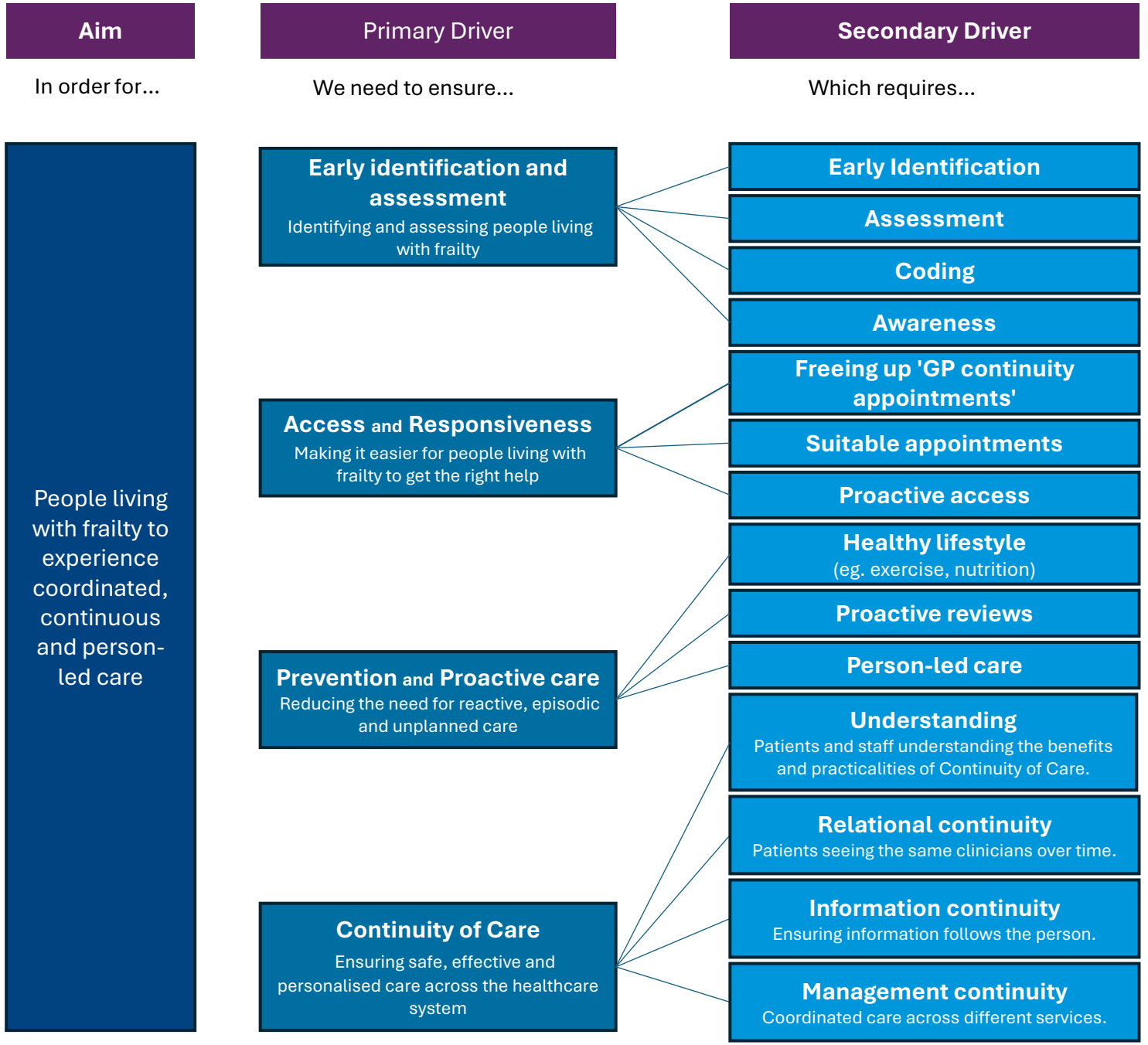
Healthcare Improvement Scotland

Driver Diagram

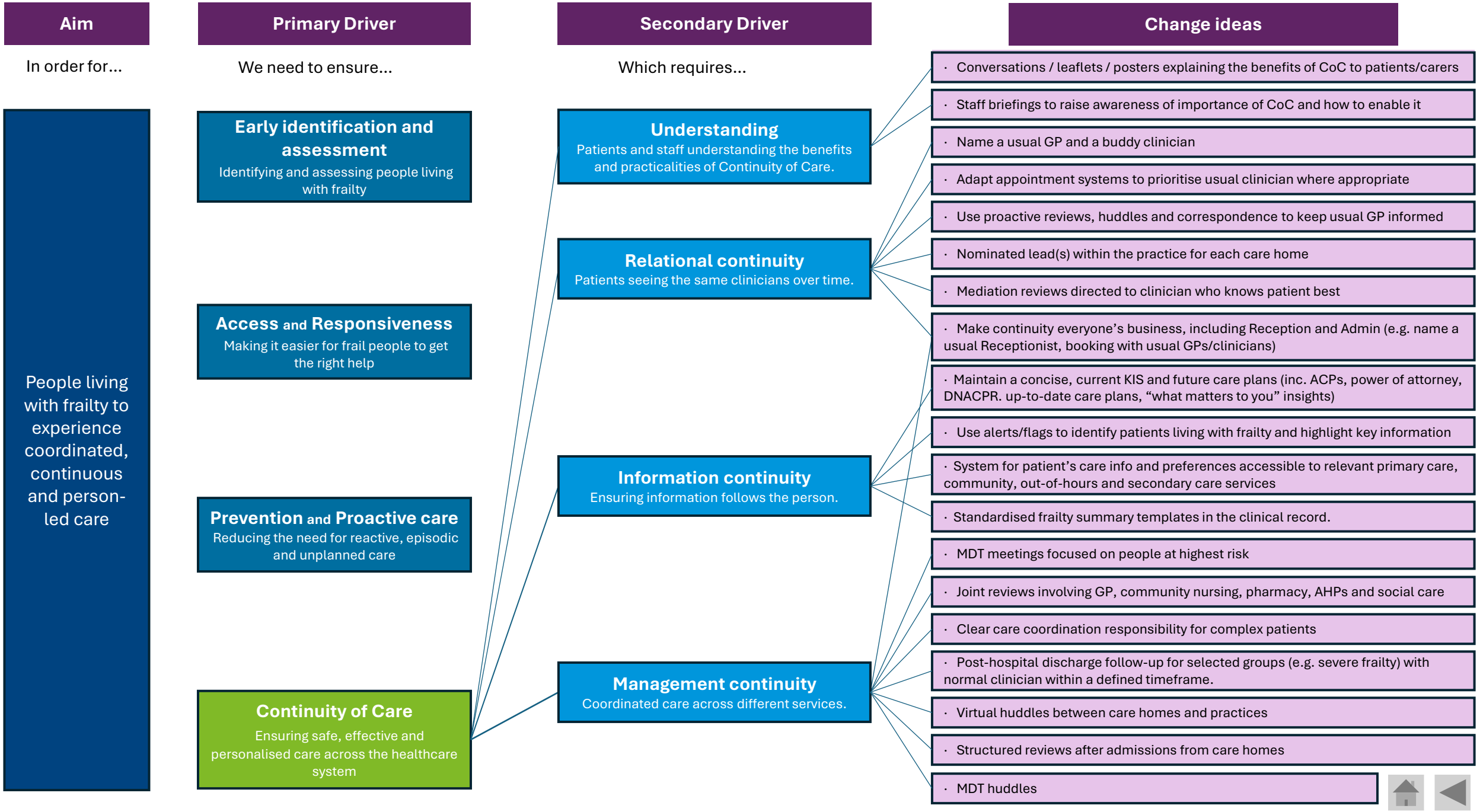
People living with frailty experience coordinated, continuous and person-led care



Aim	Primary Driver	Secondary Driver	Change ideas
In order for…	We need to ensure…	Which requires…	Ideas to ensure this happens…
People living with frailty to experience coordinated, continuous and person-led care	**Early identification and assessment** Identifying and assessing people living with frailty	**Early Identification**	· Population health searches (eg. eFI) · Review palliative care register · KIS reviews · Review care home residents · Review community nursing caseload · Review people requesting home visit in last month · Review people who fall · Clinical judgement following routine consultations · Review recent hospital discharges · Prompt to code for frailty syndromes (example of eFI prompt)
	Access and Responsiveness Making it easier for frail people to get the right help		
	Prevention and Proactive care Reducing the need for reactive, episodic and unplanned care	**Assessment**	· Assessment using Rockwood Clinical Frailty Scale
		Coding	- **Mild Frailty** (4-5) – eg. for DES 2Jd0, - **Moderate** Frailty (6) - eg. for DES 2Jd1, - **Severe** Frailty (7-9) - eg. for DES 2Jd2)
	Continuity of Care Ensuring safe, effective and personalised care across the healthcare system	**Awareness**	· Raise awareness among staff and patients using visual prompts (examples) · Share evidence-based training/resources (example)

