctor or healthcare team if you're worried about frailty

These steps all help prevent frailty and improve life if you live with frailty.

What can my doctor do?

If you have frailty, you will usually be supported by a team led by a GP or a specialist doctor for older people (geriatrician).

They will be able to:

- Offer **support, advice** and **treatment**
- Answer your **questions**

.uk/sites/default/files/content/attachment 07-05/rockwood_cfs.pdf

Produced by the British Geriatrics Society January 2023. Review date: January 2025

British Geriatric Improving health for older people

Tests of change – So what and next steps

- The form contains suggested next steps for all scores.
- The patient information leaflet titled “Keep Fit, Keep Well” is to be provided to all patients when the Rockwood is completed.
- A Rockwood prompt card for staff badges.

“My knowledge of frailty has increased”

“I think this is a fantastic tool for our home teams to be using”

DUMFRIES AND GALLOWAY
Health and Social Care

Tests of change – early identification and proactive planning

- Realistic medication management.
- Established tools - 7 steps of polypharmacy, realistic clinical conversations and clinical tools.
- Deprescribing trend with 25% of deprescribed medications having a high anti-cholinergic burden in an elderly cohort.

<u>Future steps</u>

- Collaboration with geriatricians.
- Scale and spread.

DUMFRIES AND GALLOWAY Health and Social Care

Tests of change - transition in care and ageing well

- Geriatrician advice line.
- Ageing well toolkit.

https://rightdecisions.scot.nhs.uk/ageing-well-in-development/

DUMFRIES AND GALLOWAY Health and Social Care

Final thoughts

- We are focused on frailty and ageing in D&G.
- Further connections with related programmes required locally and nationally.
- Continue to network.
- National public communication on ageing well.
- Rolling frailty and ageing well programme.

DUMFRIES AND GALLOWAY
Health and Social Care

Healthcare Improvement Scotland

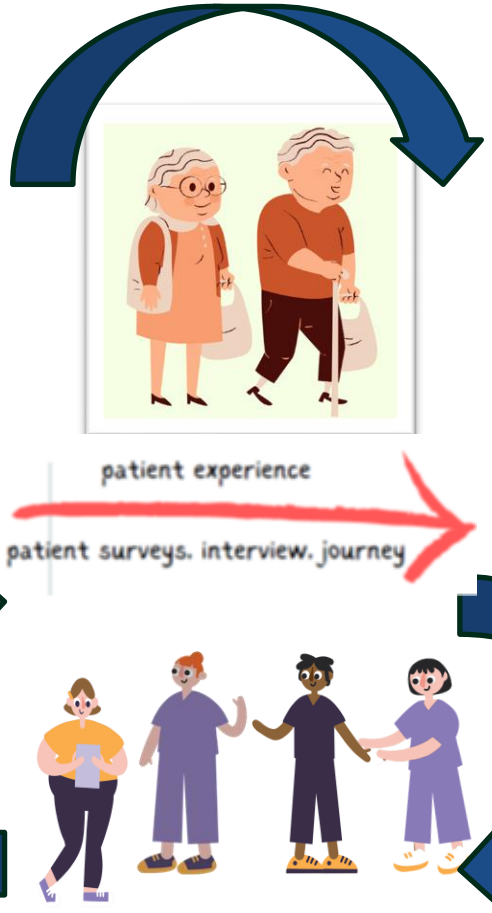
NHS Tayside

Perth and Kinross HSCP and NHS Tayside

Perth and Kinross frailty collaborative
May 2023 - Nov 2024

Consultations

- Support for vulnerable groups.
- System issues.
- Communication and information.
- Mental health and wellbeing.
- Quality of care.



Elderly of P&K

- Ageing well.
- Identify frail elderly.
- Community follow up discharge.
- Future care planning.
- Engagement.
- Support for carers.

Priorities of the project

- Identification and documentation of frailty in hospital and community.
- Education of staff.
- Transfer of information into community.
- Post hospital follow up.

Motivations staff

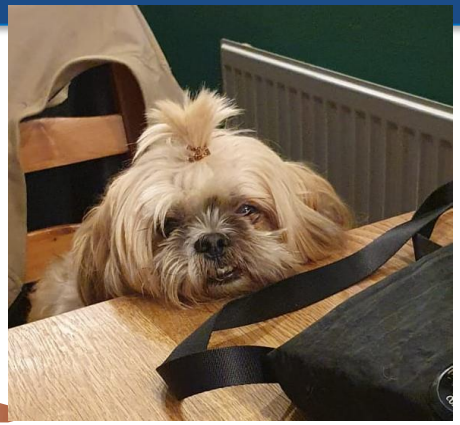
- Integrated working.
- Roles and responsibilities clear.
- Person centred planning.
- Discharge planning.
- Education and training frailty.
- Transitions of care.
- Carer support.
- Clinical Care Standards.

Frailty education and simulation sessions

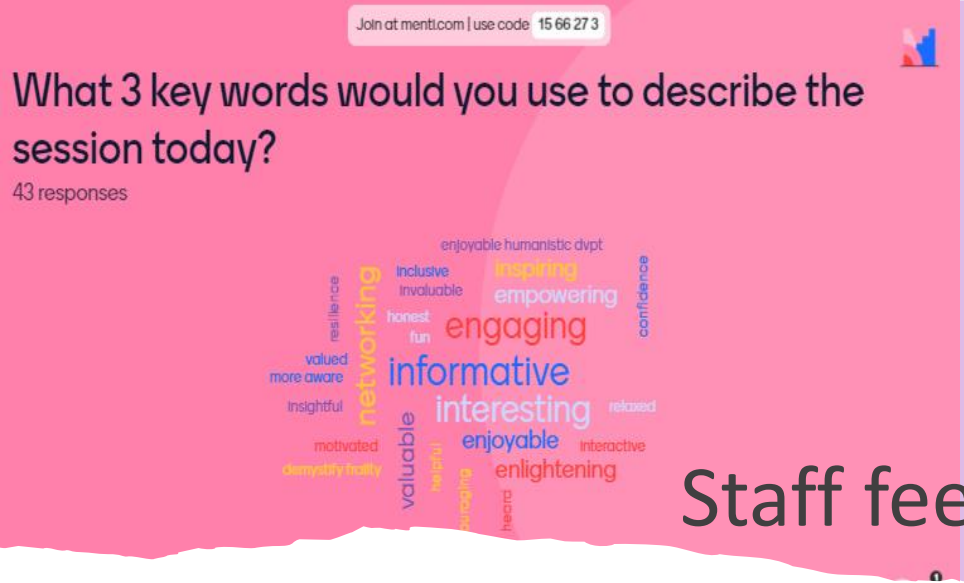
Health and Social Care staff

Betty Boo! and Henry Hops

Dr Julie Mardon, Clinical Director Simulation



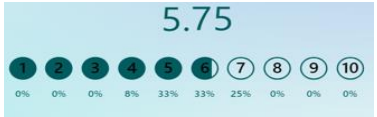
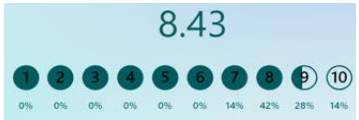
HART team



Staff feedback

- Existing confidence recognising frailty using simulation.
- Enhanced observational skills; human connections.
- Appreciation of integrated multidisciplinary working.
- Learning about the world of others in HSCP.
- Change of mindset, permission to work differently.
- We can all have a future care planning conversation.
- Areas for improvement: reduce multiple care plans, decrease delays in system, require staff directory of services.

Evaluation of simulation sessions

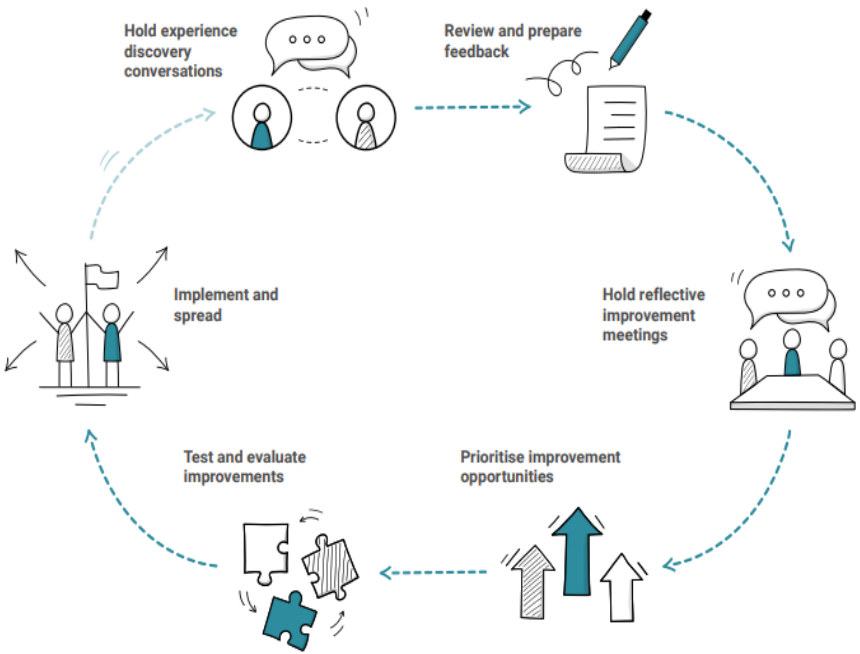
	Before - Level of knowledge and confidence Scale 1-10	After - Level of knowledge and confidence Scale 1-10	
Knowledge about frailty			Knowledge about frailty
Knowledge identifying frailty			Knowledge identifying frailty
Confidence identifying and assessing people at risk of frailty			Confidence identifying and assessing people at risk of frailty
Identifying and assessing people at risk of falling			Identifying and assessing people at risk of falling
Recognising a deteriorating person becoming unwell			Recognising a deteriorating person becoming unwell
Confidence responding to a person who is becoming unwell			Confidence responding to a person who is becoming unwell

Most impactful improvement – coordinator/key worker

- Keep people out of hospital.
- What matters to the person – RESPECT conversations.
- Treated at home.
- Medication follow up.
- Communicating and linking with community teams to respond to person on discharge.
- Support for carers and family.
- Learning between acute and community teams and outcome for patients.
- Influenced way ahead for P&K.

- Gaps in education identified.
- 78 patients sampled Feb-Aug 24 (huge resource of care).
- Business unit March 24-Aug 24, overall 38 patients readmitted within Tayside within 7 days as emergency.
- From April 2024- 100% coordinator allocated to follow up actions with MDT members.
- Follow up bloods, medication reviews, DN visits, SW review, welfare checks, FCP, carers support, catheter, psychiatry, respiratory.
- 87% had CFS, 38% CFS was shared in EDD on discharge.

Patient and family stories – co-production health and social



Case note reviews of journey:

- Identified missed opportunities – referrals to LINCS pathway, managing carers expectations of discharge.
- Avoided crisis from happening due to coordinator.

CEIM (Care Experience Improvement Model)

Themes identified:

- Carers support required.
- Future care planning.
- Better communication needed.
- Medication changes not known.
- Lack of follow up.
- Multiple people involved.
- Compliance aids/equipment required.

Betty Boo's story and **L**ocality **In**tegrated **C**are **S**ervice

83yr lady
Atraumatic knee pain

Husband with dementia drove her to A&E - vulnerability

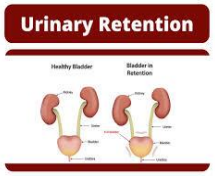
Knee replacement

Short admission and discharge

Complications

2 falls

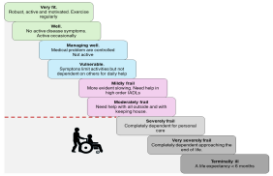
Diarrhoea



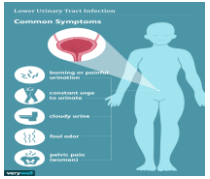
Urinary retention

Escalation

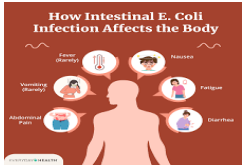
Referred **LINCS for MDT triage**



Assess/manage frailty



Urine infection



MSSU E-coli detected

Toilet transfer assessment / equipment

Advised firmer edged mattress

Neighbours supportive

Community alarm declined prior / re-requested

Improvements – communication and information

Patient unclear about advice from orthopaedics about post discharge rehabilitation

Mobility almost back to baseline

CFS score 4

Disliked label 'Acute Frailty Unit'

Unaware of common side effects of meds

No recall of receipt EDD

Who to contact and when for complications?

EDD could have signposted contacts for seeking advice

Would have liked written info as not retained from verbal method in hospital

Info re risks of meds, delirium, UTI, frailty

Patient identified as frail by **LINCS** for community

LINCS focus lessens risk of readmission

LINCS focus aim to reverse frailty

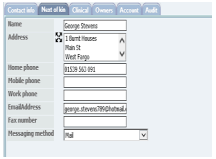
LINCS actioned for missed opportunities

Key safe on health / social care systems

Multifactorial falls assessment advising on reducing trip hazards

Good footwear

Regular eyesight checks



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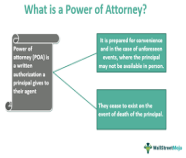


Advice on POA given

Signposting of where to seek wider information

Health and social care services – validation of need and support available

Co-dependency

Who to contact if unable to care for husband

Written info provided next to telephone

Key learning

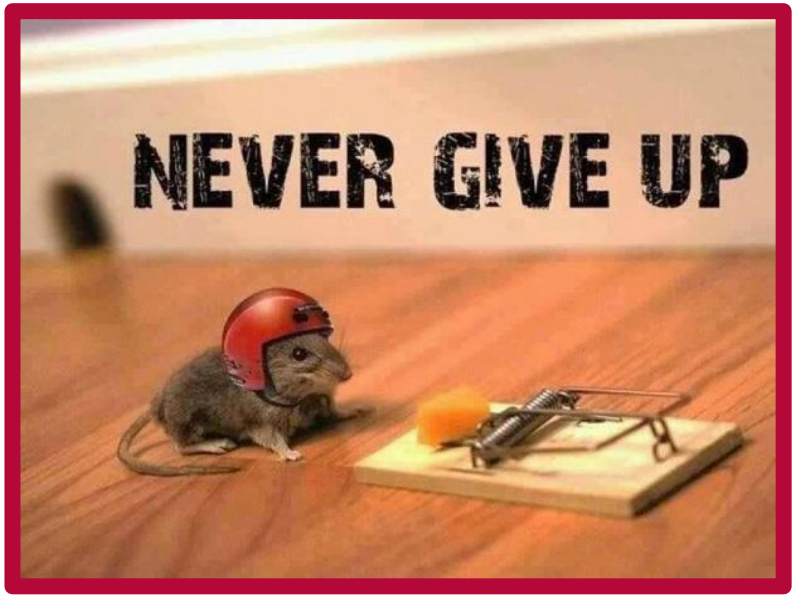
Quality improvement is HARD → Learning about QI on the project → Leadership and buy-in are fundamental

↓

Won people over by testing and showing the realities → Improvement requires commitment , resilience, tenacity, persistence, and flexibility → Embedding change and spreading is of high importance but HARD

↓

Influenced older people's transformation programme Perth and Kinross → Better integrated working → Recognition of teams' right thing to do for our patients



CO-ORDINATOR ROLE: RIGHT PERSON, RIGHT TIME AND RIGHT PLACE

Key learning

- Doing “what matters to the person”
- Developing vision and belief
- Understanding existing capacity and capability
- Focus smaller, one thing e.g. CFS, whole person journey versus frailty score
- Understanding of role and responsibilities of other teams in H&S e.g. HART team
- Build and support staff for wrap around, trusted assessor
- Streamlined referral processes, by having a coordinator
- Carers involvement in planned discharge

COORDINATOR ROLE: RIGHT PERSON, RIGHT TIME AND RIGHT PLACE

The Good, the Bad and the Ugly!!!

