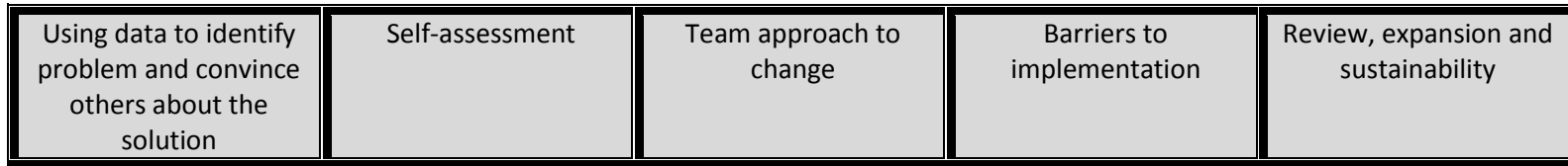


Service level toolkit – web based



About the toolkit

You are an anaesthetist, a surgeon, an oncology specialist, or other acute care physician. In your service, your and other team members' training may not have focused on the needs of older people. There may be a lack of confidence and expertise in managing older people and conditions associated with ageing. Yet you are interested in improving care for these patients who come to your service.

You may have seen research evidence and you may have talked to your colleagues and reflected on personal experience. You may have collected own data showing the care for frail older people in your service could be improved. Or you may have been asked to improve your service performance in respect to this patient group.

There are different starting points on your journey to improve care for frail older people in your service, and this toolkit will try to assist you on that journey.

Each chapter brings together knowledge about key challenges in improving healthcare, resources proven to help in overcoming these challenges (many have been collated online as part of the NHS Change Model^a, the NHS Scotland Quality Improvement Hub^b, and the Welsh 1000 Lives Plus^c), and

^a <http://www.nhs.uk/capacity-capability/change-model.aspx>

^b <http://www.qihub.scot.nhs.uk/>

^c <http://www.1000livesplus.wales.nhs.uk/qi-guide>

experiences of those who have successfully improved care for frail older people in acute settings across the country. This way the toolkit aims to bring together a combination of clinical and implementation knowledge, together with practical experiences of leaders in improving care for frail older people.

A key part of the toolkit is the self-assessment (Chapter 2), a unique tool developed to give your team the opportunity to identify service level competencies that are already in place and those in need of further development. It also offers recommendations about what to do when gaps in service provision are identified.

The toolkit is aimed at teams who will lead on improving the care for frail older people provided by their services. To be successful, improvement efforts require a concerted effort of a range of actors, not only those “on the ground” but also actors located outside individual services. The toolkit will eventually be supplemented by several other interventions, currently in development, that will target other audiences at the levels of strategic and operational management, and a tool to help patients and carers take an active role in their care. We believe that a **multi-level approach** to improvement enhances the chances of more effective change (see Box 1), and ensure that clinicians and their colleagues “on the ground” are not working in isolation.

Box 1 *Multi-level approach to change*

- 1) **Strategic (regional) level:** Relevant strategic players, namely System Resilience Groups (SRGs) with Chief Executives and Commissioners as their attendees, will be alerted about the problem in care such as higher than expected volumes of attendance and high admission rates, length of stay, readmission rates and institutionalisation. They will be offered a solution in the form of improving care for the frail older patients detailed in this toolkit, and prompted to take action, e.g. to include service development in strategic planning, and delegate implementation to operational arms..
- 2) **Operational (trust) level:** Managers will be presented with convincing evidence of the problem, for example national reports from Royal Colleges, data from the NHS benchmarking audit on acute care for older people and patient stories. Their action will ideally be supported by strategic level decisions. Divisional and service managers will delegate service development across the hospital to non-geriatric services and provide support to improvement teams. Support may include: oversight by experienced senior clinical and managerial teams from different directorates and specialities, dedicated

measurement team, devolved budgetary autonomy, project management support, and service level review.

- 3) **Service level** will see improvement teams being set up who will lead on embedding CGA in services. This is the area covered by this toolkit.
- 4) **Patient and carer level** will be empowered to take a more active role in their care, if they wish to do so. Patients and carers may influence the ways acute services are provided locally, and will be targeted by a specific intervention (an information leaflet or a video) to increase awareness about high-quality care for frail older people. In turn, patient and carers will be able to demand the care from their services.

CHAPTER 1: Using data to identify problem and convince others about the solution

“One fundamental, but often poorly met, challenge for improvement efforts is that of convincing people that there is a real problem to be addressed. ... Trying to convince clinical teams who think they are already doing well to change is likely to be futile unless they can be shown that action is really needed.” (13)

The first challenge on your improvement journey is to identify whether there are areas of the care you provide for frail older patients that could be improved. This closely associates with a second challenge – convincing others that the solution to the problem is the right one.

You will start defining the problem in your service which can be improved by introducing the process of holistic assessment and co-ordination of frail older patients known as Comprehensive Geriatric Assessment (CGA – see Box 2). CGA is the accepted gold standard method of care for frail older people in hospital.

Box 2 *Comprehensive geriatric assessment (CGA)*

CGA is defined as ‘a multidimensional, interdisciplinary diagnostic process to determine the medical, psychological, and functional capabilities of a frail older person in order to develop a coordinated and integrated plan for treatment and long-term follow-up’ (14).

To demonstrate the value of the introduction of Comprehensive Geriatric Assessment (CGA) into your systems and processes, it is vital to be able to show how it has made a difference to the quality and effectiveness of the service provided. There is good evidence from the international research literature that introducing CGA is associated with improved outcomes at various levels, including service-level outcomes reduced length of stay and reduced in-hospital complications, and potential system-level cost savings. The following table summarises the evidence found in a recent review of reviews of CGA interventions:

