Healthcare Improvement Scotland

Focus on Frailty programme: acute hospital frailty services

Change package

August 2026

NHS SCOTLAND

Contents

Introduction

This change package is designed to support teams in acute hospitals improve patient experience and access to services which are person-led and coordinated for older people living with frailty. It consists of high-level outcomes supported by change ideas that, when tested and implemented, lead to improvement. It brings together what is known about best practice, selected evidence and the experience of people working in health and social care. It is aligned with the Ageing and Frailty Standards (2024) and the Foundations for Community and Hospital Front Door Frailty Services (2025).

What is included in this change package?

- driver diagram
- change ideas
- guides, tools and signposts to the supporting evidence and examples of good practice, and
- guidance to support measurement.

We hope that you find the information provided useful. Whilst care has been taken in the selection of the materials included, a comprehensive search of the evidence has not been undertaken. Healthcare Improvement Scotland is not responsible for the content or the accuracy of the enclosed literature, guidelines and tools.

Guidance on using this change package

This change package is a resource to support teams to use quality improvement methods to improve access to person-led, coordinated health and social care for people living with or at risk of frailty. Teams are encouraged to identify areas for improvement relevant to their local context. It is not expected that teams will work simultaneously on all aspects of the change package. The change concepts and measures are not exhaustive. We recommend teams develop change concepts to fit their context and seek local quality improvement support, if available, in the development of additional measures as required.

Understanding what needs to change

Before starting a project, it is important for teams to understand what parts of their service need to change to ensure everyone has a shared sense of why and is focused on changes that will impact most beneficially on their system and service.

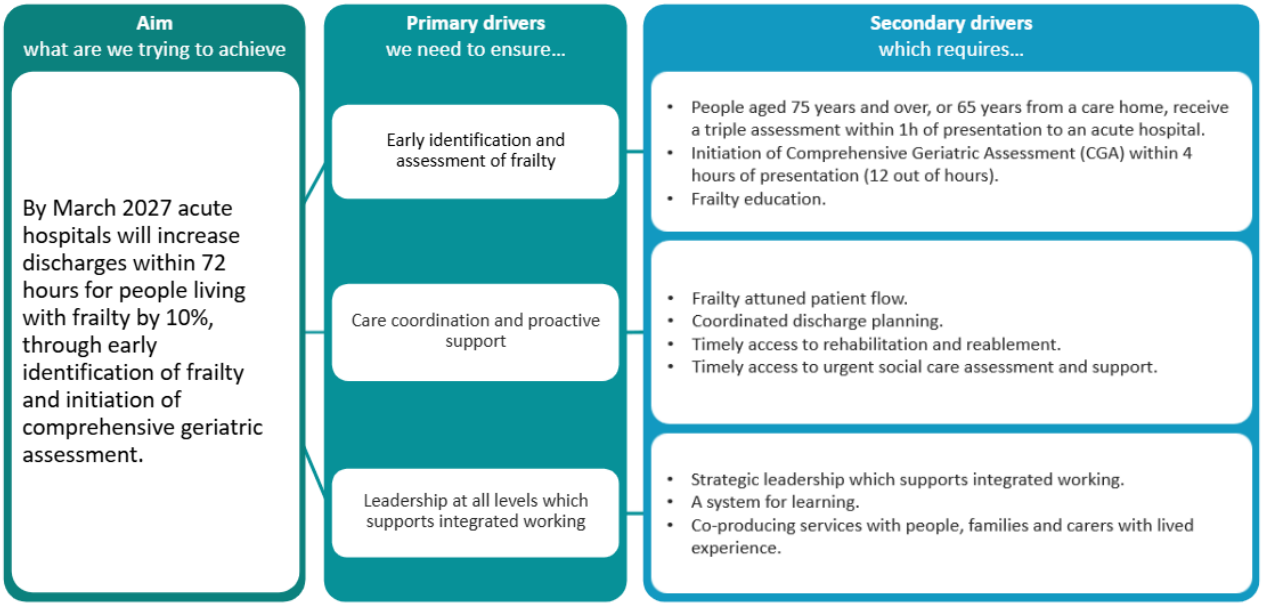
A driver diagram is a tool that visually presents a team's theory of how an improvement goal will be achieved. It articulates which parts of the system need to change, in which way and includes ideas of how to make this happen. It is used to help plan improvement projects and ensure team engagement.