- Data doesn't always reflect **efforts** of project team.
- **Balance evidence** of change through measurement and **priorities of roles.**
- Readmission **data long time to obtain.**
- Readmission data for PRI **doesn't reflect** coordinator role.
- **WILL TAKE US TIME TO CHANGE OUTCOMES.**
- **Sampling small** for readmissions in AFU.
- Person dependent **require presence,** engagement of support for the teams to embed.
- Quantitative data –number patients **allocated** to a co-ordinator and follow up.

- **Actions FOLLOWED UP less measurable** – qualitative.
- Identification of clinical frailty score on admission and comprehensive geriatric assessment **not documented. Revisit.**
- Requires creative ways of **handover across services.**
- Electronic Discharge Document communications **potential for additions** like future care planning and elements of CGA.
- EDD bundle –**variable inclusion** of info by FYs.
- EDD test **person dependent.**
- **Sustainability** of systems and processes required.

CO-ORDINATOR ROLE: RIGHT PERSON, RIGHT TIME AND RIGHT PLACE

Challenges

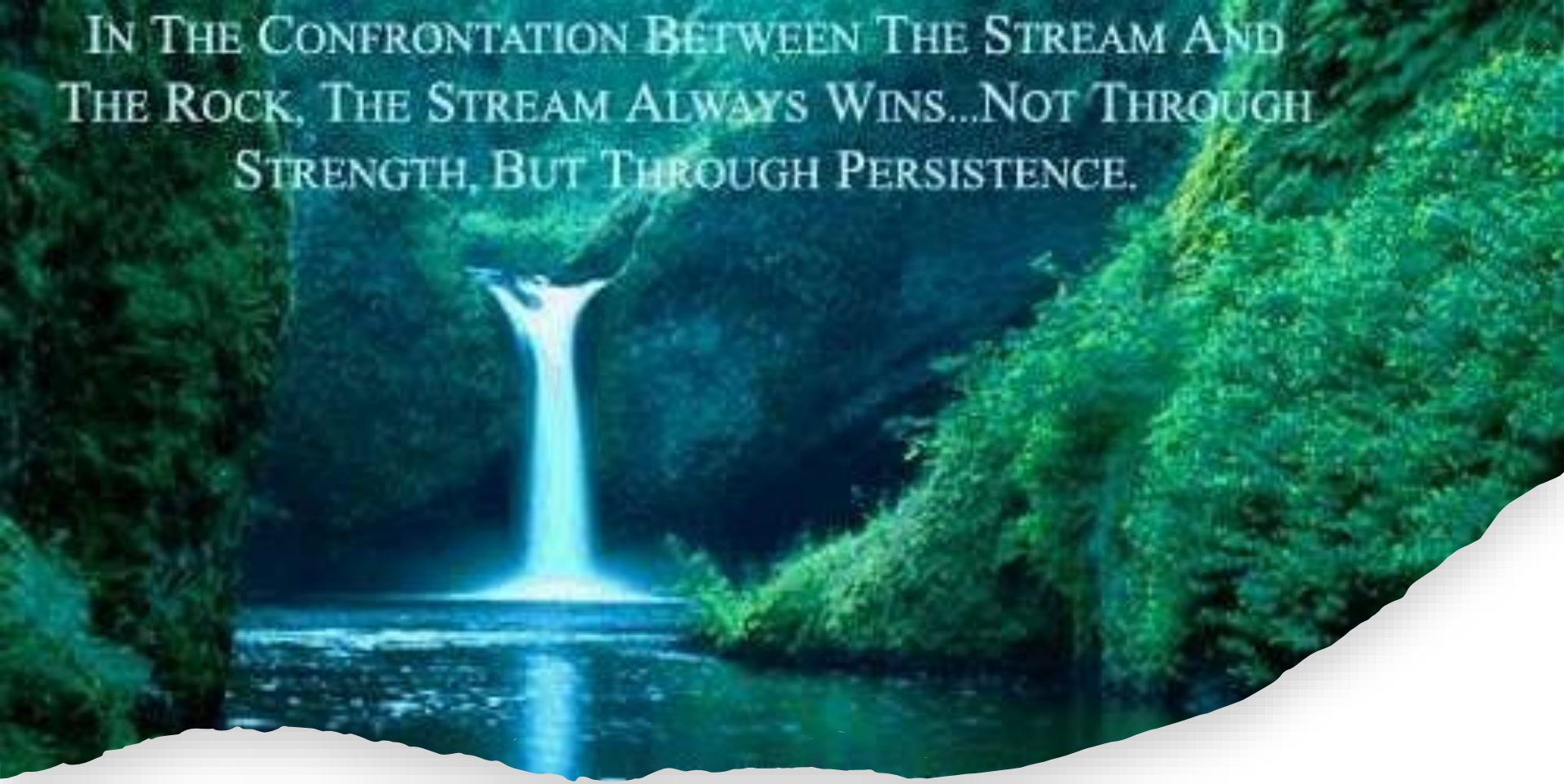
- Managing change - people/culture.
- Balancing national and local drivers vs improvement.
- Building capacity/capability for improvement.
- Resources to spread changes, work differently.
- Role and responsibilities.

- Hearts and minds of staff.
- Demand vs supply on service.
- Changing structures P&K.
- Leadership and resilience.
- Sustainability of changes.
- Ageing and frailty standards.

CO-ORDINATOR ROLE: RIGHT PERSON, RIGHT TIME AND RIGHT PLACE

What next?

- Spread the learning. More focus in community across 3 localities
- ANP role development to provide clinical leadership in PRI
- Improve communication across wards and AFU in PRI to ensure CFS shared-revisit staff education
- Unpaid carer information to be tested
- Simulation offered across P&K staff-HART team supporting
- Continue testing improvements based on stories and journeys
- Sharing events– celebrating Tayside, ageing and frailty board, senior management team P&K
- National simulation network
- PKHSCP frailty MCN
- Keep going!


In The Confrontation Between The Stream And
The Rock, The Stream Always Wins...Not Through
Strength, But Through Persistence.

Thank you for listening!!!!

Thanks to our project team!

Project team

Careen Mullen McKay, Nurse Consultant
Sal Peterson, Lead General Practitioner
Deirdre Cameron, Improvement Advisor
Monica Thomson, Clinical Coordinator, LINCS
Sarah Simpson, Researcher/Project Manager
Gemma Porter, Frailty Nurse
Amy McGregor, Lead Advanced Nurse Practitioner
Heather Nairn, Trainee Nurse Practitioner
Sam Dean, Lead Advanced Nurse Practitioner
Donna Clark, Consultant Physician
Andreea Paius, Policy and Commissioning Officer
Valerie Riddell, Team Leader, Social Work
Allison Gallacher, Business Improvement Officer
Sharon Johnstone, Senior Nurse

Healthcare Improvement Scotland

NHS Ayrshire & Arran

NHS Ayrshire and Arran and South Ayrshire HSCP

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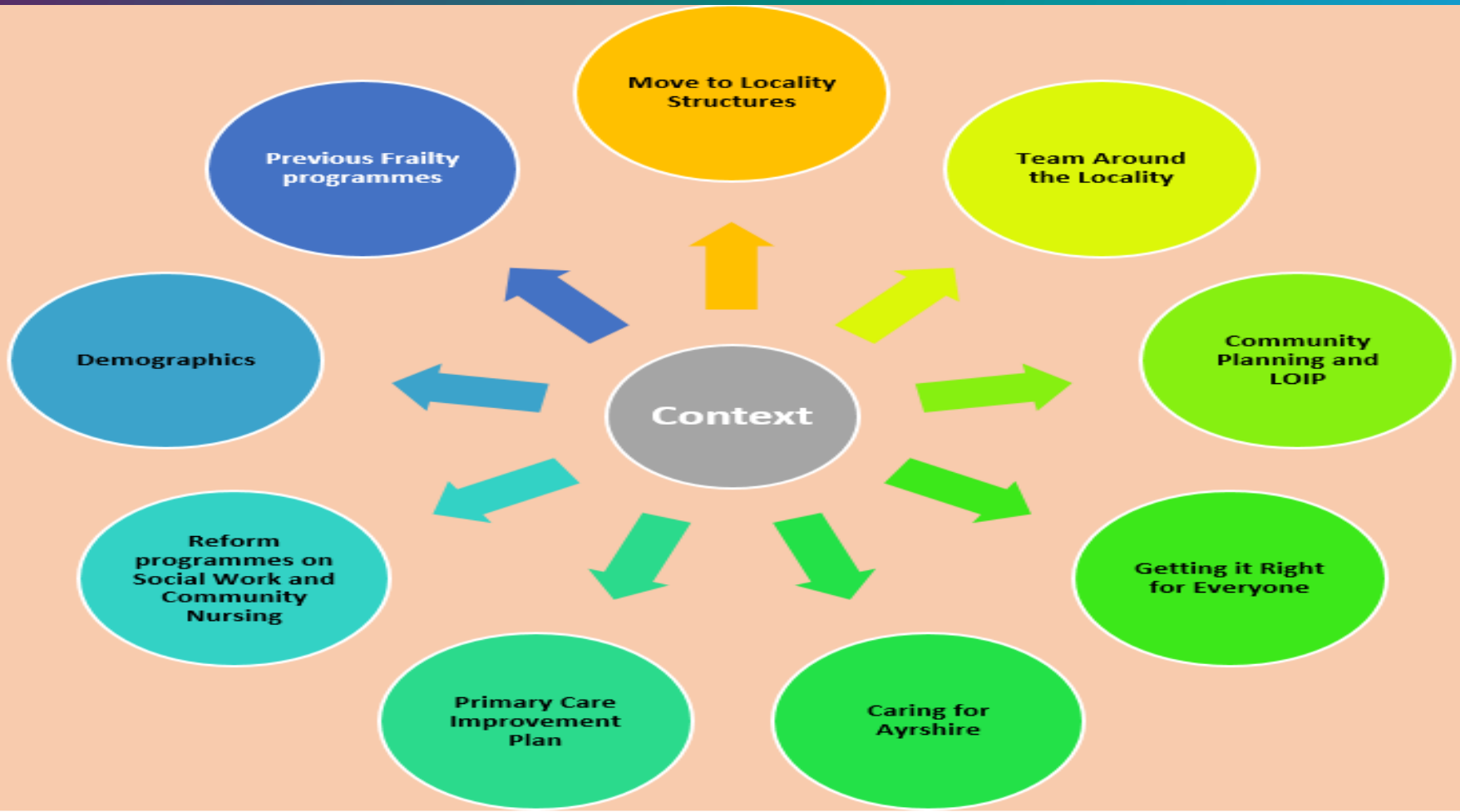
Goals

The discrete Focus on Frailty element formed part of a broader approach to consider frailty across the whole health and care system.

This included the development of population health approaches, preventative and early intervention work, work within and linked to frailty as presenting at GP Practices and in community health services and acute based work.

Due to the scope involved, there was a more focused aspect concentrating on more bounded work around the Troon and Dundonald locality, with the intention to roll out across all six South Ayrshire localities.

Context


Move to Locality Structures
Previous Frailty programmes
Team Around the Locality
Demographics
Context
Community Planning and LOIP
Reform programmes on Social Work and Community Nursing
Getting it Right for Everyone
Primary Care Improvement Plan
Caring for Ayrshire

'Quality is Everyone's Business'

south ayrshire health & social care partnership

NHS Ayrshire & Arran

Driver Diagram

SAHSCP Focus on Frailty

Aim / Outcome

Through early identification and assessment of frailty, more people aged over 65 in South Ayrshire HSCP, who are living with or at risk of developing frailty will have improved Healthy Life Expectancy and improved access to and experience of person centred and co-ordinated health and social care services

By December 2024, through early identification and assessment of frailty, 30% of people aged over 65 registered with Troon and Dundonald General Practices, who are living with or at risk of developing frailty will have improved access to and experience of person centred and alternatives to co-ordinated health and social care services

Primary Drivers

1. Places, spaces and communities that are supporting people to thrive
2. Early identification and assessment
3. Proactive, co-ordinated and person-centred community health and social care
4. Holistic acute care when needed
5. Leadership and culture to support integrated working

Drivers

- Age friendly communities
- Ageing well strategy in CPP
- Able to access places and spaces which are inclusive, safe and accessible

- Locality based wellbeing networks
- Ahead of the Curve
- Improved integrated working within Health and Social Care teams
- Digital technology
- Access to information, advice and support

- MDT around the GP Practice and locality
- Robust referral pathways
- Early as possible support in health and care journeys
- Competencies, supervision and training
- Information sharing
- Full hollistic early assessment of frailty within Care Homes/General Practice carried out by a DN who is operating at an advanced level
- ReSPECT (CNR Programme)

- Integrated and clear acute arrangements and pathways throughout hospital journeys

- 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

Change Ideas for Testing

Continue South Ayrshire as WHO Age Friendly community
Continue development of OP engagement through Champion's Boards (including Troon Board)
Develop Troon front door Connect shop front along with VASA and others
Include redesigned Social Work front door as part of the Connect shop front
Develop and disseminate public facing Frailty leaflet setting out 'offer'

Pilot groups on falls prevention, Wellness Recovery Action Plan, stress management

Develop written and online resources on Frailty for professionals, and members of the public

Pilot a Frailty training package in one area.

Develop well-being review based on HIS Frailty indicators and the comprehensive geriatric assessment.

Develop training on frailty

Pilot the EFi as a method of identifying individuals for the Frailty pathway

Preferred place of care/FCP/SMP

Develop frailty cohort model at front door with frailty MDT

Sharing learning through HIS Frailty learning system
Celebrating success
Process to share information between teams and services
Engagement with Team around the Person Journey maps

Degree of frailty

e-Frailty Index	Rockwood clinical frailty scale	
Fit	**1. Very fit** – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.	
	2. Well – People who have no active disease symptoms but are less fit than category 1. Often, they exercise or are very	
	3. Managing well – People whose medical problems are well controlled, but are not regularly active beyond routine walking	
Mild frailty	**4. Vulnerable** – While not dependent on others for daily help, often symptoms limit activities. A common complaint is being "slowed up", and/or being tired during the day.	
	5. Mildly frail – These people often have more evident slowing, and need help in high order IADLs (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.	
Moderate frailty	**6. Moderately frail** – People need help with all outside activities and with keeping house. Inside, they often have problems with stairs and need help with bathing and might need minimal assistance (cuing, standby) with dressing.	
Severe frailty	**7. Severely frail** – Completely dependent for personal care, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).	
	8. Very severely frail – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.	
	9. Terminally ill – Approaching the end of life. This category applies to people with a life expectancy <6 months, who are not otherwise evidently frail.	

Population level, primary prevention
Ageing Well Strategy
Age Friendly Communities

Early intervention and link to community resources

Proactive Co-ordinated Community based care

- **Primary Care OT led assessment and wider MDT interventions. Use of eFrailty tool**
- **Care at Home staff supported to recognise change in frailty status and refer to services**
- **Community based services stopping admission such as H@H and ICT, Step Up beds, etc**
- **Future care planning for severely frail – for example care home residents – and reducing inappropriate hospital use**

Holistic hospital care when needed

International Day/week of Older Persons

Ageing Well in South Ayrshire

South Ayrshire COMMUNITY PLANNING Partnership

We are committed to building a grassroots movement to create opportunities for healthy ageing in South Ayrshire that is owned and supported by all sectors and players being led by our local Community Planning Partnership. We want communities where:

- People are enabled to live actively, purposefully and independently and to contribute within their communities.
- Older people are respected, listened to and celebrated with maximum choice and control about how they live their lives.
- Barriers to healthy and active living are removed and older people are enabled to flourish.
- Older people are integral to the whole lives of communities and where there is good connection with older people from all generations.
- We support people as early in their health and care journeys as possible to help prevent poor health as they age.
- Information, advice and support is made available in different ways, to allow everyone to feel informed and equipped to live lives as they wish.
- The voice of older people informs the way services are provided and where the health and care services that support our older people are formed around their needs and their perspectives.
- We foster a culture of partnership rather than dependency.
- Age is not seen as a barrier to living vital and productive lives.
- Older people have access to supportive social friendship networks and groups as much as they wish to or require.
- We utilise technology of all sorts to enable a ageing well community.
- We proactively support older people's wellbeing, both physical, mental, emotional, social and spiritual.
- Places and spaces are inclusive, safe and accessible.

