Living and dying well with frailty collaborative

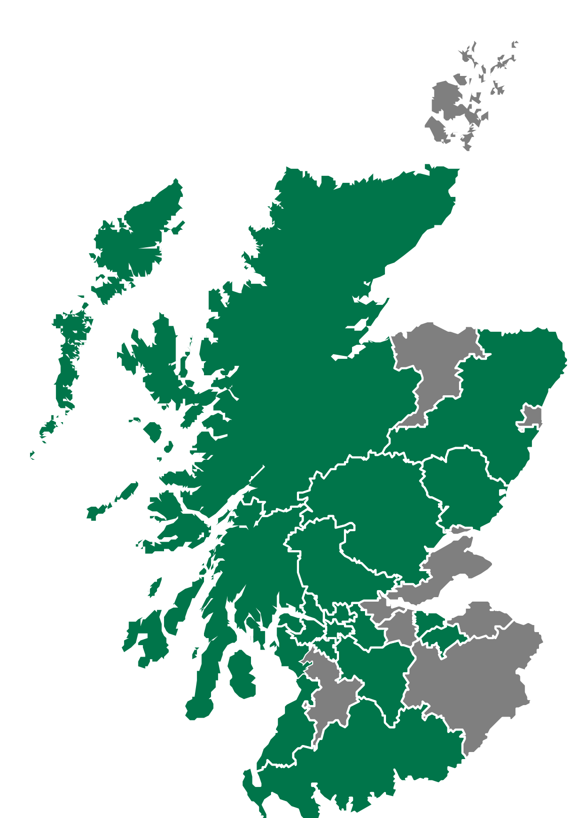
Learning Session 1

19 September 2019

#LWiCFrailty

GLA0919

Welcome!



Housekeeping

- No fire alarms
- Toilets
- Filming/photography
- Breaks and lunch

Connect

#LWiCFrailty

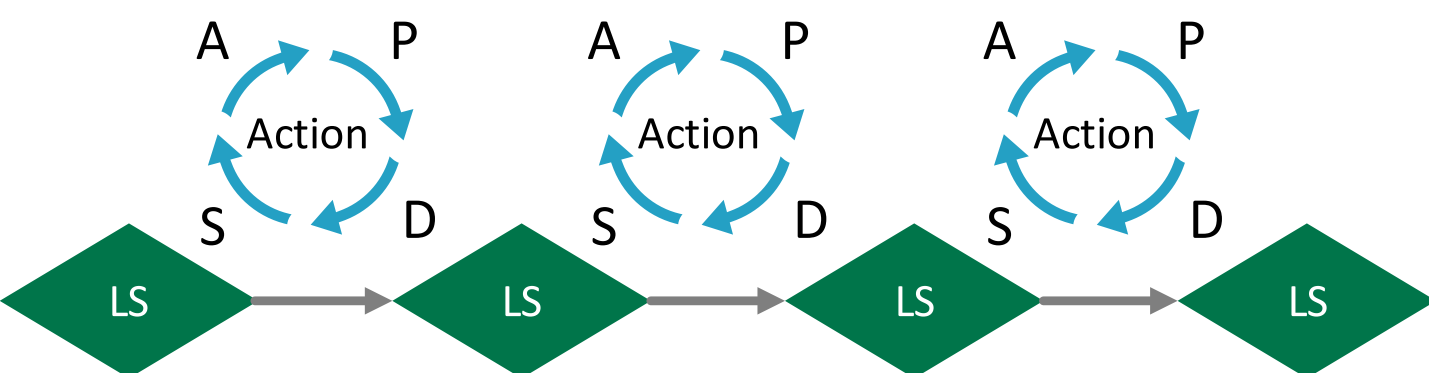
GLA0919

Our mission

…to improve how teams identify and enable people aged 65 and over to live and die well with frailty in the community.

Mr Lucas

Collaborative structure



IHI Breakthrough Series whitepaper, 2003

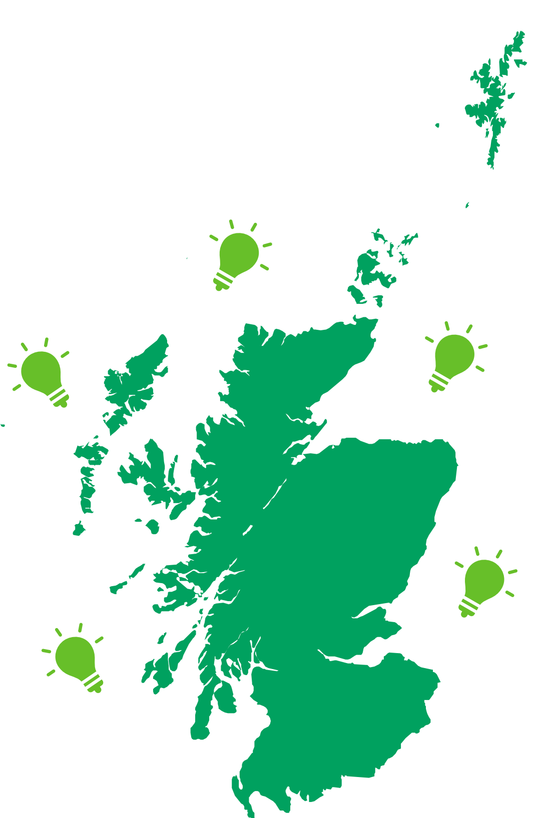
Learning session 1

Today's learning session will prepare

you for the first action period

Learn about Quality Improvement and Measurement

Learn from other teams in Scotland and share your work



Use your learning to develop a plan of your next steps

Agenda

Time	Session
09:30	Welcome
09:45	Living with frailty in the community – a personal experience
10:15	Getting to know each other better
10:30	Comfort break
10:45	Learning about improvement
13:00	Lunch
13:30	Learning from across Scotland
14:30	Team planning time
16:00	Close

A personal experience of frailty

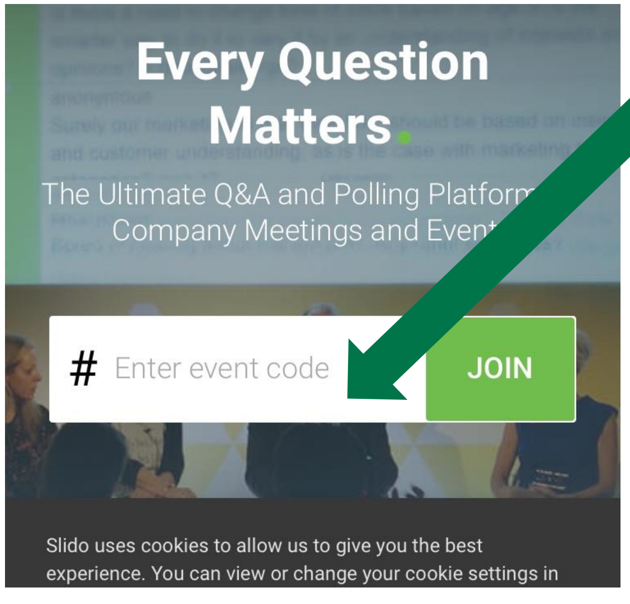
Introduction to Slido

1) Sign on to the wifi
   (Password = **GLA0919**)

2) Open your internet browser
   (safari/explorer/google)

