Healthcare Improvement Scotland

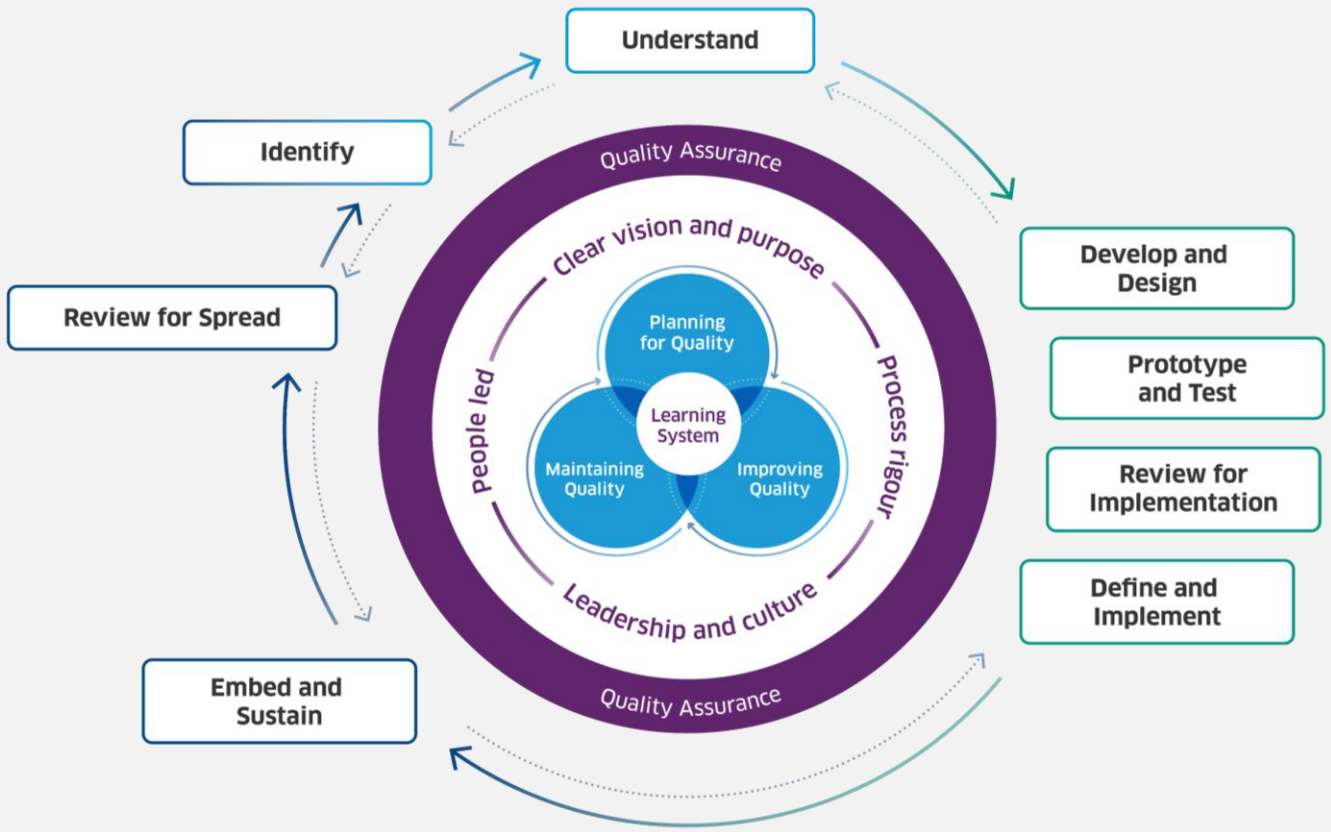
Scottish Approach to Change

Case Study: Focus on Frailty

October 2025

NHS SCOTLAND

The Scottish Approach to Change



The Scottish Approach to Change includes two aspects:

- the **Steps of Change** – which outline the process that should be undertaken when delivering change, and
- the **Enablers for Change** – the other aspects that are essential to enabling successful change.

The Scottish Approach to Change is integrated with the HIS Quality Management System Framework. It explains how to use a quality management system approach through a change process.

