Mild Frailty and use of Primary Care

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Quality issue / initial problem

We know that over 8000 people are living with frailty in Midlothian. We can now stratify people into 'mild', 'moderate' and 'severe' cohorts. We also know that demand for primary care services is increasing. We want to look at the frequent attenders from the mild frailty group to identify how needs could be better met and as a result, improve the quality of contact with primary care.

Specific aim

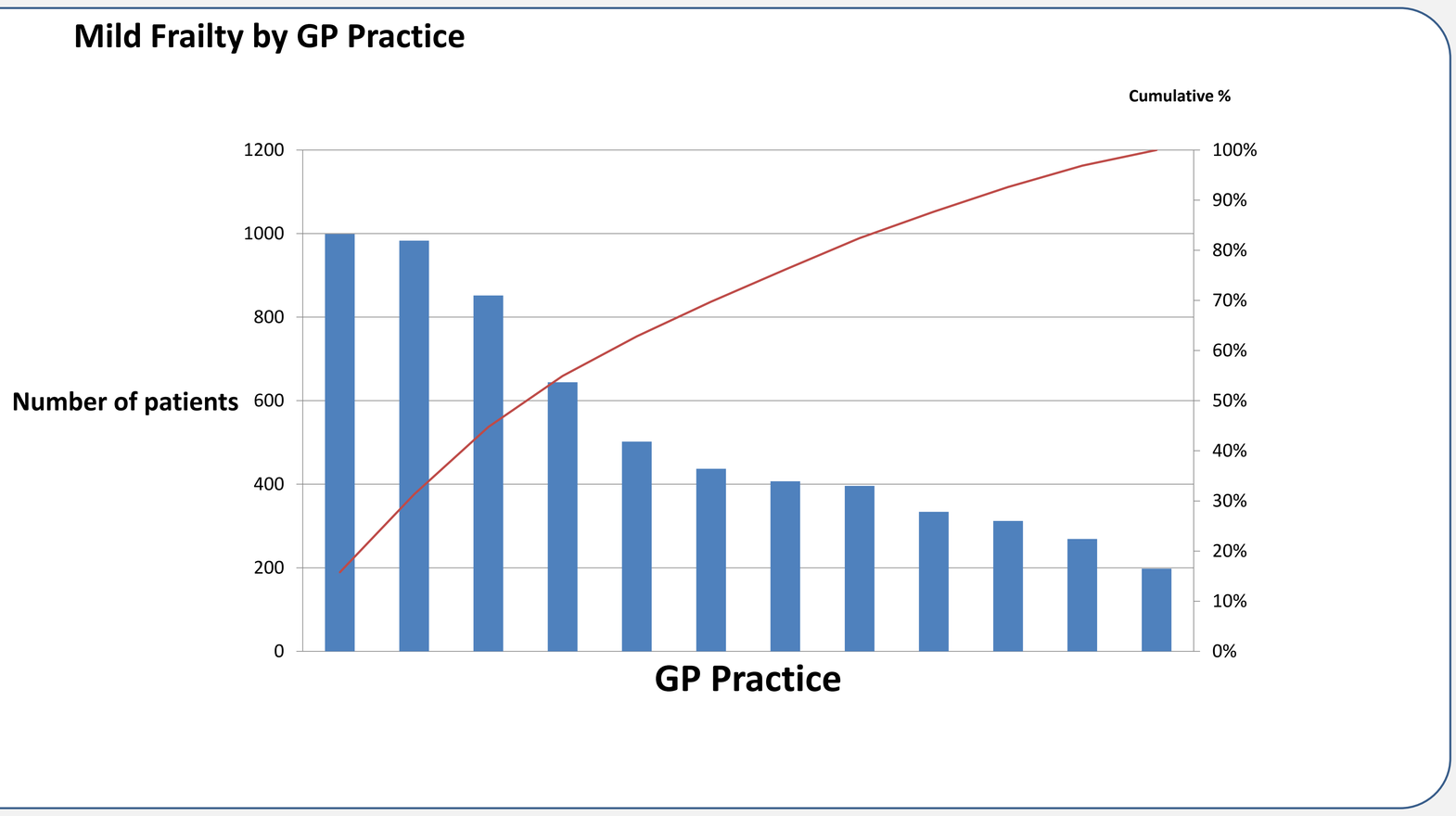
To improve the patient experience and reduce the number of contacts with primary care

Measurement of improvement

Chart 1 shows our 12 GP Practices and the number of patients for each who have 'mild frailty'.

With one GP practice, we will look at all primary care contacts over the last 6 months- produce a second Pareto Chart.

Process map the top 5 attenders with the Primary Care Team and identify tests of change (examples below). Gather Patient and Staff Experience.



Tests of change

- Offer longer appointment times
- Continuity of care- see same clinician
- Referral to other services, e.g. Red Cross

Tools

- Pareto Charts
- Driver Diagram
- Process Mapping
- Emotional touch points

Effects of change

To understand common reasons why people living with mild frailty use primary care (medical and non-medical). Identify how needs could be better met. Use of eFI across Midlothian means that a more proactive/preventative approach can be taken for this cohort of patients

Lessons learned and message for others

Ensure you can get the data easily- this is a test of change in itself

Get project team buy in and support at an early stage

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