3) Visit **www.sli.do** or **www.slido.com**

Introduction to Slido



LWiCFrailty

Wifi: **GLA0919**

Visit www.sli.do or www.slido.com

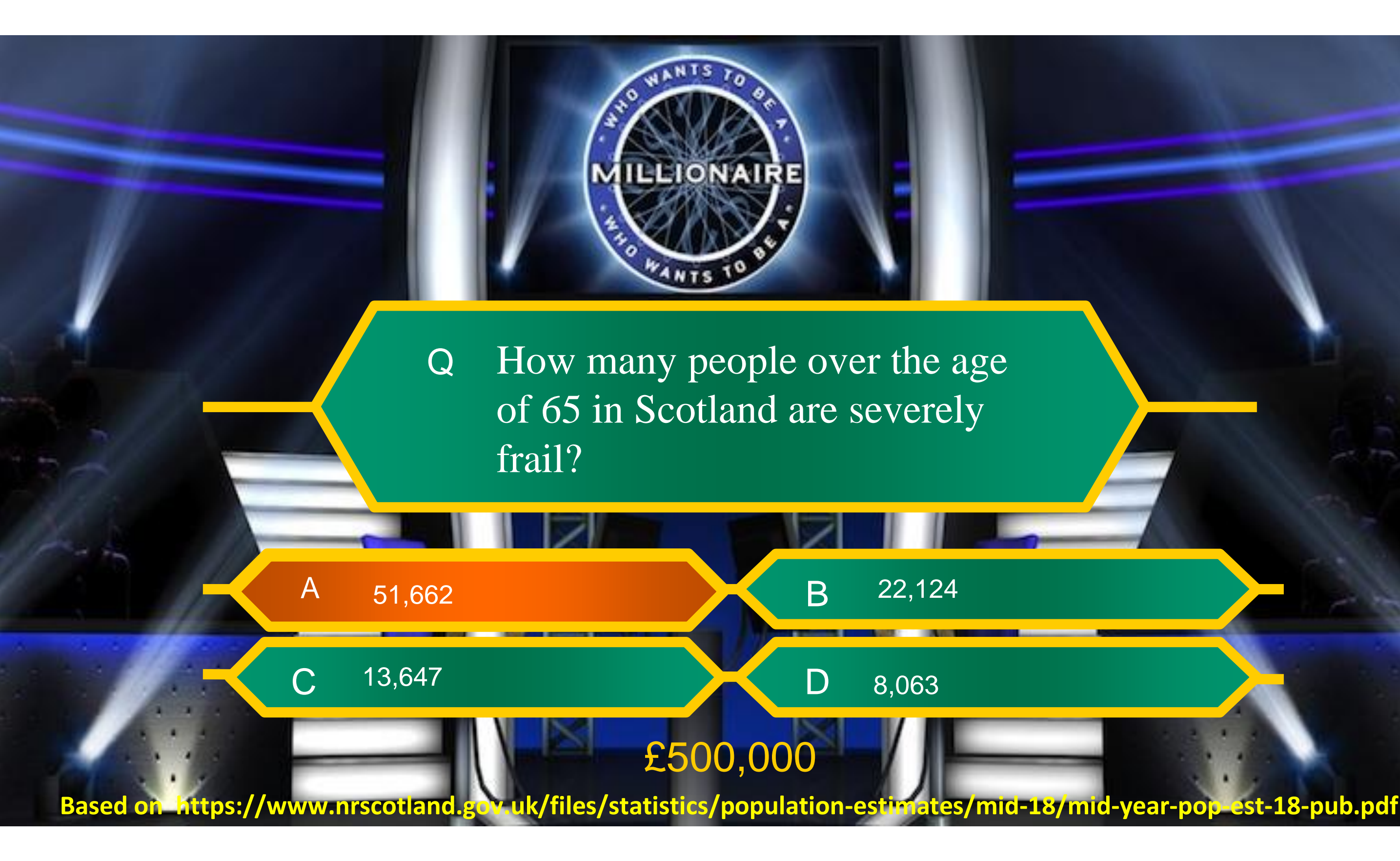
‘Liking’ Questions & Polls

LWiCFrailty Learning Sessi...
QUESTIONS IDEAS POLLS
Ask the speaker
Type your question
There are no questions asked yet.
Ask the first one!
sli.do
Ask

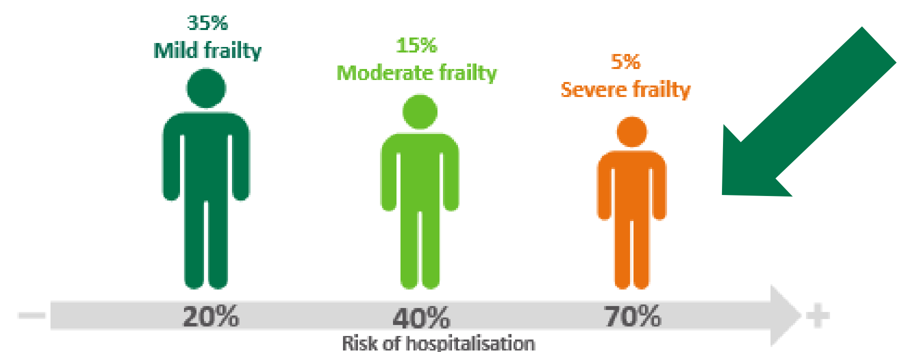
Main stage
QUESTIONS POLLS
10 questions Popular
Filip
9 min ago
9
What are some useful skills I can learn in less than 5 minutes?
Rachel
<1 min ago
7
How does Elon Musk run his famously efficient meetings?
Lucy
13:34
1
What is the most telling thing about someone's personality?

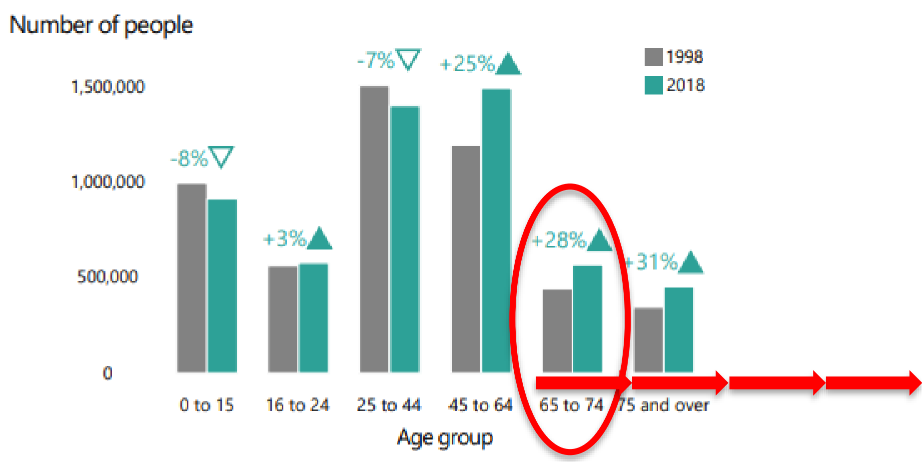
LWiCFrailty Learning Sessi...
QUESTIONS IDEAS POLLS
Ask the speaker
Type your question
There are no questions asked yet.
Ask the first one!
sli.do
Ask

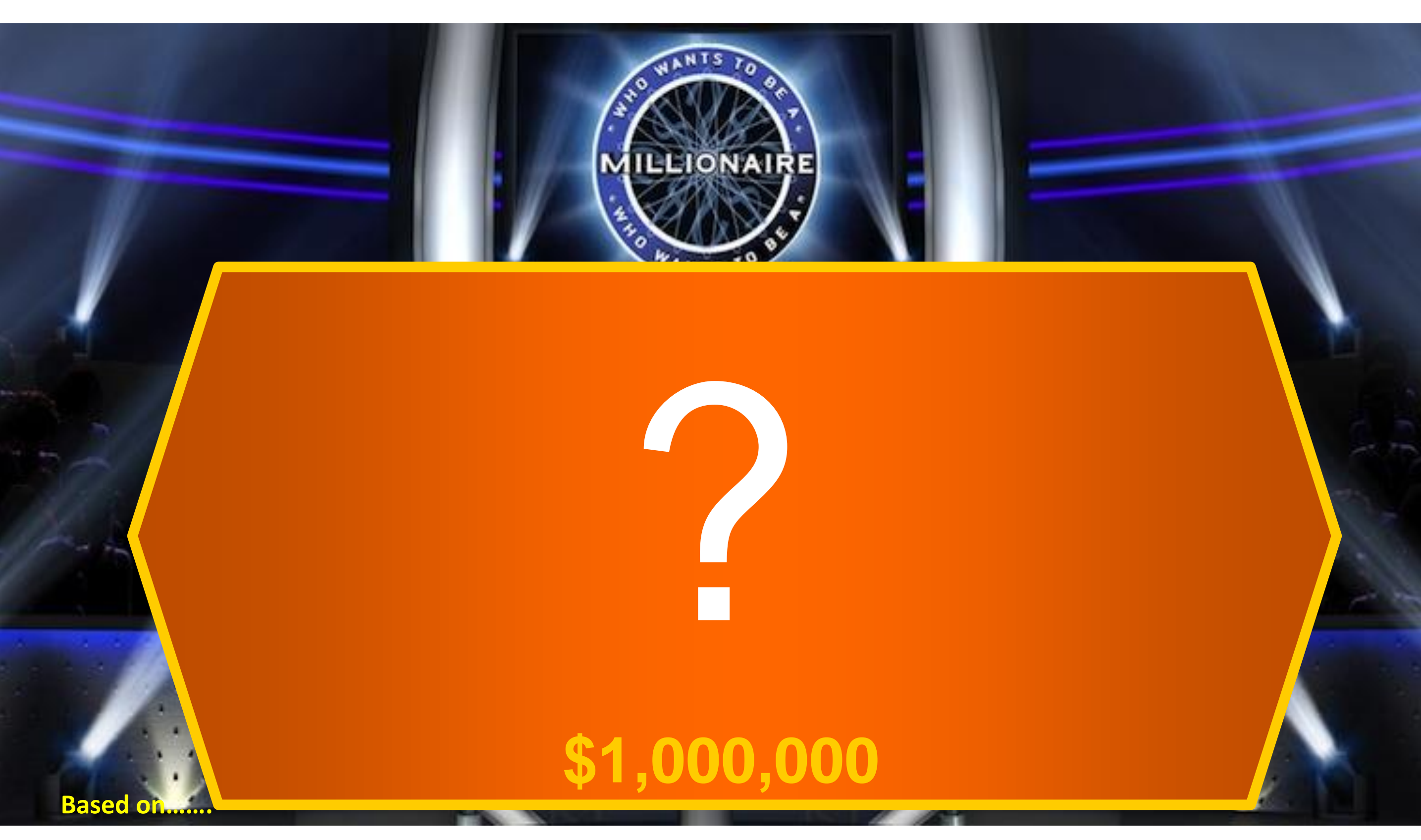
Let’s give it a go! ☺


WHO WANTS TO BE A
MILLIONAIRE
WHO WANTS TO BE A
Q How many people over the age of 65 in Scotland are severely frail?
A 51,662
B 22,124
C 13,647
D 8,063
£500,000
Based on https://www.nrscotland.gov.uk/files/statistics/population-estimates/mid-18/mid-year-pop-est-18-pub.pdf

And that's just the 5% of over 65 year olds!





