

# An HSCP approach to using data to improve the care of people with frailty

*A local story from Living Well in Communities*

There are 12 GP practices making up one GP cluster in Midlothian Health and Social Care Partnership (HSCP) with approximately 95,000 people registered to these. In 2015 the HSCP estimated that there were around 3,500 living with frailty. Using the electronic frailty index (eFI) to identify people with frailty has shown there are more than 8,500 people within the HSCP who can be classified as mild, moderate or severely frail. The HSCP and the Midlothian GP Cluster are using the eFI to identify and improve the quality of care of those most at risk from frailty.

## ***Why was a change needed?***

The GP Cluster in Midlothian ranked frailty as its highest priority and one GP described the issue as ‘the global warming of primary care’ – the changes and increased pressure are incremental, however it will have a big impact in coming years. The experience of clinicians was that the number of people with frailty was increasing and there was concern that practices and the HSCP would not cope with meeting health and care needs without a better understanding of the populations’ need to inform how the Midlothian frailty system of care responds.

A big challenge for General Practices and the HSCP was how to identify people living with frailty. There was a feeling that the system of care was not optimised to consistently identify or anticipate the needs of someone living with frailty.

The cluster and the HSCP started exploring the benefit of using the electronic Frailty Index (eFI). Using data held in General Practice they found there were over twice as many people living with frailty as was first thought. The eFI offered the potential to use a validated approach to frailty stratification and population segmentation which crucially was based on GP patient records instead of relying on age or hospital-derived data to identify frailty.

## ***What did you do?***

There was a curiosity amongst GPs and practice staff about what the data would show and enthusiasm across the HSCP and the cluster to make better use of the eFI. Practices worked to improve the quality of coding whilst the HSCP worked with the cluster Quality Lead to develop a learning collaborative, combining data analysis with quality improvement to make practical use of the eFI.

The eFI uses read codes in patient records from four dimensions: *disease state; symptoms and signs; laboratory test results; disability*. The cluster identified that coding completeness in some areas needed improvement, for example requirement for care or mobility/transfer difficulties. Most practices decided to use the opportunity of inviting people to attend routinely scheduled flu clinics in order to carry out simple observational tests to help identify frailty (i.e. gait speed and time to get out of chair). Where someone was identified as frail the practice contacted them in a timely manner either by phone or by posted questionnaire to answer questions that were then recorded in the patient record. This method of inviting and identifying patients was highly effective. After updating the coding using this method the number of people estimated to have frailty in Midlothian was 8,350 (March 18). This has subsequently increased by 5%.

The HSCP was granted funding through the Health Foundations *Advancing Applied Analytics* programme. This additional funding allowed a senior information analyst to be employed and provided financial support to practices. This enabled GPs to form a learning collaborative, led by the HSCP, which allowed them dedicated time to explore the data and lead quality improvement (QI) projects with results shared in the learning collaborative.

The learning collaborative met twice in the first year with more meetings between individual practices and the HSCP's frailty team. Information on frail patients was shared at practice-level on demographics, practice-activity, hospital-activity, prescribing and continuity of care in practices. Most practices completed one or more QI projects using the eFI to segment the practice population. QI projects focused on frequent attendees to primary care, deprescribing, Key Information Summaries (KIS) and Anticipatory Care Planning (ACP). A case study describing the journey of one practice can be found [here](#).

The HSCP was supported by the Healthcare Improvement Scotland Improvement Fund to use the eFI to connect people estimated to have mild frailty to an established 3<sup>rd</sup> sector service, neighbourhood links, run by the [British Red Cross](#).

### **What next?**

The learning collaborative is continuing and the HSCP has provided funding for the analyst to provide dedicated sessions to practices to allow them to continue to use their data to inform improvements to the system of care for individuals with frailty. After a year of learning from testing, the emphasis is shifting to sustainability of the work, scaling successful QI projects and improving capacity, pathways and coordination of care across communities. The work now underway through the Midlothian Frailty Learning Collaborative and the HSCP includes:

- **Improving coordination of care within a community.** The Penicuik Frailty Multidisciplinary Team (MDT) meeting has evolved after learning from a study meeting to [Oban](#) and through multiple PDSA cycles. Penicuik Practice has been testing the role of enhanced medical input from GPs and other professionals from health, social care and third sector ahead of the MDT. The HSCP is interested in how this approach aligns with the development of the GP as the 'expert medical generalist' as described in the new GP contract.
- **Improving connectivity of services.** The collaboration between three General Practices and British Red Cross' Neighbourhood Links service has shown a disconnect between important third sector services in the frailty system of care. As this project continues British Red Cross workers are receiving training to assess and fit basic home adaptations (i.e. handrails) which is reducing the workload of occupational therapists and improving access around the home for patients. The HSCP also wants to understand the service user perspective more fully, in terms of being proactively contacted and directed to a service, rather than the conventional approach of a service responding to an expressed need or support with a life event.
- **Improving continuity of care and access in a larger General Practice.** Newbattle Practice is assessing the impact of dedicated frailty support to high risk patients within the Practice. The equivalent of 1 WTE GP will support 400 people estimated to have moderate or severe frailty through eFI. During the one-year pilot the relationship with existing HSCP services will be developed and the project will be evaluated against patient and staff experience and impact on practice and hospital activity. SOURCE data shows that this group of patients accounts for around 8% of the total spend of Midlothian Integrated Joint Board's hospital unscheduled care activity in the Edinburgh Royal Infirmary.
- **Improving pathways.** Findings from the programme have identified three pathways that need review and development: Weight management and nutrition; mobility; and support claiming entitled benefits.
- **Using technology to improve the frailty system of care.** Midlothian HSCP has received funding from the Scottish Government's Technology Enabled Care Pathfinder Programme. Working with the Digital Health and Care Institute the ambition is for technology to support development of more anticipatory frailty systems of care.

### **Key points**

- Leadership - The HSCP and GP cluster demonstrated strong leadership and engagement from the outset of the work, by jointly prioritising frailty and allowing practices time to commit to making improvements – this has been key to the success of the project.
- Early identification – Inviting patients to attend a flu clinic and at the same time using simple observational methods to determine frailty was an effective way to identify frail individuals and improve coding.
- Learning collaborative - The learning collaborative involved people who were enthusiastic in testing new ideas, in some cases these were individuals who hadn't previously been involved in HSCP work. Opening up opportunities to new people as well as those already involved can create and strengthen networks. The collaborative was key to allowing GPs dedicated time to learn from their data and make improvements.
- QI tools and techniques - Using Quality Improvement methods provided a framework to better understand the data. There was already a good level of QI knowledge in the learning collaborative from clinicians attending national and Lothian QI courses and from support provided by the NHS Lothian Quality Directorate.