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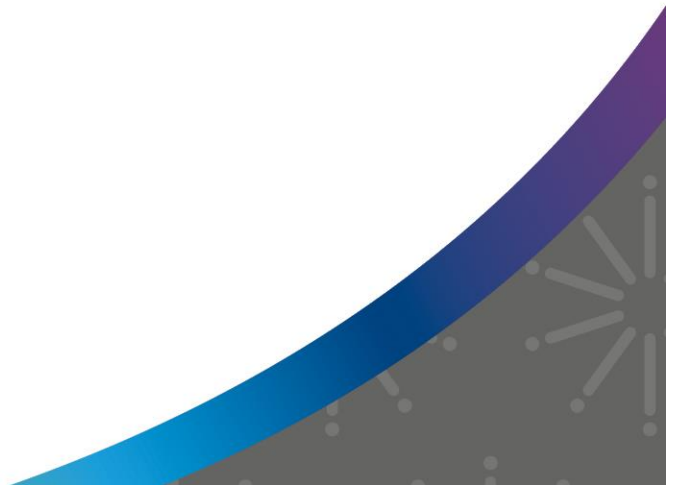
Living and Dying Well with Frailty

Driver Diagram and Change Package

June 2019



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Published June 2019

www.healthcareimprovementscotland.org

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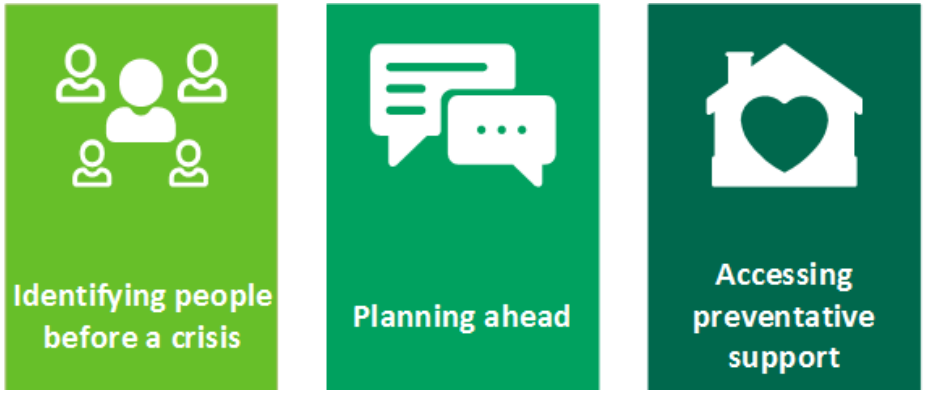
Living Well in Communities

Living Well in Communities works with health and social care services to enable more people with complex care needs to live well in their community for longer. We aim to:

- improve support for people with long term conditions, people with frailty and people nearing the end of their life,
- enable people to die well in the place of their choice, and
- maximise the impact of preventative and anticipatory care to reduce pressures on carers, hospitals and community services.

Living Well in Communities focuses on three key areas to enable people to live well in their community for longer. They are:



Living Well in Communities has launched the Living and Dying Well with Frailty Collaborative. The purpose of the collaborative is for participating teams to improve how they identify and enable people aged 65 and over to live and die well with frailty in the community.

How to use this change package

This change package is a resource for teams to use during the Living and Dying Well with Frailty Collaborative. It has been produced to support teams when they design and implement changes to improve how people aged 65 and over live well with frailty in the community.
There are three distinct parts to this Change Package; Driver Diagram, Change Ideas and Measures.
It is a toolkit containing a **menu** of options for improvement teams working on this topic. The contents include:

- evidence informed interventions, linked to potential change ideas which can be tested by a team to achieve the improvement aim,
- examples of how these interventions can be planned in practice, and
- list of potential measures that can be used to measure progress

Teams are not expected to focus on all of the interventions within this document, but are required to commit to at least the following elements as part of the collaborative:

- use the electronic frailty index (eFI) through SPIRE to identify people living with frailty aged 65 years and over.
- engage in anticipatory care planning conversations with people living with frailty and record the information in the Key Information Summary (KIS).
- work within a multidisciplinary team to consider the holistic needs of the person, and
- use quality improvement methods to structure the work, including using data to learn how changes are being implemented and the impact they make.