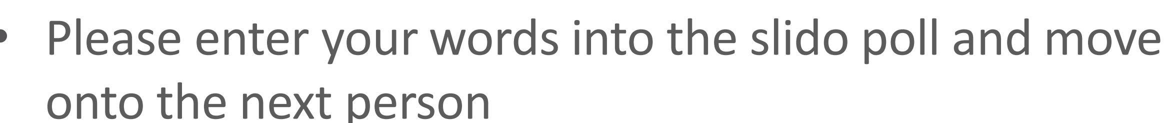

WHO WANTS TO BE A
MILLIONAIRE
?
$1,000,000
Based on……..

Temperature Check

10 mins

- In your away teams please introduce yourself and finish the sentence:

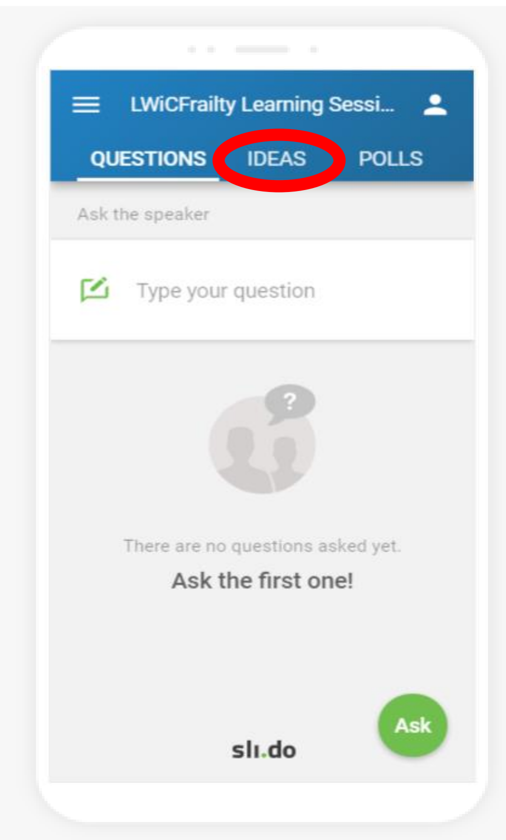
"I want to be involved in the frailty collaborative because…?"



- Please enter your words into the slido poll and move onto the next person

Consider:
- Why is it important to you?
- What specific skills / knowledge can you offer?
- What can be gained from this work?
- Why is this important to our citizens?

Summary



Measurement for Improvement

Scott Purdie and Nathan Devereux

Improvement Hub

Enabling health and social care improvement

GLA0919

I'm not sure if it's worked or not. How will I know?
Hmmm! If the force you cannot feel, DATA you must use

Introduction

By the end of this session you will…

- Be familiar with the 3 core measures of the collaborative
- Understand why using data for improvement is beneficial
- Understand why plotting data over time is so important

3 Core Measures

A shift from unplanned to planned activity and an increase in anticipatory care planning.

- Rate of unplanned bed days per 1000 over-65 population (National)
- Rate of unscheduled GP home visits per 1000 over-65 population, (Local data)
- Percentage of Key Information Summaries for frail population (Local data)

Different Uses of Data

Measurement for accountability

Measurement for research

Measurement for improvement

Solberg, L. I., Mosser, G., & McDonald, S. (1997). The three faces of performance measurement: Improvement, accountability and research. *Joint Commission Journal on Quality Improvement,* 23(3), 135-147

Why do we need data for improvement?

IMPROVEMENT JOURNEY

Understand System

PEOPLE

PROCESSES

SERVICE USERS

readiness for change

Develop AIM and change theory

Identify specific change ideas

Build a project plan

It's OK if a test fails; it's all LEARNING

Test changes START SMALL

PLAN | DO | ACT | STUDY

Test under different conditions

PLAN | DO | ACT | STUDY

It won't happen by MAGIC!

Implement changes that work

Build into everyday work

PLAN for scale up / spread if appropriate

CONTEXT IS KEY

AIM

INFLUENCING FACTORS

What can we actually DO to impact on these?

Evidence?

Experience?

WHAT? WHO? WHEN? WHERE? HOW?

ALWAYS THINKING ABOUT...

interconnections

SYSTEMS

motivation

communication

PEOPLE

relationships

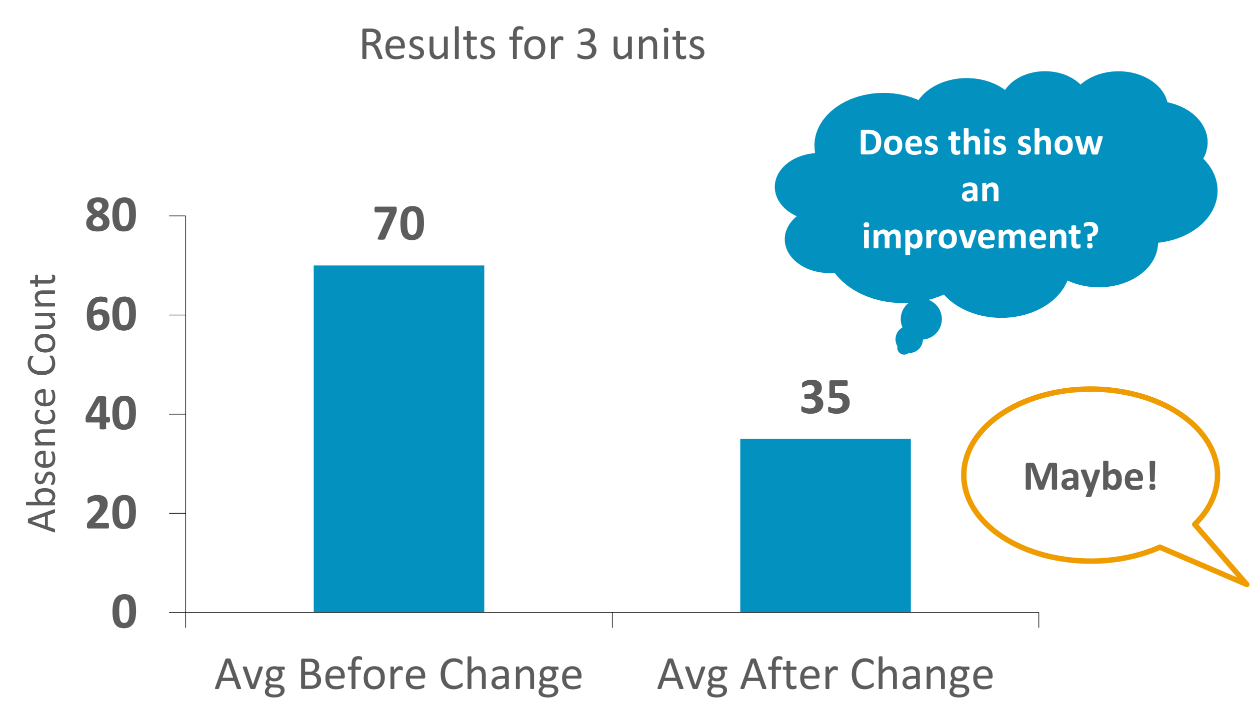
WHAT'S THE DATA TELLING US?

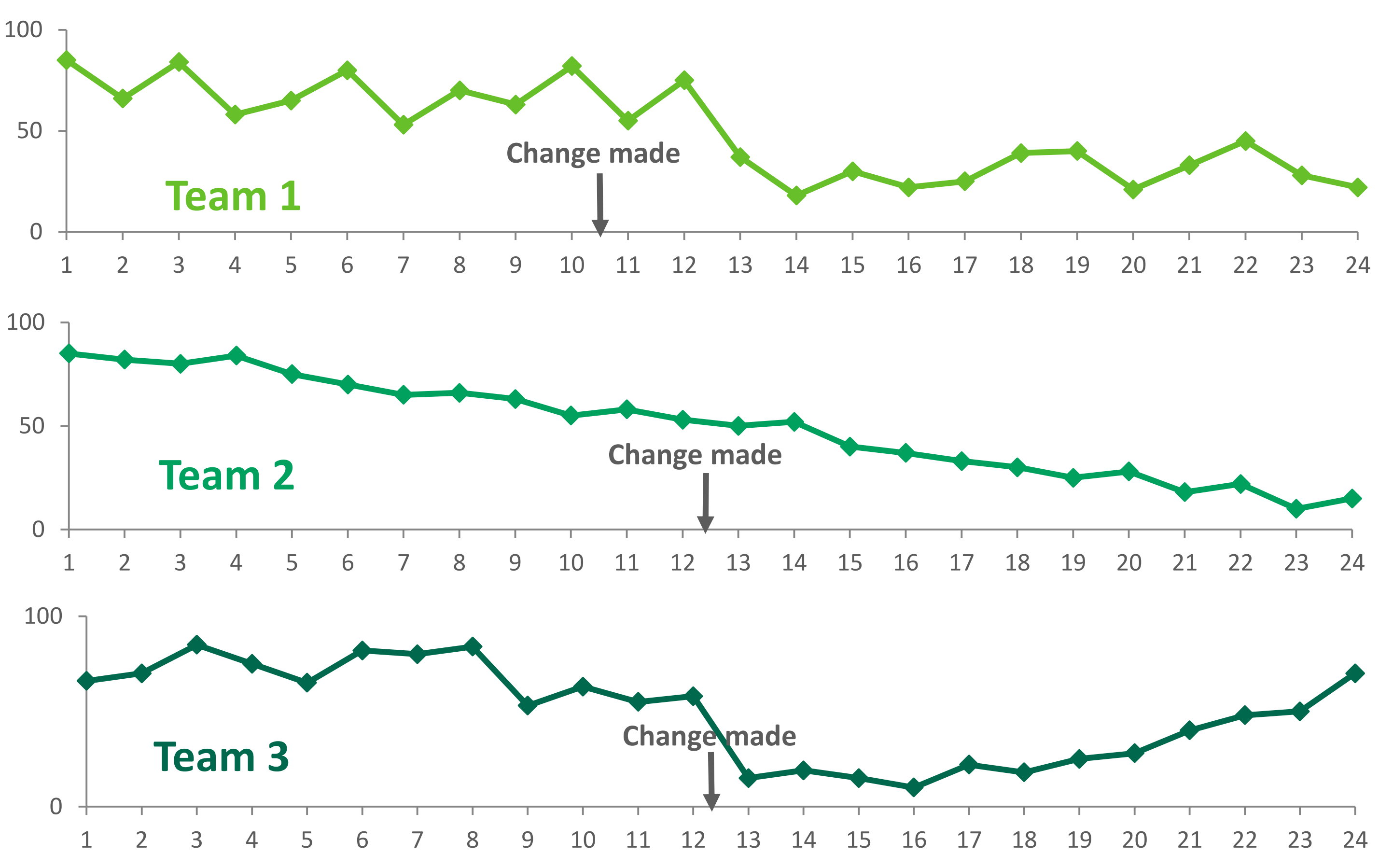
Catherine Hayes

Why do we need data for improvement?

