Healthcare Improvement Scotland | ihub

Interested in improving how you support people aged 65 and over to live and die well with frailty in their community?

We are calling for applications from Health and Social Care Partnerships and GP Clusters to join the new Living and Dying Well with Frailty Collaborative.

The collaborative aims to improve earlier identification, anticipatory care planning and shared decision-making, and support a multi-disciplinary approach so that people living with frailty get the support they need, at the right time, at the right place.

By October 2020 the collaborative will:

- reduce hospital bed days for people aged 65 and over by 10%, per 1,000 population
- reduce unscheduled GP home visits for people aged 65 and over by 10%, per 1,000 population, and
- increase percentage of anticipatory care plans in the Key Information Summaries (KIS) for people living with frailty by 20% per 1,000 population.

During the collaborative, GP practices and community teams will:

- use the Electronic Frailty Index (eFI) through SPIRE to identify people aged 65 and over living with frailty
- engage in anticipatory care planning conversations with these individuals and record the information in the Key Information Summary (KIS)
- work within a multi-disciplinary team to consider the holistic needs of the person, and
- use quality improvement methods to structure the work, including using data to learn how changes are being implemented and the impact they make.

Applications for the collaborative are accepted between **17 June 2019 and 19 July 2019**.

More information about the collaborative and how to apply is available on our website: ihub.scot/living-and-dying-well-with-frailty

Get in touch to discuss your application. Email hcis.livingwell@nhs.net or call 0131 314 1232.

Successful teams will comprise a Health and Social Care Partnership Lead, GP representative, quality improvement and data lead, and key members of the Health and Social Care Partnership and GP Cluster. Teams will receive improvement and clinical expertise from the ihub and have the opportunity to learn from teams across Scotland at our learning sessions:

Session	Date
Introductory WebEx	27 August AM or 28 August PM
Learning session 1	19 September 2019
Learning session 2	27 February 2020
Learning session 3	June 2020
Learning session 4	October 2020

Clinical care benefits of joining the collaborative:

- Support to use and interpret the eFI through SPIRE so that you can improve how you identify the people living with frailty in your community who are likely to have increased levels of need and make greater use of unplanned services.
- Improve quality of life for people living with frailty by understanding which individuals within your population are experiencing a change in their level of frailty and could benefit from earlier intervention.
- Guidance on multi-disciplinary working to harness the potential of community support and assign the right roles to the right people.
- Guidance and materials to improve anticipatory care approaches that put the person with frailty at the centre of decision-making and improve a person's experience if and when they encounter transitions of care.
- Guidance on adopting a realistic medicine approach to ensure appropriate care for people living with frailty.
- Improvement and analytical expertise to demonstrate the impact of your work through data and evaluation techniques.

Professional development benefits from joining the collaborative:

- Recognition for innovating identification and support in a community setting.
- Learn from clinical and topic experts relating to living and dying well with frailty.
- Opportunities to meet and learn from peer teams throughout Scotland.
- A structure to learn about quality improvement and how to apply it in your work, including:
  - access to national data and measurement experts
  - access to national quality improvement experts to test, implement and scale ways of working, and
  - information on links to professional development and quality improvement related financial incentives.

This collaborative compliments the ihub's Frailty at the Front Door Collaborative which is currently open for applications from new acute sites to improve outcomes for people with frailty in acute hospitals. Visit the ihub's website for more information on Frailty at the Front Door.

As well as this collaborative, later in the year we will be inviting teams to participate in a collaborative with the aim of improving the coordination of palliative and end of life care for older people who are resident in a care or nursing home. Further information will follow.