Primary drivers

The primary drivers are the key components of the system that must change to deliver the aim. They are not listed in order of priority. The primary drivers align with the Ageing and Frailty Standards (2024) and Foundations for Hospital Front Door Frailty (2025).

Public Services Delivery (PSD) Scotland's QI Zone provides more information about Driver Diagrams.

Driver diagram: acute hospital frailty services



Change ideas

Change ideas are specific practical changes the team can make to alter the processes in their service. These ideas can be tested, and the impact measured to understand and evidence if this change leads to improvement. Project teams should select change ideas based on their understanding of their local system. A range of change ideas will need to be tested to ensure there are changes to all primary drivers.

The following pages provide some suggestions of change ideas that have been tested in teams who have participated in the improvement programme. Some may be more relevant to healthcare settings while others are more social care focused. The change ideas are grouped by the primary driver that they influence. Project teams are encouraged to generate their own change ideas that will help drive change in their local systems. One way of generating ideas is to use the question "How might we?" For example, "How might we engage carers more meaningfully?".

Primary driver: early identification of frailty and comprehensive geriatric assessment (CGA)

Secondary driver	Change ideas
People aged 75 years and over, or 65 years from a care home, receive a triple assessment	Use Clinical Frailty Scale or THINK Frailty in triage. Electronic recording of frailty screening.

within 1 hour of presentation to an acute hospital	Delirium screening using the 4AT tool. Identification of deterioration using NEWS 2.
Initiation of CGA* within 4 hours of presentation (12 hours if out of hours (OOH))	***CGA of**: **Mobility and function**. Active wards and change ideas which promote safer mobility. **Mental health - delirium and cognition**. Use of TIME bundle. **Medicine reconciliation and polypharmacy review.** Medicines reconciliation within six hours of admission and polypharmacy review. **Multimorbidity**. Seven-day service from a specialist frailty multi-disciplinary team (MDT). **Social and environmental**. Standardised CGA proforma. **Diagnosis and treatment plan**. 24/7 frailty assessment area within unscheduled care. Electronic recording and communication of CGA. **Future care plan and 'What matters to me'**. Future care planning and use of 'What Matters to Me' conversations and boards.
Frailty education	Standardised frailty education appropriate to role. Protected time for staff frailty education and simulation.

Primary driver: care coordination and proactive support

Secondary driver	Change ideas
Frailty attuned patient flow	Standard Operating Procedures, which are communicated and understood across care pathways. Frailty awareness within the bed management team.
Coordinated discharge planning.	Integrated MDT board rounds or huddle twice daily. Use of planned date of discharge process.

	Discharge coordinator roles aligned to a health and social care partnership. Hospital at Home referral pathway. Rapid access to outpatient hot clinics and imaging slots. Discharge to Assess referral pathways.
Timely access to rehabilitation and reablement.	Timely Allied Health Professional first assessment. Goal setting from admission from Physiotherapy and Occupational therapy. Deconditioning or reconditioning education for patients, families and carers.
Timely access to urgent social care assessment and support.	Enhanced community support in line with expressed wishes and future care plan. Integrated discharge hubs.

Primary driver: leadership and culture to support integrated working

Secondary driver	Change ideas
Strategic leadership which supports integrated working.	System-wide frailty strategy. NHS board frailty improvement work is appraised by Clinical and Care Governance groups. Local frailty leads network.
A system for learning.	Regular multidisciplinary huddles to review local data and prioritise improvement actions. Process to understand and share system learning from bright spots and adverse events.
Co-producing services with people, families and carers with lived experience.	Use of Care Experience Improvement Model (CEIM), including Discovery Conversations.