Once teams have used the eFI to identify the population they wish to focus on, this change package should be used to:

- build engagement and create the will to change around the topic,
- identify and prioritise the intervention the team wish to focus on,
- consider which changes the team will undertake, and determine what improvements these changes will lead to, and
- consider what other changes may be required at a later date.

Driver Diagram

The driver diagram on page 7 describes the elements that need to be in place to achieve improvements in supporting individuals with frailty to remain within their community.

Primary drivers are high level ideas that, if implemented, can help to achieve the improvement aim. Secondary drivers are a series of actions which, when undertaken, will contribute to the primary drivers, and in turn the aim. To deliver the aims of this collaborative, participating teams are asked to commit to the four primary drivers shown in the driver diagram and develop local change ideas relating to these.

The driver diagram has been developed by

- using the best evidence available,
- learning from testing, and
- taking into consideration the key areas that senior leaders and frontline staff could have an impact on.

Interventions

To identify the interventions to be used by participating teams a review of evidence relating to community-based interventions was undertaken by Healthcare Improvement Scotland. The review looked at evidence for interventions in frailty that are community based, focused on the prevention of harms or poor outcomes, and supported by high-level evidence. The interventions are summarised in the driver diagram.

Teams will decide the activities they wish to deliver that are linked to the four drivers for change, **but will be asked to commit to at least the following elements of the change package:**

- use the eFI through SPIRE to identify people with frailty aged 65 years and over,
- engage in anticipatory care planning conversations with people with frailty and record the information in the Key Information Summary,
- work within a multidisciplinary team to consider the holistic needs of the person, and
- use quality improvement methods to structure the work, including using data to learn how changes are being implemented and the impact they make.

Living and Dying Well with Frailty Driver Diagram

Measurement Plan

This measurement plan includes process and outcome measures that have been developed to support teams to collect data that will inform the tests of change they undertake as part of their improvement work.

Outcome measures

Outcome measures allow teams to describe and measure the impact of improvement work, and how the system impacts on patient's health and wellbeing. Participating teams will be asked to sign up to the three main measures of the collaborative so that the impact of the work can be recorded over time. As part of the collaborative, there is an expectation that participating teams agree to sharing their local data with other areas. Teams will also be supported to develop additional outcomes as required locally.

Reduce hospital bed days for people aged 65 and over by 10%, per 1,000 population		
Operational definition	**Data collection**	**How will the data be shared?**
Total number of bed days that result from a non-elective admission for over 65s, divided by, total 65+ population, multiplied by 1000	Routine data collected as part of patients being admitted to hospital. Bespoke analysis required to know numbers of patients over 65 years of age. Collected on a quarterly basis for all patients Source: LIST analysts NSS	National data collected and displayed in run charts, updated quarterly. Level of breakdown for local area to be agreed.

Reduce unscheduled GP home visits for people aged 65 and over by 10%, per 1,000 population		
Operational definition	**Data collection**	**How will the data be shared?**
Count of unscheduled home visit requests for people over 65. Define as those who are 65 or over at the time the request is made. Multiple unscheduled requests to the same person will be included as separate requests.	Bespoke data collection as part of a local audit process: Source Local team. Collected on a monthly basis.	Displayed in run charts, updated monthly. Level of breakdown for local area to be agreed.

Increase percentage of anticipatory care plans in the Key Information Summary (KIS) for people living with frailty by 20%, per 1,000 population		
Operational definition	**Data collection**	**How will the data be shared?**
The percentage of KIS [Derived as: (total KIS for 65s and over / all number of 65s and over) x 100].	Collected on a monthly basis Source: Data and Measurement Team, HIS, local team	National data collected and displayed in run charts, updated monthly. Level of breakdown for local area to be agreed.