Working together to make South Ayrshire the best place in Scotland to live and age well.

At the early stage part of the frailty journey this work has included:

- early preventative approaches in community settings,
- attendance at local mass vaccination clinics (really successful with self referrals received at each clinic),
- use of Functional Fitness MOT,
- pro-active falls prevention group,
- use of self-assessment frailty resource.

This is an amazing service, it's great that you are here talking to people. Health services need to go and find people in their communities.
(Nurse at vaccination clinic)

Comments from Ayr United Functional Fitness MOT session

" I felt reassured that I was as fit as I thought I was, as have been keeping active and it was nice to see this being measured in some way, just for my own peace of mind."

" A really good event, lovely staff and everything was explained to me, so I knew what to expect. I would recommend this to anyone."

"It was fantastic to have a service brought into the community so I don't have to travel to a GP or hospital to do this. I have been pleased by the results of the exercises that I am actually doing OK for my age."

"It was a very well run event. The information has helped me recognise I wasn't quite as strong as I could be and I need to do something about it. I wouldn't have known this as tend not to go to my GP."

" Just wonderful! The people were so nice and it was really enjoyable. I would love to do this again!"

Feeling more confident since coming along and haven't fell since started

A lot more confident, less dizzy. My leg strength has improved. Enjoy the social interaction too and always feel welcome

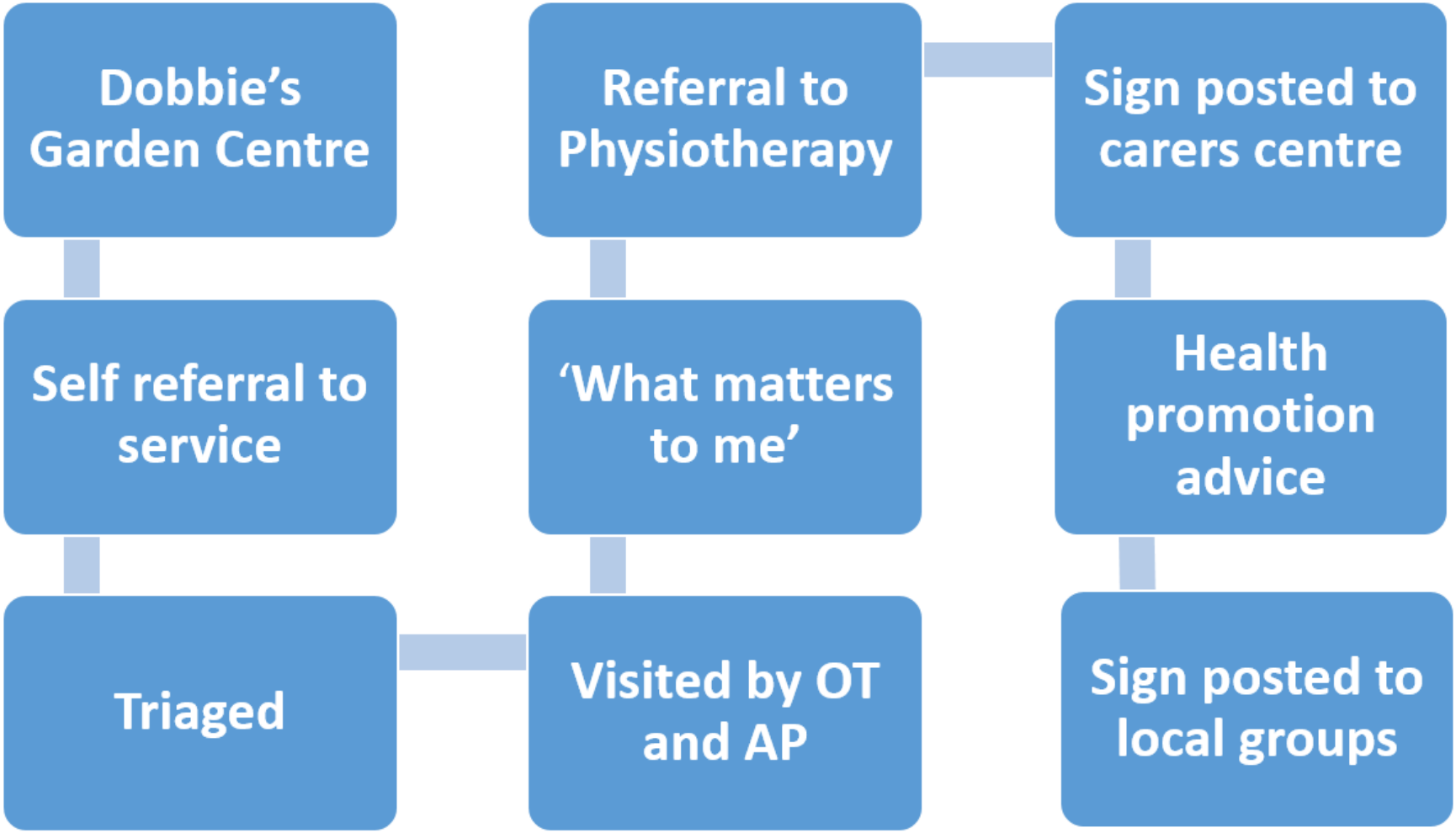
Walking has improved and my friends have commented on this. I feel better balanced when walking faster

Feel I have physically improved and don't feel like I am going to fall so much anymore

I also now do exercises at home

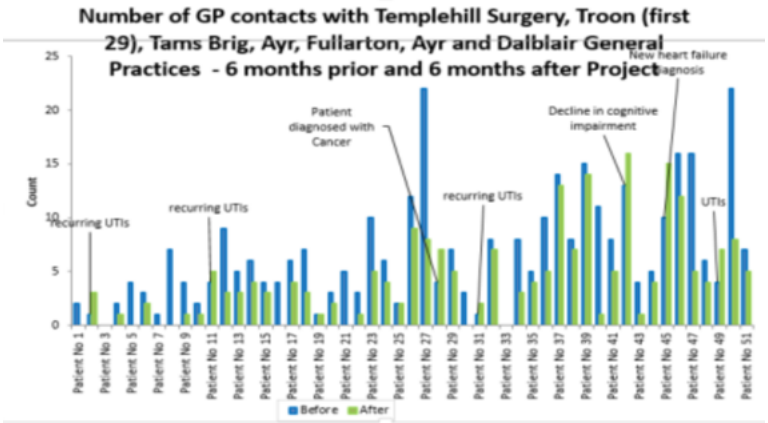
Definitely helped my confidence. I enjoy the company and the staff are so nice

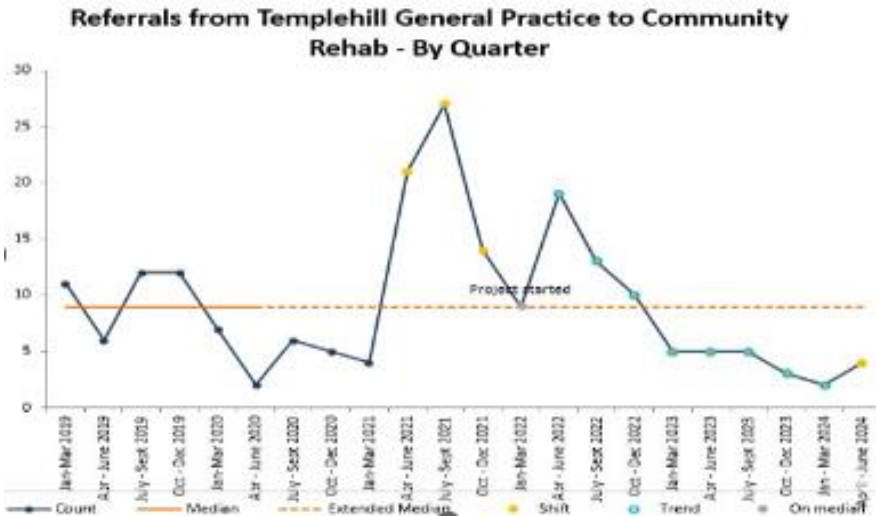
Feed back from Tesco Pro-Active Group
July – October 2024.


Dobbie's Garden Centre
Referral to Physiotherapy
Sign posted to carers centre
Self referral to service
'What matters to me'
Health promotion advice
Triaged
Visited by OT and AP
Sign posted to local groups

Tests of change

Using the eFrailty tool and having the Ahead of the Curve team in all GP practices following the initial pilot work, we can show impact using OT functional assessment tools.

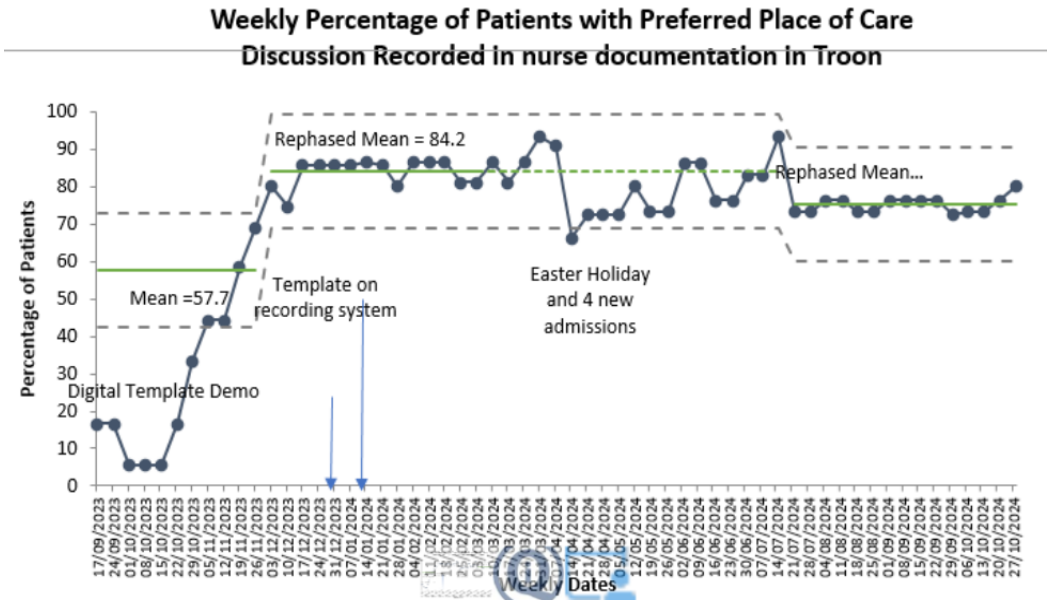




Tests of change

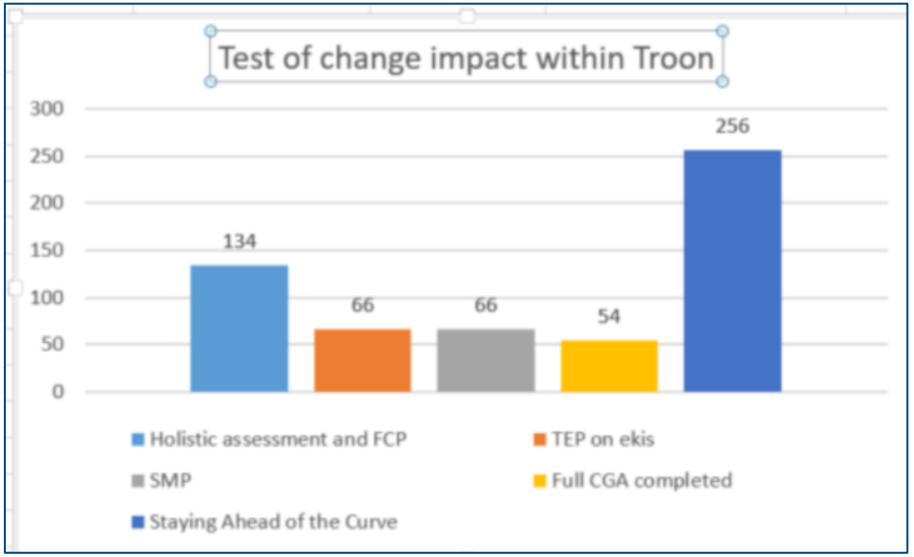
When people are at a more advanced stage of frailty, we have demonstrated impact through:

- comprehensive geriatric assessments,
- Future Care Planning,
- better MDT working, initially within Troon,
- preferred place of care.



Tests of change

By December 2024, through early identification and assessment of frailty, 30% of people aged over 65 registered with Troon and Dundonald General Practices, who are living with or at risk of developing frailty will have improved access to and experience of person centred and alternatives to co-ordinated health and social care services

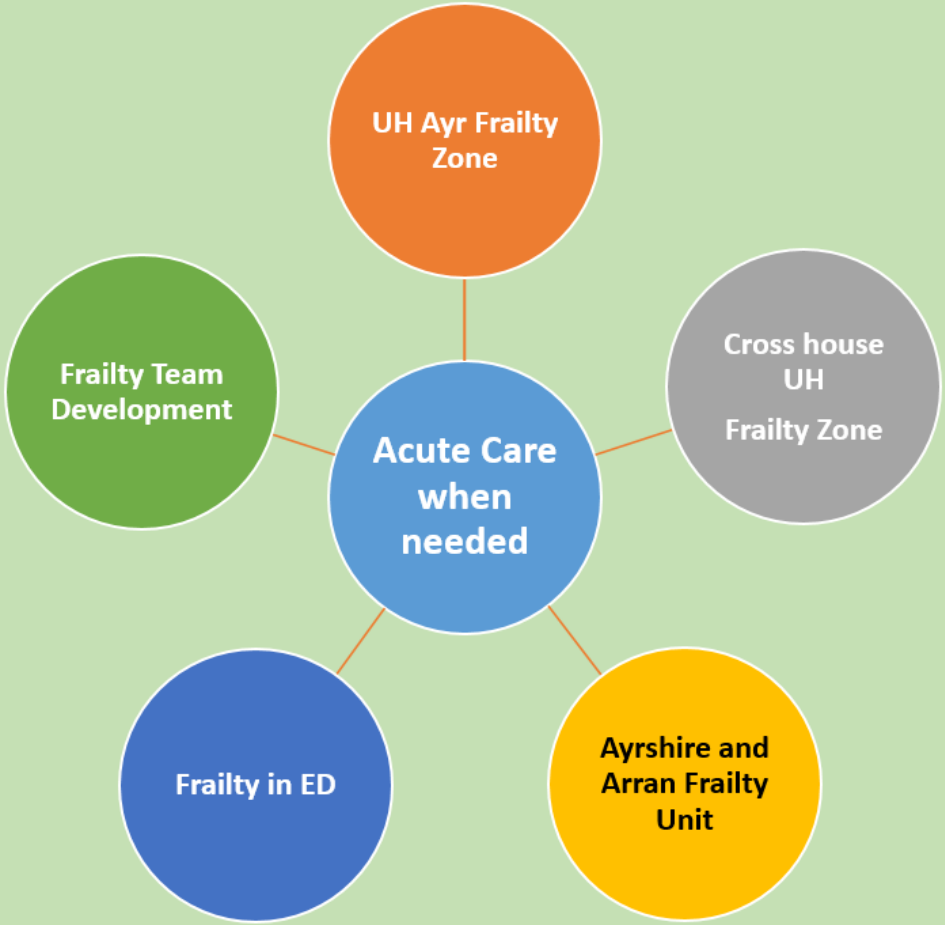


We are at 26%+ at present, so not far off aim within our driver diagram (30%).