Outcome	Metric	Effect size	Cost savings?	Review references
Length of stay	Length of stay at discharge	Mixed – ranging from no significant difference to significant difference (p=0.02), and trend to reduction in length of stay from 4-9 days over the reviews	Reduction in costs ¹ ; suggests optimal for overall outcome achievement ⁷ ; slightly, significantly lower cost of hospital care ¹¹	Ellis et al. ^{1*} , Fox et al. ^{2*} , van Kraen et al. ³ , Kammerlander et al. ⁴ , Fox et al. ^{7*} , Deschodt et al. ⁹ , Ellis et al. ^{10*} , Bazta et al. ¹¹ , Fealy et al. ¹²
Readmissions	Readmission to hospital at one month, three months, six months and one year	No significant effects in most reviews. Negative effect in one study. Trend of 15% less likely to be readmitted		Ellis et al. ^{1*} , Fox et al. ² , van Kraen et al. ³ , Linertová et al. ⁵ , Conroy et al. ⁶ , Deschodt et al. ⁹ , Ellis et al. ^{10*} , Bazta et al. ¹¹ , Fealy et al. ¹²
Admission to long term care	Discharged to and living at home Institutionalisation (living in residential care at end of scheduled follow-up)	Between 5 and 30% All reviews except 11 showed meaningful trend up to significant reduction in admission to care		Ellis et al. ^{1*} , Fox et al. ^{2*} , Fox et al. ^{7*} , Ellis et al. ^{10*} , Bazta et al. ¹¹ Ellis et al. ^{1*} , Fox et al. ^{2*} , van Kraen et al. ³ , Conroy et al. ⁶ , Fox et al. ^{7*} , Ellis et al. ^{10*} , Bazta et al. ¹¹ , Fealy et al. ¹²
Other service level outcomes	Cost of Geriatric Unit Overall Societal costs	p=0.02 No quantitative analysis	Costs of acute unit care were significantly lower than usual care Each study reported was ‘cost effective’ in not increasing overall societal cost	Fox et al. ² Fox et al. ⁷
*Reference 1 reviewed the same studies as reference 10; Reference 2 reviewed the same studies as reference 7				

Some studies have looked at the impact of CGA on the process of care and reduction in complications that in turn, lead to the service related benefits, such as reduced length of stay. For example, the ‘POPS’ evaluation has shown that the intervention group had fewer post-operative medical complications including pneumonia (20% vs 4% [p = 0.008]) and delirium (19% vs 6% [p = 0.036]), and significant improvements in areas reflecting multidisciplinary practice including pressure sores (19% vs 4% [p = 0.028]), poor pain control (30% vs 2% [p<0.001]), delayed mobilisation (28% vs 9% [p = 0.012]) and

inappropriate catheter use (20% vs 7% [$p = 0.046$]). Length of stay was reduced by 4.5 days. There were fewer delayed discharges relating to medical complications (37% vs 13%) or waits for OT assessment or equipment (20% vs 4%).(15,16,9)

Services that have successfully improved care for frail older patients demonstrated how introducing holistic assessment and management for frail older patients was also about “making life easier” for the service. Identifying *the right* problem was key.

“We had a very objective approach to [engaging surgical wards]. We were [showing] data, showing where the problems were, in terms of length of stay in terms of cancellations – things that impacted on them directly – and illustrating how we could potentially help with that. [We] were sowing the seeds of the advantages of collaborative working, and then saying, ‘OK, well we will start in one small area, but we’ll bring data back to you in three months’ time and show you what’s happened, as a consequence’. And then gradually, as we started doing that, people started to see the benefits.” (Consultant Geriatrician)

You may therefore wish to target improvements in one of these outcomes through your efforts to improve your service. Establishing a local baseline for these outcomes will be one of your first steps.

Convincingly demonstrating an impact on ‘distal’ outcomes, such as length of stay or quality of care is more difficult in day-to-day service provision than in research settings, where numbers of patients are smaller, patient characteristics are more varied, and resources for measurement across the patient pathway are more constrained. Therefore it may be better to be more modest in what you measure, focusing for example on process measures rather than service outcomes, making good use of routinely collected and readily available data, and ensuring any additional data collection is feasible and carefully targeted.

As well as being important in demonstrating the value of change to others, measurement is also crucial for understanding and evaluating the impact of change within your team. Chapter 5 of the [How to Improve](#) guide produced by the Welsh 1000 Lives Plus campaign contains useful guidance on measurement for improvement. Effective measurement for improvement is about getting the right balance between the burden of extra data collection and interpretation, which can be time-consuming, and ensuring that you have collected enough data, consistently, to be able to understand the impact your changes are making. [Run charts](#) are a simple, but statistically robust, way of plotting how measures are, or are not, changing over time, and whether or not the changes you are making are resulting in real and sustained shifts in the processes and outcomes intended.

Using data to define the problem and to monitor it continuously throughout your journey will allow you to:

- know where your service stands in relation to the standards of care
- generate interest in those in charge of finance
- generate buy-in from colleagues
- identify what is working well and what is not working so well in improving care
- ultimately, show the benefits of improvement

This data is different from data for judgment; the latter is not helpful in developing a service. It is important that you negotiate the use of measurement for improvement with those overseeing the evaluation of the service so that they do not rush to judge a service before it is ready for judgement! It may take many months to establish a service to stage where a more summative assessment can be undertaken to look at the relative benefits.

In considering whether your service can provide better care for frail older patients you may also wish to look at:

- web-based 'frailty dashboard' indicating the size and nature of the problem derived from the Nuffield data – this will look at service level outcomes, such as attendance and admission rates, bed-days (not length of stay as this is very dependent upon admission rates), readmission rates. You may also be able to collate some patient related outcomes, such as satisfaction (e.g. friends and family test), and mortality. Other patient related outcomes such as function, mood, quality of life are fantastic if available but not routinely collected as outcomes in most places.
- national reports from Royal Colleges
- data from the NHS benchmarking audit on acute care for older people^d
- patient stories^e

These data sources can be useful for working out the nature and size of the problem, and therefore what to focus on improving – in contrast to process measures that should be used during the improvement process itself.

