Healthcare Improvement Scotland

Focus on Frailty programme: integration and pathways between community and hospital

Change package

August 2026

NHS SCOTLAND

Contents

Introduction

This change package is designed to support teams in health and social care partnerships (HSCPs), GP practices and 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 concepts
- 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.

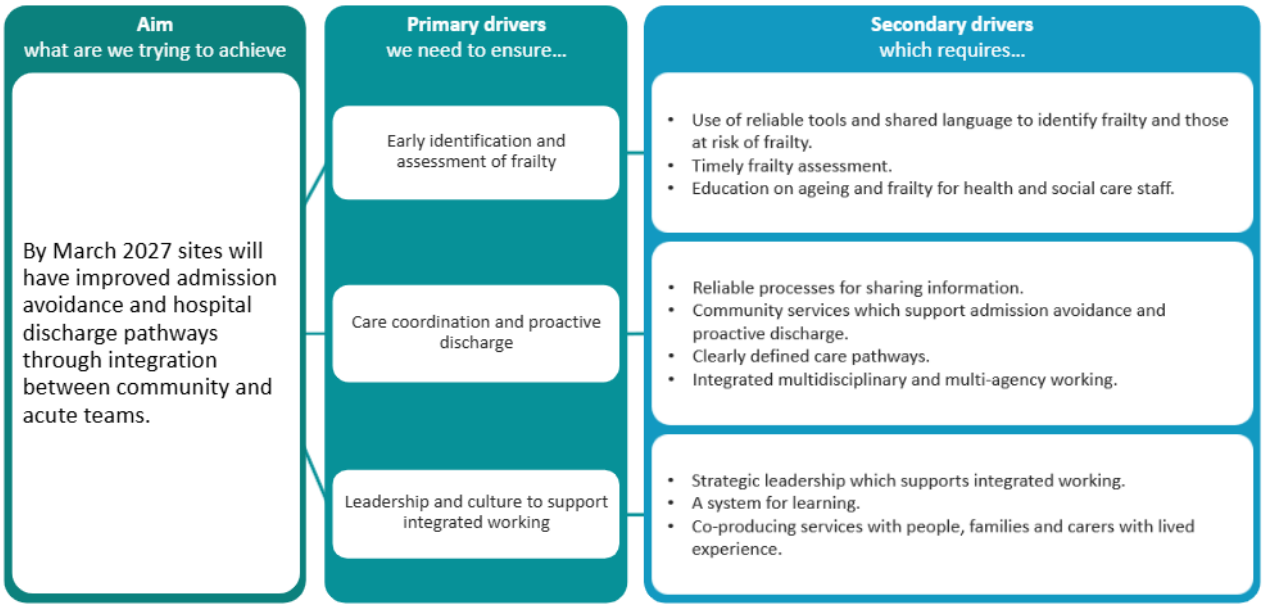
A driver diagram is a tool that visually presents a team's theory of how an improvement goal will be achieved. It articulates which parts of the system need to change, in which way and includes ideas of how to make this happen. It is used to help plan improvement projects and ensure team engagement.

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 aligns 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: integration and pathways between community and hospital



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 and assessment of frailty

Secondary driver	Change ideas
Use of reliable tools and shared language to identify	Frailty screening using the Clinical Frailty Scale.

frailty and those at risk of frailty.	
Timely frailty assessment.	Use of comprehensive geriatric assessment.
Education on ageing and frailty for health and social care staff.	Frailty education appropriate to role.

Primary driver: care coordination and proactive discharge

Secondary driver	Change ideas
Reliable process for sharing information.	Future Care Planning conversation updated on the Key Information Summary.
Community services which support admission avoidance and proactive discharge.	Rapid access to rehabilitation and reablement clinics. Professional to Professional advice line.
Clearly defined care pathways.	Discharge to Assess referral pathway. Hospital at Home referral pathway. Step up and step down referral pathway.
Integrated multidisciplinary and multi-agency working	Multidisciplinary team huddles. Social care assessment and support.

Primary driver: leadership and culture to support integrated working

Secondary driver	Change ideas
Strategic leadership which supports integrated working.	Ageing and frailty included in clinical and care governance processes. Frailty leadership network. Frailty strategy.
A system for learning.	Connections with local, regional and national learning systems.

