2017
Frailty Coordination at the Front Door Driver Diagram, Change Package and Measurement Plan
**Driver Diagram**

<table>
<thead>
<tr>
<th>Aim</th>
<th>Primary Driver</th>
<th>Secondary Driver/Change Concept</th>
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</table>
| **To improve outcomes and experience for older people living with frailty presenting to acute services by:** | **Improving recognition of frailty (within agreed population of interest)** | **Early recognition of frailty**  
- Early recognition of frailty using a reliable process  
- Establish a multi-disciplinary CGA with the appropriate level of autonomy to make decisions that determine the pathway of care  
- Ensure the CGA team is involved in the coordination of care as early as possible in the person’s journey to facilitate good decision making  
- Educate and raise awareness so that staff understand their role and expected response regarding frailty screening and assessment  

**Improving the response and review for people identified as frail** | **Initiation of CGA**  
- Engage with patient, family, carers as early as possible to establish history, the person’s wishes and support needs  
- Ensure the CGA team is involved at the earliest possible opportunity to commence CGA  
- Initiate CGA to diagnose, plan and direct the person to the correct pathway of care  

**Improving the coordination of care for people living with frailty** | **Early, coordinated, multi-disciplinary planning**  
- Embed daily frailty focused, multi-disciplinary huddle involving the CGA team and representatives from hospital, community, primary and health and social care settings.  
- Use these discussions to support early diagnosis and holistic planning for treatment, rehabilitation, support and long term follow up  
- Consider the available range of care options offered locally across hospital, community, intermediate care and health and social care to ensure coordinated support is attuned to the specific needs of the person, with the focus on support at home or a homely setting wherever possible.  
- Optimise transitions to place of care through multi-disciplinary/multi-agency working.  

**Enabling teams to deliver a reliable coordinated response for people living with frailty** | **Conditions for successful improvement:**  
- Leadership that aligns and supports strategic and improvement goals  
- Teams that have the right skills and a shared purpose for improvement  
- Understand and utilise your context  

*For the purpose of the collaborative the population of interest is people over 75 years of age*
Definition of frailty - Frailty is a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves. Around 10% of people aged over 65 years have frailty, rising to between a quarter and a half of those aged over 85 years. Also about 5-10% of all emergency department (ED) attendees and 30% of patients in acute medical units are older people with frailty.

Older people living with frailty are at risk of adverse outcomes such as dramatic changes in their physical and mental wellbeing after an apparently minor event which challenges their health, such as an infection or new medication. It is important to understand the difference between frailty, long term conditions and disability. Many people with multiple long term conditions (so called multi-morbidity) will also have frailty which may be masked when the focus is on other disease based long term conditions. Likewise, some people whose only long term condition is frailty may be low consumers of health care resources and not regularly known to their GP (until they become bed bound, immobile or delirious as a result of an apparently minor illness). There may be overlap between the management approaches for people with multi-morbidity and those with frailty but these conditions are not identical.

Definition of comprehensive geriatric assessment (CGA) - Comprehensive geriatric assessment (CGA) is a multidimensional and usually interdisciplinary diagnostic process designed to determine a frail older person’s medical conditions, mental health, functional capacity and social circumstances. The purpose is to plan and carry out a holistic plan for treatment, rehabilitation, support and long term follow up. CGA is part of an integrated approach to assessment based on the following principles:

- The older person is central to the process
- Their capacity to participate voluntarily must be assessed, and if lacking, then there needs be a system to address their needs in an ethical fashion.
- Links between social and health care should be good enough for older people who need comprehensive assessment to receive it in a timely and efficient manner, and proportionate to their degree of need.
- Assessments should be standardised and carried out to a reliable standard

Definition of a CGA huddle – A succinct multidisciplinary (and multiagency) discussion that uses the diagnostics from CGA to support early and effective care coordination. The membership of the huddle should include representation from across the pathway of care, with the appropriate level of expertise and autonomy to make care decisions regarding discharge, admission to specialty ward or transfer. Membership and format of the huddle will vary depending on the site but the principles of timely decision making, and the means to effectively coordinate care are essential.
## Change package