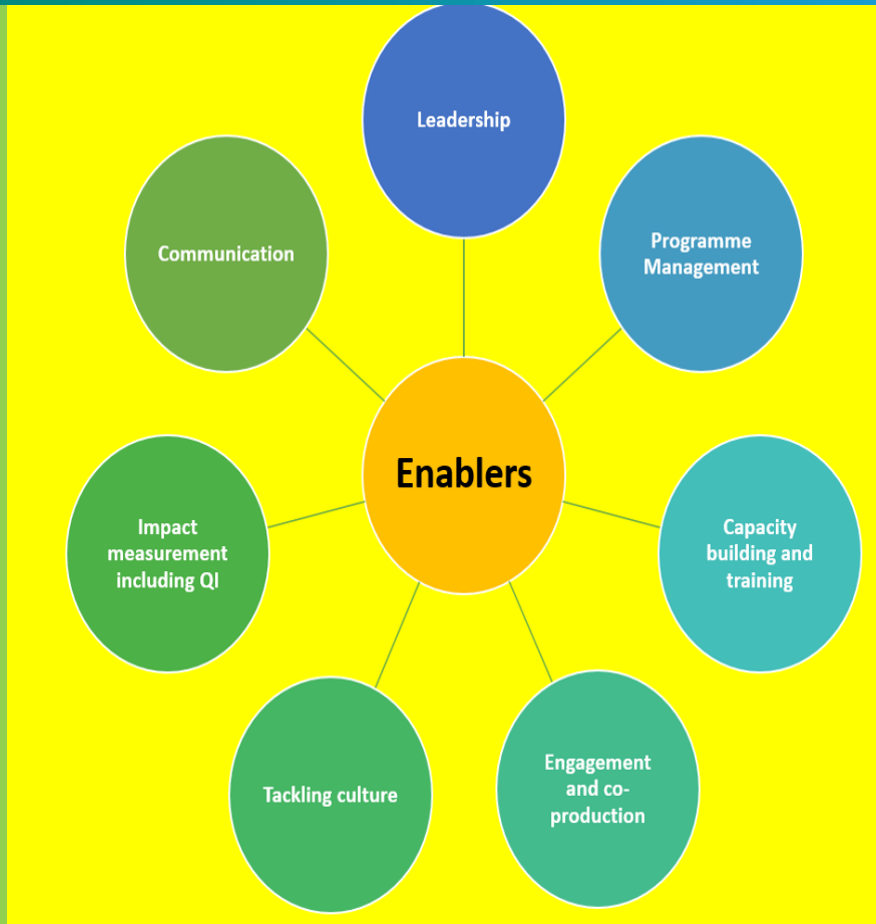
Patient story

Young adult with paraplegia -

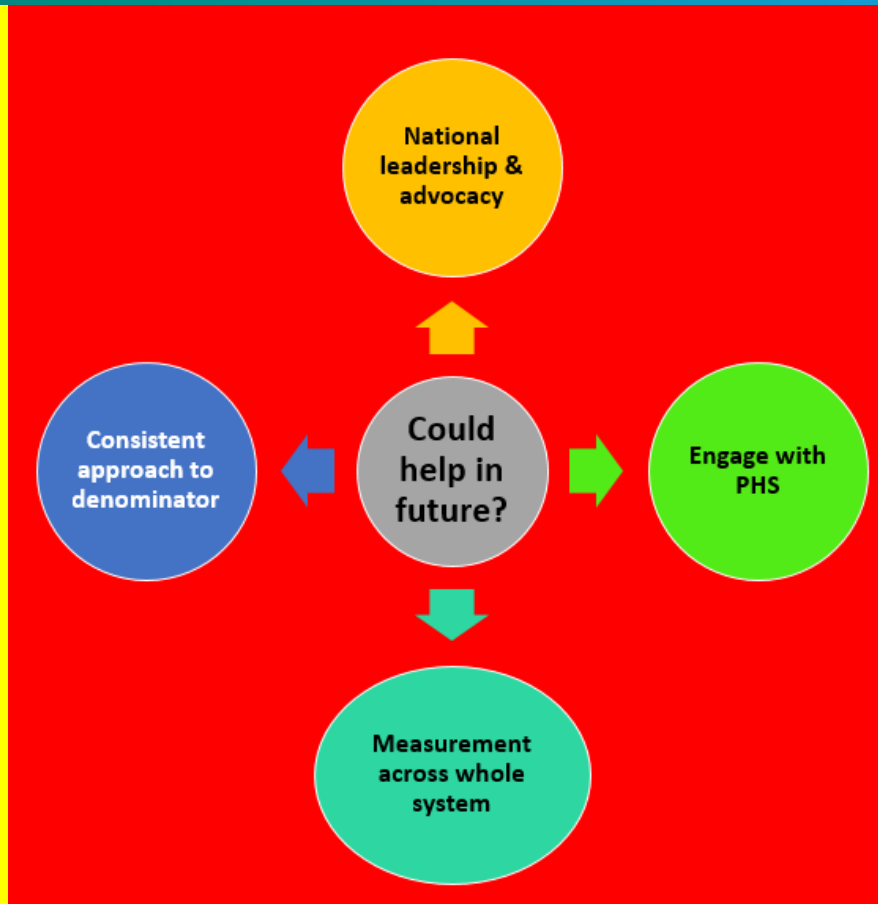
- History of drug and alcohol dependency and self-harm resulting in frequent attendance and admissions to hospital.
- 15 admissions/attendances for self-harm/seizures recorded during period May 2023-May 2024.
- Transferred to the care of the Troon MDT locality team in May 2024.
- Unable to manage daily living activities and finances, incontinent, poorly nourished, confined to home, no social interaction and estranged from family members and his child.
- Disengaged from health and social care professionals.
- MDT approach adopted.
- One 24 hour stay in hospital for treatment of possible sepsis.
- No longer confined to home, shops independently and enjoys cooking.
- In contact with family members and enjoys regular coffees with his father.


UH Ayr Frailty Zone
Frailty Team Development
Cross house UH
Frailty Zone
Acute Care when needed
Frailty in ED
Ayrshire and Arran Frailty Unit

Challenges and enablers



Support and learning



Final thoughts

We are proud of…

- Attempting to look at the whole system including upstream approaches.
- The local workers - for example, OTs, OTAs and community nurses, that have demonstrated real change within the whole programme.

Our advice would be…

- Whilst focus on small tests of change is positive, there is a need to think about the whole system in a coherent, articulated way along the lines of BGS joining the dots document.

Our next steps are…

- Taking stock session on 3 December 2024 to develop next iteration of our approach, particularly at locality level.

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HEALTH & SOCIAL CARE MORAY

NHS Grampian and Moray HSCP

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Goals

What were your goals in being part of the Focus on Frailty programme?

- Creating the conditions for a whole system frailty model.
- Early identification and assessment of frailty.
- Proactive integrated planning and management.
- Active engagement with the public in healthy ageing.
- Collaboration with the Digital Health Institute to maximise the potential for digital innovation.

Context

What is the context of your work?

- Realistic medicine model.
- Emphasis on early intervention and prevention.
- Frailty at the Front Door.
- Occupational therapists and physiotherapists eFI project.
- Occupational therapists working within GP practices across Moray as a test of change.
- Home First – including hospital without walls, discharge 2 assess and self-management.
- Unscheduled care pathway work.
- Frailty as a core component within all MDT's.

Challenges and enablers

What challenges and enablers have you encountered?

- Data – difficult to get i.e. lack of replacement for SPIRE.
- Current financial climate.
- Whole system working.
- Primary care/community - front door/secondary care.
- Strategic oversight group.
- Grampian frailty group/plan.

Support and learning

What programme support or learning has had an impact?

- HIS site visits.
- HIS point of contact.
- Webinars.
- Conferences.
- Cross over with other HSCPs.

Tests of change

- Making every opportunity count.
- Community appointment days.
- Pharmacotherapy.
- Identification of frailty – primary and secondary care.
- Frailty bundles.
- Education programmes for staff.
- PCOT – EQ5D and falls/frailty programme.
- Dedicated frailty ward.
- Digital Health Institute personal data store/community connections.

Measurement and outcomes

How do you know if the changes are an improvement?

- MEOC – lived experience data.
- Pharmacotherapy – patient medication, finance and care provision data.
- System barriers in acute setting – frailty bundle.
- Data for front door and primary care work – linkage of eFI and clinical frailty score.
- PCOT – 69% improvement, qualitative data.
- DHI – citizen and staff feedback.
- CAD – video.

Community appointment day video

[Community Day Patients - YouTube]


difficult to extract
data
manual extraction
measurement
resource heavy
mild
patients
eFI
not easy to find
hidden data
frailty score
outcome
resources
heavy
systems
rockwood
moderate
extraction
frailty
severe


data
systems
patients
difficult to extract
resources heavy
measurement
eFI
hidden data
outcome
manual extraction
resource heavy
frailty score
rockwood
moderate
not easy to find
frailty
severe
mild

Final thoughts

What final thoughts do you want to share about your journey in the Focus on Frailty programme?

- Whole system working and collaboration.
- Commitment of staff.
- D2A/START.
- Frailty icon.
- Frailty at the front door work.
- Pan-Grampian work – NHSG Frailty board.
- Digital Health Institute.
- GIRFE.
- PCOT – pain management and Tai Chi/Qigong (RCOT funding).

Healthcare Improvement Scotland

NHS Greater Glasgow and Clyde

NHS Greater Glasgow and Clyde, Glasgow Royal Infirmary

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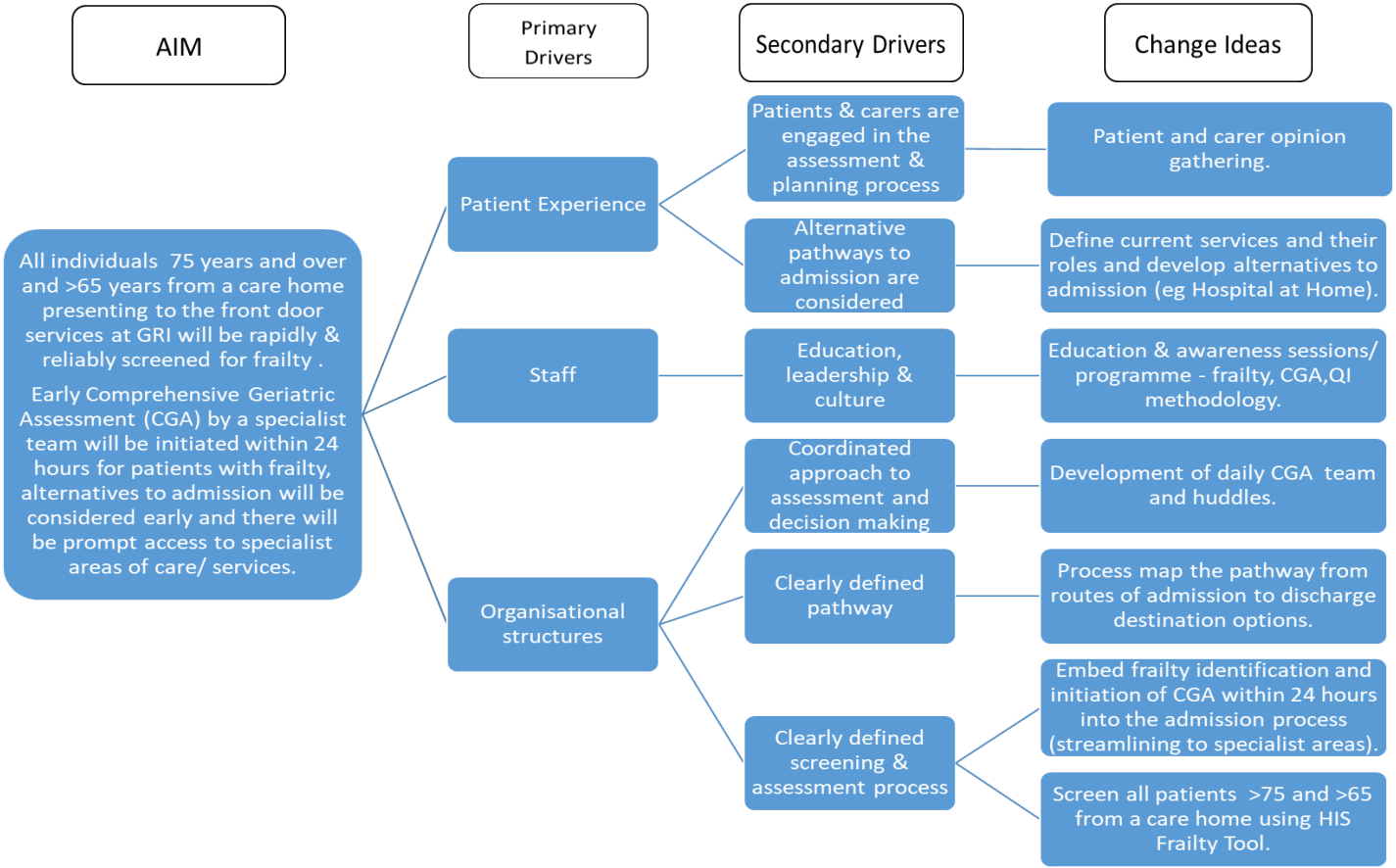
Goals

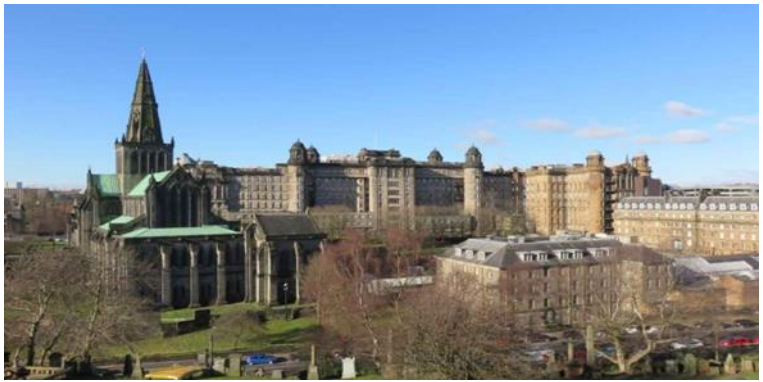

AIM
Primary Drivers
Secondary Drivers
Change Ideas
All individuals 75 years and over and >65 years from a care home presenting to the front door services at GRI will be rapidly & reliably screened for frailty .
Early Comprehensive Geriatric Assessment (CGA) by a specialist team will be initiated within 24 hours for patients with frailty, alternatives to admission will be considered early and there will be prompt access to specialist areas of care/ services.
Patient Experience
Staff
Organisational structures
Patients & carers are engaged in the assessment & planning process
Alternative pathways to admission are considered
Education, leadership & culture
Coordinated approach to assessment and decision making
Clearly defined pathway
Clearly defined screening & assessment process
Patient and carer opinion gathering.
Define current services and their roles and develop alternatives to admission (eg Hospital at Home).
Education & awareness sessions/ programme - frailty, CGA,QI methodology.
Development of daily CGA team and huddles.
Process map the pathway from routes of admission to discharge destination options.
Embed frailty identification and initiation of CGA within 24 hours into the admission process (streamlining to specialist areas).
Screen all patients >75 and >65 from a care home using HIS Frailty Tool.

Context

GRI

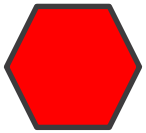
- North-East Glasgow
- 17 bedded acute receiving area
  - under different managerial control
  - no resident AHPs
- 3 ECANs (elderly care assessment nurses) in post
- 11 in-patient older people's wards
- Two off-site rehab hospitals
  - Lightburn Hospital
  - Stobhill Hospital
- Assessment and rehabilitation centres on both off-site locations.

- Many previous tests of change/ attempts to improve and develop service for older people with frailty
  - benefits demonstrated
  - changes not sustained or continued to progress for variety of reasons
  - appetite still there.

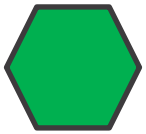


Context

All patients 75 and over are automatically assigned a black hexagon. Ideally also automatically for those 65 and over from a care home but some complex logistics with this.