Using data for improvement

^d <http://www.nhsbenchmarking.nhs.uk/index.php>

^e <https://www.youtube.com/watch?v=I0TVbhHdg4A>

Box 3 provides an example of the use of data for improvement – in this case establishing a process to identify frailty in the emergency department – but the principles apply other areas too:

Box 3 *How do we embed the use of frailty tools in our setting?*

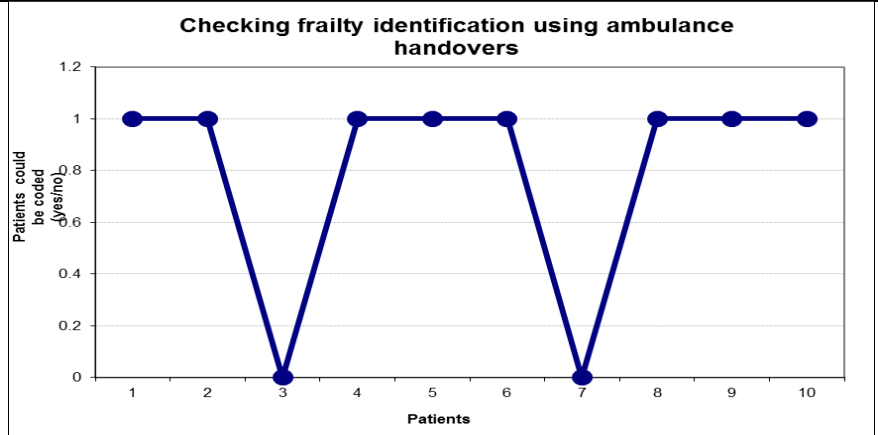
Making the use of frailty tools part of an everyday practice takes a bit of time, but it is not that difficult. There are four key steps, each of which is a PDSA cycle.

1. The ambulance service will almost certainly be able to **provide the information** necessary to use one of the frailty tools. This admission interface covers that vast majority of patients relevant to frailty services.
2. When the ED or AMU nurse takes a handover from the ambulance service, they need to **populate a frailty box** on the handover proforma that all hospitals will use. Different versions can be found in different hospitals, but all hospitals have some sort of handover/immediate assessment form.
3. This frailty score can then be added to your **electronic hospital record**. Different systems operate in different hospitals, some covering just ED, some also including the AMU and the rest of the hospital. If your setting is IT ready, then ask your IT team to create a frailty field, which can be used for tracking purposes.
4. The final step is to check that the **frailty identification leads to an action**. Depending on your setting, this might be a referral to a frailty team, frailty unit, or special documentation – however your deliver CGA, check that it is being done for older people with frailty and urgent care needs.

Embedding frailty tools in your setting will be greatly aided by the use of PDSA cycles.

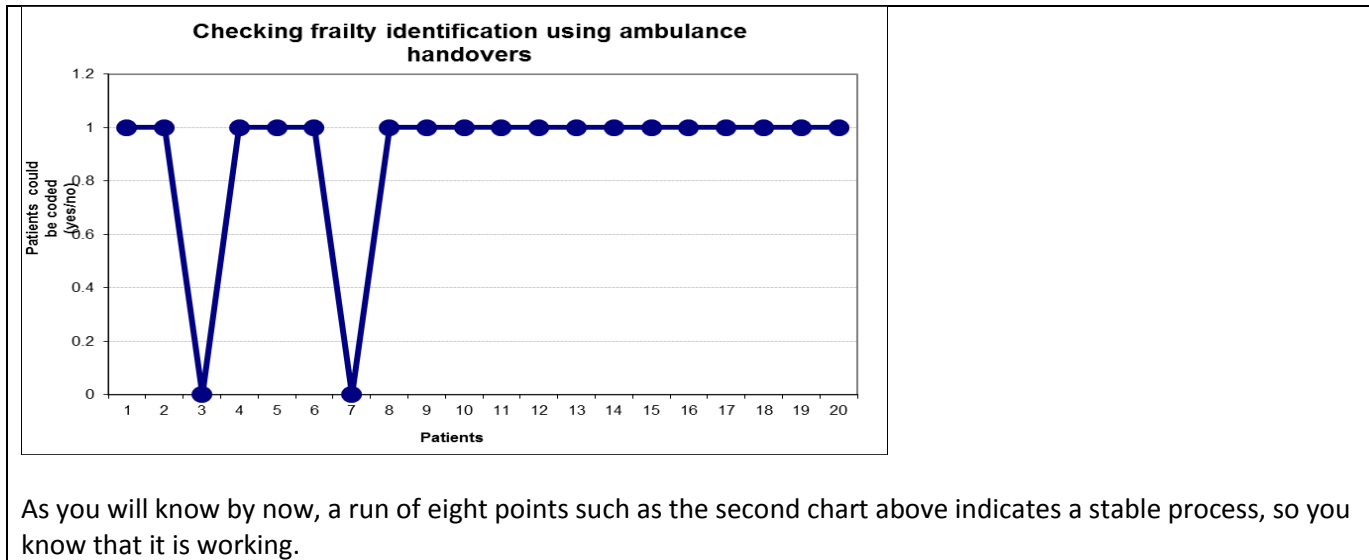
Step 1 check that the ambulance crew provide most of the information required

For this you will need a clinical data collector – nurse specialist, doctor, therapist, whoever, just so long as they know what the information means and can turn it into your chosen frailty score. Check the process works using run charts – remember, you don't need to check many patients – perhaps just ten older patients (65+) should be enough. You'll then get a run chart that looks something like this where 1 means that patient could be scored and 0 means they could not:



This one shows that two patients could not be coded – you need to understand why not, and if appropriate change the process to ensure that they can be coded in the future. It might be that the ambulance service are not capturing information on cognition, in which case you need to get them to start doing so. It might take a while to sort, but if the ambulance team can see how this will help their patient, and reduce their waits in ED, then they will be happy to help. You might need to get some senior support.

Test again after the process change and you will hopefully get a run chart like this:



Use the same approach for other steps in embedding frailty identification.

KEY CHALLENGES (p.6-8) (13)

Convincing people that there is a problem

Use hard data to demonstrate the extent of the problem and patient stories and voices to secure emotional engagement. Use peer-led debate and discussion.

Convincing people that the solution chosen is the right one

Come prepared with clear facts and figures, have convincing measures of impact, and be able to demonstrate the advantages of your solution. Involve respected senior figures.

THE NHS CHANGE MODEL

First steps towards quality improvement: A simple guide to improving services is a resource providing a short overview with the most relevant tools and other resources.