Primary driver: early identification of frailty and comprehensive geriatric assessment (CGA)

Measurement

An example programme measure for early identification of frailty and comprehensive geriatric assessment is the percentage of people with comprehensive geriatric assessment (CGA) initiated after frailty identification. For more information and a data collection template, please see the programme measurement plan.

Secondary driver: People aged 75 years and over, or 65 years from a care home, receive a triple assessment within 1 hour of presentation to an acute hospital

Older people are at higher risk of poor health outcomes when they present at urgent and unscheduled care services.[1] Prompt identification of frailty allows for timely access to further assessment, investigations, treatment and coordinated care.[1] By understanding the severity of frailty, preventative and proactive support can be tailored, helping individuals return to the community and remain independent for as long as possible.[2,3]

Change ideas

- Use Clinical Frailty Scale or THINK Frailty in triage.
- Electronic recording of frailty screening.
- Delirium screening using the 4AT tool.
- Identification of deterioration using NEWS 2.

Selected evidence and guidelines

British Geriatrics Society. Joining the Dots: A blueprint for preventing and managing frailty in older people [online]. 2023 [cited 2026 Mar 19]; Available from: https://www.bgs.org.uk/sites/default/files/content/attachment/2023-03-06/BGS Joining the Dots - A blueprint for preventing and managing frailty in older people.pdf

Healthcare Improvement Scotland. Ageing and Frailty Standards [online]. 2024 [cited 2026 Mar 19]; Available from: https://www.healthcareimprovementscotland.scot/wp-content/uploads/2024/11/Ageing-and-Frailty-Standards-November-2024.pdf

Kim DH, Rockwood K. Frailty in Older Adults. The New England journal of medicine. 2024;391(6):538–548; Available from: https://doi.org/10.1056/nejmra2301292

Rockwood K, Song X, MacKnight C, Bergman H, Hogan DB, McDowell I, et al. A global clinical measure of fitness and frailty in elderly people. CMAJ. 2005;173(5):489-495; Available from: https://doi.org/10.1503/cmaj.050051

Tools and resources

ADL Smartcare Ltd. The Life Curve™ [online]. 2025	The LifeCurve is an app-based toolkit designed to help individuals understand and manage the ageing process by tracking their functional abilities and providing personalized advice.
British Geriatrics Society course. Frailty - Identification and Interventions [online]. 2025.	This is a comprehensive in-depth resource on frailty in older people. It is aimed at health and social care professionals who provide care and services for older people living with frailty. This elearning course is funded by NHS England and is free until the end of June 2026.
Dalhousie University Geriatric Medicine Research. Clinical Frailty Scale [online]. 2021	Judgement-based clinical tool that assesses the person's illnesses, function and cognition to generate a frailty score ranging from 1 (very fit) to 9 (terminally ill). The Clinical Frailty Scale can be viewed on the Right Decision Service, Healthcare Improvement Scotland. Clinical Frailty Scale tool (copied with permission from Dalhousie University). [online] 2024.
Healthcare Improvement Scotland. Foundations for hospital front door frailty services [online]. 2025	This supports the development of frailty care pathways in acute hospitals. It includes admission and discharge planning.
Healthcare Improvement Scotland. THINK Frailty tool [online]. 2025	Tool supporting screening for frailty as an adjunct to clinical judgment. Can be used to screen all people over 75 and people resident in care homes over 65.
MacLullich A, Ryan T, Cash H. 4AT rapid clinical test for delirium. 2011	Evidence based tool for detecting delirium, designed for use in clinical practice. The tool can be accessed here Right Decision Service, Healthcare Improvement Scotland. 4AT delirium screening tool [online]. No date.

Royal College of Physicians. National Early Warning Score (NEWS) 2 [online]. 2017.	Information on the NEWS2 tool that is used to determines the degree of illness of a patient and prompt critical care intervention.