<table>
<thead>
<tr>
<th>Primary Driver</th>
<th>Secondary Driver</th>
<th>Change concepts and ideas for PDSA testing</th>
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<tbody>
<tr>
<td>Improving recognition of frailty (within agreed population of interest)</td>
<td><strong>Early recognition of frailty</strong>&lt;br&gt;• Early recognition of frailty using a reliable process&lt;br&gt;• Establish a multi-disciplinary CGA with the appropriate level of autonomy to make decisions that determine the pathway of care&lt;br&gt;• Ensure the CGA team is involved in the coordination of care as early as possible in the person’s journey to facilitate good decision making&lt;br&gt;• Educate and raise awareness so that staff understand their role and expected response regarding frailty screening and assessment</td>
<td>• Use a frailty assessment tool as an adjunct to clinical judgment that is reliable at identifying frailty and prioritising for CGA to reduce variation of process. Two suggested tools-&lt;br&gt;  o HIS “Think Frailty” Tool&lt;br&gt;  o or Rockwood clinical frailty scale&lt;br&gt;• Agree locally, your criteria for CGA ie with HIS tool you could agree a minimum number of elements ticked “yes”. With Rockwood you could agree minimum cut off point.&lt;br&gt;• Prioritise screening for frailty as early as possible in the journey (i.e. first point of access, emergency departments and acute medical units)&lt;br&gt;• Target screening for your agreed population of interest&lt;br&gt;• Develop a multidisciplinary CGA team that has the appropriate level of expertise i.e. (Geriatrician, Physiotherapist, Consultant Nurse, Advanced nurse practitioners, Occupational Therapists, Staff nurses specialising in Frailty and Assistant Frailty Practitioners)&lt;br&gt;• Use evidenced based standards and guidance to develop CGA team</td>
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Click here to go to British Geriatric Society website for information on [Fit for Frailty & CGA](link)
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<th>Initiation of CGA</th>
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<td>• Engage with patient, family, carers as early as possible to establish history, the person's wishes and support needs</td>
<td><strong>• Test and implement a process to communicate people identified with frailty with the CGA team</strong></td>
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<td>• Ensure the CGA team is involved at the earliest possible opportunity to commence CGA (where indicated)</td>
<td><strong>• Commence Comprehensive Geriatric Assessment that include the following domains:-</strong></td>
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| • Initiate CGA to diagnose, plan and direct the person to the correct pathway of care |   - Medical  
|                                                                 |    - Mental Health  
|                                                                                                                                 |    - Functional capacity  
|                                                                 |    - Social circumstances  
|                                                                 |    - Environment  
<p>| | | <strong>• Develop advanced roles with a competency framework for front door teams. Please see attachment containing draft copy of competency framework developed by NHS Fife’s front door team.</strong> |
| | <strong>FRAILTY ADVANCED NURSE PRACTITIONERS COMPETENCIES1.docx</strong> | <strong>• Maximise the flexibility of the team by defining role specific and non-role specific tasks i.e. define minimum grade within team that can conduct tasks such as history taking, blood sampling, physical observations and basic functional assessment</strong> |
| | | <strong>• Identify skill gaps and access local training</strong> |</p>
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<td>- Embed daily frailty focussed, multi-disciplinary huddle involving the CGA team and representatives from hospital, community, primary and health and social care settings</td>
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<td>- Use these discussions to support early diagnostics and holistic planning for treatment, rehabilitation, support and long term follow up</td>
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<td>- Consider the available range of care options offered locally across hospital, community, intermediate care and health and social care to ensure coordinated support is attuned to the specific needs of the person, with the focus on support at home or a homely setting wherever possible</td>
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<td>- Optimise transitions to place of care through multi-disciplinary/multi-agency working.</td>
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<th>Leadership that aligns and supports strategic and improvement goals</th>
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<td>- Develop and test a multi-disciplinary frailty focused huddle aiming for 7 day cover. The membership of the huddle should include geriatricians, ANP/AHP’s, service managers, discharge coordinators, inpatient ward staff, social work and intermediate care representation. The huddle membership will vary depending on the site but must include individuals with the autonomy to make senior care decisions such as decision to discharge, admit to specialty ward or transfer</td>
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<tr>
<td>- Work in partnership with patients, their family, carers and multidisciplinary team members to facilitate timely transfer to point of care as determined by the CGA.</td>
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| - Organisational, operational and clinical leaders role model behaviours that build will, generate engagement and support innovation |
| - Organisational, operational and clinical leaders use coaching conversations, appreciative inquiry, and learning from data to build will, engage others and develop improvement ideas |
| - Service users and their families are involved in the design and delivery of improvement projects |
| - Data, case studies and service user stories are through board and governance structures to maximise opportunities for learning and spread of quality improvement activity. |
Teams that have the right skills and a shared purpose for improvement

- Teams have access to resources (people, data and information, knowledge and skills) to engage in improvement activity and build improvement expertise.
- Teams are able to align improvement activity with experiences and outcomes for people in their care.
- All people who are working in the service e.g. clinical support workers or housekeeping staff have the opportunity to inform improvement ideas and participate in improvement activity.
- Service users have the opportunity to inform improvement ideas and participate in improvement activity.