<http://www.nhs.uk/mediaservices/2591385/signature.pdf>

Measurement for Improvement

<http://www.nhs.uk/mediaservices/2594838/signature.pdf>

OTHER RESOURCES

Measurement for improvement

NHS Scotland Quality Improvement Hub introduction to run charts: <http://www.qihub.scot.nhs.uk/knowledge-centre/quality-improvement-tools/run-chart.aspx>

1000 Lives Plus Wales *How to Improve* guide:

<http://www.1000livesplus.wales.nhs.uk/sitesplus/documents/1011/T4I%20%281%29%20How%20to%20%20Improve%20%28Feb%202011%29%20Web.pdf>

The One Hour Improvement Expert: How to Become an Improvement Measure Expert in 60 Minutes https://prezi.com/xvcdfn9wk5tb/how-to-become-an-improvement-measure-expert-in-60-minutes-ah/?utm_campaign=share&utm_medium=copy

The A to Z of measurement

<http://www.nhs.uk/mediaservices/2581374/signature.pdf>

The run chart: a simple analytical tool for learning from variation in healthcare processes, 2011.

<http://qualitysafety.bmj.com/content/20/1/46.abstract>

CHAPTER 2: Self-assessment: where is our service and what to aim for?

You may already have a good idea about the service outcomes you wish to improve, and you may also have an idea about organisational change needed to achieve the improvement. For example, you may think that the best organisational change will be to establish a regular geriatric review for patients you identify as likely to benefit. Or you may be thinking about setting up a monthly geriatrician-led clinic for your frail older patients, and improving their identification on your ward or clinic.

These are valid plans that may lead to improvement. However, you should consider the evidence which has consistently shown that care for frail older people in non-geriatric acute care settings is better when assessment and management of frail older patients is **integrated** into the whole service (see Box 4).

Box 4 *When is assessment and management of frail older patients integrated into your service?*

Evidence suggests that **integrating** assessment and management of frail older patients into your service is a more effective way of organising care than having a consultation geriatric service at arm's length. (2) Greater effectiveness relates mainly to joint decision making and **shared control** over patient identification and treatment by geriatric and non-geriatric expertise.

"It's very nice doing joint ward rounds, [geriatricians and surgeons,] because you end up with lots of two-way education, a lot more understanding of where each of us is coming from, and I think it's just very good for the patient to see that we are working together, and that we are making joint decisions, together with the patient, and providing them with that more overall information which is what the patients want rather than it being purely about the surgical complications." (Consultant Geriatrician)

"Because for the nature of CGA you can't have it as a liaison because of it being such a team approach and you need the team that you are working with to be working together with you with the shared vision. You can't have liaison." (Geriatrician)

To give you a better idea of what organisational change may be needed, we have developed a **self-assessment tool**. It will allow you to compare existing service provision to what gold-standard care for frail older people should look like in an acute care setting. This way it will help you to identify service-level

competencies already in place as well as any gaps that will need to be addressed in planning organisational changes to integrate assessment and management of frail older people as part of your service.

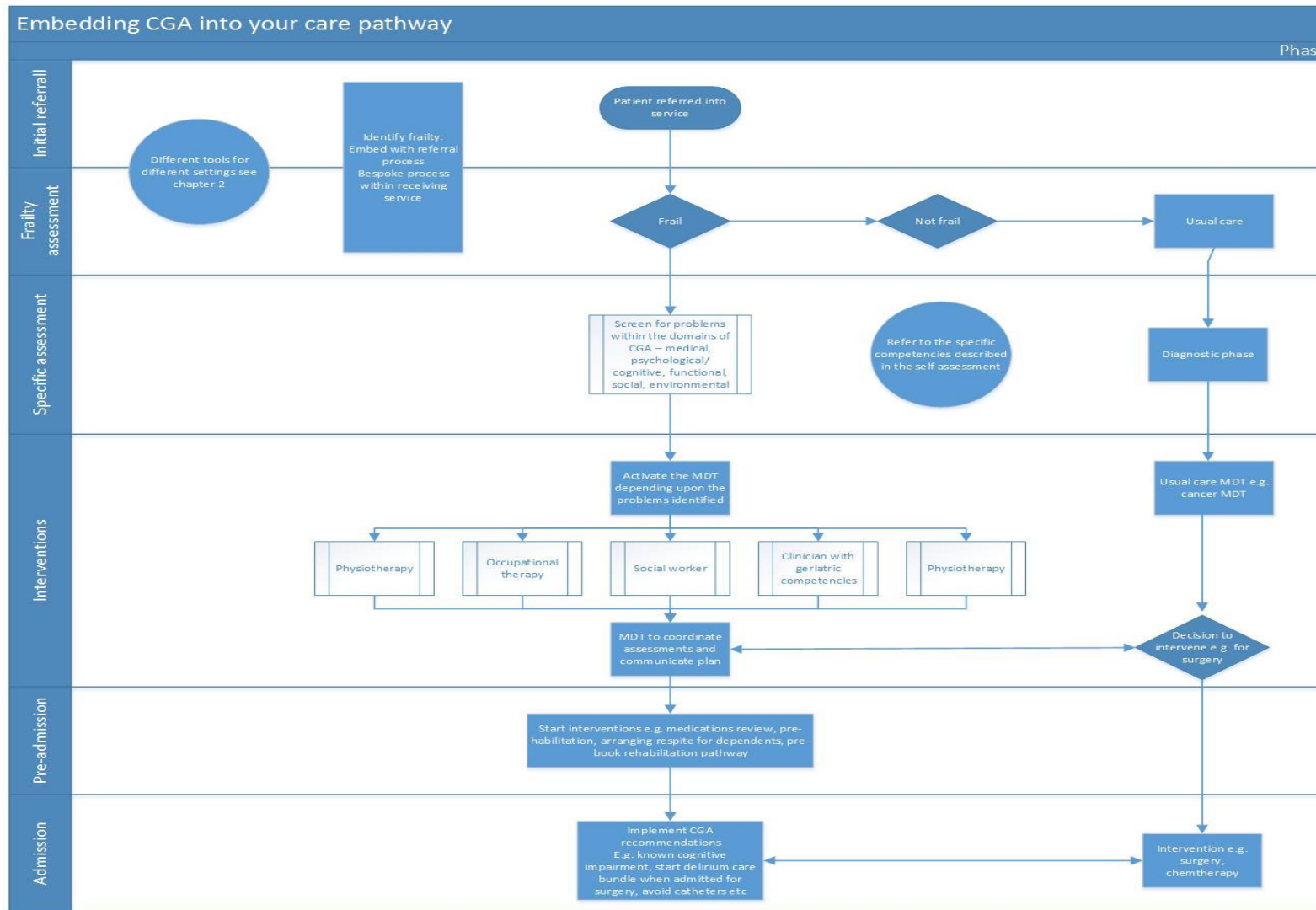
When you open the **self-assessment tool** (see Appendix 1), you will find it has two parts.