Secondary driver: initiation of CGA within 4 hours of presentation (12 hours if out of hours (OOH))

CGA on admission to acute hospital is the gold standard approach to improving outcomes for older people living with frailty.[1,4,5] The effective application of CGA for older people improves independence, reduces harms associated with deconditioning, delirium and polypharmacy, and reduces length of stay, unplanned re-admissions and the need for long-term care.[1,2,3,5,6] CGA leads to development of a personalised care plan and implementation of tailored interventions in a coordinated way.[2]

Change ideas

CGA of:

- **Mobility and function**. Active wards and change ideas which promote safer mobility.
- **Mental health - delirium and cognition**. Use of TIME bundle.
- **Medicine reconciliation and polypharmacy review.** Medicines reconciliation within six hours of admission and polypharmacy review.
- **Multimorbidity**. Seven-day service from a specialist frailty multi-disciplinary team (MDT).
- **Social and environmental**. Standardised CGA proforma.
- **Diagnosis and treatment plan**. 24/7 frailty assessment area within unscheduled care. Electronic recording and communication of CGA.
- **Future care plan and 'What matters to me'**. Future care planning and use of 'What Matters to Me' conversations and boards.

Selected evidence and guidelines

British Geriatrics Society. Comprehensive Geriatric Assessment Hub [online]. 2025 [cited 2026 Mar 19]; Available from: https://www.bgs.org.uk/CGA

British Geriatrics Society. Joining the Dots: A blueprint for preventing and managing frailty in older people[online]. 2023 [cited 2026 Mar 19]; Available from: https://www.bgs.org.uk/sites/default/files/content/attachment/2023-03-06/BGS Joining the Dots - A blueprint for preventing and managing frailty in older people.pdf

British Geriatrics Society. Silver Book II [online]. 2021 [cited 2026 Mar 19]; Available from: https://www.bgs.org.uk/resources/resource-series/silver-book-ii

Ellis G, Gardner M, Tsiachristas A, Langhorne P, Burke O, Harwood RH, et al. Comprehensive geriatric assessment for older adults admitted to hospital. Cochrane database of systematic reviews. 2017;9:CD006211; Available from: https://doi.org/10.1002/14651858.CD006211.pub3

Healthcare Improvement Scotland. Ageing and Frailty Standards [online]. 2024 [cited 2026 Mar 19]; Available from: https://www.healthcareimprovementscotland.scot/wp-content/uploads/2024/11/Ageing-and-Frailty-Standards-November-2024.pdf

Kim DH, Rockwood K. Frailty in Older Adults. The New England Journal of Medicine. 2024;391(6):538–548; Available from: https://doi.org/10.1056/nejmra2301292

Tools and resources

British Geriatrics Society, Comprehensive Geriatric Assessment Hub [online] 2025.	The CGA hub: • Defines CGA. • Explains how CGA works as a clinical intervention at a practical level. • Outlines the key evidence base for CGA across various health and care settings. • Provides an intricate guide for each domain of CGA, to help clinicians and teams understand the detail behind these interventions.
Public Services Delivery Scotland. Future care planning (REDMAP) [online]: 2025 (TURAS log in required)	Future care planning framework, guidance and resources.
Healthcare Improvement Scotland. Foundations for hospital front door frailty services [online]. 2025	This supports the development of frailty care pathways in acute hospitals. It includes admission and discharge planning.
NHS Scotland. 7 steps to appropriate polypharmacy [online]. 2022	Practical, step-by-step guide for managing polypharmacy.

Secondary driver: frailty education

Having a well-trained workforce who are supported to continually develop is key to ensuring the needs of people with frailty are met. It is recommended that staff in all health and care settings receive education and continuing professional development in ageing and frailty.[1,2,7] Training should develop competencies in skills, knowledge and attitudes.[4] This will allow staff to identify frailty and work within a multidisciplinary team to plan and deliver care to meet the needs of an ageing society.[1]

Change ideas

- Standardised frailty education appropriate to role.
- Protected time for staff frailty education and simulation.