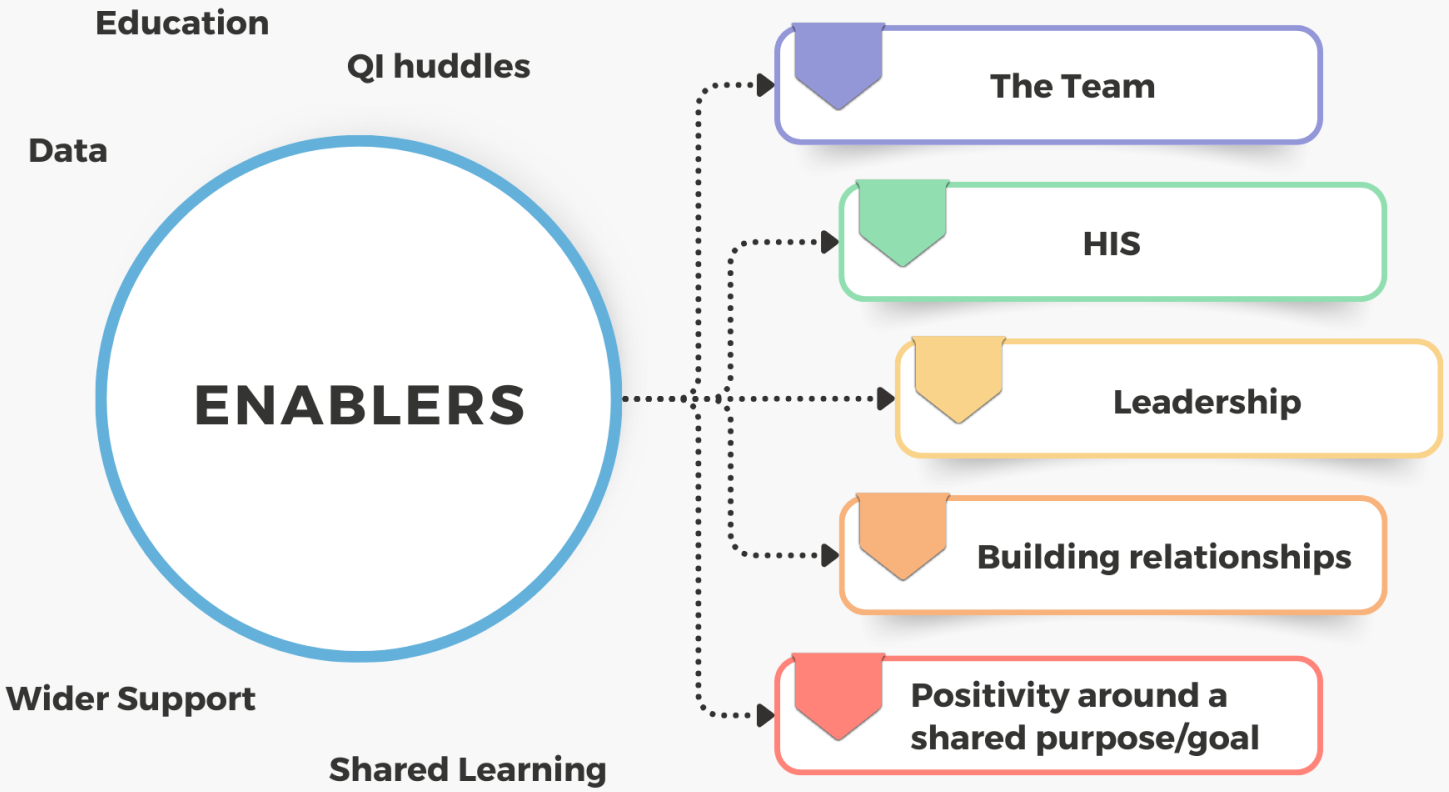
Patients with frailty but may require other specialty input initially (e.g stroke).



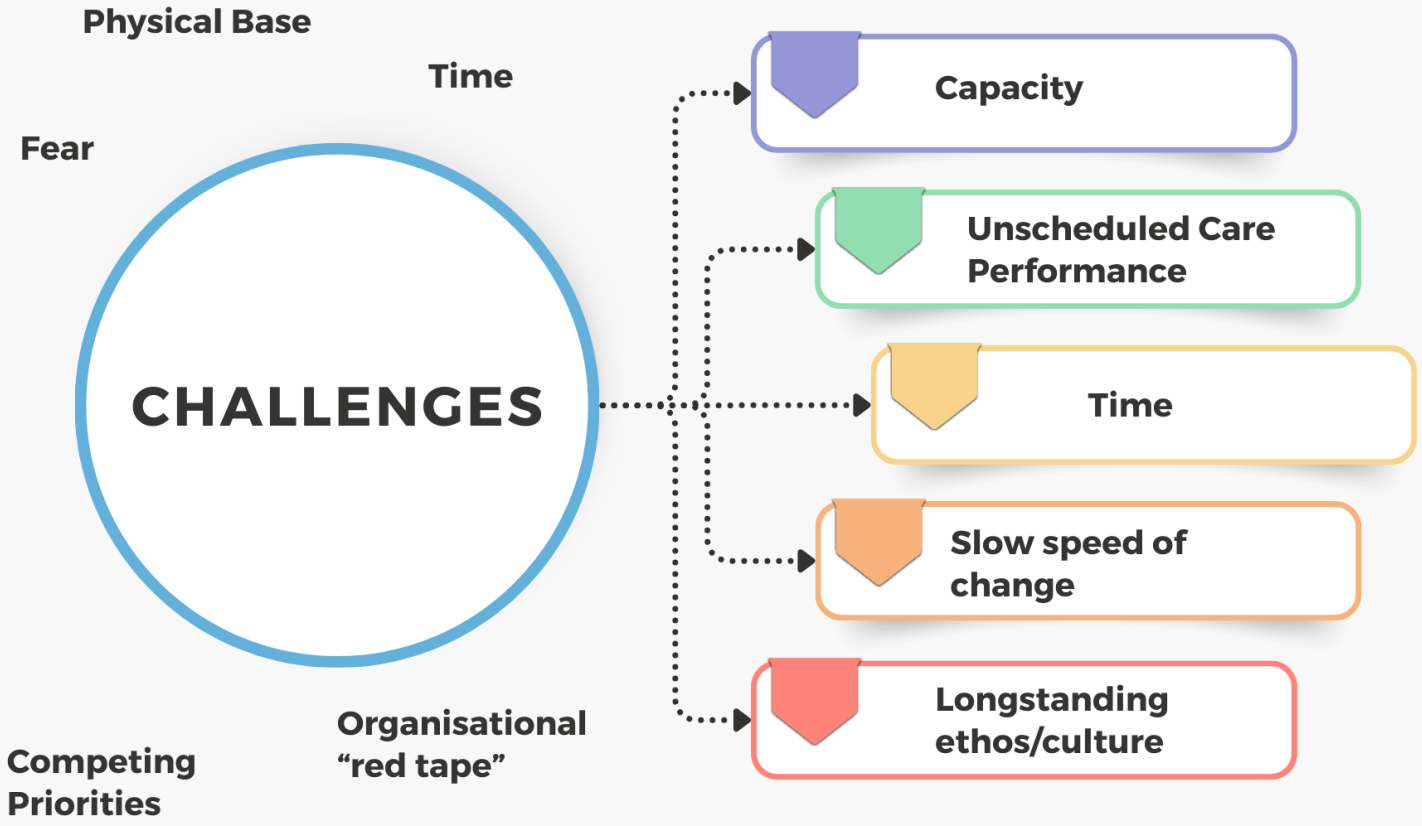
Patients with frailty, for CGA.

Patients 75 and over who are felt not likely to have frailty (icon disappears on trak).