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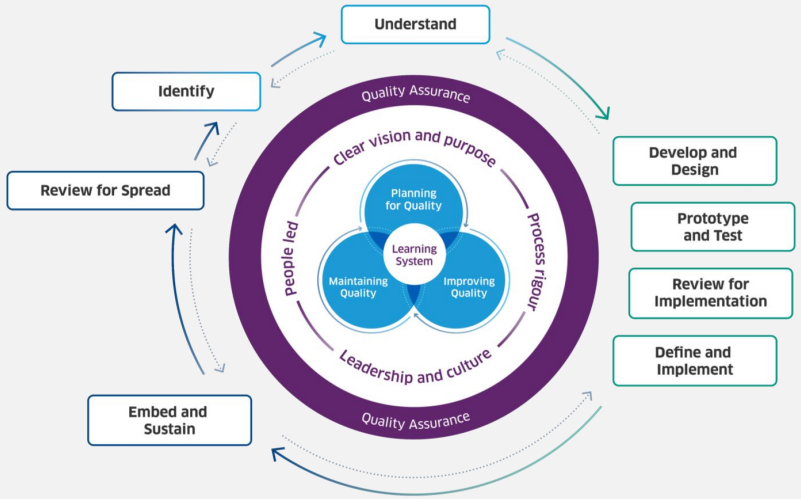
Focus on Frailty

This Case Study provides an example of the Scottish Approach to Change, showing how the steps of change and the enablers of change can be used in practice to deliver change.



The Focus on Frailty programme is a national improvement and implementation programme. The programme supports health and social care teams **to improve access, experience, and outcomes of health and social care for older people living with frailty**.

The programme has a particular focus on setting up hospital front door frailty pathways and improving integrated care coordination across primary, community and acute care.

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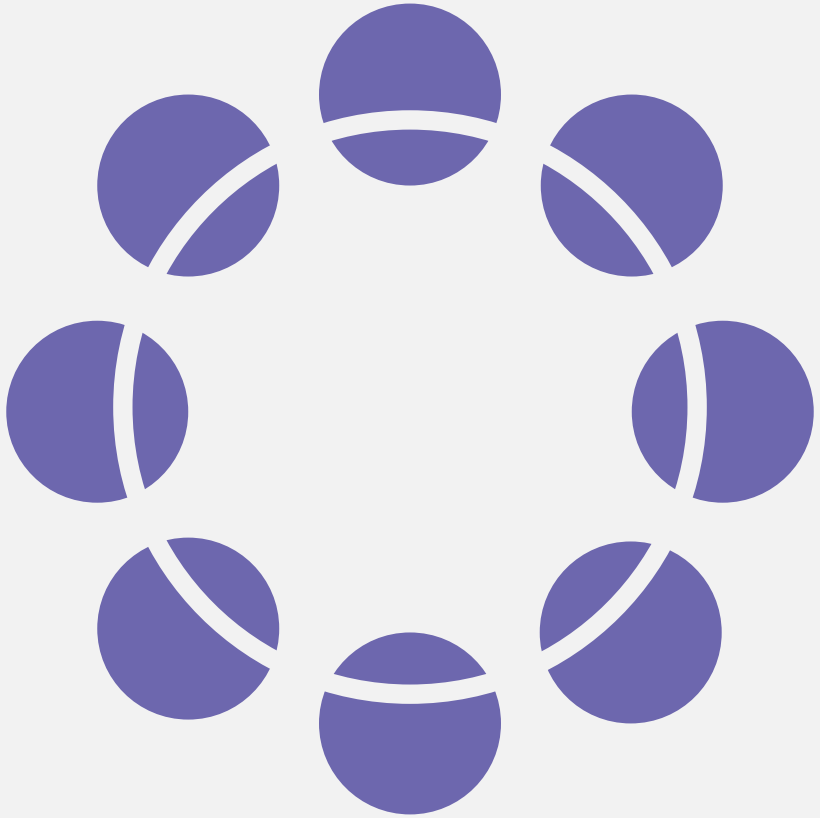
The Steps of Change

How did they make the change?