Process measures and proposed change ideas

Process measures should allow teams to determine if the steps in the system are performing as planned, and if they are on track in their improvement efforts. The next section of this change package describes some examples a team may wish to use to track their progress towards the desired outcomes. **It should be noted, teams are not expected to collect data on all the proposed measures, only those which relate to their area of testing.**

The percentage of a process measure is calculated by dividing the numerator by the denominator and multiplying by 100. For example, to calculate the percentage of ACP summaries recorded on KIS:

- Numerator = 50 (50 patients had an ACP summary recorded on KIS)
- Denominator = 100 (100 patients had an ACP conversation take place)
- 50/100 = 0.5 x 100 = 50
- 50% of patients had an ACP summary recorded on KIS

Change ideas

The following pages will take the primary and secondary drivers within this change package, and provides examples of change ideas and process measures for each of these which you can adapt to your local context. It is designed as a guide to support teams to test changes, however it should be reinforced that these are examples, and teams may wish to test their own change ideas and process measures which are not listed within this document.

Based on the evidence review undertaken by Healthcare Improvement Scotland, each change idea displays a guide to the frailty level the idea is suitable for. The frailty levels are mild, moderate and severe.

Mild frailty

Moderate frailty

Severe frailty

Primary Driver: Identify people aged 65 and over living with frailty in the community

Secondary drivers:

- Case find people at risk using the e-Frailty Index
- Code as frail on local systems
- Multi-dimensional assessment
- Monitor change and deterioration over time

Operational definitions key: N: Numerator
D: Denominator

Change idea: Use the eFI to identify and refine changing/high risk population		**Frailty level:** 
Process measures	**Operational Definition**	**Data collection guidance**
Number of individuals identified using the eFI	Count of individuals identified in relevant cohort of high risk population	eFI report/Local systems

Change idea: Discuss at risk population group based on eFI results to identify suitable intervention		**Frailty level:** 
Process measures	**Operational Definition**	**Data collection guidance**
Number of individuals identified using the eFI and discussed at MDT	N: No of individuals discussed at MDT D: No of individuals identified in cohort	eFI report/Local systems

Primary Driver: Support people living with frailty to plan for their future care needs, and when appropriate, death

Secondary drivers:

- Anticipatory care planning conversations, including recording information in the Key Information Summary
- Carers assessment
- Adult carers support planning

Change idea: Ensuring individuals with the most complex needs have a recently updated KIS		**Frailty level:** 
Process measures	**Operational Definition**	**Data collection guidance**
% of identified individuals where ACP conversation has taken place	N: No of individuals where ACP conversation has taken place D: No of individuals identified for ACP	NSS monthly KIS extract
% of identified individuals with an ACP summary recorded on KIS	N: No of individuals who have an updated EKIS following ACP discussion D: No of individuals where ACP conversation has taken place	NSS monthly KIS extract

Change idea: Ensuring ACP conversation is carried out and recorded by the most relevant professional e.g. third sector organisation		**Frailty level:** 
Process measures	**Operational Definition**	**Data collection guidance**
No of individuals who have had an ACP conversation with someone not based in the GP practice	Count of individuals where ACP conversation has taken place outside the GP practice	Local data collection

Change idea: Adult carers support planning		**Frailty level:** 
Process measures	**Operational Definition**	**Data collection guidance**
% of adult carers who have participated in ACP conversation	N: No of carers where ACP conversation has taken place D: No of carers referred for participation in ACP	NSS monthly KIS extract

Primary Driver: Support people living with frailty to access preventative support in the community

Secondary drivers:

- Key worker
- Exercise and physical activity interventions
- Lifestyle and nutritional interventions
- Polypharmacy review
- Reablement
- Vaccinations
- Community based geriatric services
- Palliative and end of life care

Change idea: Key worker to support individual to navigate access to community support		**Frailty level:** 
Process measures	**Operational Definition**	**Data collection guidance**
Number of frail individuals/families allocated a key worker	Count of individuals/families allocated a key worker	Local data collection

Change idea: Home based or supervised physical exercise programme		**Frailty level:** 
Process measures	**Operational Definition**	**Data collection guidance**
Number of individuals undertaking exercise programme	N: No of individuals undertaking exercise as referred D: No of individuals given exercise programme/referral	Local data collection

Change idea: Smoking cessation groups		**Frailty level:** 
Process measures	**Operational Definition**	**Data collection guidance**
% of individuals who attended service referral	N: No of individuals with service referral uptake D: No of individuals referred to services	Local data collection