- **First** it assembles key **service-level competencies** that together ensure high-quality care for frail older patients, and prompts you to check whether they are routinely available in your service.
- **Second** it offers evidence-based **tools and actions** to fill gaps in those competencies.

You may be able to answer some of the questions in the toolkit straight away. However, there may be areas where you are not sure about how your current practice looks. For some of the questions, it may be that you have local policies and protocols in place, but they are inconsistently followed in practice. We suggest taking time to complete the self-assessment tool, rather than seeking to complete it instantaneously. Discuss the questions with your colleagues in your team to gain their views on the strengths and weaknesses of current practice, and consider undertaking reviews (e.g. PDSA style measurement) of current practice (for example, via case notes), particularly where you are not sure whether things are being done consistently, or where you suspect there may be a gap between the existence of a local policy and what actually happens.

To help you start to think about the aspects of your service that need reviewing, Figure 1 provides a schematic representation about how CGA might be embedded into a service (in this case a cancer service, but the principles should apply more broadly). You will see that there are key points that need testing to determine if they are in place already or not, for example, frailty identification, screening for geriatric syndromes, involvement of the geriatric (as opposed to cancer Multidisciplinary Team (MDT)), communication and coordination in an MDT meeting etc.

Figure 1: Embedding CGA into care pathway



CHAPTER 3: Team approach to change

Quality improvement leaders should be unwavering in their goal, confident they will reach it, and humble enough to ask everyone to help them get there (17)

Designing solutions and delivering change is more effective when delivered by a core team of people who invest in engaging with a network of stakeholders. You may wish to start thinking about the advocates of improving care for frail older people in your service early. Inviting everyone who can help you reach your goal is beneficial in planning change, in explaining the need for change, and in sharing practical tasks in making change happen. Mutual support provided by the team will also help you deal with frustrations, and review your progress.

As support for change widens and ownership of it expands, late adopters are also likely to get on board with your project.

It is better when members of the team have personal interest and stake in the change. People who may become part of your core team include:

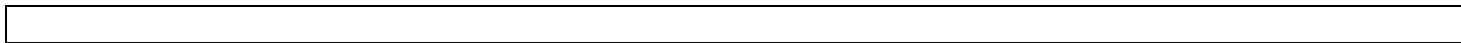
- Senior **medical** practitioner in your service (such as a surgeon, anaesthetist, emergency physician, urologists, and other specialists depending on your service)
- Senior **nursing** practitioner in your service
- Practitioner with geriatric **expertise**
- General **manager** in your area with access to and influence in organisational and financial decision-making processes
- Practitioners involved in **multidisciplinary teamwork** (such as a **social worker, physiotherapist, occupational therapist, discharge co-ordinator or case manager**)

Multi-disciplinary teams

In your improvement teams you will be working along the premise that high-quality care for frail older people is not 'done' by geriatricians. As evidence suggests, effective assessment and management is done across multiple domains (medical, psychological, environmental, social and functional), accompanied by case management and iteration of management plans. As such, it requires a co-ordinated multi-disciplinary effort.

See a short video illustrating how multi-disciplinary teams operate:

<https://vimeo.com/132073531>



Successful improvement initiatives often involve developing a clinician-led approach to improvement and involved professional bodies to counter the tendency to see improvement as management-led and imposed. They involve representatives from all areas and professions involved in designing the change, though in the NHS, input from a senior medical doctor is usually critical. Multidisciplinary teams with enough external support also ensure the skill mix required to deliver the improvement (13). Designing joint decision making ideally can help to generate a sense of shared purpose.

It's a very complex social dynamic isn't it, the way a unit functions and I think consequently you have to have people signed up to the shared objectives, and in the past, as we have gone on this journey we have got outcome data that shows that we make things better we get more people home, and we have a much lower readmission rate so based on those broad concepts we know what we are doing works. (Consultant Geriatrician)

Identifying the right team to involve in **planning** organisational change may include activities such as:

- Process mapping
- Stakeholder mapping (who are the key people to influence?)
- Mapping skills available / skills missing
- Considering questions such as how many people do we need, where do we get them, and who to ask for resources?

Team approaches to **engaging others** may include activities such as:

- Corridor conversations and quick reviews may be more suitable for busy practitioners than organising formal meetings.
- Making sure you are not missing out key people who need to be consulted or who have influence in the right places
- Systematic targeting via existing departmental meetings

KEY CHALLENGES (p.8-11) (13)

Getting data collection and monitoring systems right

This always takes much more time and energy than anyone anticipates. It's worth investing heavily in data from the outset. External support may be required. Assess local systems, train people, and have quality assurance.

Excess ambitions and 'projectness'

Over-ambitious goals and too much talk of 'transformation' can alienate staff if they feel the change is impossible. Instead, match goals and ambitions to what is realistically achievable and focus on bringing everyone along with you. Avoid giving the impression that the improvement activity is unlikely to survive the time span of the project.

Leadership

Getting leadership for quality improvement right requires a delicate combination of setting out a vision and sensitivity to the views of others. 'Quieter' leadership, oriented towards inclusion, explanation and gentle persuasion, may be more effective. This may require additional training.

THE NHS CHANGE MODEL

Shared purpose

"A clear sense of shared purpose is essential to any successful change. Organisations whose communities are strong, passionate and committed to delivering improvement and outcomes, create shared purpose as a common thread. Shared purpose connects us with our commitment and contribution to our core values - the things that bring us into health and care to deliver outcomes that matter to local communities, beyond just what we do as individuals, teams or organisations. We need to know not just what problems we are trying to solve and why it matters, but what our vision is for the future and why that future matters."