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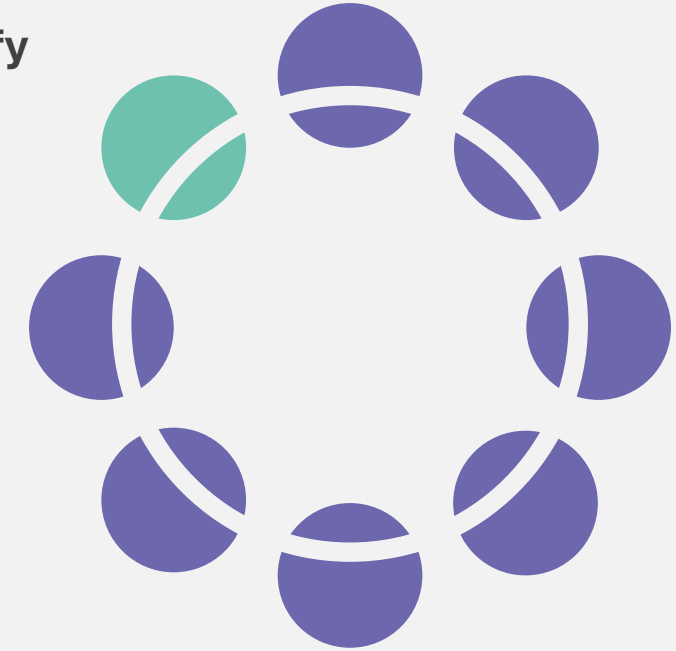
Identify



Healthcare Improvement Scotland's **Ageing and Frailty Standards** describe the problem:

- Older people living with frailty are amongst the **most vulnerable** in our society. They can be at **risk of harm** if we do not understand and address their needs, or if our **systems and services are inadequate, ineffective or poorly coordinated**.

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Understand

Identify

The Focus on Frailty programme supports health and social care teams to:

- **Understand the evidence base:** older people living with frailty are likely to benefit from integrated, multiagency planning and delivery of care.

- **Understand their systems**:
  - identify key stakeholders in the hospital, community and pre-hospital interfaces
  - map the current service
  - map current service user journeys
  - identify baseline data, and
  - model demand for a front door frailty service.

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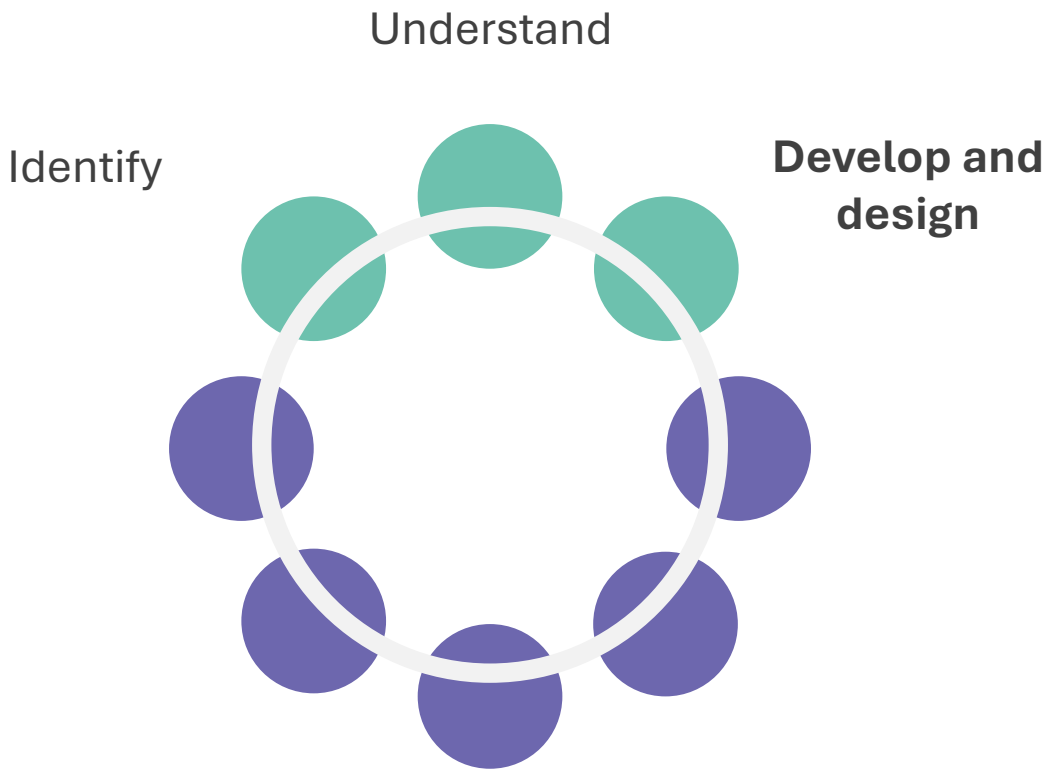

The Focus on Frailty programme has supported health and social care teams to co-design new front door frailty services.