- To understand what needs improved
- To understand variation
- For testing changes
- For monitoring progress
- To tell the story of your improvement journey

Averages before and after a change





Team 1
Change made
100
50
0
1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
Team 2
Change made
100
50
0
1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
Team 3
Change made
100
0
1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
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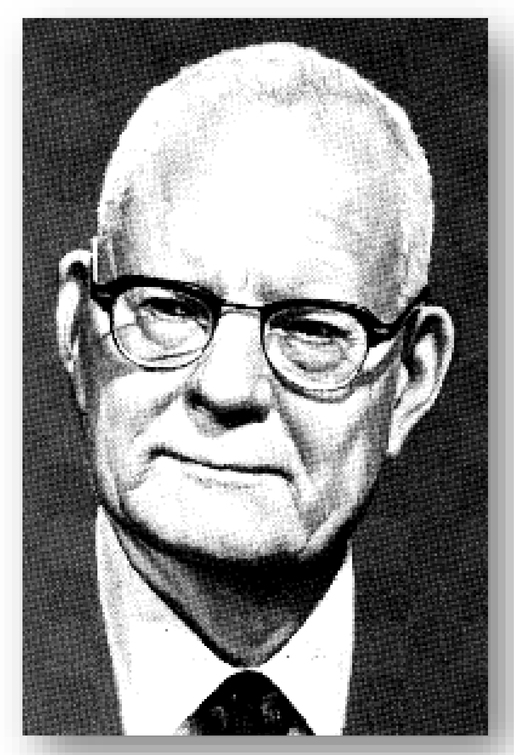
24

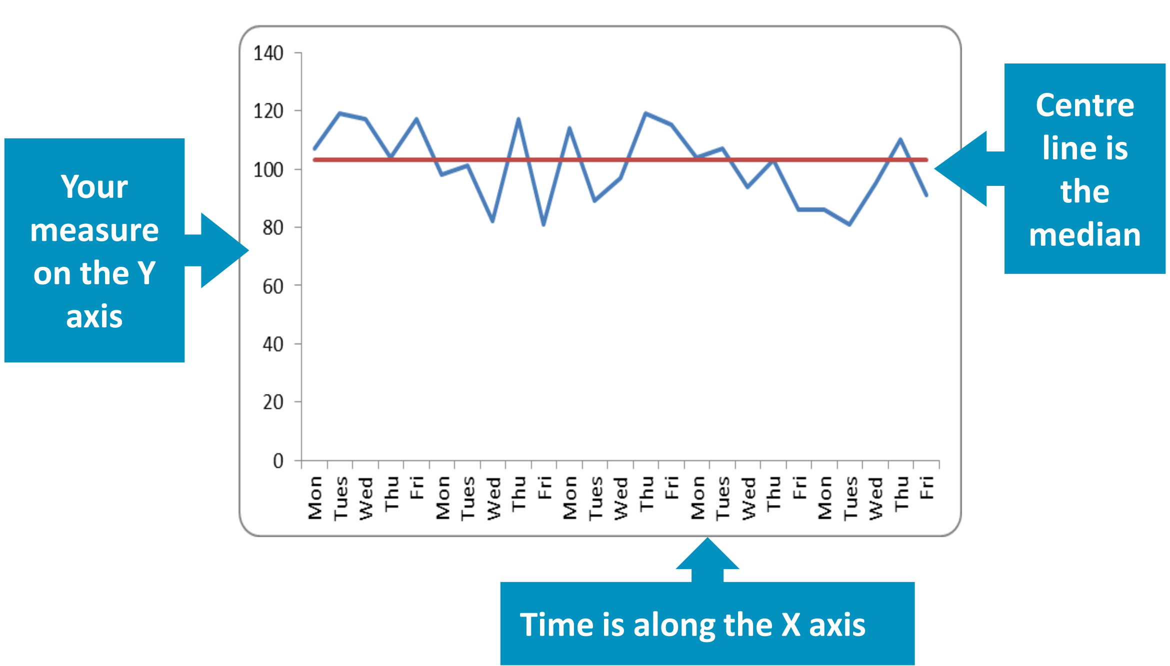


“When you have two data points, it is very likely that one will be different from the other.”

W. Edwards Deming

Run Charts

Display data to make process performance visible



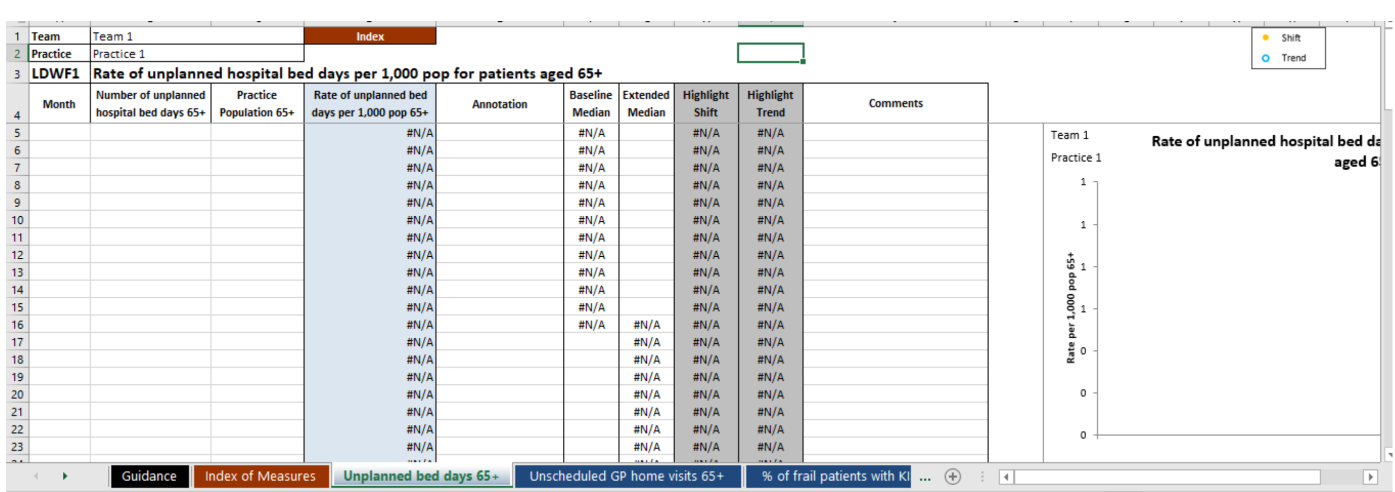
Baseline data

Can you get data back in time?