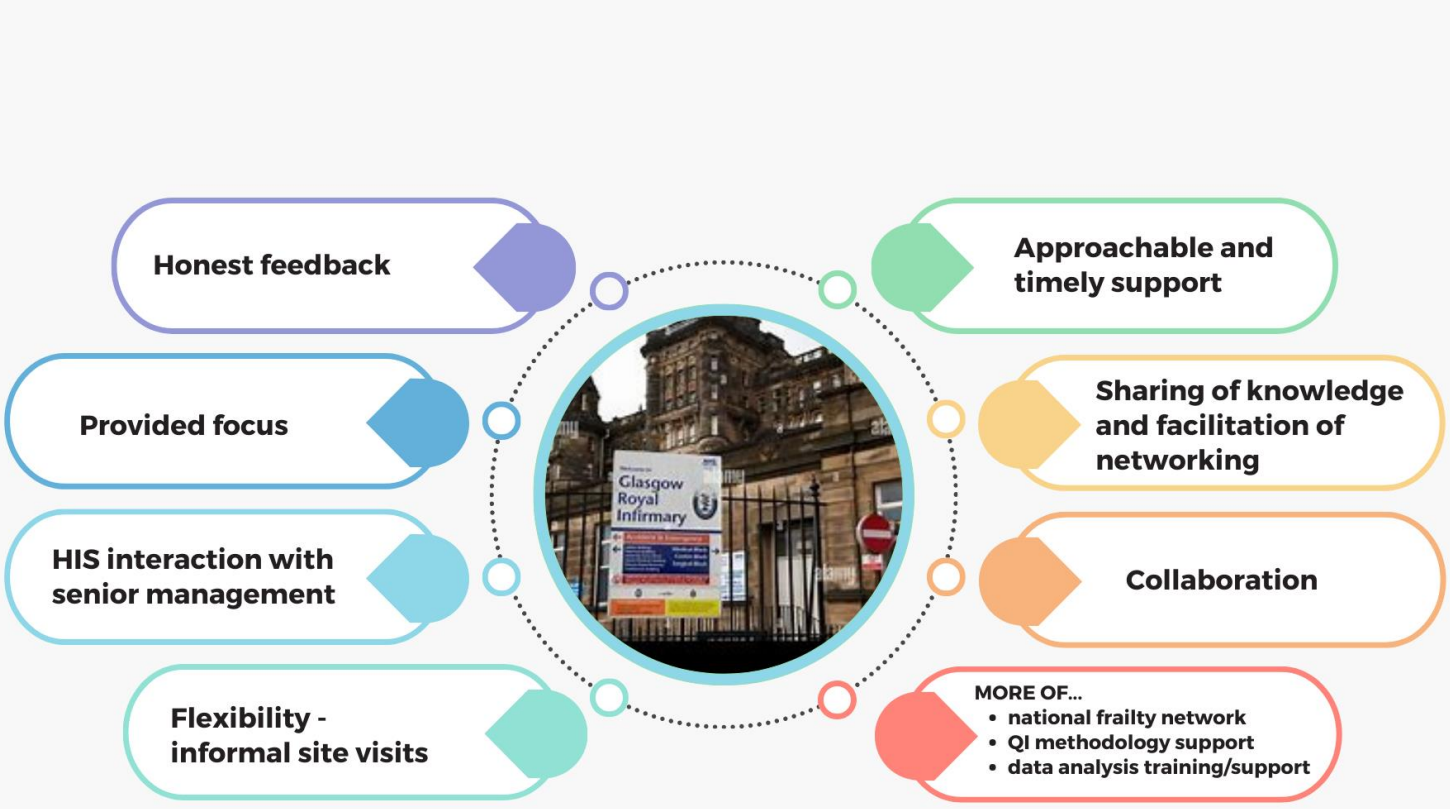
Challenges and enablers



Challenges and enablers

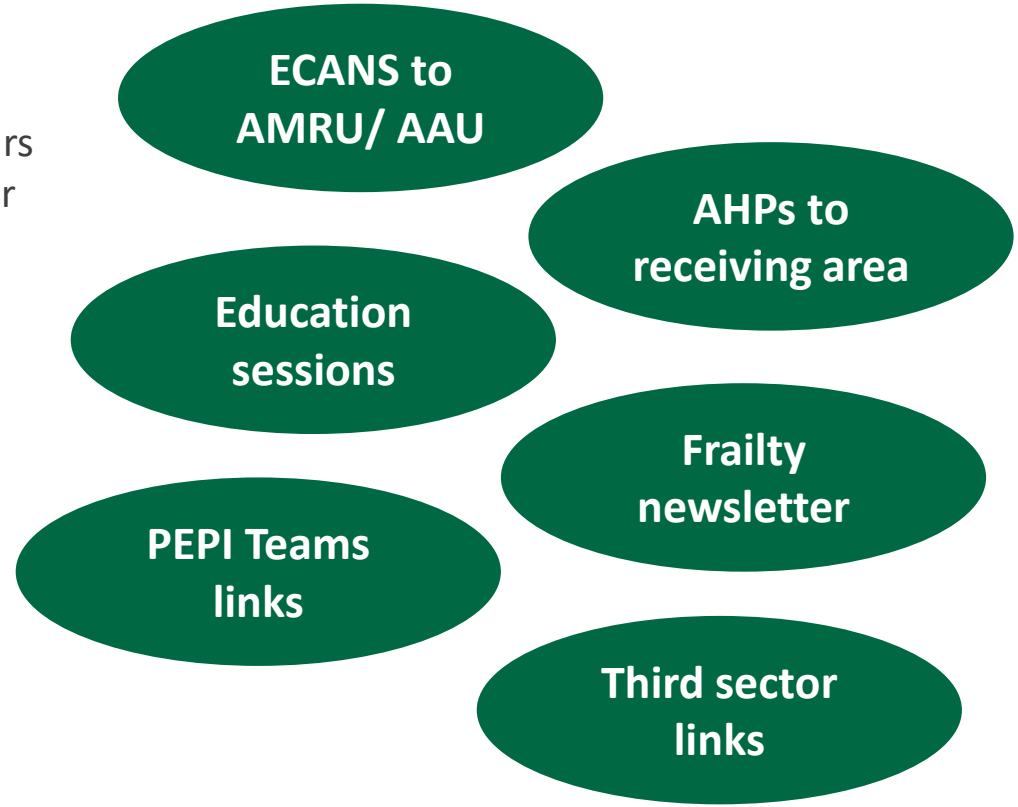


Support and learning

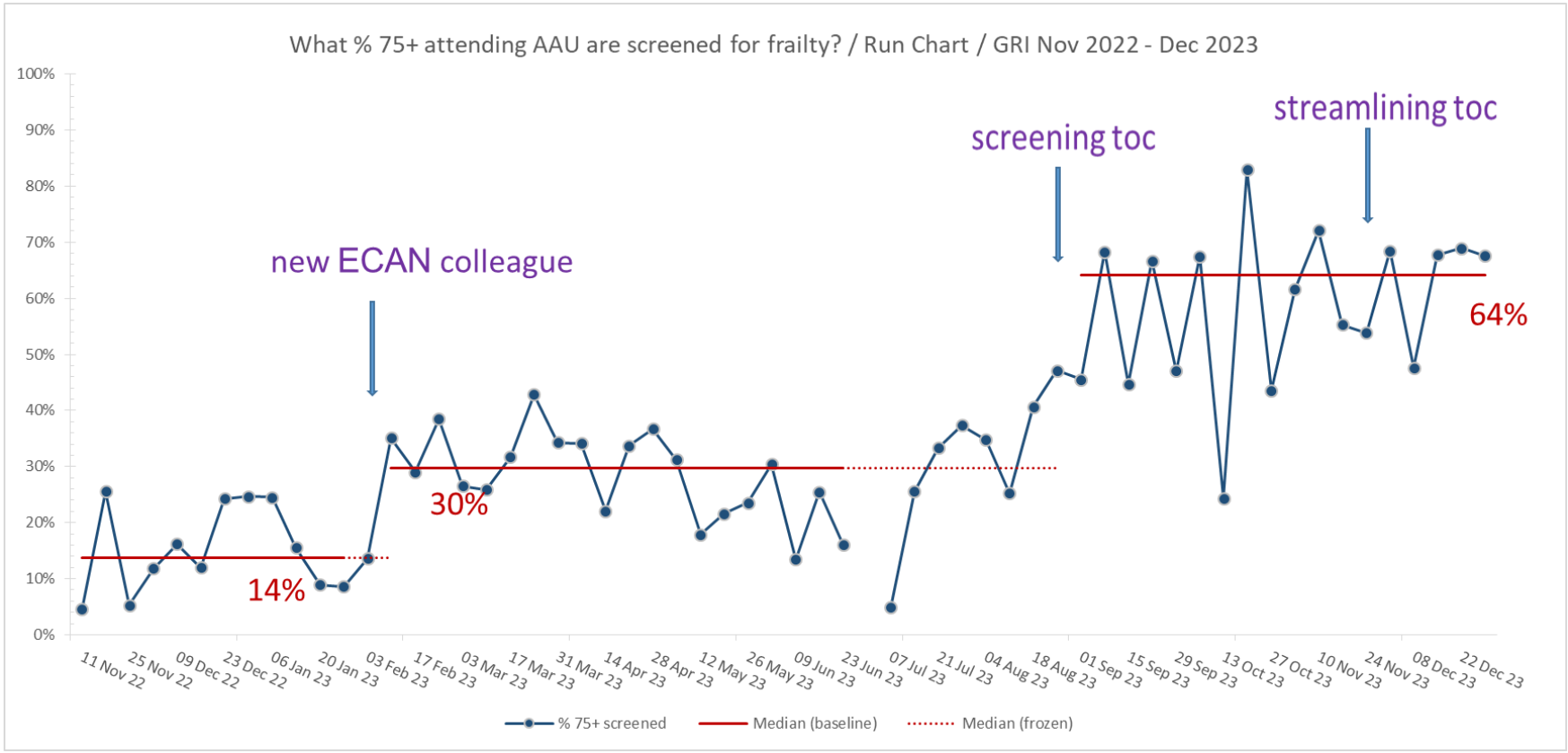


Tests of change

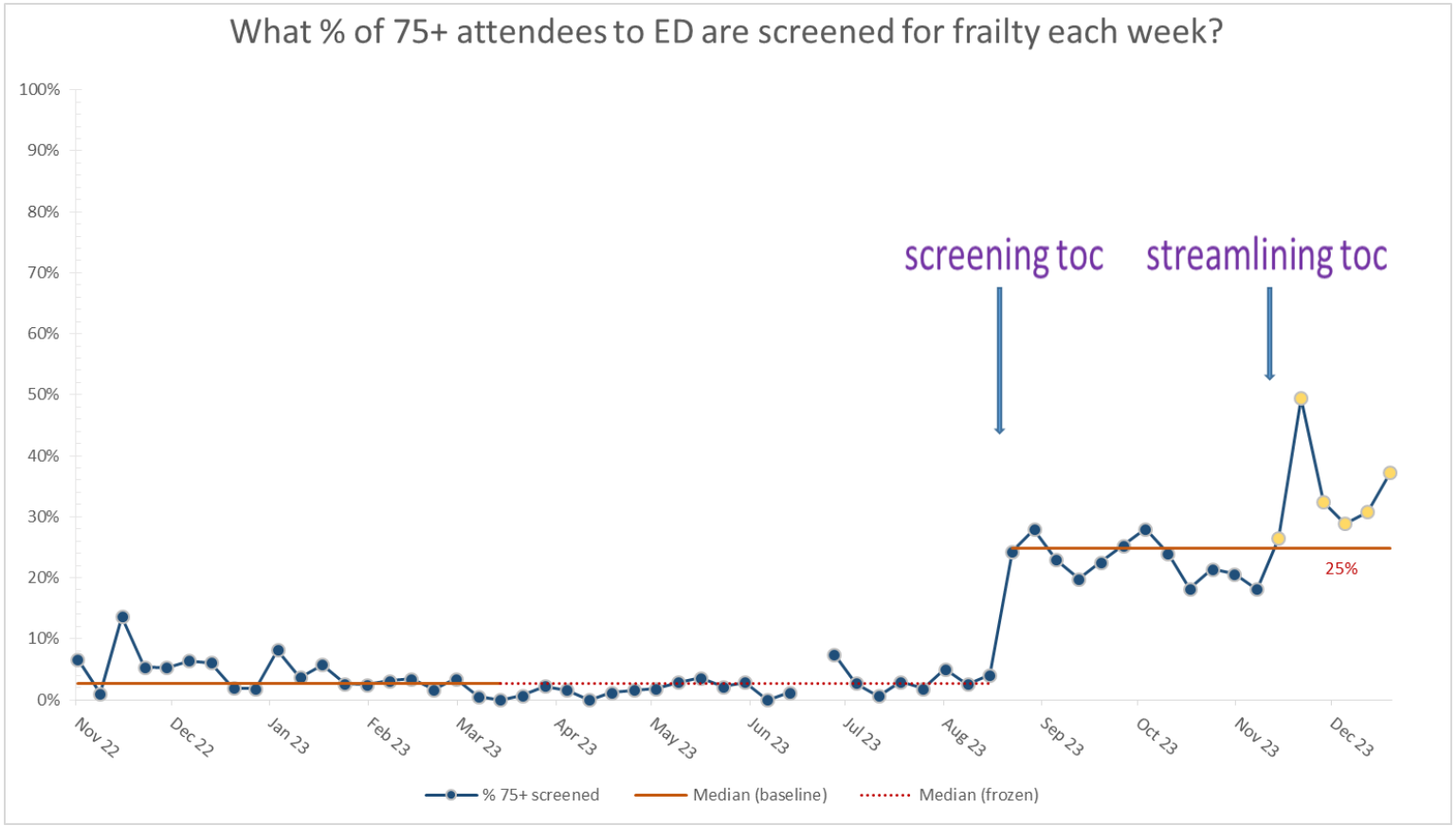
1. **FRAILTY IDENTIFICATION**
   - Patients 75 years and over (and 65 years and over from care home) screened for frailty.
   - Electronic version of HIS frailty assessment tool.
2. **STREAMLINING TO INITIATE EARLY CGA**
   - OPS receiving area (ward 53).
   - Specialty downstream wards.
3. **CGA HUDDLES**
   - Frailty assessment pro forma.
4. **RAPID ACCESS CLINICS**
   - Support discharge.



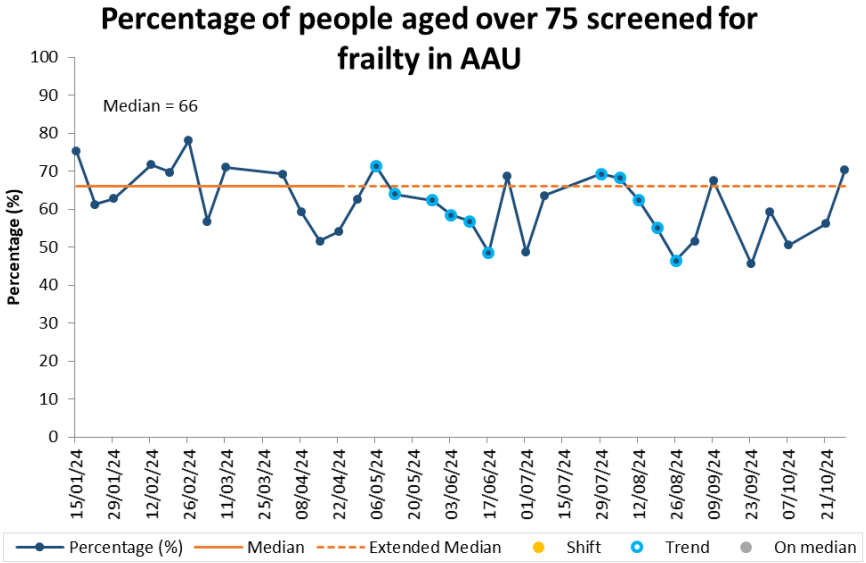
Measurement and outcomes - identification

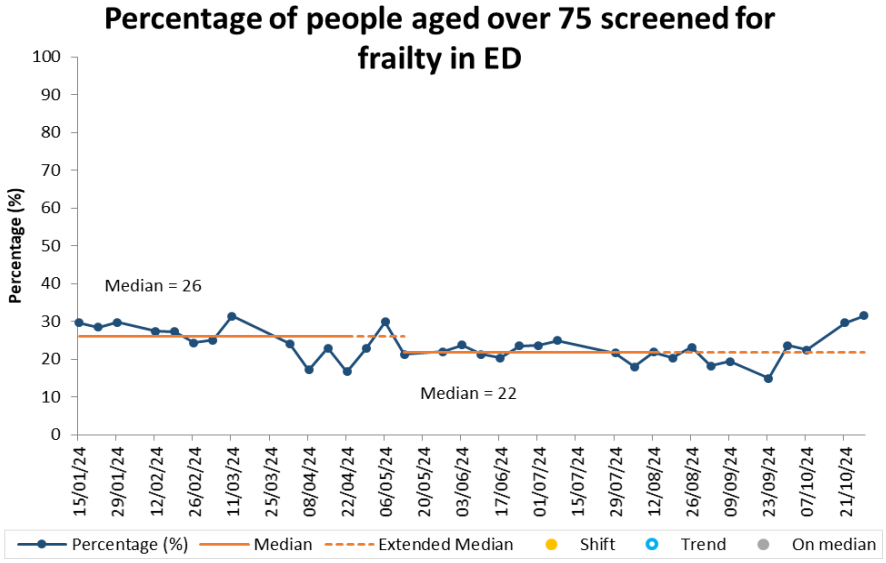


Measurement and outcomes - identification

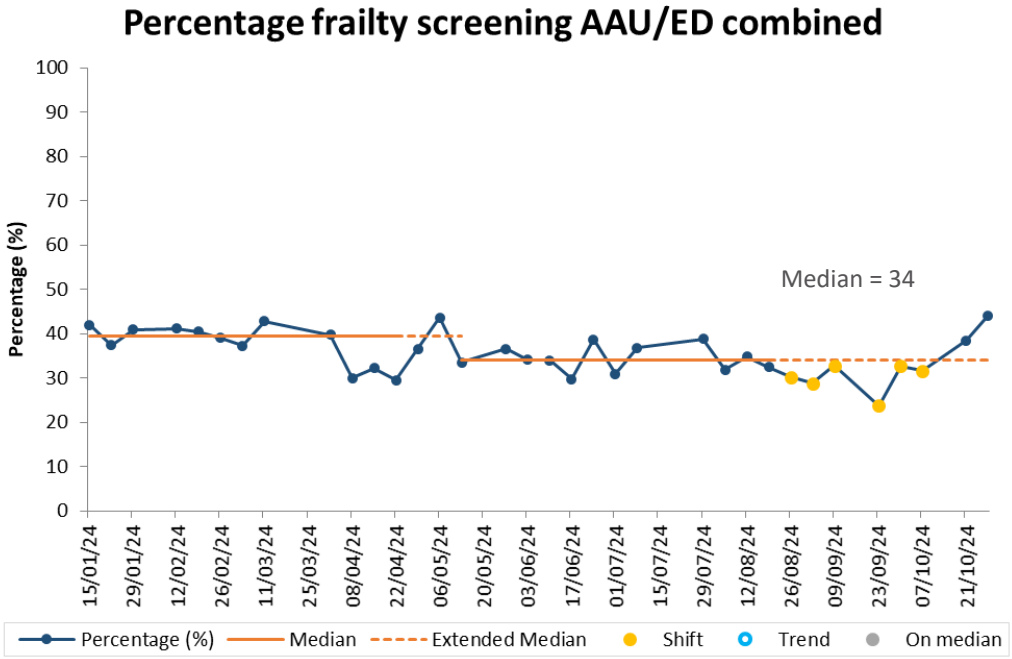


Measurement and outcomes - identification





Measurement and outcomes - identification



74% patients 75 years and over who come through AMRU are screened for frailty

Measurement and outcomes - streamlining

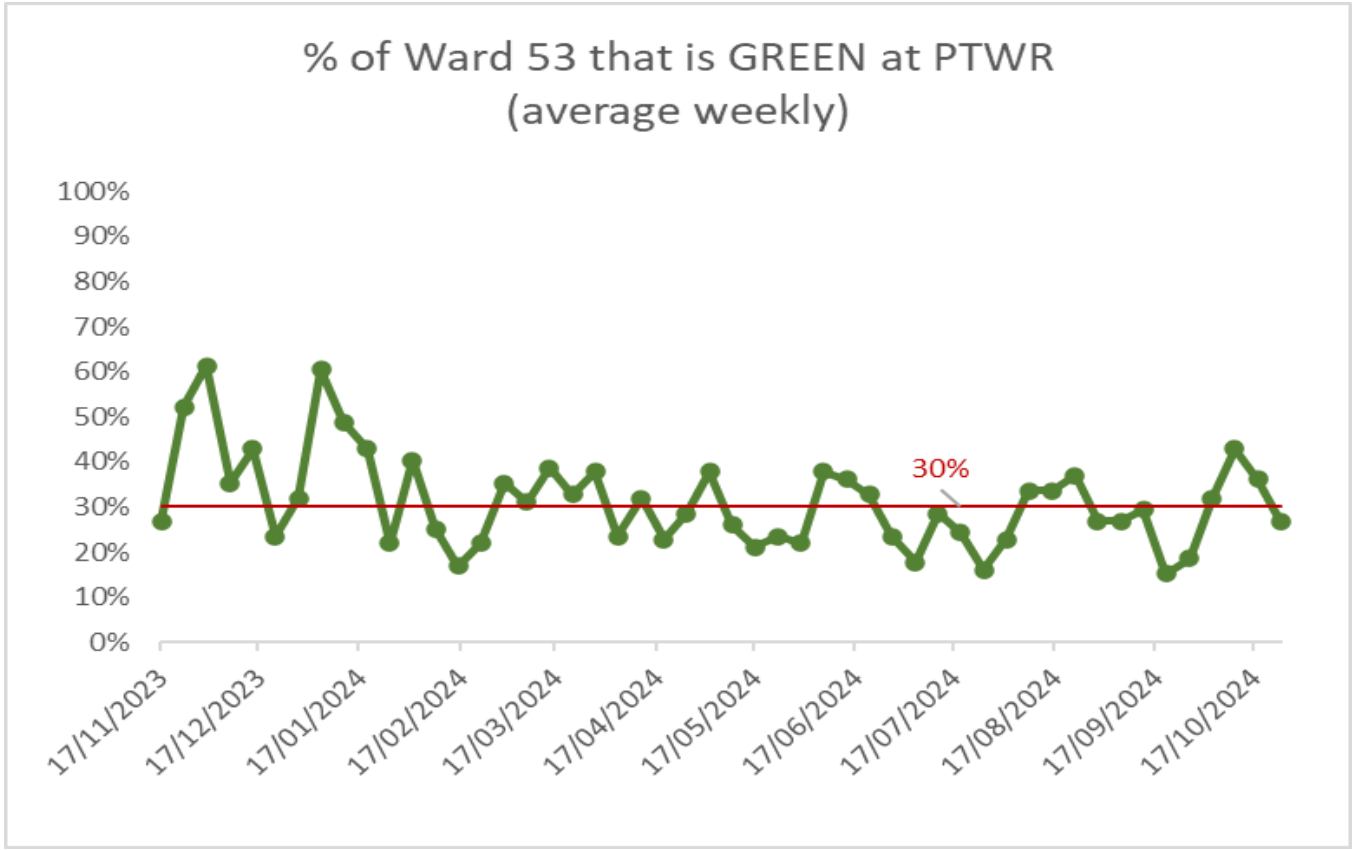
- Percentage of people with frailty and requiring CGA being cared for by OPS.

70%

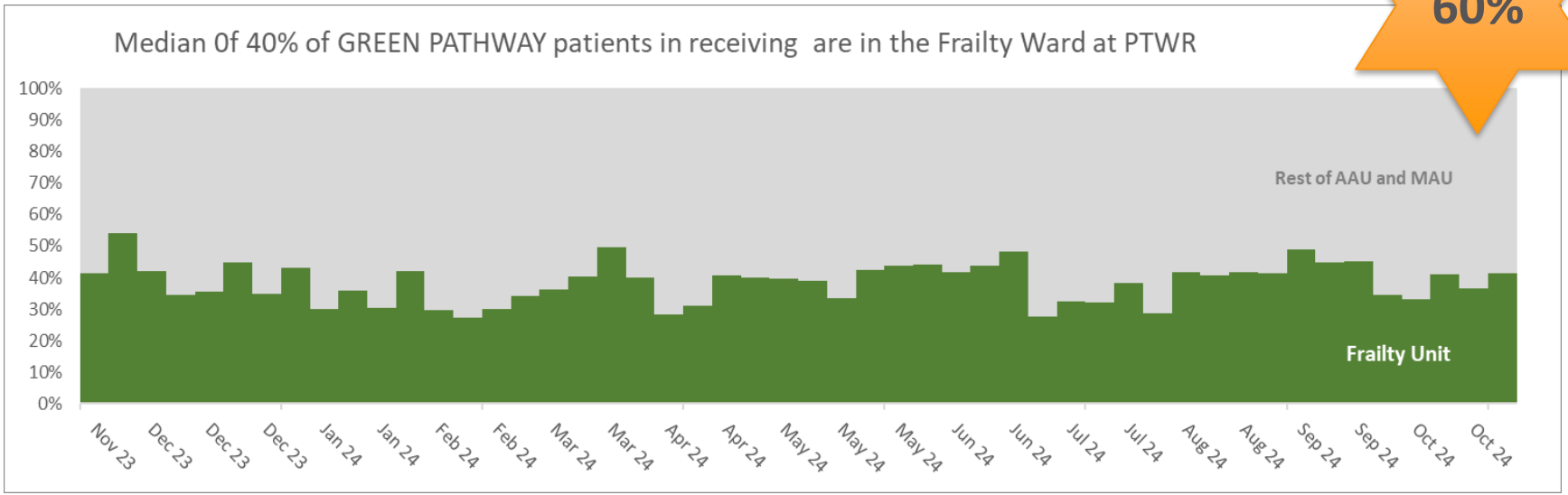
- Of those patients screened in the downstream OPS wards, what percentage have frailty and need CGA?