Understand and utilise your context

- Learn from data, service user and staff experience to inform improvement plans.
- Improvement activity is aligned with relevant local or organisational initiatives or aims in order to build clear and joined up clinical and improvement goals.
Environment, workspace and relationships maximise opportunity for inter professional/ inter disciplinary joint working, communication and integration of clinical and improvement goals across team or service boundaries.

- Team and leadership test out he Model for Understanding Success in Quality (MUSIQ calculator).

   There are lots of factors to do with the context in which you work that will impact on the viability of your quality improvement project. These factors can be grouped in several broad categories: the team working on the project, the microsystem in which they function, local QI support and capacity, the organisation in which you work, and the environment external to your organisation.

MUSIQ tool & BMJ Quality Article

- After completing the MUSIQ tool, use this as a discussion point for a consultation with your organisational sponsor. See if they can help you find ways to target the areas of your context where preparation for QI is less well developed.

- Project charter are developed to communicate your vision, project plan, change ideas and measures.
A suite of quality improvement and project management tools are used to help understand your system, generate ideas, identify challenges and develop solutions e.g.

- Task analysis
- Process mapping
- Shadowing
- Simulation
- Service user and staff experience
- Pareto analysis

Process map person's journey involving all appropriate stakeholders and iHub improvement and data team to support understanding of system and develop tailored minimal data set that demonstrates improvements

Develop simple mechanisms for data collection including local data support to extract data from local systems

Utilise culture or climate surveys (for staff and / or patients) to identify areas of need to maximise team engagement and generation of improvement ideas and activity.

Develop improvement and subject matter knowledge and skills for teams and leaders, (e.g. process mapping; PDSA cycles, run charts and interpretation of improvement data) through education and coaching e.g. through face to face, using a multi-professional approach; or online QI learning such as on TURAS platform (NES)
• Consider changes to ways of working and aligning activity to meet improvement goals.

• Team communication approaches that flatten hierarchy to influence shared values, respect for roles and ability to challenge.

• Use data within wards and departments to encourage conversations that help to plan your improvements

• Communication and processes that learn from and celebrate success

• Develop activities such as leadership walk rounds that facilitate a closer interface and sharing of learning between teams, disciplines and leaders

• Close the learning and feedback loop by developing reporting, sharing and evaluation mechanisms which connect data and learning from improvement initiatives with board and governance agendas.

• Ensure links with subject matter experts and improvement teams to identify opportunities for collaboration. There are a number of work streams that potentially impact on the aim of the collaborative such as Unscheduled Care Improvement Programme (6 essential actions), Living Well in Community (frailty and falls, anticipatory care panning and palliative care), Active and Independent Living Improvement Programme (AILIP) and the Person Centred Health and Care (What matters to you?).
Clinical guidance and resources -
http://www.bgs.org.uk/good-practice-guides/resources/goodpractice/gpgcgassessment
http://www.bgs.org.uk/campaigns/fff/fff_full.pdf
http://www.bgs.org.uk/campaigns/fff/fff2_full.pdf

Evidence base –
http://www.bmj.com/content/343/bmj.d6553
Measurement Plan
This measurement plan has been produced to guide teams to collect data on process reliability that will inform the tests they undertake as part of their improvement work. The measurement plan also includes outcome, balancing and service measures that will be collated from existing data sets.

A reporting template is being developed to support the collection and interpretation of process measures.

Process reliability is a critical step in improving outcomes. Figure 1 describes the process of recognition and care coordination for people living with Frailty who present at acute hospitals.
**Process Measures**
These process measures include guidance on eligible patients, data sources and operational definitions. These are intended to offer guidance and are not prescriptive as they may need to be amended according to local context. The process measures below have been produced to support teams who are not able to capture process reliability on the entire population of interest. Sampling will allow teams to generate enough data on the reliability of their processes which is a critical step to achieving the desired outcomes.