Living Our Local Values Toolkit

http://www.institute.nhs.uk/building_capability/living_our_local_values/living_our_local_values.html

Leadership

Leading Large Scale Change is a guide provides principles to apply within various healthcare setting

http://www.institute.nhs.uk/leading_large_scale_change/information/leading_large_scale_change_homepage.html

OTHER RESOURCES

Building communities, engaging others

Skilled for Improvement? Learning communities and the skills needed to improve care: an evaluative service development, 2014.

http://www.health.org.uk/sites/default/files/SkilledForImprovement_fullreport.pdf

Public Narrative Participant Guide introduces Public narrative as a storytelling based technique that enables connecting to people and calling them to take action

<https://www.ndi.org/files/Public%20Narrative%20Participant%20Guide.pdf>

Corridor Conversations: Clinical Communication in Casual Spaces. In: *The Discourse of Hospital Communication Tracing Complexities in Contemporary Health Care Organizations*, 2007.

http://link.springer.com/chapter/10.1057/9780230595477_9

Story Telling

<http://www.qihub.scot.nhs.uk/knowledge-centre/quality-improvement-tools/story-telling.aspx>

Quality improvement through clinical communities: Eight lessons for practice, 2012.

https://www2.le.ac.uk/departments/health-sciences/research/soc-sci/pdf-resources/Quality%20improvement%20through%20clinical%20communities_Eight%20lessons.pdf

Leadership

The NHS Leadership Academy brings together tools and resources to support the Healthcare Leadership Model

<http://www.leadershipacademy.nhs.uk/resources/healthcare-leadership-model/supporting-tools-resources/>

Process Mapping

NHS Scotland Quality Improvement Hub guidance on process mapping

<http://www.qihub.scot.nhs.uk/knowledge-centre/quality-improvement-tools/process-mapping.aspx>

Process Mapping – An Overview

http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/process_mapping_-_an_overview.html

Process Mapping, Analysis and Redesign

[http://www.nhs.uk/media/2594717/ilg - process mapping analysis and redesign.pdf](http://www.nhs.uk/media/2594717/ilg_-_process_mapping_analysis_and_redesign.pdf)

CHAPTER 4: Barriers to implementation

Engaging staff and overcoming a perceived lack of ownership are among the biggest challenges in improvement efforts (13)

The overarching message about successful improvement shows how **social relationships** in organisations are key for embedding the technical features of change. A lot of time and energy in leading organisational change will require you to uncover and mitigate barriers. Part of this will mean understanding rather than judging when people resist. Reasons may include perceived losses or real barriers.

“I think the barrier to making things better is an attitudinal change in certain folk who won’t accept the input and I think for some of the nurses on the ground, who don’t have an attitude towards it which is either positive or negative, to get across the importance of the key components of what you are trying to achieve.” (Consultant Geriatrician)

“One of the challenges was that it wasn’t [...] seen as not a useful thing. So the fact that I was finding things that were important, and needed, was actually seen as being a problem because potentially I might be finding problems that people didn’t want to see.” (Physiotherapist)

Peter Pronovost, a physician and a quality improvement guru, has had a great deal of first-hand experience in dealing with what he called adaptive challenges to change. Adaptive challenges refer to people’s loyalties, priorities, beliefs and habits that may lead to resisting change. It is these adaptive challenges that “will determine whether your intervention is adopted and implemented” (p.563) (17). Some key points Pronovost highlighted to those dealing with adaptive challenges were:

- embrace and talk to dissenters rather than bully and avoid them,
- listen and understand why they are resisting – the intervention may pose some unrecognised risks or burdens
- communication, communication, communication is key to managing fears and perceived losses
- remember “WIIFM” – What Is In It For Me. Apart from doing the right thing and putting the patient first, everyone wants to maximise their interests and get something from the change effort
- benefits must be visible to overcome resistance

KEY CHALLENGES (p.11-19) (13)

The organisational context, culture and capacities

Staff may not understand the full demands of improvement when they sign up, and team instability can be very disruptive. Explain requirements to people and then provide ongoing support. Make sure improvement goals are aligned with the wider goals of the organisation, so people don't feel pulled in too many directions. It is important that the organisational culture supports learning and development.

Tribalism and lack of staff engagement

Overcoming a perceived lack of ownership and professional or disciplinary boundaries can be very difficult. Clarify who owns the problem and solution, agree roles and responsibilities at the outset, work to common goals and use shared language. Intermediaries, such as training staff, are likely to have a role here. Protected staff time may help to secure engagement

Balancing carrots and sticks – harnessing commitment through incentives and potential sanctions

Relying on the intrinsic motivations of staff for quality improvement can take you a long way, especially if 'carrots' in the form of incentives are provided – but they may not always be enough. It is important to have 'harder edges' (sticks) to encourage change, but these must be used judiciously and are likely to require the support of senior executives, professional bodies and those designing reward structures.

THE NHS CHANGE MODEL**The NHS Institute's spread and adoption tool**

A practical tool that synthesises the best evidence available on the factors that support the spread and adoption of innovation is now available.

<http://www.institute.nhs.uk/spread>

Energy for Change

A YouTube animation introduces an important leadership skill to prevent burnout and disillusionment amongst staff.

<https://www.youtube.com/watch?v=XBwcYYy3u74>

OTHER RESOURCES

NHS Scotland Quality Improvement Hub on making numbers meaningful for quality improvement

<http://www.qihub.scot.nhs.uk/knowledge-centre/quality-improvement-tools/making-the-numbers-meaningful-for-quality-improvement.aspx>

Managing the Human Dimension of Change

<http://www.nhs.uk/media/2594818/ilg-managing-the-human-dimensions-of-change.pdf>

Influencing sceptical staff to become supporters of service improvement: a qualitative study of doctors' and managers' views.

Quality and Safety in Health Care 2004; **13**:108-114.

<http://qualitysafety.bmj.com/content/13/2/108.full>

How to spread good ideas - A systematic review of the literature on diffusion, dissemination and sustainability of innovations in health service delivery and organisation, 2004.

http://www.nets.nihr.ac.uk/data/assets/pdf_file/0020/81245/BP-08-1201-038.pdf

CHAPTER 5: Review, expansion and sustainability

It may be that your effort to improve care for frail older patients secures funding for an initial, time-limited period. A review at the end of that period will be an opportunity to show the contribution of your work to improving care rather than a prelude to ending the service.