If not start collecting data ASAP

Example of Data Collection Tool

Will help to show impact of changes



Team	Team 1		Index
Practice	Practice 1		

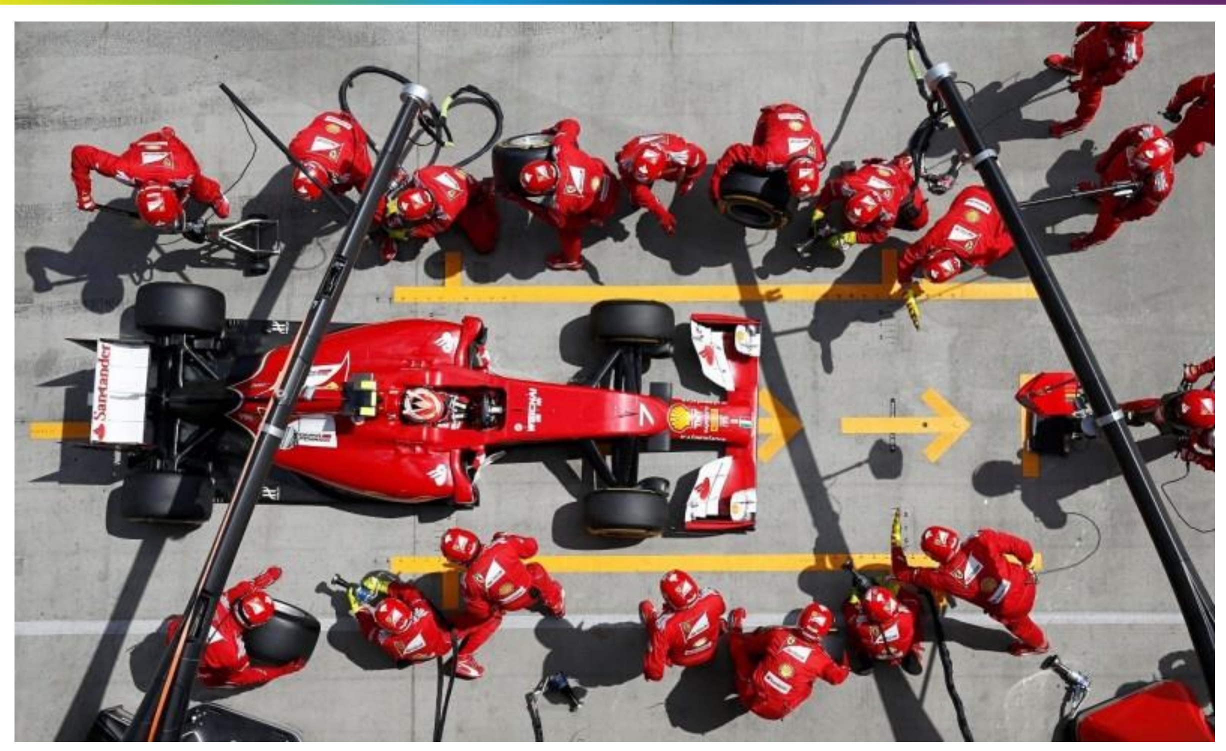
LDWF1 Rate of unplanned hospital bed days per 1,000 pop for patients aged 65+

Month	Number of unplanned hospital bed days 65+	Practice Population 65+	Rate of unplanned bed days per 1,000 pop 65+	Annotation	Baseline Median	Extended Median	Highlight Shift	Highlight Trend	Comments
			#N/A		#N/A		#N/A	#N/A	
			#N/A		#N/A		#N/A	#N/A	
			#N/A		#N/A		#N/A	#N/A	
			#N/A		#N/A		#N/A	#N/A	
			#N/A		#N/A		#N/A	#N/A	
			#N/A		#N/A		#N/A	#N/A	
			#N/A		#N/A		#N/A	#N/A	
			#N/A		#N/A		#N/A	#N/A	
			#N/A		#N/A		#N/A	#N/A	
			#N/A		#N/A		#N/A	#N/A	
			#N/A		#N/A		#N/A	#N/A	
			#N/A		#N/A	#N/A	#N/A	#N/A	
			#N/A			#N/A	#N/A	#N/A	
			#N/A			#N/A	#N/A	#N/A	
			#N/A			#N/A	#N/A	#N/A	
			#N/A			#N/A	#N/A	#N/A	
			#N/A			#N/A	#N/A	#N/A	
			#N/A			#N/A	#N/A	#N/A	
			#N/A			#N/A	#N/A	#N/A	

Measurement Submission Overview

- Share your data on a monthly basis, including the three core outcome measures
- Overview of the collaborative produced each quarter
- Additional measures can be added to the data collection tool

Roles and responsibilities



Thoughts and Questions?

What data will you need locally?

By the end of this session you will…

- Be familiar with the 3 core measures of the collaborative
- Understand why using data for improvement is beneficial
- Understand why plotting data over time is so important

Next steps

- Data collection tool will be made available
- Work as a team to agree your measurement plan
- Clarify your roles and responsibilities

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Learning about improvement methods

Workshop on the essentials of quality improvement to support you through the frailty collaborative

Tom McCarthy- Improvement Advisor
Michelle Church- Improvement Advisor

Improvement Hub

Enabling health and social care improvement

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By the end of this session you will…

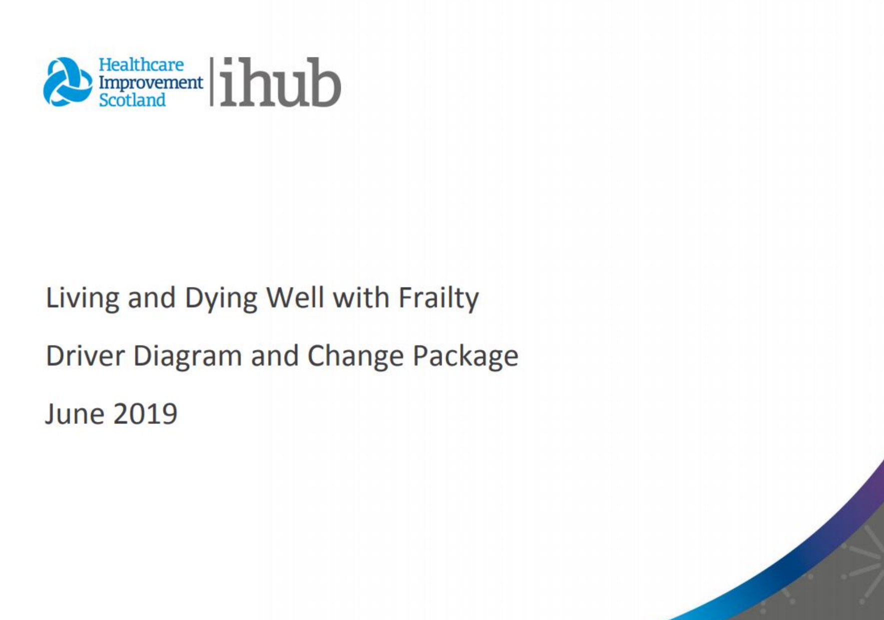
- Understand a bit more about the change package
- Receive an introduction to some of the theory of how we spread improvement and some of the potential challenges
- Recognise the importance of adapting things to suit where you work
- Explore your roles in spreading improvement
- Know where you can get more help

Love
Story

STANDING
ON THE
SHOULDERS
OF GIANTS

TWO POUNDS
1997

The National Change Package



https://ihub.scot/media/6416/bts-collab-change-package-20190627-v2-0.pdf

The Living Well with Frailty Driver Diagram

Outcome

People 65 years and over with frailty, will experience a good life and death, including more time at home or in a homely setting.

- Reduce unplanned hospital bed days
- Reduce unscheduled GP home visits
- Increase use of anticipatory care planning and Key Information Summary

Primary driver

Identify people aged 65 and over living with frailty in the community.

Secondary drivers

- Case find people at risk using the e Frailty Index (Essential activity)
- Create diagnosis for frailty
- Multi-dimensional assessment
- Monitor change and deterioration over time

Primary driver

Support people living with frailty to plan for their future care needs, and when appropriate, death.

Secondary drivers

- Anticipatory care planning conversations, including recording information in the Key Information Summary (Essential activity)
- Carer's assessment
- Informal/Adult carers support planning

Primary driver

Support people living with frailty to access preventative support in the community.

Secondary drivers

- Key worker
- Exercise interventions and physical activity
- Lifestyle and nutritional interventions
- Polypharmacy review
- Reablement
- Vaccinations
- Community-based geriatric services
- Palliative and end of life care

Primary driver

Develop effective multidisciplinary team working focused on person-centred, preventative care.

Secondary drivers

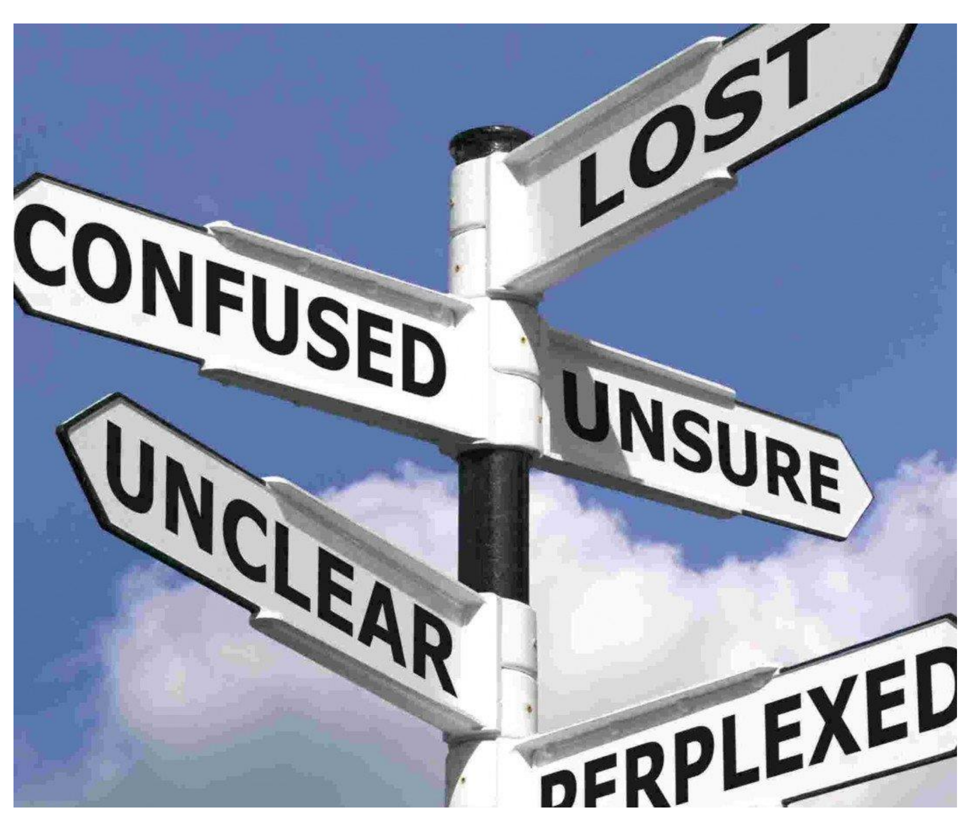
- Communication and collaboration within a multi-disciplinary team, including a multidisciplinary review (Essential activity)
- Understand what support is available in communities and how to access support
- Use quality improvement methods, including data over time, to drive improvement (Essential activity)