Aim	Primary Driver	Secondary Driver	Change ideas
In order for...	We need to ensure...	Which requires...	Ideas to ensure this happens...
People living with frailty to experience coordinated, continuous and person-led care	**Early identification and assessment** Identifying and assessing people living with frailty		
	Access and Responsiveness Making it easier for frail people to get the right help	**Freeing up 'GP continuity appointments'**	· Maximise use of wider PC team (eg. Pharmacy First, Optometry, Minor injuries) · Care navigation · Workflow optimisation · Serial prescription · Acute prescription
		Suitable appointments	· Longer appointment slots for people with frailty. · Home visits targeted to those who benefit most. · Protected same-day 'continuity' appointments
		Proactive access	· Review of booking process · Virtual wards for people with escalating needs · 'Ward style' visits to care homes · Phone or face to face follow-up with a familiar clinician when appropriate.
	Prevention and Proactive care Reducing the need for reactive, episodic and unplanned care		
	Continuity of Care Ensuring safe, effective and personalised care across the healthcare system		

Aim	Primary Driver	Secondary Driver	Change ideas
In order for...	We need to ensure...	Which requires...	Ideas to ensure this happens...
People living with frailty to experience coordinated, continuous and person-led care	**Early identification and assessment** Identifying and assessing people living with frailty		
	Access and Responsiveness Making it easier for frail people to get the right help		
	Prevention and Proactive care Reducing the need for reactive, episodic and unplanned care	**Healthy lifestyle** (eg. exercise, nutrition)	· Signposting to appropriate community resources
		Proactive reviews	· Regular proactive reviews for those with complex needs. · Regular 'ward-round' style visits / videocalls to care homes · Scheduled frailty reviews for those with severe frailty · Polypharmacy reviews (7 steps process, Improvement examples)
		Person-led care	· "What matters to you" conversations during routine contacts. · Opportunities to consider anticipatory / future care planning · Longer appointment slots for people with frailty for holistic care · Falls, nutrition and social isolation screening.
	Continuity of Care Ensuring safe, effective and personalised care across the healthcare system		


Aim
In order for...
People living with frailty to experience coordinated, continuous and person-led care
Primary Driver
We need to ensure...
Early identification and assessment
Identifying and assessing people living with frailty
Access and Responsiveness
Making it easier for frail people to get the right help
Prevention and Proactive care
Reducing the need for reactive, episodic and unplanned care
Continuity of Care
Ensuring safe, effective and personalised care across the healthcare system
Secondary Driver
Which requires...
Understanding
Patients and staff understanding the benefits and practicalities of Continuity of Care.
Relational continuity
Patients seeing the same clinicians over time.
Information continuity
Ensuring information follows the person.
Management continuity
Coordinated care across different services.
Change ideas
· Conversations / leaflets / posters explaining the benefits of CoC to patients/carers
· Staff briefings to raise awareness of importance of CoC and how to enable it
· Name a usual GP and a buddy clinician
· Adapt appointment systems to prioritise usual clinician where appropriate
· Use proactive reviews, huddles and correspondence to keep usual GP informed
· Nominated lead(s) within the practice for each care home
· Mediation reviews directed to clinician who knows patient best
· Make continuity everyone's business, including Reception and Admin (e.g. name a usual Receptionist, booking with usual GPs/clinicians)
· Maintain a concise, current KIS and future care plans (inc. ACPs, power of attorney, DNACPR. up-to-date care plans, "what matters to you" insights)
· Use alerts/flags to identify patients living with frailty and highlight key information
· System for patient's care info and preferences accessible to relevant primary care, community, out-of-hours and secondary care services
· Standardised frailty summary templates in the clinical record.
· MDT meetings focused on people at highest risk
· Joint reviews involving GP, community nursing, pharmacy, AHPs and social care
· Clear care coordination responsibility for complex patients
· Post-hospital discharge follow-up for selected groups (e.g. severe frailty) with normal clinician within a defined timeframe.
· Virtual huddles between care homes and practices
· Structured reviews after admissions from care homes
· MDT huddles