Services that not only receive continued funding but expand their capacity often build their success on committed use of evidence in reviews, and sharing this evidence widely to ensure a growing buy-in from funders and colleagues.

“We started [as] a funded project about 12 years ago with funding for 2 years for a registrar, clinical nurse specialist, an OT and a social worker. That was it essentially. And [we] started in orthopaedic elective patients only. [After] having shown a reduction in post-operative complications and improvement in length of stay without an increase in readmission, the Trust continued to fund the service, and has gradually supported the expansion of the team. [We now] cover all of the surgical subspecialties at [organisation 1]; the only one we don’t cover at the moment are cardiothoracic.” (Consultant Geriatrician)

“We were getting a lot of resource and a lot of support because we were doing what was evidenced, and we evidenced it was making an impact” (Consultant Geriatrician)

KEY CHALLENGES (p.19-21) (13)

Securing sustainability

Sustainability can be vulnerable when efforts are seen as ‘projects’ or when they rely on particular individuals. From an early stage, projects need to identify future funding sources, or identify ways to use resources more efficiently in order to sustain improvements. Successful outcomes should be written into standards, guidelines and procedures to ensure they are embedded in routine activities.

Considering the side effects of change

It’s not uncommon to successfully target one issue but also cause new problems elsewhere. This can cause people to lose faith. Be vigilant about detecting unwanted consequences and be willing to learn and adapt.

THE NHS CHANGE MODEL

National Audit Office Guide: Initiating successful projects, 2011

<https://www.nao.org.uk/report/nao-guide-initiating-successful-projects-3/>

Developing Informatics Skills and Capability

<http://www.hscic.gov.uk/disc>

Portfolio, Programme and Project management (P3M) Resource Centre

<http://systems.hscic.gov.uk/p3m/resource/index.html>

OTHER RESOURCES

Spread and sustainability

NHS Scotland Quality Improvement Hub on spread and sustainability

<http://www.qihub.scot.nhs.uk/knowledge-centre/quality-improvement-topics/spread-and-sustainability.aspx>

The Sustainability and Spread of Organizational Change: Modernizing Healthcare, 2006.

https://books.google.co.uk/books/about/The_Sustainability_and_Spread_of_Organiz.html?id=BvsnTaE78b8C&redir_esc=y&hl=en

Evaluating improvement

Benefits Realisation Plan

<http://www.qihub.scot.nhs.uk/knowledge-centre/quality-improvement-tools/benefits-realisation-plan.aspx>

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Appendix 1: Service self-assessment

Frailty Screening

Are we delivering high-quality care for frail older people?	How to fill in the gaps															
<p>We are assessing for frailty in people aged 65+ at every entry into the service using a recognised tool.</p> <p>In people with frailty, we routinely screen for the presence of common geriatric syndromes in addition to our usual assessments:</p> <table border="0" data-bbox="353 730 996 1109"> <tr> <td>Pain</td> <td>Delirium and dementia</td> </tr> <tr> <td>Depression</td> <td>Nutrition and hydration</td> </tr> <tr> <td>Skin integrity</td> <td>Sensory loss</td> </tr> <tr> <td>Falls and mobility</td> <td>Activities of daily living</td> </tr> <tr> <td>Continence</td> <td>Vital signs</td> </tr> <tr> <td>Safeguarding issues</td> <td>End of life care issues</td> </tr> </table>	Pain	Delirium and dementia	Depression	Nutrition and hydration	Skin integrity	Sensory loss	Falls and mobility	Activities of daily living	Continence	Vital signs	Safeguarding issues	End of life care issues	<p><i>Tool</i></p> <p>Rockwood Clinical Frailty Scale (CFS)</p> <p>Identification of Senior At Risk (ISAR)</p> <p>Silver code</p> <p>PRISMA-7</p> <p>Edmonton Frail Scale</p>	<p><i>Settings in which the tool has been tested</i></p> <p>ED/AMU</p> <p>ED/AMU</p> <p>ED/AMU</p> <p>ED/AMU</p> <p>Surgery (pre-op)</p>	<p><i>Time to complete</i></p> <p>41 seconds</p> <p>66 seconds</p> <p>54 seconds</p> <p>52 seconds</p> <p>Assesses multiple domains in less than 5 min</p>	<p><i>Predictive properties</i></p> <p>AUC for mortality = 0.72 (18)</p> <p>AUC for functional decline, readmission or death = 0.68 (19)</p> <p>When predicting mortality in the ED setting, area under the curve = 0.70 (20)</p> <p>Sensitivity = 78%, specificity = 75% for moderate-to-severe functional decline (21)</p> <p>Validated for use among non-geriatricians (22)</p>
Pain	Delirium and dementia															
Depression	Nutrition and hydration															
Skin integrity	Sensory loss															
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	<p>'Comprehensive assessment of frailty'</p> <p>Routine cardiac surgical practice</p> <p>Includes laboratory and other tests - 10–20 min</p> <p>Identifies patients at high risk of post-operative death (11)</p>
<p>Medical</p> <p>We are aware that pain is under-reported and undertreated in people with frailty, we have adapted our pain assessment process with this in mind, specifically we use adapted pain scale for people with cognitive impairment.</p> <p>We routinely assess the risk of pressure sores and generate a specific action plan to care for skin in people at risk.</p> <p>We ask all older people with frailty about faecal and urinary continence issues; we undertake initial basic assessments, and we are able to refer into continence services when needed.</p> <p>We are aware of the prevalence of asymptomatic bacteriuria in older people with frailty from various settings. We are aware of the positive and negative predictive values of urine dips in older people, with and without lower urinary tract symptoms. Accordingly, we do not use urine dips in older people other than to exclude UTI in people with Lower Urinary Tract Symptoms or otherwise unexplained delirium.</p> <p>We are aware of the dangers of urinary catheterisation in older people (catheter associated sepsis, detrusor instability, falls), we only catheterise patients where it is critical to their care – for example for urinary retention. We have a nurse led protocol that allows early withdrawal of catheters by default.</p> <p>We routinely check for safeguarding concerns and have an agreed pathways for assessment of people for whom abuse might be an issue.</p>	<p>Abbey pain scale can be used for people with cognitive impairment.</p> <p>Waterlow or SSKIN score can be used to assess the risk of pressure sores.</p> <p>Initial basic assessment includes e.g. identification and management of constipation.</p> <p>An audit can establish whether urine dips are used in older people.</p> <p>The nurse led protocol can be found in many services nationwide. Peer learning can support developing one locally.</p>