Key: Essential activity for all members of the collaborative

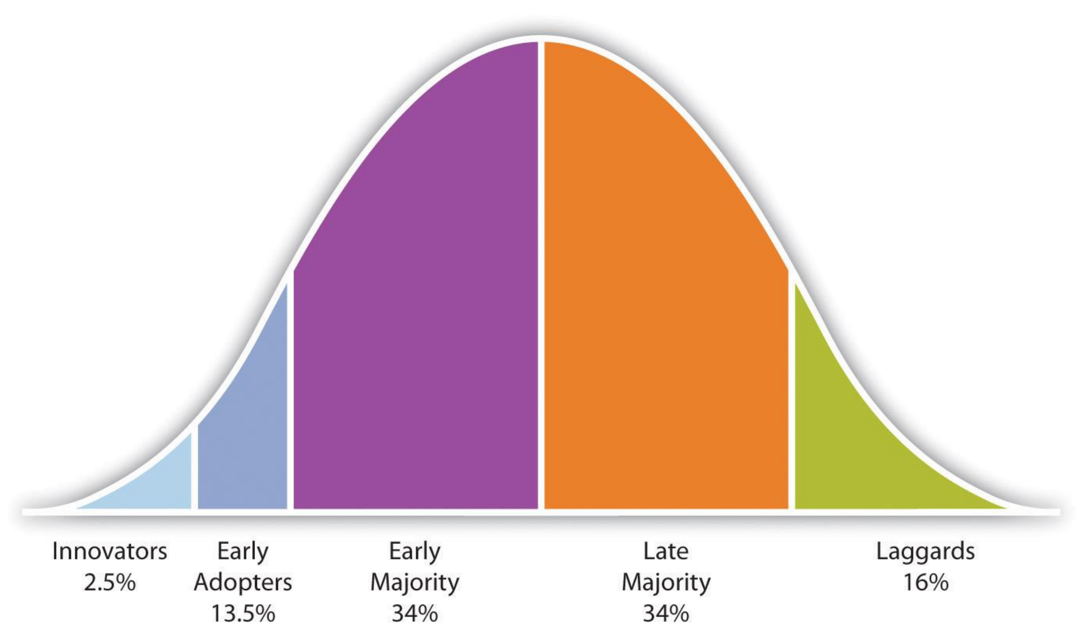
What do you think?

1. Get into small groups (approx 3-5 ish)
2. Discuss what you have just heard about the change package
3. We'll take a couple of points of feedback from the room

What next?

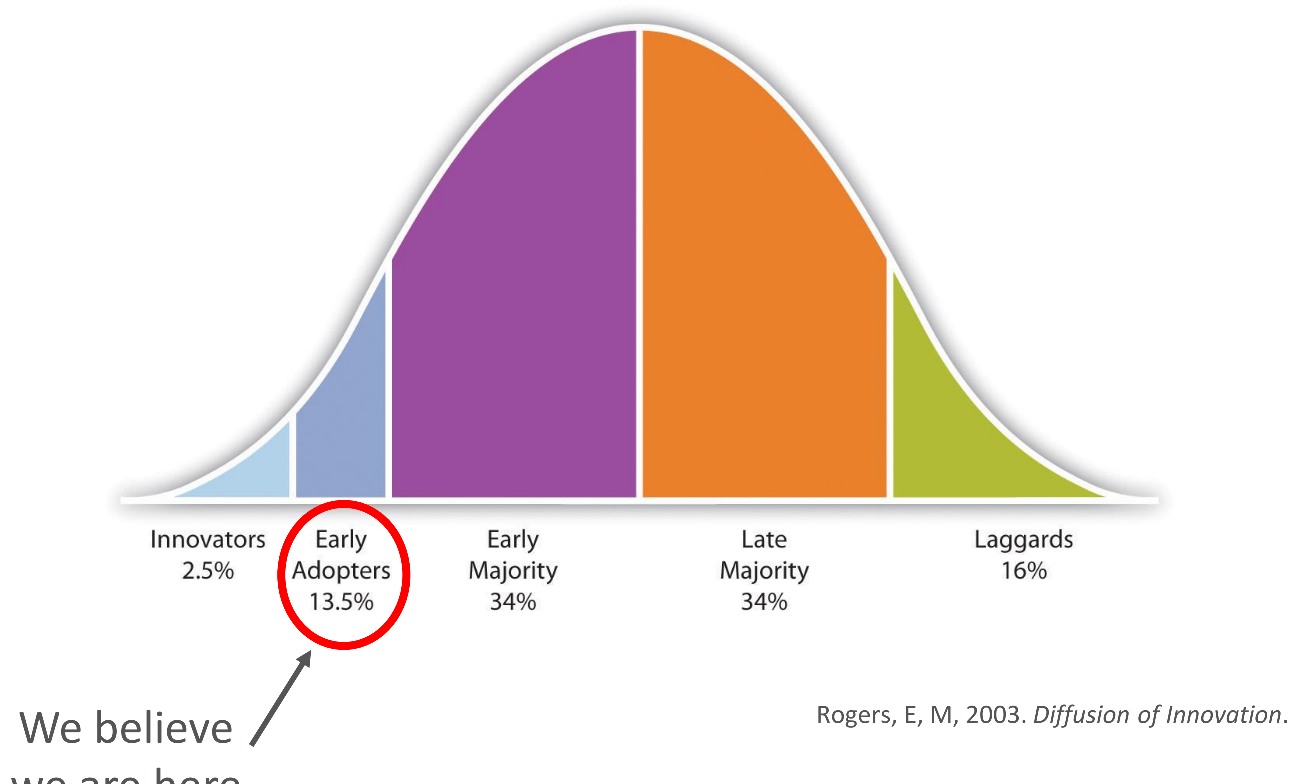


Spreading change: diffusion of innovation



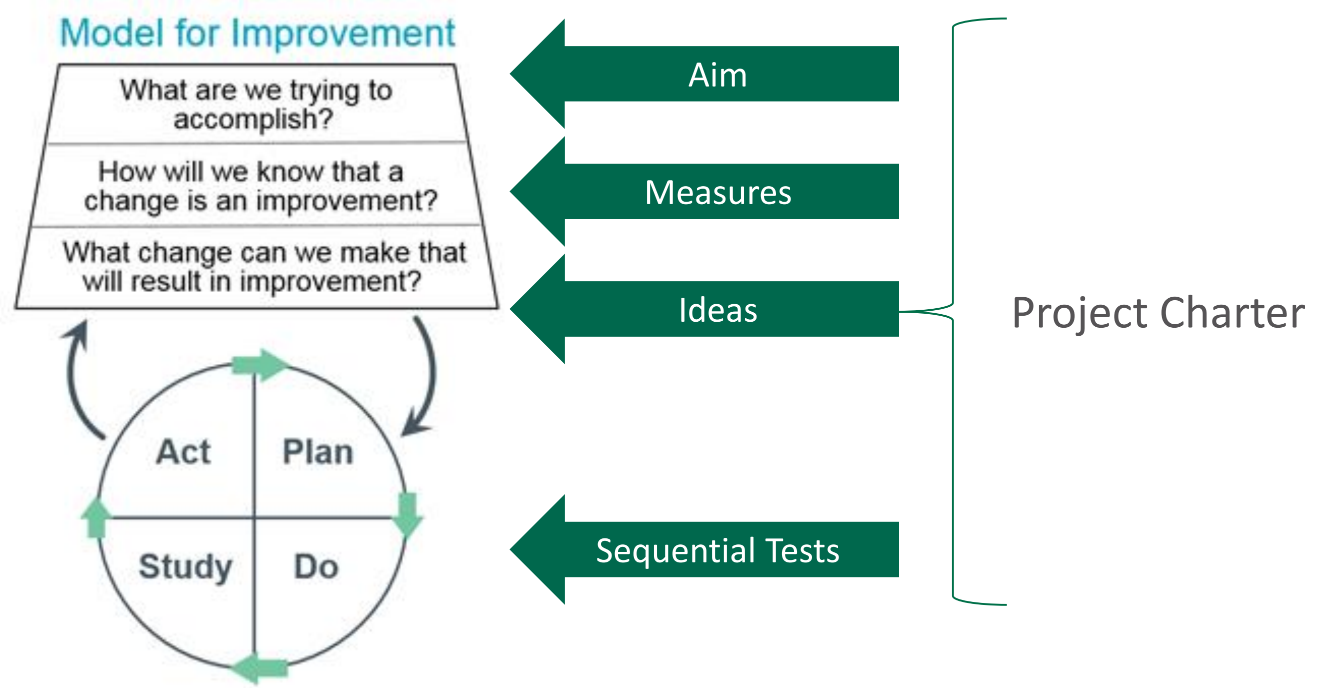
Rogers, E. M., 2003. *Diffusion of Innovation*.