Change idea: Drugs and alcohol education groups		**Frailty level:** 
Process measures	**Operational Definition**	**Data collection guidance**
% of individuals who attended service referral	N: No of individuals with service referral uptake D: No of individuals referred to services	Local data collection

Change idea: Nutritional screening		**Frailty level:** 
Process measures	**Operational Definition**	**Data collection guidance**
% of individuals who attended service referral	N: No of individuals with service referral uptake D: No of individuals referred to services	Local data collection

Change idea: Monthly pharmacy medication reviews		**Frailty level:** 
Process measures	**Operational Definition**	**Data collection guidance**
Number of medication reviews being carried out monthly	Count of medication reviews per month	Local systems

Change idea: Monthly pharmacy medication reviews		**Frailty level:** 
Process measures	**Operational Definition**	**Data collection guidance**
% of individuals with a review who's medication was adjusted	N: No of individuals where medication was adjusted D: No of individuals with a medication review	Local systems

Change idea: Assigning individuals to one clinician with overall responsibility for their medications, ensuring continuity of care		**Frailty level:** 
Process measures	**Operational Definition**	**Data collection guidance**
% of individuals with a review by the same clinician	N: No of individuals whose review was carried out by the same clinician as previously D: No of individuals with a medication review	Local systems

Change idea: Involving individuals in goal setting		**Frailty level:** 
Process measures	**Operational Definition**	**Data collection guidance**
% of individuals reaching set goals within 6 weeks	N: No of individuals reaching set goals within 6 weeks D: total number of individuals in sample	Manual local data collection

Change idea: Mobile immunisation units/vaccination reminders		**Frailty level:** 
Process measures	**Operational Definition**	**Data collection guidance**
% of people identified as frail with influenza vaccination	N: No of people identified as frail with an influenza vaccination D: No of individuals identified as frail	e-FI report/local systems

Change idea: Conduct Comprehensive Geriatric Assessment (CGA)		**Frailty level:** 
Process measures	**Operational Definition**	**Data collection guidance**
% of care planning discussions taking place	N: No of individuals where care planning discussion took place D: No of individuals using service	Local systems
% of MDTs with geriatrician specialist advice	N: No of MDTs with specialist geriatric advice D: No of MDTs taking place	Manual local data collection
% of individuals with completed comprehensive geriatric assessment	N: No of individuals with completed CGA D: No of individuals using service	Local systems

Change idea: Ongoing 'planning cycles' to inform care		**Frailty level:** 
Process measures	**Operational Definition**	**Data collection guidance**
% of care planning discussions taking place	N: No of individuals where care planning discussion took place D: No of individuals using service	Local systems
% of MDTs with geriatrician specialist advice	N: No of MDTs with specialist geriatric advice D: No of MDTs taking place	Manual local data collection

Change idea: Assessment tools i.e. supportive and palliative care indicators tool		**Frailty level:** 
Process measures	**Operational Definition**	**Data collection guidance**
% of individuals identified for palliative register	N: No of individuals on palliative care register D: No of individuals applicable for palliative care register	Local systems

Primary Driver: Develop effective multidisciplinary team working focused on person-centred, preventative care.

Secondary drivers:

- Communication and collaboration within a multi-disciplinary team, including a multi-disciplinary review
- Understand what support is available in communities, and how to access support
- Use quality improvement methods, including data over time, to drive improvement

Change idea: Structured MDT review (e.g. through use of falls and frailty assessment tools) MDT meeting good practice guide available here		**Frailty level:** 
Process measures	**Operational Definition**	**Data collection guidance**
Occurrence of MDT meetings	Locally agreed frequency	Local systems/manual local data collection
% of MDT meetings with relevant team members	Locally agreed attendees	Local systems/manual local data collection
Number of individuals discussed at MDT requiring action	D: No of individuals discussed at meeting N: No of individuals requiring further action	Local systems/manual local data collection