Co-producing services with people, families and carers with lived experience.	Use of patient experience to inform service improvement.

Primary driver: early identification and assessment of frailty

Measurement

An example programme measure for early identification and assessment of frailty: 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: use of reliable tools and shared language to identify frailty and those at risk of frailty

Identifying frailty early allows for timely interventions that can significantly improve a person's quality of life.[1] The Clinical Frailty Scale is one evidence-based tool that uses clinical judgement to recognise the severity of frailty.[2] By understanding the severity of frailty, preventative and proactive support can be tailored, helping individuals stay well and independent for as long as possible.[1,3]

Change ideas

- Frailty screening using the Clinical Frailty Scale.

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

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

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

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.
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 here Right Decision Service, Healthcare Improvement Scotland. Clinical Frailty Scale tool (copied with permission from Dalhousie University). [online] 2024.
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.

Secondary driver: timely frailty assessment

If frailty is suspected, a CGA should be carried out to determine underlying factors and identify appropriate interventions.[2] CGA in the community has been linked to a reduction in physical frailty and unplanned hospital admissions without affecting the risk of nursing home admission or death.[2,4,5,6]

Change ideas

- Use of comprehensive geriatric assessment.

Selected evidence and guidelines

British Geriatrics Society. CGA in Primary Care Settings [online]. 2019 [cited 2026 Mar 10]; Available from: https://www.bgs.org.uk/cgatoolkit

British Geriatrics Society. Comprehensive Geriatric Assessment Hub [online]. 2025 [cited 2026 Mar 10]; 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 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

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

National Institute for Health and Care Research. Frailty: research shows how to improve care [online]. 2025 [cited 2026 Mar 10]; Available from: https://doi.org/10.3310/nihrevidence_64717

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.

Secondary driver: education on ageing and frailty for health and social care staff

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.[1,3,7] Training should develop competencies in skills, knowledge and attitudes.[8] 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

- Frailty education appropriate to role.

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 e-learning 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 discharge

Measurement

An example programme measure for care coordination and proactive discharge is: the percentage of people identified as living with moderate to severe frailty, who have a future care plan recorded on Key Information Summary. For more information and a data collection template, please see the programme measurement plan.

Secondary driver: reliable process for sharing information

A single integrated care plan should be accessible to all those involved in a person's care.[1,8] Plans should be created and shared digitally where possible.[1] Systems should allow information to be shared between acute and community settings.[8]

Change ideas

- Future Care Planning conversation updated on the Key Information Summary.

Selected evidence and guidelines

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 indicator IND206: Multiple long-term conditions: frailty register [online]. 2019 [cited 2026 Mar 10]; Available from: https://www.nice.org.uk/indicators/ind206-multiple-long-term-conditions-frailty-register/chapter/indicator

Tools and resources

Public Services Delivery Scotland: Future care planning (REDMAP) [online]: 2025 (TURAS log in required)	Future care planning framework, guidance and resources.

Secondary driver: community services which support admission avoidance and proactive discharge

People living with frailty are at risk of poor outcomes if they are admitted to and stay in hospital longer than necessary.[1,3,9] Community services that support admission avoidance can reduce the risk of deconditioning and poor outcomes for these patients.[3,4] If a person with frailty is admitted to hospital, proactive discharge and future care planning should begin immediately and involve an integrated multidisciplinary team.[1,8,9] This will ensure the patient is supported in the community on discharge.[9]

Change ideas

- Rapid access to rehabilitation and reablement clinics.
- Professional to Professional advice line.

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. CGA in Primary Care Settings [online]. 2019 [cited 2026 Mar 19]; Available from: https://www.bgs.org.uk/cgatoolkit

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

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 community frailty services [online]. 2025	A resource that supports the development of community-based frailty services.

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.

Secondary driver: clearly defined care pathways

Admission to hospital following a deterioration in health should be avoided if possible.[1] Prompt community and social care assessments can help prevent hospital admission.[1] Hospital at home may be a suitable alternative to inpatient care.[1,10,11] 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.[1,8]

Change ideas

- Discharge to Assess referral pathway.
- Hospital at Home referral pathway.
- Step up and step down referral pathway.