Spreading change: diffusion of innovation

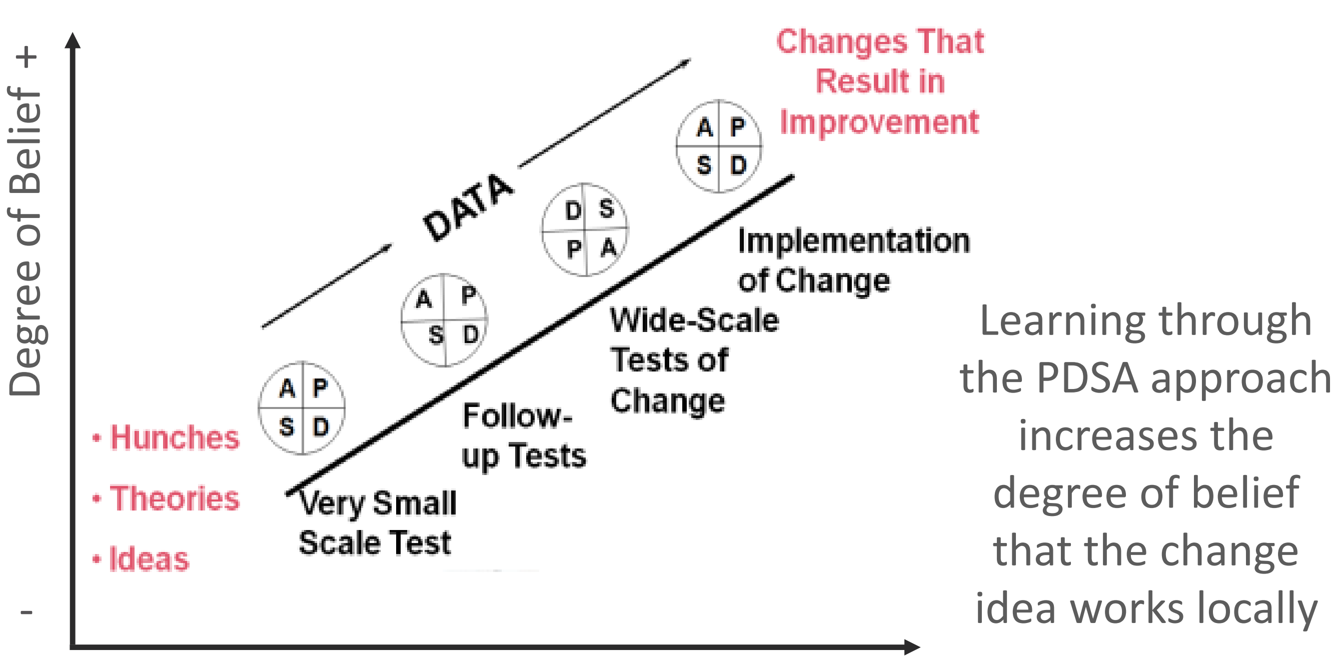


The Model for Improvement

You are already starting to use this!!!



Using PDSA Cycles to embed change



Tell your story

What?

Build evidence that your change ideas work

Why?

For scale up to work, others will need to be convinced your change ideas work

How?

Working as a team, learn through measuring your ideas in practice

Simulation

Aim: Longest spin

Measure: Time of spin

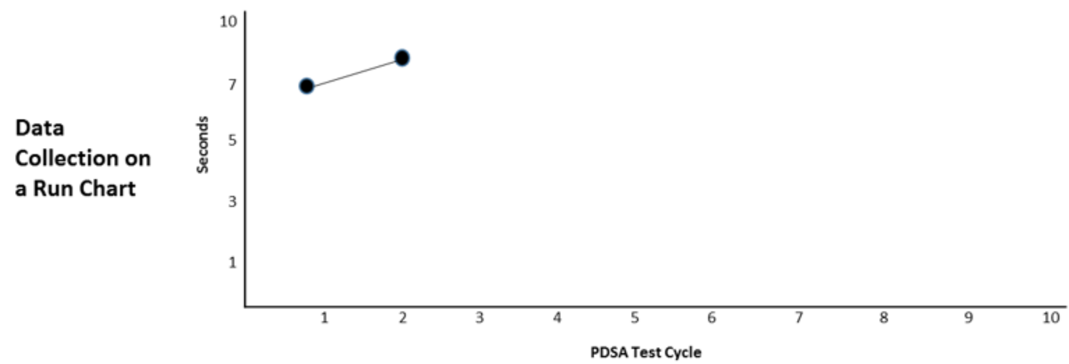
Tools: Coins, timer (phone), PDSA worksheet, run chart

Approach: In teams run cycles using different coins, spinning technique, person and surface. Nominate scribe and timer.

Beware: PDSA cycles are not about tasks (don't need a meeting to decide who is spinning…)

Simulation

#	Plan		Do	Study	Act
#	**What questions? Theories?**	**Prediction**	**What do you see? How Long?**	**How did what you see match prediction?**	**What now? Adopt, adapt, abandon?**
1	Large coins last longer	10p = 10 seconds	Started to wobble. Time = 7	No, Three seconds short. Large Size/weight	Adapt - Test 2p
2	2p will spin longer	2p = 10 seconds	Started to lose spin fast. Time = 8	Two seconds short. Size may be more important	Adapt?



The King of Sweden's Lion

Summary: 5 key messages

1. **Look at the change package.** We are standing on the shoulders of giants. There is lots of evidence out there of what can help improve practice. Take ideas and shamelessly plagiarise. Help us add to the change package.
2. **Beware of the spread trap**. Think about how we can embed new ways of working into everyday practice.
3. **Use improvement methodology** to build belief. Use tests of change to implement. Adapt your ideas as you go. Engage with people e.g. your home teams, people using services and relatives/ carers
4. **Tell your story**. You will need to gather data (quantitative and qualitative) satisfy yourselves that changes are leading to improvements.
5. **Ask for help**: the LWIC team will be delighted to support you.

Next Steps

1. Review the change package as a team and consider the essential and optional change ideas.
2. Plan where you want to start. What is your preferred change idea for your system? Why?
3. Think about how you are going to spread changes in your system. How will you convince yourselves and others that a change is an improvement?
4. Consider what help do you need? What skills are available in the team and what do you want additional support with?
5. Be prepared to share your learning.

Checkout

Write on a post it note your key lightbulb moment from this session and leave on a flip chart.

References and Further Reading

- Slow Ideas: *Some innovations spread fast. How do you speed the ones that don't?, Atul Gwande* *https://www.newyorker.com/magazine/2013/07/29/slow-ideas*
- The Improvement Guide, Langley et al (2009)
- Adapt: why success always starts with failure, Tim Harford (2011)
- King of Sweden's Lion: *https://www.iflscience.com/plants-and-animals/this-is-the-hilarious-result-of-an-18thcentury-guys-attempt-to-stuff-a-lion/*
- Quality Improvement Zone, NES Education for Scotland (NES) *https://learn.nes.nhs.scot/741/quality-improvement-zone*

Learning from across Scotland

Table	Topic	Speaker / Details
1	Virtual Community Wards	Karen Simpson, Aberdeenshire
2	Learning from an enhanced community service	Rebecca McLaren & Eileen Downham, Angus
3	Oban living well project	Pauline Jesperson, Argyll and Bute
4	Challenges in raising the profile of eFrailty Index	Roddy Ireland, East Renfrewshire
5	What has been happening…….Frailty at the front door and ACP	Kim Britton, Dumfries and Galloway
6	Improving Frailty Care at Midlock GP Practice	Ken O'Neill, Glasgow City
7	Developing the approach to frailty- bringing the learning from the MDT in to primary care	Emma Cummings, Inverclyde
8	Progress to date in North Lanarkshire	Liz Kearny, North Lanarkshire
9	The electronic frailty index in Midlothian HSCP	Jamie Megaw, Midlothian
10	Integrated care teams and community nursing	Amanda Taylor, Perth and Kinross
11	Locality response service	South Lanarkshire
12	Rockwood clinical frailty scale – experience in West Dunbartonshire	Fiona Wilson, West Dunbartonshire
13	Answering your questions on SPIRE and eFI	Thomas Monaghan, Living Well in Communities Mike McCabe, ISD
14	Living and dying well: the ambulance service contribution Physical activity and its role in prevention and treatment of frailty	Andrew Parker and Vicky Burnham, Scottish Ambulance Service Eileen McMillan, Health Scotland
15	The housing sector's role in meeting the needs of people living with frailty The role of technology enabled care Home safety visits	James Battye, People, Place and Housing (HIS) Ann Murray, TEC Telecare Sarah Robertson and Stephen Harkins, Fire and Rescue