Selected evidence and guidelines

British Geriatrics Society. Joining the Dots: A blueprint for preventing and managing frailty in older people [online]. 2023 [cited 2026 Mar 10]; Available from: https://www.bgs.org.uk/sites/default/files/content/attachment/2023-03-06/BGS Joining the Dots - A blueprint for preventing and managing frailty in older people.pdf

British Geriatrics Society. Silver Book II [online]. 2021 [cited 2026 Mar 10]; Available from: https://www.bgs.org.uk/resources/resource-series/silver-book-ii

Healthcare Improvement Scotland. Ageing and Frailty Standards [online]. 2024 [cited 2026 Mar 10]; Available from: https://www.healthcareimprovementscotland.scot/wp-content/uploads/2024/11/Ageing-and-Frailty-Standards-November-2024.pdf

National Institute for Health and Care Excellence. NICE guideline NG16: Dementia, disability and frailty in later life – mid-life approaches to delay or prevent onset [online]. 2015 [cited 2026 Mar 10]; Available from: https://www.nice.org.uk/guidance/ng16/chapter/Recommendations

Tools and resources

British Geriatrics Society course. Frailty - Identification and Interventions [online]. 2025.	This is a comprehensive, in-depth resource on frailty in older people. It is aimed at health and social care professionals who provide care and services for older people living with frailty. This eLearning course is funded by NHS England and is free until the end of June 2026.
British Geriatrics Society. Frailty Hub: Education and Training [online]. 2020	eLearning and other training materials on frailty.

Primary driver: care coordination and proactive support

Measurement

An example programme measure for care coordination and proactive support is average geriatric length of stay. For more information and a data collection template, please see the programme measurement plan.

Secondary driver: frailty attuned patient flow

People living with frailty are at risk of poor outcomes if they stay in hospital longer than necessary.[1,2,7,8] If a person with frailty is identified, they should be assessed and if necessary admitted to the most appropriate area.[1,2]

Change ideas

- Standard Operating Procedures, which are communicated and understood across care pathways.
- Frailty awareness within the bed management team.

Selected evidence and guidelines

British Geriatrics Society. Joining the Dots: A blueprint for preventing and managing frailty in older people[online]. 2023 [cited 2026 Mar 19]; Available from: https://www.bgs.org.uk/sites/default/files/content/attachment/2023-03-06/BGS Joining the Dots - A blueprint for preventing and managing frailty in older people.pdf

Healthcare Improvement Scotland. Ageing and Frailty Standards [online]. 2024 [cited 2026 Mar 19]; Available from: https://www.healthcareimprovementscotland.scot/wp-content/uploads/2024/11/Ageing-and-Frailty-Standards-November-2024.pdf

Tools and resources

Guide Template for developing Standard Operating Procedures (SOP's) [online]. 2026	Template for developing Standard Operating Procedures (SOPs). Example SOPs are available on the Focus on Frailty programme MS Teams channel.

Secondary driver: coordinated discharge planning

People living with frailty are at risk of poor outcomes if they stay in hospital longer than necessary.[1,2,8,9] Admission to hospital following a deterioration in health should be avoided if possible.[1] If admission to hospital is required, access to a specialist frailty team can improve patient outcomes.[1] Proactive discharge and future care planning should begin on admission and involve an integrated multidisciplinary team.[1,4] This will ensure the patient is supported in the community on discharge.[9]

Change ideas

- Integrated MDT board round or huddle twice daily.
- Use of planned date of discharge process.
- Discharge coordinator roles aligned to a health and social care partnership.
- Hospital at Home referral pathway.
- Rapid access to outpatient hot clinics and imaging slots.
- Discharge to Assess referral pathways.

Selected evidence and guidelines

Audit Scotland. Delayed discharges: A symptom of the challenges facing health and social care [online]. 2026 [cited 2026 Mar 19]; Available from: https://audit.scot/uploads/2026-01/nr_260108_delayed_discharges.pdf

British Geriatrics Society. Silver Book II [online]. 2021 [cited 2026 Mar 19]; Available from: https://www.bgs.org.uk/resources/resource-series/silver-book-ii

Healthcare Improvement Scotland. Ageing and Frailty Standards [online]. 2024 [cited 2026 Mar 19]; Available from: https://www.healthcareimprovementscotland.scot/wp-content/uploads/2024/11/Ageing-and-Frailty-Standards-November-2024.pdf

National Institute for Health and Care Research. Frailty: research shows how to improve care [online]. 2025 [cited 2026 Mar 19]; Available from: https://doi.org/10.3310/nihrevidence_64717

Tools and resources

Healthcare Improvement Scotland. Developing reliable frailty care pathways [online]. 2025	Improvement work undertaken by Glasgow Royal Infirmary as part of the Focus on Frailty programme between September 2023 and August 2025.