- **Development of an aim, measurement plan, and theory of change**, for example a driver diagram.
- **Engagement with service users, families and carers, and staff is essential to co-design**. This has involved local patient experience teams where they are available.

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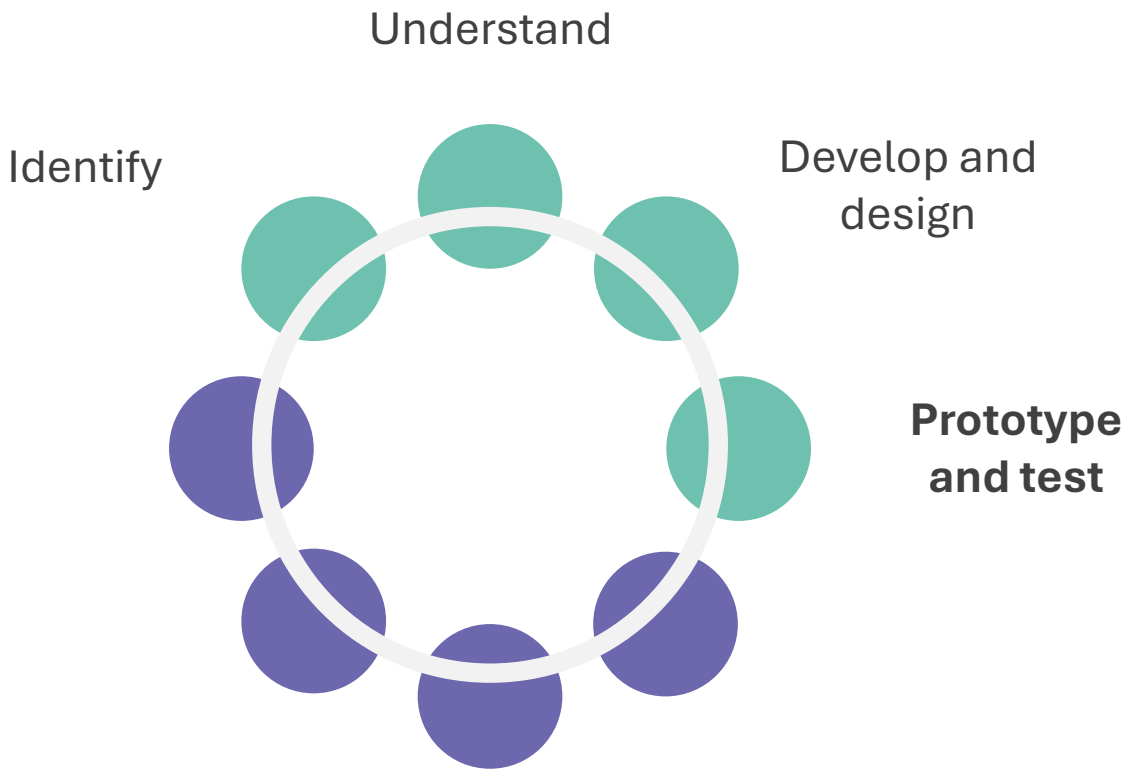

The Focus on Frailty programme supports health and social care teams to develop and test new hospital frailty services including:

- **defining frailty bed space** in hospital,
- **agreeing and testing the remit of a hospital frailty team, governance and reporting structures**
- **developing the frailty pathway** across unscheduled care including testing processes for timely electronic identification and initiation of comprehensive geriatric assessment, and
- **testing standard operating procedures** which cover: working as a multidisciplinary team, prioritising workload, and how the pathway functions.

This is supported by the Key steps to setting up a front door frailty service (April 2025) resource.