Team Working - It’s over to you

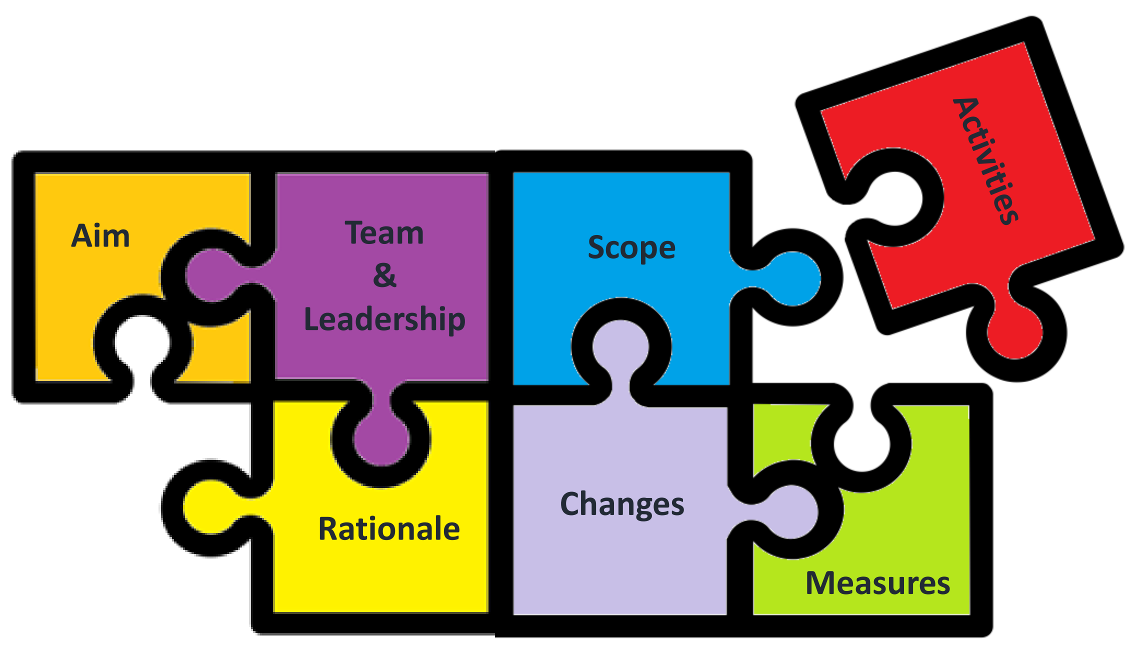
Objectives
At the end of this session you will have:

- the opportunity to **reflect** on today’s learning and plan as an AWAY TEAM
- the opportunity to produce a **revised draft** of your project charter [final version due: 18th October]
- produced a **concise list of actions** with clear roles and responsibilities.

Why have a project charter?

Antoine de Saint-Exupery (1900-1944)

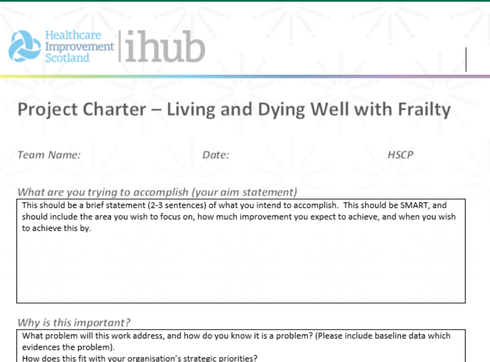
What makes up a good project charter?



Adapted from noun project art. Created by ‘BomSymbols’.

Why is a project charter important?

- Clear (SMART) co-designed aim
- Connects the WHOLE team (home & away)
- Leadership commitment & Team ownership
- Manages expectations
- Clear roles and responsibilities
- Plans what needs to be done by when
- Identify and mitigate possible risks



Healthcare Improvement Scotland | ihub

Project Charter – Living and Dying Well with Frailty

Team Name: *Date:* *HSCP*

What are you trying to accomplish (your aim statement)

This should be a brief statement (2-3 sentences) of what you intend to accomplish. This should be SMART, and should include the area you wish to focus on, how much improvement you expect to achieve, and when you wish to achieve this by.

Why is this important?

What problem will this work address, and how do you know it is a problem? (Please include baseline data which evidences the problem).
How does this fit with your organisation's strategic priorities?

What resources are on your tables?

Outcome

People 65 years and over with frailty, will experience a good life and death, including more time at home or in a homely setting.

- Reduce unplanned hospital bed days
- Reduce unscheduled GP home visits
- Increase use of anticipatory care planning and Key Information Summary

Primary driver	*Secondary drivers*
Identify people aged 65 and over living with frailty in the community.	💡 Case find people at risk using the e Frailty Index • Create diagnosis for frailty • Multi-dimensional assessment • Monitor change and deterioration over time
Support people living with frailty to plan for their future care needs, and when appropriate, death.	💡 Anticipatory care planning conversations, including recording information in the Key Information Summary • Carer's assessment • Informal/Adult carers support planning
Support people living with frailty to access preventative support in the community.	• Key worker • Exercise interventions and physical activity • Lifestyle and nutritional interventions • Polypharmacy review • Reablement • Vaccinations • Community-based geriatric services • Palliative and end of life care
Develop effective multidisciplinary team working focused on person-centred, preventative care.	💡 Communication and collaboration within a multi-disciplinary team, including a multidisciplinary review • Understand what support is available in communities and how to access support 💡 Use quality improvement methods, including data over time, to drive improvement

💡 Essential activity for all members of the collaborative

What resources are on your tables?

Mild	Moderate	Severe
Nutritional interventions	Reablement	Bed based intermediate care
Exercise and physical activity	Polypharmacy review	Community-based geriatric services
Smoking cessation	Primary care MDT	Palliative care
Reduce alcohol	Falls management	Hospital at home
Reduce social isolation	Anticipatory care planning	Anticipatory care planning
Housing adaptations	Immunisation	Adult carers support planning

What resources are on your tables?

Disease State

Arthritis

Diabetes

Heart Valve Disease

Parkinson's Disease

Skin Ulcer

Atrial Fibrillation

Foot Problems

Hypertension

Peptic Ulcer

Stroke and TIA

Chronic Kidney Disease

Fragility Fracture

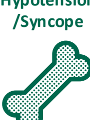
Hypotension /Syncope

Peripheral Vascular Disease

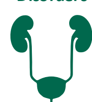
Thyroid Disorders

Coronary Heart Disease

Heart Failure


Osteoporosis

Respiratory Disease


Urinary System Disease

Symptoms / Signs

Dizziness

Polypharmacy

Dyspnoea

Sleep Disturbance

Falls

Urinary Incontinence

Memory and Cognitive Problems

Weight Loss and Anorexia

Disability

Activity Limitation

Requirement for Care

Housebound

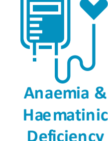
Social Vulnerability

Hearing Loss

Vision Problems - Blindness

Mobility and Transfer problems

Abnormal Lab Value


Anaemia & Haematinic Deficiency

What resources are on your tables?

Action /Activity	By When?	Away Team Member Name					
		Alec	Jo	Sam	Tom	Kim	Someone else?
1) Brief the Home Team		R	C	A	R	I	
2) Meet with LIST		R	A	C	I		
3) etc….		R	R	C	A	I	
4) etc….							
5) etc….							

R = Responsible A = Accountable C = Consulted I = Informed

YOU!

Credit for noun project logos: ‘parkjisun’ & ‘Georgiana Ionesca’

For the remainder of session (till 4pm)

- Please work in your teams to discuss and refine your project charter.
- Plan your next steps as team using the Action Plan-RACI

You may wish to discuss:

- Your SMART aim

- What cohort of citizens/patients will you be focusing on?

- The change ideas you plan on testing

- How will you measure these?

Team planning

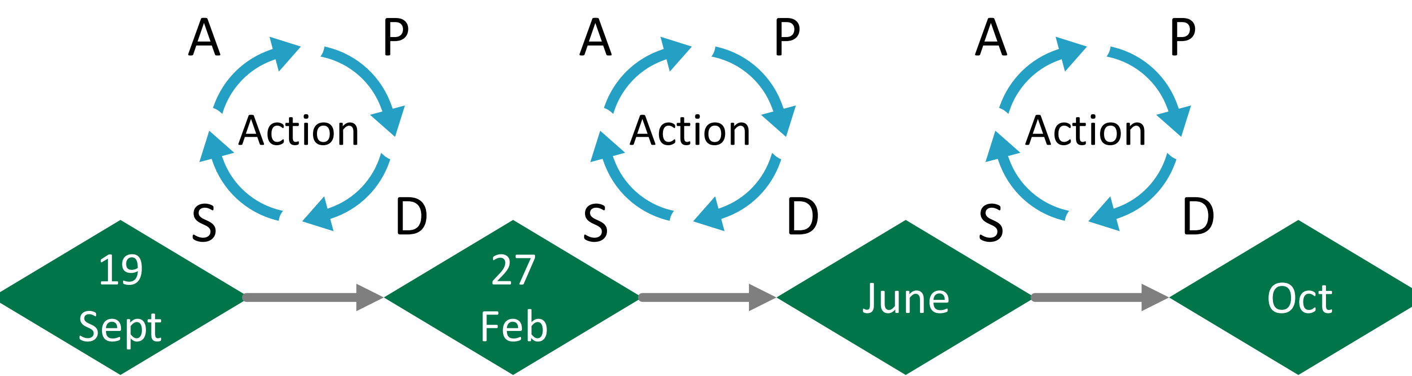
Queen Elizabeth Suite

Table	Team
1	Angus
2	Perth and Kinross - North West Perthshire Cluster
3	Perth and Kinross – Kinross, Bridge of Earn, Errol and Abernethy Cluster
4	Aberdeenshire
5	Highland and Western Isles
6	Midlothian
7	Glasgow City
8	Clackmannanshire and Stirling
9	East Dunbartonshire
10	West Dunbartonshire
11	Dumfries and Galloway
12	North Ayrshire - Arran Medical Group
13	North Ayrshire - Largs Medical Group; Cumbrae Medical Practice
14	South Ayrshire
15	South Lanarkshire

Waverley Suite

Table	Team
1	Argyll and Bute
2	East Renfrewshire
3	Inverclyde
4	North Lanarkshire
5	Renfrewshire

Collaborative timescales



On your marks, get set.....

- ✓ Share your learning with your Home Team
- ✓ Start your tests of change
- ✓ Document your progress and record data over time

Safe journey