<p>We routinely undertake nutritional assessments, and initiate feeding charts for people at risk, and can refer on to dietetics where necessary</p> <p>We always check people's hearing and vision, and have access to hearing and visual aids in our service.</p> <p>We are aware of the frequency of polypharmacy in people with frailty, especially those with multiple comorbidities; we are aware of the risk of drug-drug and drug-disease interactions, and we have undertaken an initial medicine rationalisation, guided by evidence based criteria.</p> <p>Having undertaken the initial assessment and management, we are able to gain access to a clinician with appropriate skills in managing complexity, diagnostic uncertainty or challenging symptom control,</p>	<p>MUST score can be used in nutritional assessments.</p> <p>A local supply of reading lenses, and hearing aids and batteries can support implementation.</p> <p>STOPP-START checklist can be used to undertake medicine rationalisation.</p> <p>One option is to consider referral to geriatric medicine.</p>
<p>Mental health</p> <p>We perform brief cognitive screening on admission/initial assessment, and then assess for delirium vs dementia in those with cognitive impairment, using standardised tools.</p> <p>We assess for delirium every day in people with cognitive impairment that are admitted to hospital.</p> <p>We are aware of the frequency and sometime atypical presentation of depression in older people; we ask all older people about their mood and we are able to manage or signpost people to local services that can help manage mood disorders.</p>	<p>AMT-4 or AMT-10 can be used to perform brief cognitive screening. CAM-4 or 4AT can be used to assess for delirium vs dementia.</p> <p>Staff in all areas of our service can use the 4AT or CAM</p> <p>Further guidance can be found at http://www.rcpsych.ac.uk/mentalhealthinfo/improvingphysicalandmh.aspx</p>
<p>Functional</p> <p>We have identified patients who are at high risk of future falls, and have implemented our local falls prevention bundle and will consider referral to our local falls prevention programme.</p>	<p>FALLsafe (excluding the erroneous advice about urine dips!) can be used as guidance (see https://www.rcplondon.ac.uk/guidelines-policy/fallsafe-resources-original)</p>

	<p>We use a framework for assessing people who have fallen. We differentiate between syncopal and non-syncopal falls. We construct a problem list that describes the specific factors leading to a non-syncopal fall.</p> <p>In frail people with a fall and postural dizziness we provide a lying and standing blood pressure (L+S BP).</p> <p>In frail people we provide a verified walking stability test if they can walk.</p> <p>We routinely asses for and manage Activities of Daily Living.</p>
<p>Social</p>	<p>Further guidance can be found at http://www.bgs.org.uk/index.php/topresources/publicationfind/goodpractice/195-gpgcgassessment</p> <p>Clarity about roles and time scales can enhance practice. L+S BP should be assessed against specific guidelines.</p> <p>Get Up and Go can be used to verify walking stability. There should be procedure clarifying by whom, and in what time.</p> <p>Barthel or Katz scales can be used to assess ADL. In managing ADL, patients can be referred to therapists to help manage functional decline. This might be in-patient services or community based services (e.g. reablement); we only refer people for supportive packages of care once we have reviewed all their needs and have tried to optimise their physical and mental health.</p>
<p>Environ ment</p>	<p>We document current formal social care provision of people with frailty.</p> <p>We know how robust is the support network where people with frailty normally live — if there is a key person involved (loved one, carer), they have been part of the ongoing conversation.</p> <p>For frail people we contact a social worker to review the social care support plan and prepare for discharge, including meeting any new short term needs; the patient has access to engagement with their local community to prevent social isolation.</p> <p>We assess home environment of frail people to ensure it is suitably adapted to support their needs. We do so as part of promoting independence.</p>
	<p>There is a process in place which allocates roles and responsibilities for documenting current social care provision, including by whom and by when.</p> <p>Occupational health practitioners assess suitability of home environment.</p>

Multidisciplinary Care Coordination	<p>We have regular multidisciplinary team meetings (MDTs) where the outcomes of the assessments listed above are discussed.</p> <p>A key worker or care coordinator follows through the treatment plan to ensure all is enacted, and we re-discuss when plans are not working as expected.</p> <p>We ensure that the person, their carers and all health and social care practitioners involved in someone's move between hospital and home are in regular contact with each other. This is to make the transition coordinated with all arrangements in place.</p> <p>We are aware that, for some older people with frailty in the acute care setting, end of life care may be more relevant than curative approaches. We consider whether care or cure are the priority through a shared decision making process, and can adapt our treatment accordingly.</p> <p>We are able to undertake or prompt the need for advance care planning or emergency care plans. These describe patients' priorities and might include actions and interventions to avoid hospital admission in the future.</p>	<p>High-quality MDTs:</p> <ul style="list-style-type: none"> • occur at a set time and place, • usually take no more than a minute or two for each patient. • generate a problems list, stratified in terms of urgency and importance which is record in the patient notes, and the team work towards delivering during the time patients spend in the service. <p>For further guidance see https://vimeo.com/132073531</p> <p>There are established systems to share health record information between primary care, emergency services, secondary care and social services.</p> <p>For further guidance see http://www.kingsfund.org.uk/publications/people-control-their-own-health-and-care?gclid=CjwKEAjwkPS6BRD2ioKR7K245jASJAD1ZqH0liD9iLWA9yq_1o-UNIXUm6OauAdr5klpcRMVjyK6ZhoCCqXw_wcB</p> <p>For further guidance see https://www.rcplondon.ac.uk/guidelines-policy/advance-care-planning</p>
Overarching person-centred care	<p>We routinely ask what is most important to the patient (as part of person-centred care). We understand the importance of focussing on 'what matters to you' over 'what is the matter with you'.</p>	<p>Use clinical judgment and personalised goals when deciding how to apply disease-based clinical guidelines to the management of older people with frailty.</p>

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