Healthcare Improvement Scotland. Discharge coordination for older people living with frailty [online]. 2026	Improvement work undertaken by Perth and Kinross HSCP and NHS Tayside as part of the Focus on Frailty programme between May 2023 to December 2024.
Healthcare Improvement Scotland. Foundations for hospital front door frailty services [online]. 2025	This supports the development of frailty care pathways in acute hospitals. It includes admission and discharge planning.
Healthcare Improvement Scotland. Hospital at Home: guiding principles for service development [online]. 2020	Information and evidence on the provision of "Hospital at Home" services in Scotland for older people living with frailty.

Secondary driver: timely access to rehabilitation and reablement

People living with frailty are at risk of losing functional abilities, including mobility, during a stay in hospital.[7,8] Early mobilisation in hospital and rapid establishment of rehabilitation goals can prevent falls and reduce their decline.[1,9] Access to rehabilitation on discharge can prevent a further deterioration and slow or restore loss of function.[2]

Change ideas

- Timely AHP first assessment.
- Goal setting from admission from Physiotherapy and Occupational therapy.
- Deconditioning or reconditioning education for patients, families and carers.

Selected evidence and guidelines

Audit Scotland. Delayed discharges: A symptom of the challenges facing health and social care [online]. 2026 [cited 2026 Mar 19]; Available from: https://audit.scot/uploads/2026-01/nr_260108_delayed_discharges.pdf

British Geriatrics Society. Joining the Dots: A blueprint for preventing and managing frailty in older people[online]. 2023 [cited 2026 Mar 19]; Available from: https://www.bgs.org.uk/sites/default/files/content/attachment/2023-03-06/BGS Joining the Dots - A blueprint for preventing and managing frailty in older people.pdf

Healthcare Improvement Scotland. Ageing and Frailty Standards [online]. 2024 [cited 2026 Mar 19]; Available from: https://www.healthcareimprovementscotland.scot/wp-content/uploads/2024/11/Ageing-and-Frailty-Standards-November-2024.pdf

National Institute for Health and Care Research. Frailty: research shows how to improve care [online]. 2025 [cited 2026 Mar 19]; Available from: https://doi.org/10.3310/nihrevidence_64717

Tools and resources

Healthcare Improvement Scotland. Foundations for hospital front door frailty services [online]. 2025	This supports the development of frailty care pathways in acute hospitals. It includes admission and discharge planning.

Secondary driver: timely access to urgent social care assessment and support

Urgent assessment and access to social care and/or community-based support can reduce unnecessary hospital admissions following a deterioration in health.[1] People living with frailty are at risk of poor outcomes if they stay in hospital longer than necessary, which can result in higher social care needs upon discharge.[2,9] People living with frailty should have access to services to support them to return home or into a care setting as soon as possible.[1]

Change ideas

- Enhanced community support in line with expressed wishes and future care plan.
- Integrated discharge hubs.

Selected evidence and guidelines

Audit Scotland. Delayed discharges: A symptom of the challenges facing health and social care [online]. 2026 [cited 2026 Mar 19]; Available from: https://audit.scot/uploads/2026-01/nr_260108_delayed_discharges.pdf

British Geriatrics Society. Joining the Dots: A blueprint for preventing and managing frailty in older people[online]. 2023 [cited 2026 Mar 19]; Available from: https://www.bgs.org.uk/sites/default/files/content/attachment/2023-03-06/BGS Joining the Dots - A blueprint for preventing and managing frailty in older people.pdf

Healthcare Improvement Scotland. Ageing and Frailty Standards [online]. 2024 [cited 2026 Mar 19]; Available from: https://www.healthcareimprovementscotland.scot/wp-content/uploads/2024/11/Ageing-and-Frailty-Standards-November-2024.pdf

Tools and resources

Healthcare Improvement Scotland. Foundations for hospital front door frailty services [online]. 2025	This supports the development of frailty care pathways in acute hospitals. It includes admission and discharge planning.