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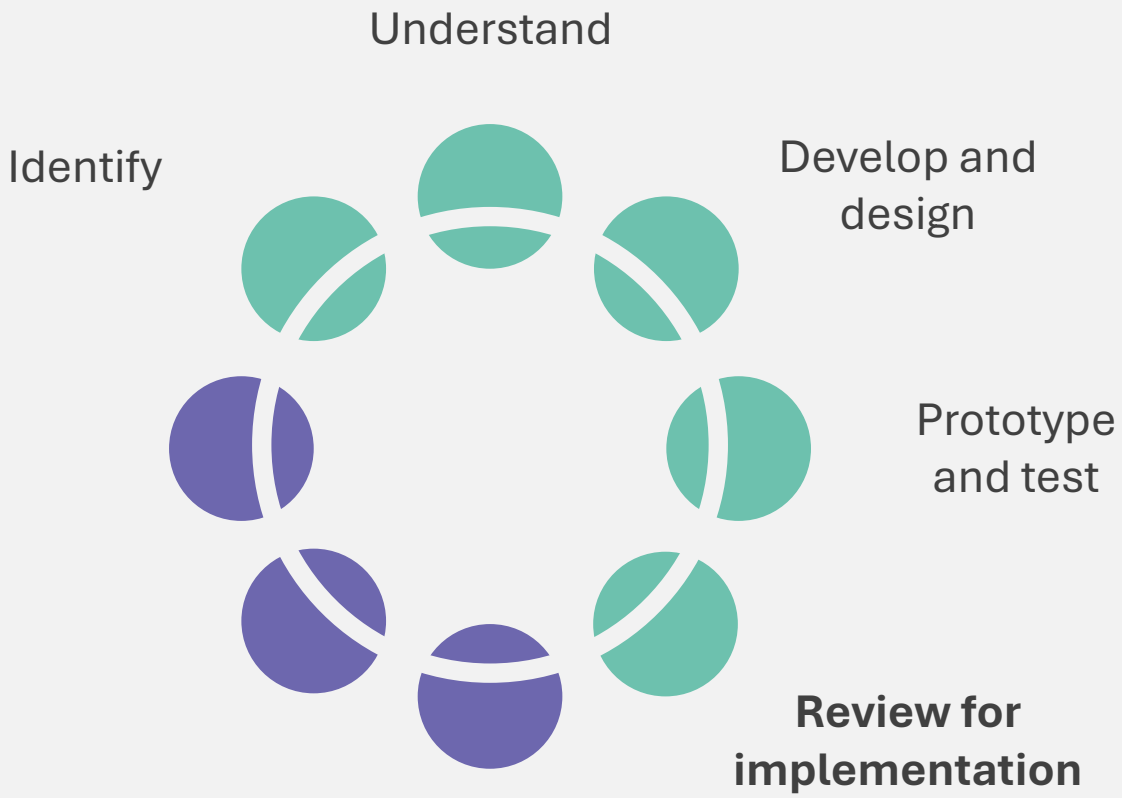

The Focus on Frailty programme supports health and social care teams to use **quality improvement methods to measure the progress and impact** of new hospital front door frailty services and community frailty services, including:

- using outcome, process and balancing measures to understand what has worked and what hasn't worked, and why, and
- making decisions about whether to adopt, adapt or abandon the test of change.