Selected evidence and guidelines

Edgar K, Iliffe S, Doll HA, Clarke MJ, Gonçalves-Bradley DC, Wong E, et al. Admission avoidance hospital at home. Cochrane Database of Systematic Reviews. 2024;3; Available from: https://doi.org/10.1002/14651858.CD007491.pub3

Healthcare Improvement Scotland. Ageing and Frailty Standards [online]. 2024 [cited 2026 Mar 16]; Available from: https://www.healthcareimprovementscotland.scot/wp-content/uploads/2024/11/Ageing-and-Frailty-Standards-November-2024.pdf

Healthcare Improvement Scotland. Older people/acute adult hospital at home services: Report of the national programme 2024/25. 2025 [cited 2026 Mar 16]; Available from: https://www.healthcareimprovementscotland.scot/wp-content/uploads/2025/07/Hospital-at-Home-Annual-Report-July-2025.pdf

Tools and resources

A Local Information System for Scotland (ALISS). The Health and Social Care Alliance [online]. 2025	An online resource to find health and wellbeing services, groups and activities across Scotland.
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. 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. 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.
Healthcare Improvement Scotland. Improving planned care pathways toolkit [online]. 2022	Quality improvement tools and resources to sustainably and affordably reduce waiting times

Secondary driver: integrated multidisciplinary and multi-agency working

Coordinated and integrated care can reduce hospital admission, risk of readmission and improve patient safety.[1,4] Integrated care planning, centred around the person's needs and wishes, ensures that people receive the care they need from the right people at the right time.[2,8,16] The delivery and coordination of frailty services is the responsibility of a multidisciplinary team of professionals.[1,16]

Change ideas

- Multidisciplinary team huddles.
- Social care assessment and support.

Selected evidence and guidelines

British Geriatrics Society. CGA in Primary Care Settings [online]. 2019 [cited 2026 Mar 10]; Available from: https://www.bgs.org.uk/cgatoolkit

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 16]; 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

Sempe L, Billings J, Lloyd-Sherlock P. Multidisciplinary interventions for reducing the avoidable displacement from home of frail older people: a systematic review. BMJ Open. 2019;9(11):e030687; Available from: https://doi.org/10.1136/bmjopen-2019-030687

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. 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. Frailty assessment and interventions tool [online]. 2024	Tool for use in health, social care and third sector to support assessment and identification of interventions to meet an individual's needs. Designed to enhance the local assessment and intervention process and documentation.
Scaling Integrated Care in Context. SCIROCCO self assessment tool [online]. 2016	Online self-assessment tool to assess a region's readiness for integrated care.
Social Care Institute For Excellence. Multidisciplinary teams working for integrated care [online]. 2023	Guidance, research and examples about multidisciplinary teams for integrated care.

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 regarding the views of staff members on integrated working and evidence that organisational processes are in place that support high quality integrated care. For more information and a data collection template, please see the programme measurement plan.

Secondary driver: strategic leadership which supports integrated working

Proactive, preventative and integrated services have a positive impact on older people living with frailty.[1,3] 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.[1,3,13]

Change ideas

- Ageing and frailty included in clinical and care governance processes.
- Local frailty leads network.
- Frailty strategy.

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

Healthcare Improvement Scotland. Ageing and Frailty Standards [online]. 2024 [cited 2026 Mar 16]; Available from: https://www.healthcareimprovementscotland.scot/wp-content/uploads/2024/11/Ageing-and-Frailty-Standards-November-2024.pdf

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.[14] They support putting knowledge into action. This can enable transformation of service delivery and improve quality of care.[15]

Change ideas

- Connections with local, regional and national learning systems.

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.[3,16,17] This will help to ensure frailty services are flexible and respond to the needs of patients and their carers.[3,16] Planning without consulting this group will result in services that do not support the people they are designed for.[3]

Change ideas

- Use of patient experience to inform improvement.

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 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: integration and pathways between community and hospital 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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3. 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.
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5. British Geriatrics Society. Comprehensive Geriatric Assessment Hub [online]. 2025 [cited 2026 Mar 19]; Available from: https://www.bgs.org.uk/CGA
6. 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
7. 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
8. 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
9. 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
10. Edgar K, Iliffe S, Doll HA, Clarke MJ, Gonçalves-Bradley DC, Wong E, et al. Admission avoidance hospital at home. Cochrane Database of Systematic Reviews. 2024;3; Available from: https://doi.org/10.1002/14651858.CD007491.pub3
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Published August 2026

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