Primary driver: leadership and culture to support integrated working

Measurement

An example programme measure for leadership and culture to support integrated working is qualitative data on staff members' views on integrated working and evidence that organisational processes are in place to support high-quality integrated care.

Secondary driver: strategic leadership which supports integrated working

Proactive, preventative and integrated services have a positive impact on older people living with frailty.[1,2] A key enabler to this is a strong system-wide strategic vision and leadership that supports integrated working to promote healthy ageing and prevent and manage frailty.[1,2,10]

Change ideas

- System-wide frailty strategy.
- NHS board frailty improvement work is appraised by Clinical and Care Governance groups.
- Local frailty leads network.

Selected evidence and guidelines

Bailey S, West M. What is compassionate leadership? London King's Fund [online]. 2022 [cited 2026 Mar 16]; Available from: https://www.kingsfund.org.uk/insight-and-analysis/long-reads/what-is-compassionate-leadership

British Geriatrics Society. Joining the Dots: A blueprint for preventing and managing frailty in older people [online]. 2023 [cited 2026 Mar 10]; Available from: https://www.bgs.org.uk/sites/default/files/content/attachment/2023-03-06/BGS Joining the Dots - A blueprint for preventing and managing frailty in older people.pdf

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Sexton JB, Adair KC, Profit J, Bae J, Rehder KJ, Gosselin T, et al. Safety culture and workforce well-being associations with positive leadership walkrounds. The Joint Commission Journal on Quality

and Patient Safety. 2021;47(7):403-411; Available from: https://doi.org/10.1016/j.jcjq.2021.04.001

Tools and resources

Healthcare Improvement Scotland. Building whole system leadership and culture for frailty improvement [online]. 2025	Improvement work undertaken by NHS Lanarkshire, in collaboration with North and South Lanarkshire Health and Social Care Partnerships (HSCPs). The team were part of the Focus on Frailty programme from May 2023 to December 2024.
Healthcare Improvement Scotland. Foundations for community frailty services [online]. 2025	A resource that supports the development of community-based frailty services.
Healthcare Improvement Scotland. Foundations for hospital front door frailty services [online]. 2025	This supports the development of frailty care pathways in acute hospitals. It includes admission and discharge planning.
Healthcare Improvement Scotland. Scottish Patient Safety Programme Essentials of Safe Care [online]. 2025	A practical package of evidence-based guidance and support that enables Scotland's health and social care system to deliver safe care.
Healthcare Improvement Scotland. Strategic planning in health and social care [online]. 2025	A resource which provides insight, support and tools for strategic planning.
Institute for Healthcare Improvement. Patient safety leadership walk-rounds [online] 2022. (note requires IHI login)	Improvement tool providing key elements for successful implementation of WalkRounds™ and sample formats and questions to ask staff.
Leading to Change. Introduction to Leadership for Success Profiles. [online]. No date.	The Leadership Success Profile is for operational leaders across health and social care and the voluntary sector. It describes the leadership characteristics required to build inclusive cultures and to support the development of a diverse population of leaders.

Secondary driver: a system for learning

Learning systems and networks connect individuals to work together and share learning.[11] They support putting knowledge into action. This can enable transformation of service delivery and improve quality of care.[12]

Change ideas

- Regular multidisciplinary huddles to review local data and prioritise improvement actions.
- Process to understand and share system learning from bright spots and adverse events.