90%

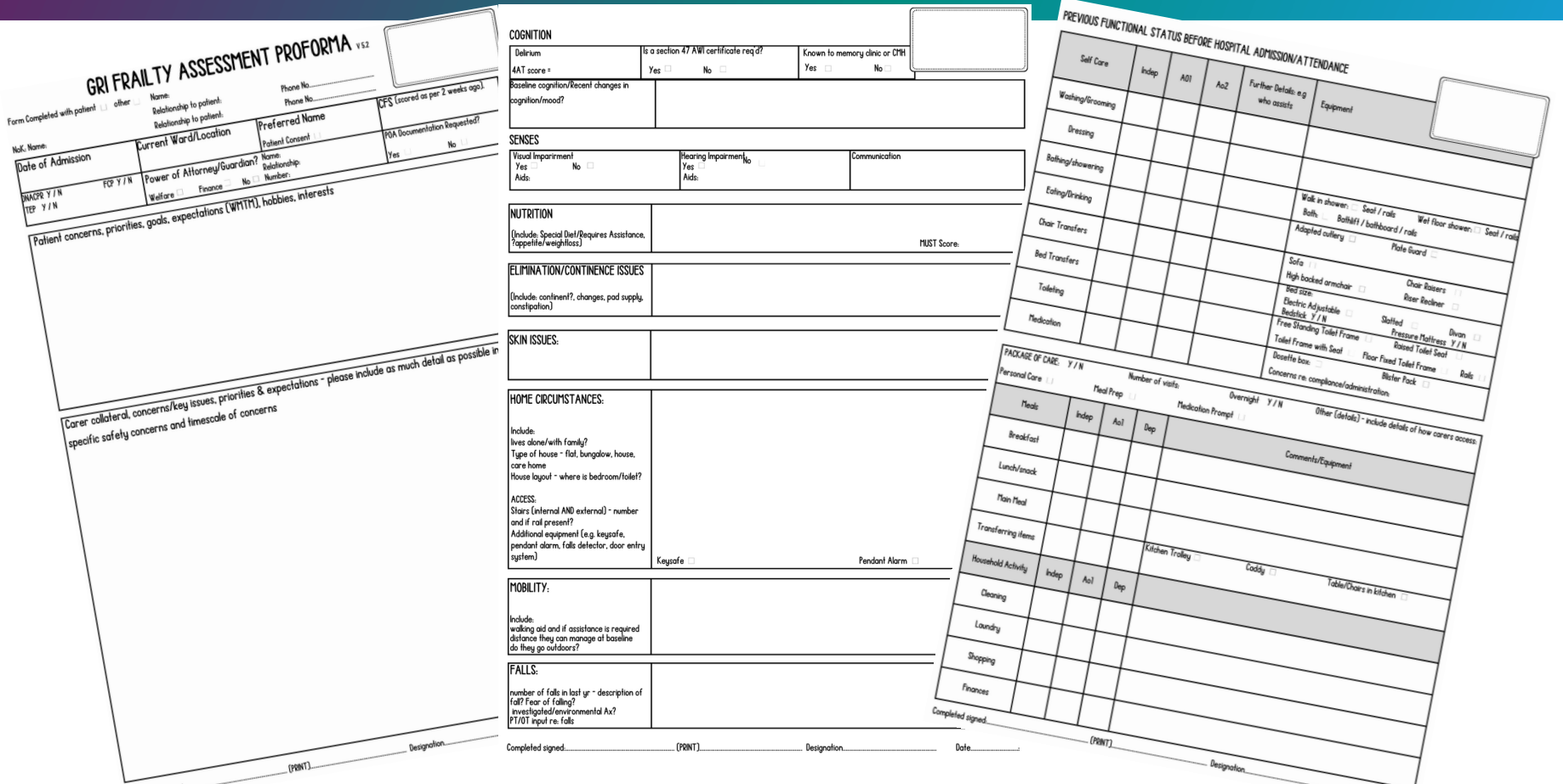
Measurement and outcomes - streamlining



Measurement and outcomes - streamlining



Measurement and outcomes – CGA Huddles



GRI FRAILTY ASSESSMENT PROFORMA v5.2

Form Completed with patient ☐ other ☐ Name: Relationship to patient: Phone No.: Relationship to patient: Phone No.:

NoK. Name:

Date of Admission | Current Ward/Location | Preferred Name Patient Consent ☐ | CFS (scored as per 2 weeks ago.)

DNACPR Y / N | FCP Y / N | Power of Attorney/Guardian? Name: Relationship: Number: | POA Documentation Requested? Yes ☐ No ☐

TEP Y / N | Welfare ☐ Finance ☐ No ☐

Patient concerns, priorities, goals, expectations (WHTM), hobbies, interests

Carer collateral, concerns/key issues, priorities & expectations - please include as much detail as possible in specific safety concerns and timescale of concerns

(PRINT)..... Designation.....

COGNITION

Delirium | Is a section 47 AWI certificate req'd? Yes ☐ No ☐ | Known to memory clinic or CMH Yes ☐ No ☐

4AT score =

Baseline cognition/Recent changes in cognition/mood?

SENSES

Visual Impairment Yes ☐ No ☐ Aids: | Hearing Impairment Yes ☐ No ☐ Aids: | Communication

NUTRITION

(Include: Special Diet/Requires Assistance, ?appetite/weightloss)

MUST Score:

ELIMINATION/CONTINENCE ISSUES

(Include: continent?, changes, pad supply, constipation)

SKIN ISSUES:

HOME CIRCUMSTANCES:

Include:
lives alone/with family?
Type of house - flat, bungalow, house, care home
House layout - where is bedroom/toilet?

ACCESS:
Stairs (internal AND external) - number and if rail present?
Additional equipment (e.g. keysafe, pendant alarm, falls detector, door entry system)

Keysafe ☐ Pendant Alarm ☐

MOBILITY:

Include:
walking aid and if assistance is required
distance they can manage at baseline
do they go outdoors?

FALLS:

number of falls in last yr - description of fall? Fear of falling?
investigated/environmental Ax?
PT/OT input re: falls

Completed signed..... (PRINT)..... Designation..... Date.....

PREVIOUS FUNCTIONAL STATUS BEFORE HOSPITAL ADMISSION/ATTENDANCE

Self Care	Indep	A01	Ao2	Further Details: e.g who assists	Equipment
Washing/Grooming					
Dressing					
Bathing/showering					
Eating/Drinking					
Chair Transfers					
Bed Transfers					
Toileting					
Medication					

Walk in shower: Seat / rails ☐ Wet floor shower: Seat / rails ☐ Bath ☐ Bathlift / bathboard / rails ☐

Adapted cutlery ☐ Plate Guard ☐

Sofa ☐ Chair Raisers ☐

High backed armchair ☐ Riser Recliner ☐

Bed size: Electric Adjustable ☐ Slatted ☐ Divan ☐

Bedstick Y / N Pressure Mattress Y / N

Free Standing Toilet Frame ☐ Raised Toilet Seat ☐

Toilet Frame with Seat ☐ Floor Fixed Toilet Frame ☐ Rails ☐

Dosette box ☐ Blister Pack ☐

Concerns re: compliance/administration

PACKAGE OF CARE: Y / N

Personal Care ☐ Number of visits: Overnight Y / N

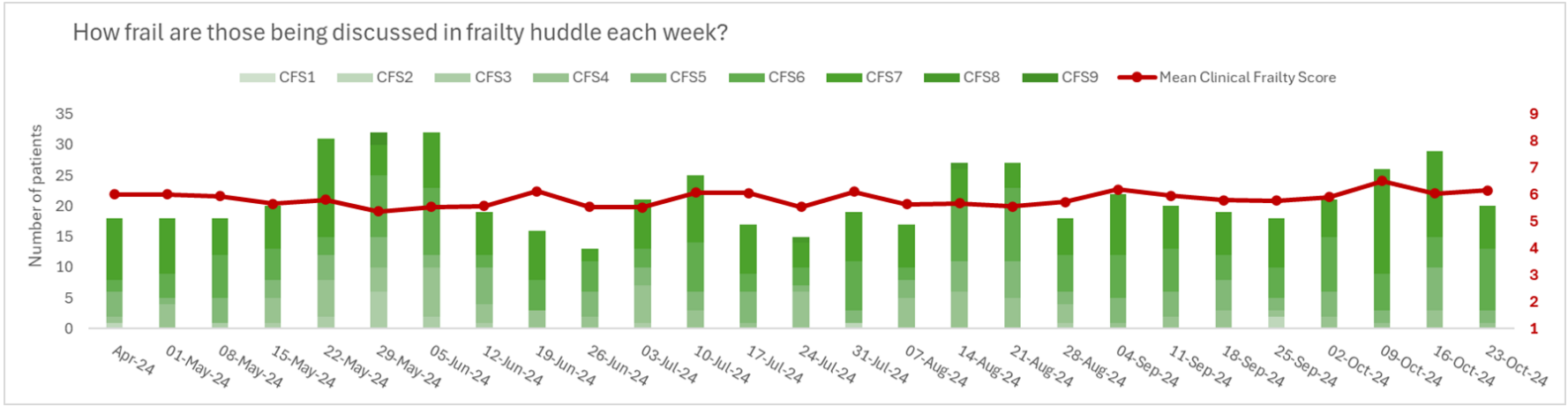
Meal Prep ☐ Medication Prompt ☐ Other (details) - include details of how carers access

Meals	Indep	Ao1	Dep	Comments/Equipment
Breakfast				
Lunch/snack				
Main Meal				
Transferring items				Kitchen Trolley ☐ Caddy ☐ Table/Chairs in kitchen ☐

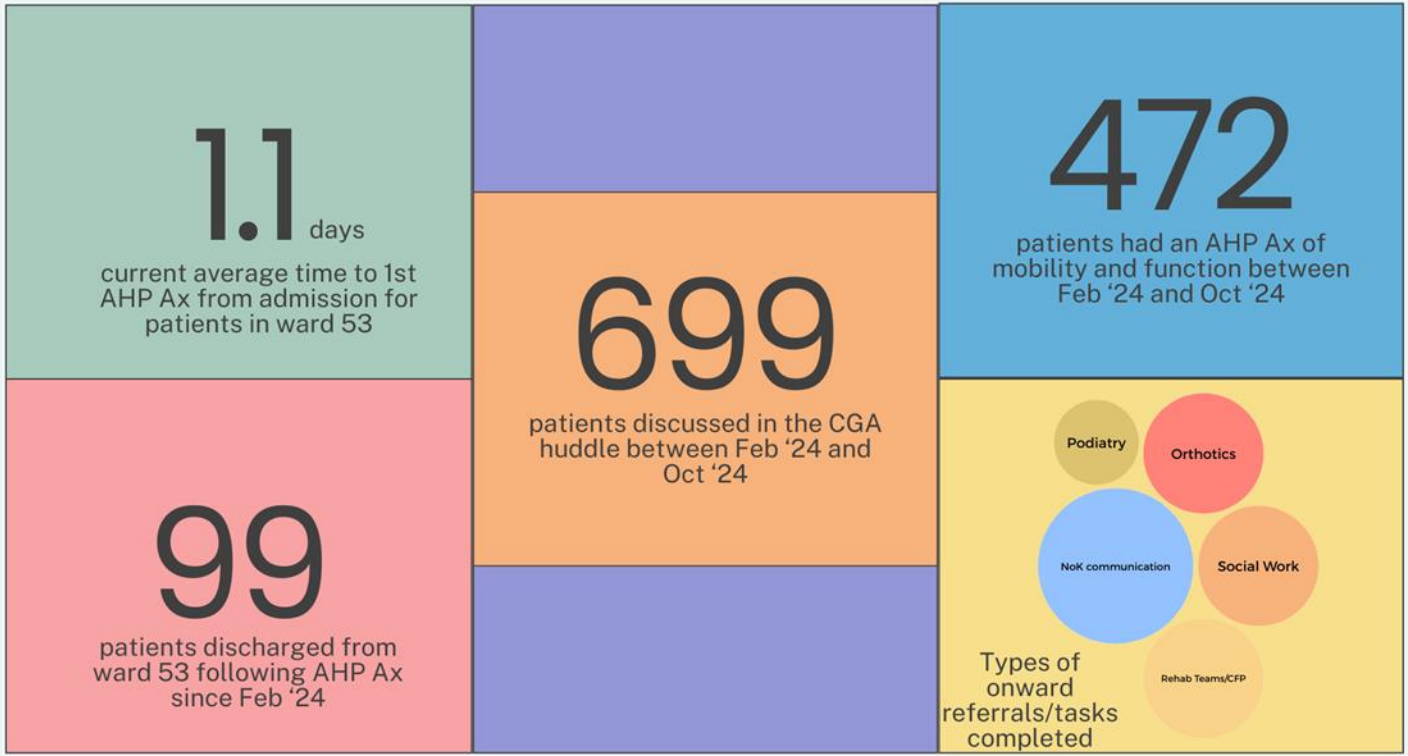
Household Activity	Indep	Ao1	Dep
Cleaning			
Laundry			
Shopping			
Finances			

Completed signed..... (PRINT)..... Designation.....