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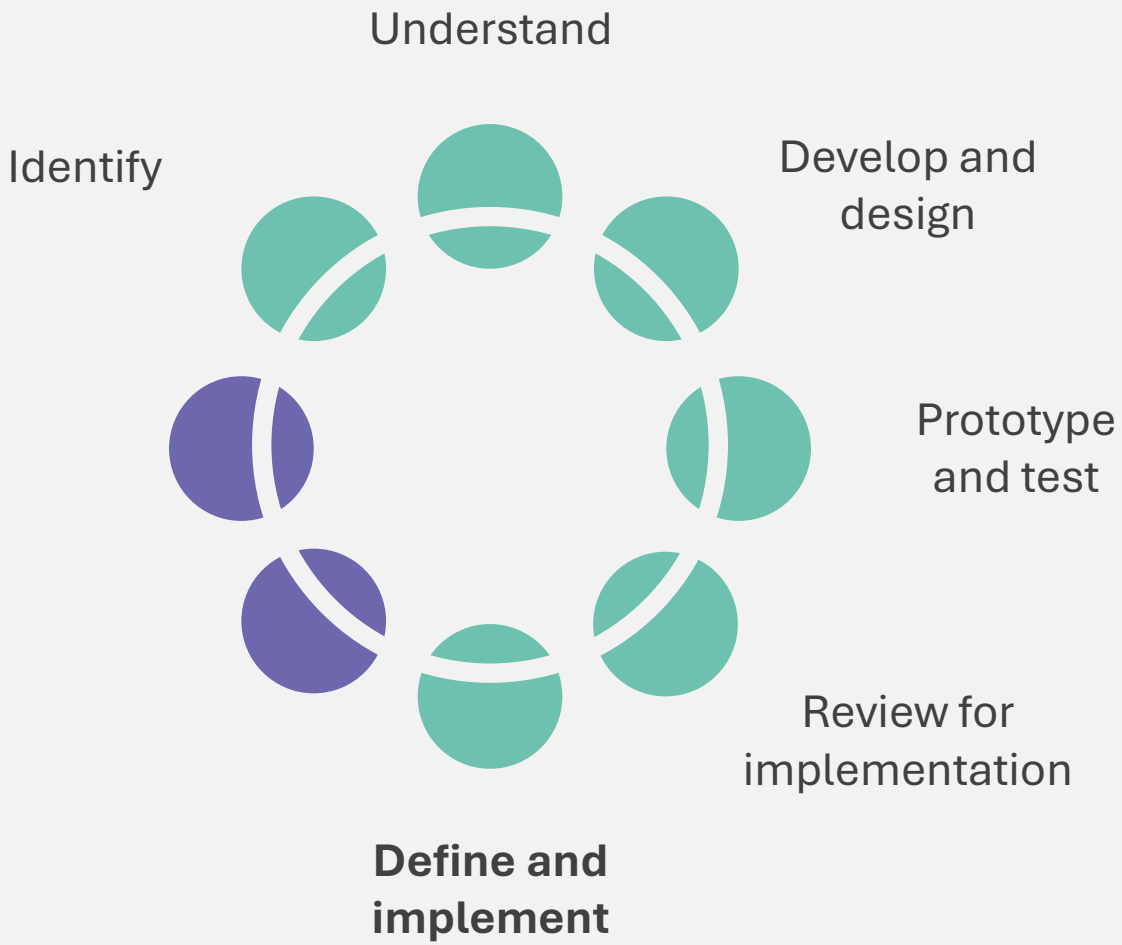

The Focus on Frailty programme supports health and social care teams to define and implement hospital front door frailty services and frailty services in the community.

- This includes **using the HIS frailty change package** which supports teams to improve the experience of and access to person led, coordinated health and social care for people living with or at the risk of frailty.

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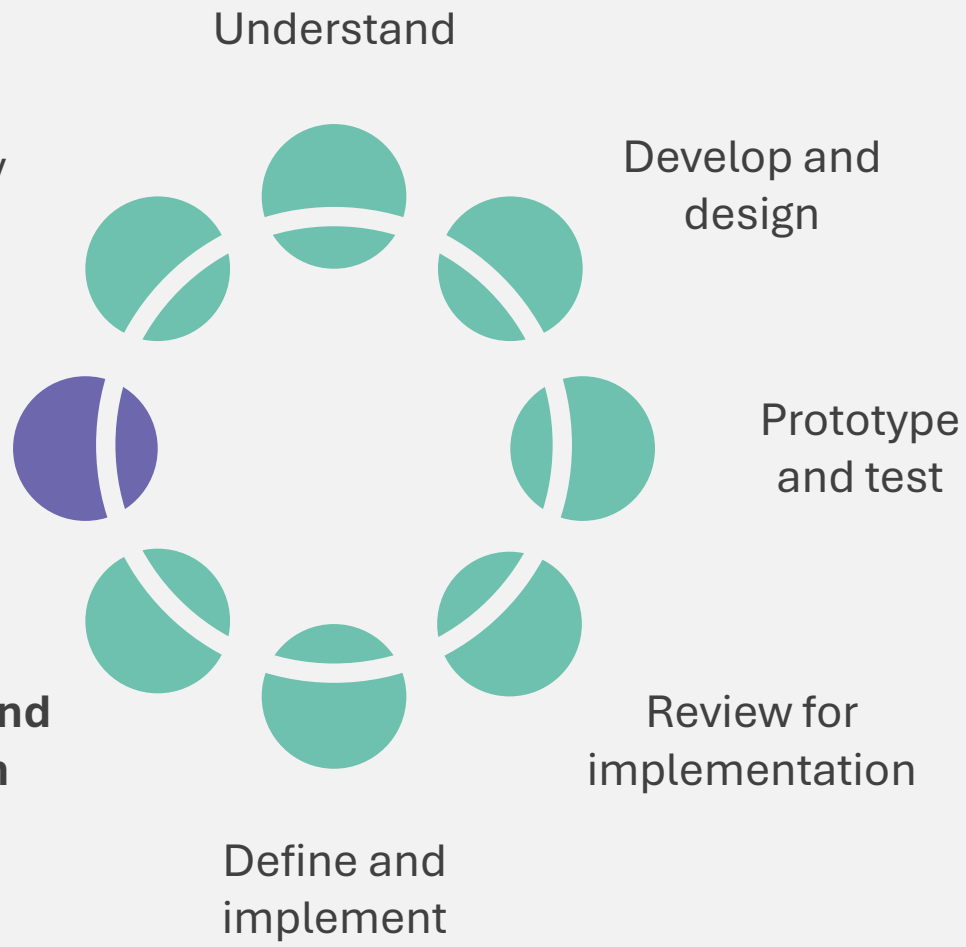