Selected evidence and guidelines

Centre for Public Impact, Healthcare Improvement Scotland, Iriss. Human Learning Systems: A practical guide for the curious [online]. 2022. [cited 2026 Mar 16]; Available from: https://www.centreforpublicimpact.org/assets/pdfs/hls-practical-guide.pdf

Davies S, Herbert P, Wales A, Ritchie K, Wilson S, Dobie L. Knowledge into action – supporting the implementation of evidence into practice in Scotland. Health Information and Libraries Journal. 2017;34(1):74-85; Available from: https://doi.org/10.1111/hir.12159

Tools and resources

British Geriatrics Society. Frailty Hub: Education and Training [online]. 2020	eLearning and other training materials on frailty.
Healthcare Improvement Scotland. HIS frailty learning system MS Teams channel [online]. 2025	Microsoft Teams channel for those working to improve care and support for people living with frailty in Scotland.
Healthcare Improvement Scotland. Learning Systems webpage [online]. 2025	Web resource describing the benefits, core components and how to establish a learning system.
Learning from Excellence. Learning from Excellence webpages [online]. no date	Website with resources and ideas to promote peer–reported excellence in healthcare.
Public Services Delivery Scotland: Quality Improvement Learner Pathways [online]. 2025 (TURAS log in required)	eLearning with a number of quality improvement modules.

Secondary driver: co-producing services with people, families and carers with lived experience

Services should be designed considering the lived experience of patients, families and carers who use them.[2,13,14] This will help to ensure frailty services are flexible and respond to the needs of patients and their carers.[2,13] Planning without consulting this group will result in services that do not support the people they are designed for.[2]

Change ideas

- Use of Care Experience Improvement Model (CEIM), including Discovery Conversations.

Selected evidence and guidelines

British Geriatrics Society. Joining the Dots: A blueprint for preventing and managing frailty in older people [online]. 2023 [cited 2026 Mar 10]; Available from: https://www.bgs.org.uk/sites/default/files/content/attachment/2023-03-06/BGS Joining the Dots - A blueprint for preventing and managing frailty in older people.pdf

O'Donnell D, Ní Shé E, McCarthy, Thornton S, Doran T, Smith F, et al. Enabling public, patient and practitioner involvement in co-designing frailty pathways in the acute care setting. BMC Health Services Research. 2019;19:797; Available from: https://doi.org/10.1186/s12913-019-4626-8

Sadler E, Potterton V, Anderson R, Khadjesari Z, Sheehan K, Butt F, et al. Service user, carer and provider perspectives on integrated care for older people with frailty, and factors perceived to facilitate and hinder implementation: A systematic review and narrative synthesis. PLoS One. 2019;14(5):e0216488; Available from: https://doi.org/10.1371/journal.pone.0216488

Tools and resources

Healthcare Improvement Scotland. Care Experience Improvement Model [online]. 2025	Framework that supports health and social care teams to make improvements directly related to feedback in a person-centred way.
Healthcare Improvement Scotland. Community led models: innovation in health and social care report [online]. 2021	Report sharing learning from innovative approaches to community-led health and social care provision.
Healthcare Improvement Scotland. Engagement practice learning and improvement system [online]. 2025	Guidance, tools and learning to support services to build the skills, knowledge, and confidence to engage with people.

Measurement

Measurement is vital for evaluating and enhancing the quality of care, ensuring accountability, and making informed decisions. A measurement plan sets out details for each measure proposed for an improvement project. Public Services Delivery (PSD) Scotland's QI Zone provides more information about Measurement Plans and an introduction to measurement for improvement.

Qualitative data is data that involves words. Stories and feedback give rich qualitative data. They are a very powerful way of finding out where opportunities for improvement lie, and of understanding and describing the impact of improvements.

Quantitative data is measurable as a number, including the numbers with a qualitative characteristic. It is possible to convert stories and feedback to numbers by either asking people to express an opinion on a statement using a rating scale like satisfaction or organising qualitative feedback into themes and counting the number in each (for example number of positive stories).

Contact us

Get in touch to provide feedback or share your plans for using the Focus on Frailty programme: acute hospital frailty services change package.

Email: his.frailty@nhs.scot

Web: Healthcare Improvement Scotland

Review date: March 2027

References

1. Healthcare Improvement Scotland. Ageing and Frailty Standards [online]. 2024 [cited 2026 Mar 19]; Available from: https://www.healthcareimprovementscotland.scot/wp-content/uploads/2024/11/Ageing-and-Frailty-Standards-November-2024.pdf

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