Measurement and outcomes – CGA huddles



Measurement and outcomes – CGA huddles



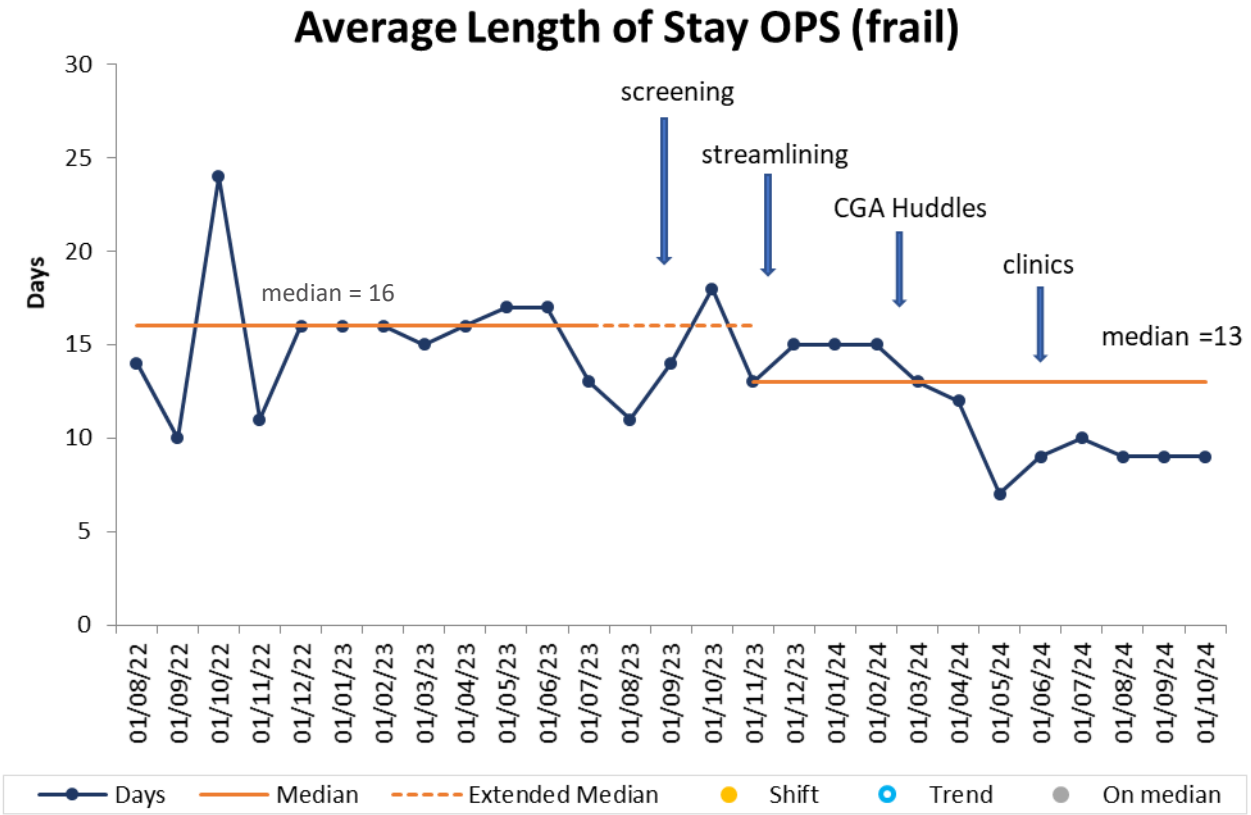
Measurement and outcomes – rapid access clinics

ARC early supported discharge - rapid access review clinic

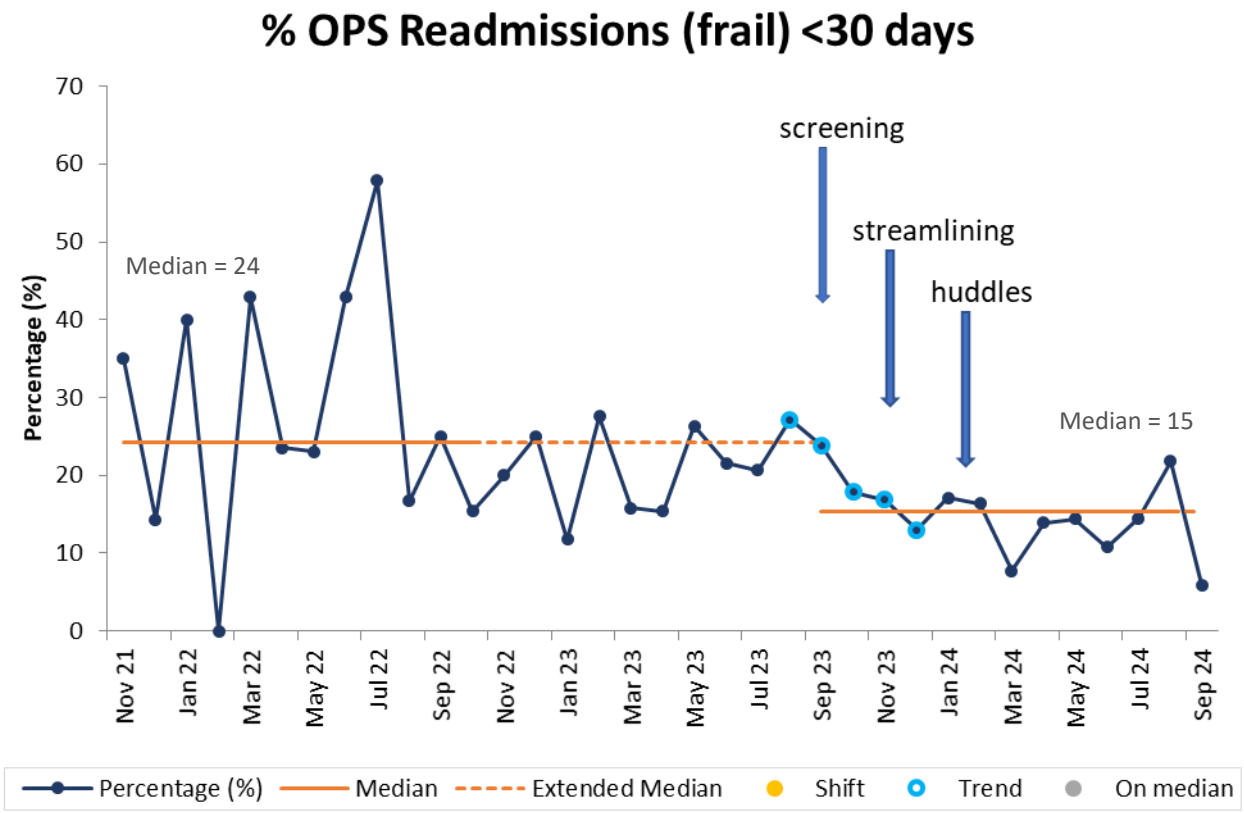
- Monday-Friday rapid access to consultant or senior specialty doctor review to support early discharge from OPS wards.
- Available to patients who would otherwise need to stay in hospital longer.
- One dedicated rapid access outpatient CT slot per week, with same day reporting.
- After 12 weeks duration.
- 25 referrals. 23 taken forward.

Day of discharge	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
No. of discharges	1	5	2	4	6	1	4

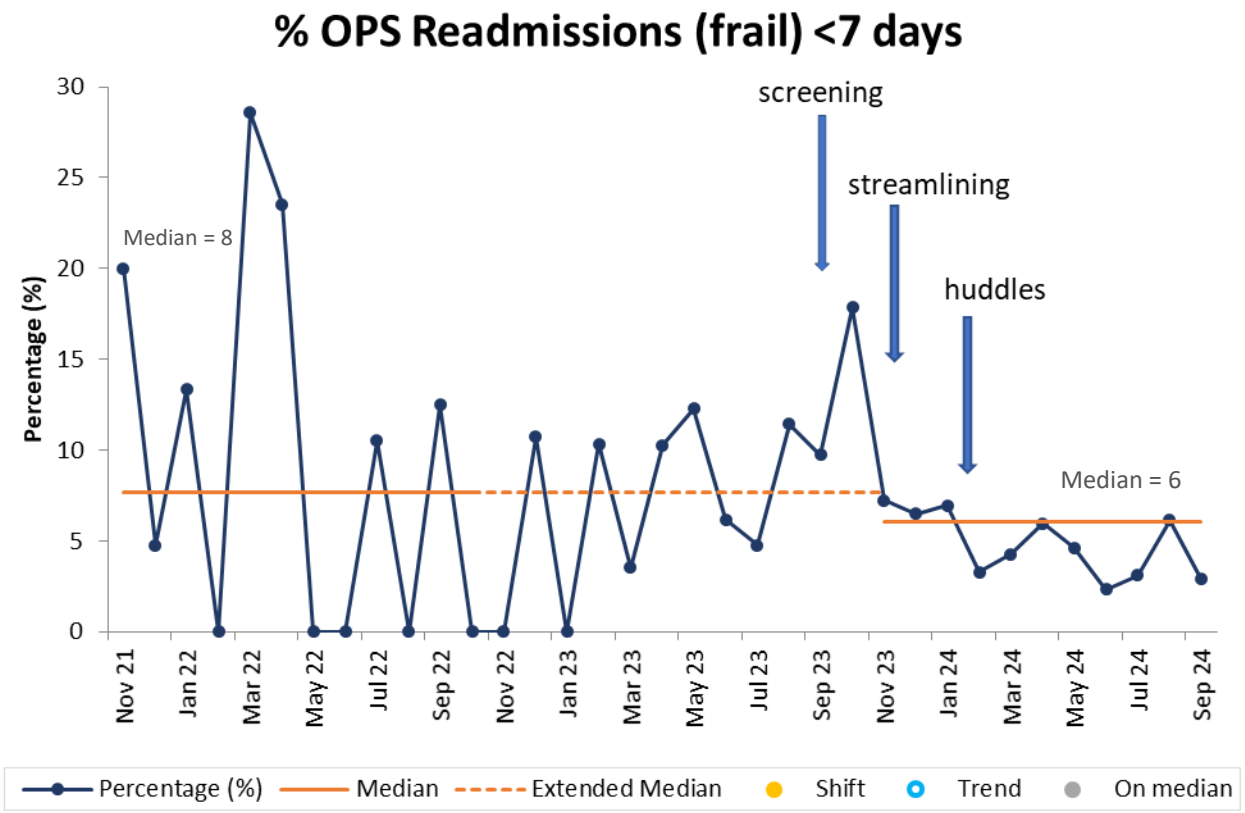
Measurement and outcomes



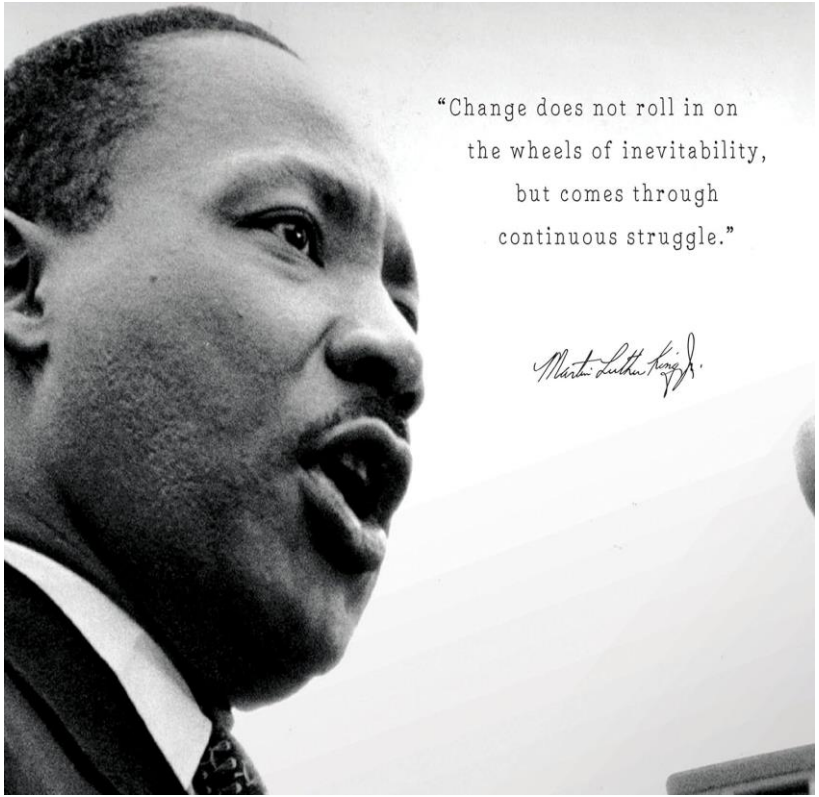
Measurement and outcomes

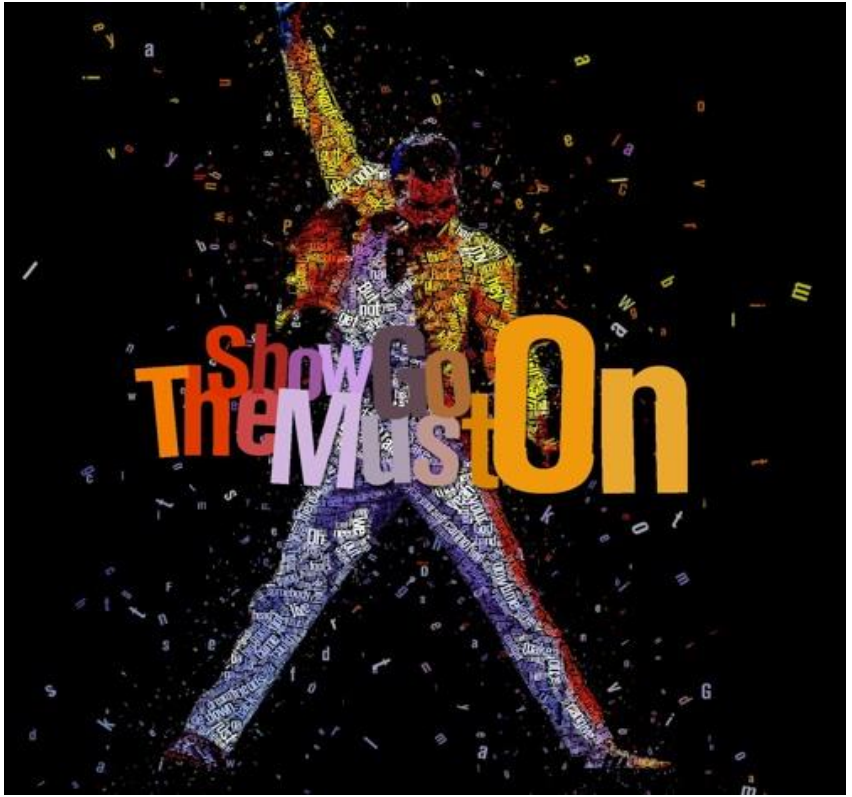


Measurement and outcomes



Final thoughts





Healthcare Improvement Scotland

Thank you and summary

Dr Lara Mitchell, National Clinical Lead for Acute,
Healthcare Improvement Scotland

Healthcare Improvement Scotland

Creating the conditions for spread, scale and sustainability

Professor Trish Greenhalgh

Introduction

Professor Trish Greenhalgh

Professor of Primary Care Health Sciences and Fellow of Green Templeton College at the University of Oxford

Healthcare Improvement Scotland

Next steps for your frailty improvement work

The Focus on Frailty team

Leading quality health and care for Scotland

NHS SCOTLAND

Aim

Teams to consider next steps to ensure spread, scale up and sustainability of their improvement work building on the keynote presentation.

Team discussion (25 minutes)

- What areas of work are a **priority** to spread, scale-up, sustain or start over the **next 6 months.**

- What **structure, strategy and support** are in place, or required, to move these forward and **who** will be involved?

Template

Team:			
What areas of work are a **priority** to spread, scale-up, sustain or start over the **next 6 months**?			
What **structure, strategy and support** are in place, or required, to move these forward and **who** will be involved?			
Structure	**Strategy**	**Support**	**Who**
To read Chrysanthi Papoutsi, Trisha Greenhalgh and Sonja Marjanovic paper on Approaches to Spread, Scale-Up, and Sustainability including the 3S scale-up infrastructure approach please scan the QR code.			

Feedback (2 minutes each)

What areas of work are a **priority** to spread, scale-up, sustain or start over the **next 6 months?**

Healthcare Improvement Scotland

Panel session

Improving health and social care for people living with frailty – where next?

Introduction

Belinda Robertson

Associate Director of Improvement,

Healthcare Improvement Scotland

Healthcare Improvement Scotland

Panel members

- Professor Graham Ellis, Deputy Chief Medical Officer, Scottish Government
- Alison Leiper, Interim General Manager, Older Peoples and Stroke Services, North Sector NHS Greater Glasgow and Clyde
- Doug Anthoney, Health and Wellbeing Manager, Age Scotland
- Tim Eltringham, Director of Health and Social Care, South Ayrshire HSCP
- Dr Malcolm Simmons, GP Partner and GP Clinical Lead for Moray, Moray HSCP
- Professor Angela Wallace, Executive Nurse Director, NHS Greater Glasgow and Clyde, Scottish Executive Nurse Directors group
- Dr Tricia Moylan, National Clinical Advisor in Unscheduled Care for CfSD

Healthcare Improvement Scotland

Closing remarks

Dr Lara Mitchell, Strategic National Clinical Lead (Acute), Healthcare Improvement Scotland

Lessons from the best sprinter of all time

- Determination and persistence.
- Vision.
- Overcoming setbacks.
- Maximising resources.
- Team.
- Consistent and smart.

Next steps from HIS

- Learning system channel – membership 1978
- Begin phase two of the Focus of Frailty programme in 2025
- Continue to share webinars, tools and resources through the frailty learning system

Frailty learning system MS Teams channel

Keep in touch

 @online_his

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Web: healthcareimprovementscotland.scot