The Focus on Frailty programme supports health and social care teams to embed and sustain hospital front door frailty services and frailty services in the community.

- **Multi-disciplinary frailty teams** are key to embedding the new front door frailty service and delivery of integrated care.
- **Leadership, culture, and a whole system approach** are essential to ensuring changes are sustainable.
- **Engagement with service users, families and carers, and staff** is also key to embedding sustainable frailty pathways.

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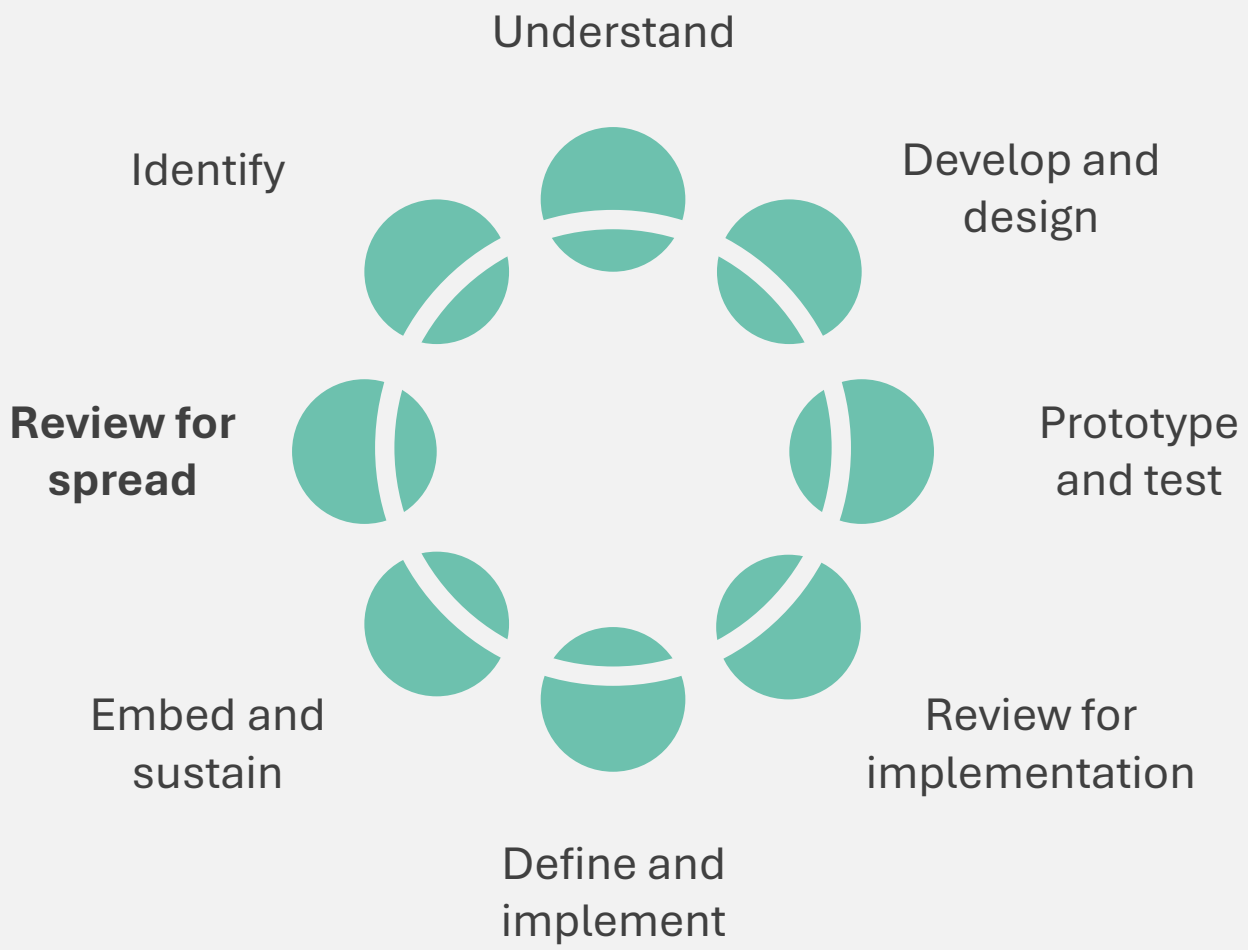