<table>
<thead>
<tr>
<th>Identifier</th>
<th>Measure Name</th>
<th>Operational Definition</th>
<th>Data Collection Guidance</th>
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</table>
| CGAP1 | Percentage of people over 75 years old who are screened for frailty on arrival to front door | To measure the reliability of the screening process. Improvement noted by an increase in percentage  
  - Numerator = total number of people in your sample who are screened for frailty using a reliable screening tool  
  - Denominator = total number of people in your sample  
  - Calculate the percentage by dividing the numerator by the denominator then multiplying by 100 | Data should be collected from case notes. It will be useful at the early stages of your improvement to capture data on each element of screening. This will help focus your efforts on areas where reliability is less strong.  
Sample - minimum of 20 case notes per month where the admission duration is greater than 24 hours (5 notes per week) drawn from your ward/area of interest.  
Review randomly selected notes with an admission duration of more than 24 hours  
Acute care team can provide toolkit to support data collection |
| CGAP2a | Percentage of people who meet the criteria for CGA who have CGA initiated within 24 hours | To measure the impact screening has on time to initiation of CGA. Improvement noted by increase in percentage  
  - Numerator = total number of people in your sample who have evidence of initiation of CGA within 24 hours of arrival in hospital  
  - Denominator = total number of people in your sample  
  - Calculate the percentage by dividing the numerator by the denominator then multiplying by 100 | Data should be collected from case notes. Sample - minimum of 20 case notes per month where the admission duration is greater than 24 hours (5 notes per week) drawn from your ward/area of interest.  
Review randomly selected notes with an admission duration of more than 24 hours  
Acute care team can provide toolkit to support data collection  
Initiation of CGA is defined as the person’s first contact with CGA team. Evidence for this includes written entry of discussion or outcome for CGA huddle together with a documented date and time. Time in hours and minutes between arrival at hospital and initiation of CGA needs to be less than 24 hours for inclusion in your numerator |
To measure the impact screening has on time to initiation of CGA
Improvement noted by reduction in time to CGA
Record time in hours & minutes from hospital admission to initiation of CGA.
Calculate median time monthly for your sample

| CGAP2b  | Average time it takes to initiation of CGA | To measure the impact screening has on time to initiation of CGA
|        |                                           | Improvement noted by reduction in time to CGA
|        |                                           | Record time in hours & minutes from hospital admission to initiation of CGA.
|        |                                           | Calculate median time monthly for your sample

Initiation of CGA is defined as the person’s first contact with CGA team. Evidence for this includes written entry of discussion or outcome for CGA huddle together with a documented date and time.

### Outcome Measures

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| CGAO1      | Average time to specialist geriatric bed          | To measure the effectiveness of CGA on early decision making
• Numerator = total time in hours and minutes to reach specialist geriatric bed following initiation of CGA
• Denominator = number of people referred to specialist bed by CGA team | Potentially paper collection and collated monthly by local data support |
|           |                                                   |                                                                                       |                                                                                           |
| CGAO2      | Percentage of people over 75 years old discharged from specified ward/unit within 24 hours | To determine if CGA has reduced the length of stay for people over 75
• Numerator = total length of stay for people over 75 admitted to specified unit
• Denominator = total number of people over 75 admitted to specified unit
• Calculate the percentage by dividing the numerator by the denominator then multiplying by 100 | Data should be collected monthly from local systems
Acute care team can provide toolkit to support data collection |
### CGA03
- **Number of people admitted to specialist inpatient geriatric bed, who’s length of stay is longer than 7 days**
- **To determine if CGA has reduced the number of people over 75 years old who’s stay exceeds 7 days**
- Improvement noted in reduction in number
- Data should be collected from local systems or from Information Services Division Scotland

### CGA04
- **Average length of stay for people admitted to specialist inpatient geriatric bed**
- **To determine if CGA has had an impact on length of stay for people admitted to specialist inpatient geriatric bed**
- Improvement noted in reduction in number
- Numerator = total number of days occupied
- Denominator = total number of people admitted to inpatient geriatric bed
- Calculate average by dividing your numerator with your denominator
- Data should be collected monthly from local systems
- Acute care team can provide toolkit to support data collection

### CGA05
- **Destination on discharge**
- **To determine if CGA has had an impact on the des**
- Recommendations may include
- Total number of people admitted to specialist geriatric bed
- Total number of people admitted to other specialty
- Total number of people transferred to locally defined are at home service
- Total number of people discharged
- Potentially paper collection weekly and collated monthly by local data support

### Balancing Measures
<table>
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<tbody>
<tr>
<td>CGAB1</td>
<td>Number of people over 75, discharged from specified ward/unit, who have re-attended within 7 days</td>
<td>To determine whether CGA may have resulted in an increase in re-attendance</td>
<td>Data should be collected monthly from local systems</td>
</tr>
<tr>
<td>CGAB2</td>
<td>Number of people over 75 years old, discharged from specified ward/unit, who have re-attended within 30 days</td>
<td>To determine whether CGA may have resulted in an increase in re-attendance</td>
<td>Data should be collected monthly from local systems</td>
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