Change idea: Relevant individuals attend MDT (i.e. AHPs, social work, geriatrician, mental health team, pharmacy, community nursing)		**Frailty level:** 
Process measures	**Operational Definition**	**Data collection guidance**
Occurrence of MDT meetings	Locally agreed frequency	Local systems/manual local data collection
% of MDT meetings with relevant team members	Locally agreed attendees	Local systems/manual local data collection

Change idea: Community link worker		**Frailty level:** 
Process measures	**Operational Definition**	**Data collection guidance**
Number of individuals referred to link worker	Count of individuals referred	Local systems/Manual local data collection

Change idea: Quality improvement training, including online modules		**Frailty level:** 
Process measures	**Operational Definition**	**Data collection guidance**
No of staff in team with knowledge of QI methods	Count of staff with QI knowledge/application	Manual local data collection

Planning tests of change - examples

The following pages provide worked examples for each of the primary drivers. Each example will take you through a secondary driver and change idea, showing how you can start to plan your test of change. It is designed as a guide to support teams to test changes, however it should be reinforced that teams **do not** need to use these examples. A template to help you prepare for your own test of change can be found here

Primary Driver: Identify people 65 years and over with frailty in the community before they experience a crisis	
Secondary Driver - Monitor change and deterioration over time	
Potential change idea	Use the eFI to identify changing/high risk population
What population will you focus on	Individuals who escalate from mild to moderate frailty
Which staff group/s are involved	Practice based administrative team
How are individuals referred to the intervention	Practice admin run eFI report and forward names to GP
Frequency of intervention	Monthly reporting
What actions could you take / factors could you consider	How many computers will have access to eFI through SPIRE? Have the relevant team members received training in SPIRE? What population will you focus on? Who will run the report? Where will the report be discussed? Who is doing the coding, and when?

Primary Driver: Support people with frailty to plan for their future care needs, and when appropriate, death Secondary Driver – Anticipatory care planning conversations, including recording key information in KIS	
Potential change idea	Ensure those most at risk have an updated KIS
What population will you focus on	Moderate to severely frail
Which staff group/s are involved	Practice based administrative team and GP to update KIS
How are individuals referred to the intervention	Practice admin run report and forward names to GP. GP discusses at MDT meeting and agrees which individuals to invite for ACP focused appointment
Frequency of intervention	Monthly (reporting/MDT meeting)
What actions could you take / factors could you consider	How will individuals be identified as requiring an ACP? How will individuals be invited to attend for ACP discussion? How long will an ACP appointment be? Who adds the ACP summary info into the KIS? What is considered a 'current' ACP? How often will ACPs be reviewed? Which healthcare professional is best placed to have the ACP conversation? If not the GP, how will the information be recorded in the KIS?

Primary Driver: Assist people with frailty to access preventative support in their community Secondary Driver - Polypharmacy	
Potential change idea	Monthly pharmacy medication reviews
What population will you focus on	Moderate to severely frail
Which staff group/s are involved	Practice based administrative team, practice based pharmacist
How are individuals referred to the intervention	Practice based admin team run efI report and refer names to practice based pharmacist following identification through eFI and discussion at MDT

Frequency of intervention	Monthly MDT referral to pharmacy
What actions could you take / factors could you consider	How are patients identified as requiring a review? How will you stratify results? Who is part of the review? Consider local formulary compliance Agree local definitions of polypharmacy – i.e. 5 medications or more, between 5 - 10 medications Is there community pharmacy support available?

Primary Driver: Develop effective multidisciplinary team working focused on person centred preventative care

Secondary driver – Communication and collaboration within a multidisciplinary team, including multidisciplinary review

Potential change idea	Relevant individuals attend MDT
What population will you focus on	All
Which staff group/s are involved	Practice based team GPs, pharmacists and ANP/community team member representatives (social work, district nurse, links worker etc)
How are individuals referred to the intervention	eFI as well as individual clinician judgement
Frequency of intervention	Monthly
What actions could you take / factors could you consider	Will the MDT have the same core staff each meeting, or will it alternate? Will it be a face to face meeting or tele/videoconference? How many patients will be discussed in an MDT? Will you have all staff groups represented, or will certain groups represent others? How will actions/next steps be recorded and shared? Will there be follow up on discussions at the next MDT?

Published June 2019

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