The Focus on Frailty programme spreads improvement by supporting health and social care teams to:

- **implement aspects of the Ageing and Frailty Standards** across the system, and
- **share practice examples, tools and resources relating to frailty improvement work** via the frailty learning system.

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The Enablers for Change

Why did it work?

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Process rigour

People- led

Leadership and culture

Clear vision and purpose

Clear vision and purpose is necessary to provide direction, motivation, and alignment for everyone involved, leading to efforts that are focused and effective.

- Within the Focus on Frailty programme and nationally there is a **clear system-wide strategic vision** for integrated delivery of services for older people living with frailty.

- A **whole system approach** is crucial to delivery of sustainable change. Making a change in one part of the health and care system may have unintended consequences for other parts of that system. For example, a front door frailty service may enabler service users to return home earlier than the current care pathway. It is important to consider:
  - whether care packages are available and in place for people to get home and supported safely earlier
  - the impact on caregivers
  - potential impact on hospital at home services

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Process rigour

People- led

Leadership and culture

Clear vision and purpose

Leadership, culture, and a whole system approach are key to sustainable change. The Focus on Frailty programme has identified key leadership and culture enablers to support successful change.

Leadership

- An executive leadership sponsor to drive the change and to influence a whole system approach to frailty.
- Integrated/joint leadership of the front door frailty service across operational management, medicine, general practice, geriatricians, nursing, allied health professionals, and adult social care.

A learning culture

- Education for everyone working with older adults, focused on developing frailty skills appropriate to role and responsibilities.
- A system to share learning and promote professional development.
- A robust and skilled workforce with the knowledge and time to support older people living with frailty.

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Process rigour

People- led

Leadership and culture

Clear vision and purpose

A people led approach to change is crucial to delivering change which is fit for purpose. The Focus on Frailty programme has worked with health and care teams to ensure a people-led approach to change.

- **Forming multidisciplinary frailty teams*** to embed a person led approach, enabling holistic care based on seeing the whole person. This has included:
  - developing a shared vision and objectives
  - building relationships between clinicians and managers working across primary, community and acute care
  - holding regular core team meetings to share learning and build momentum

- **Engaging with service users, families and carers**, and staff to develop people-led services.

- **Developing strong relationships with the third sector and community supports**.

* Multidisciplinary frailty teams include nursing, medicine, specialist frailty roles (nurses and AHPs), operational management, HSCP, pharmacy, social work, dietician, speech and language therapy, discharge coordinator, psychiatry, occupational therapy, physiotherapy, community frailty practitioners, adult social care.

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Process rigour means deliberately and systematically going through a structured process to ensure high-quality and reliable outcomes are achieved.

Quality improvement, project and programme management approaches have been used to support process rigour across the Focus on Frailty programme, including supporting heath and care teams to:

- create project charters and driver diagrams
- identify and manage risks
- link to local governance frameworks
- measure progress and impact
- undertake continuous data led improvement in partnership with service users, families and carers

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What outcomes have been achieved?

Health and social care teams have achieved the following outcomes:

- reduced the average length of stay for older people living with frailty
- improved timely access to the right care
- improved identification of older people living with frailty
- improved wellbeing for older people living with frailty
- reduced unnecessary medicines
- strengthened relationships across primary, community and secondary care
- increased knowledge of frailty

The Focus on Frailty programme has enable improvement:

"Without involvement in this programme [Focus on Frailty] we wouldn't be as far along as we are ... Healthcare Improvement Scotland being involved has helped us on the hard days and helped us with the hard stuff"
– Advanced practice physiotherapist

For more information read our Focus on Frailty programme impact report 2023-24

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