Healthcare Improvement Scotland

A frailty overview in Scotland

Dr Lara Mitchell
Consultant Older People's services QEUH,
Strategic National Clinical Lead Acute, Healthcare Improvement Scotland
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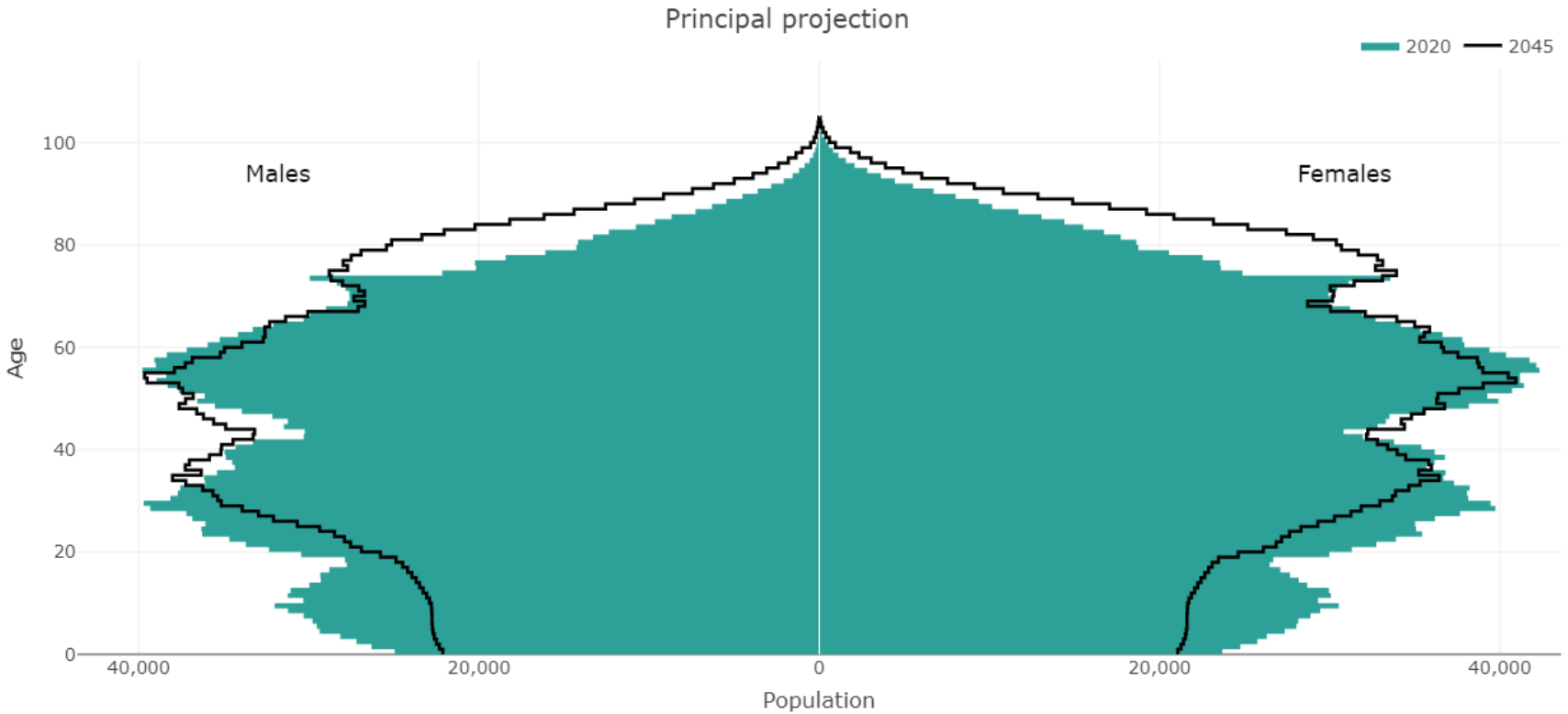
NHS SCOTLAND

Scotland is shrinking



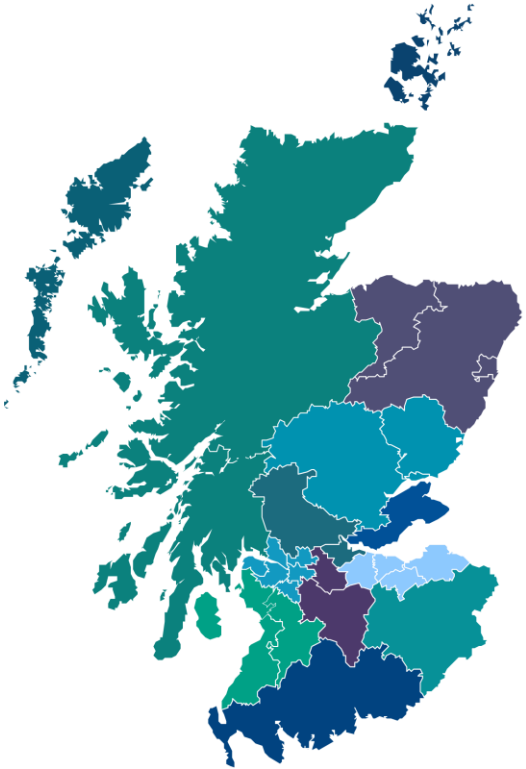
Source: National Registers of Scotland, 2022

Scotland health and social care

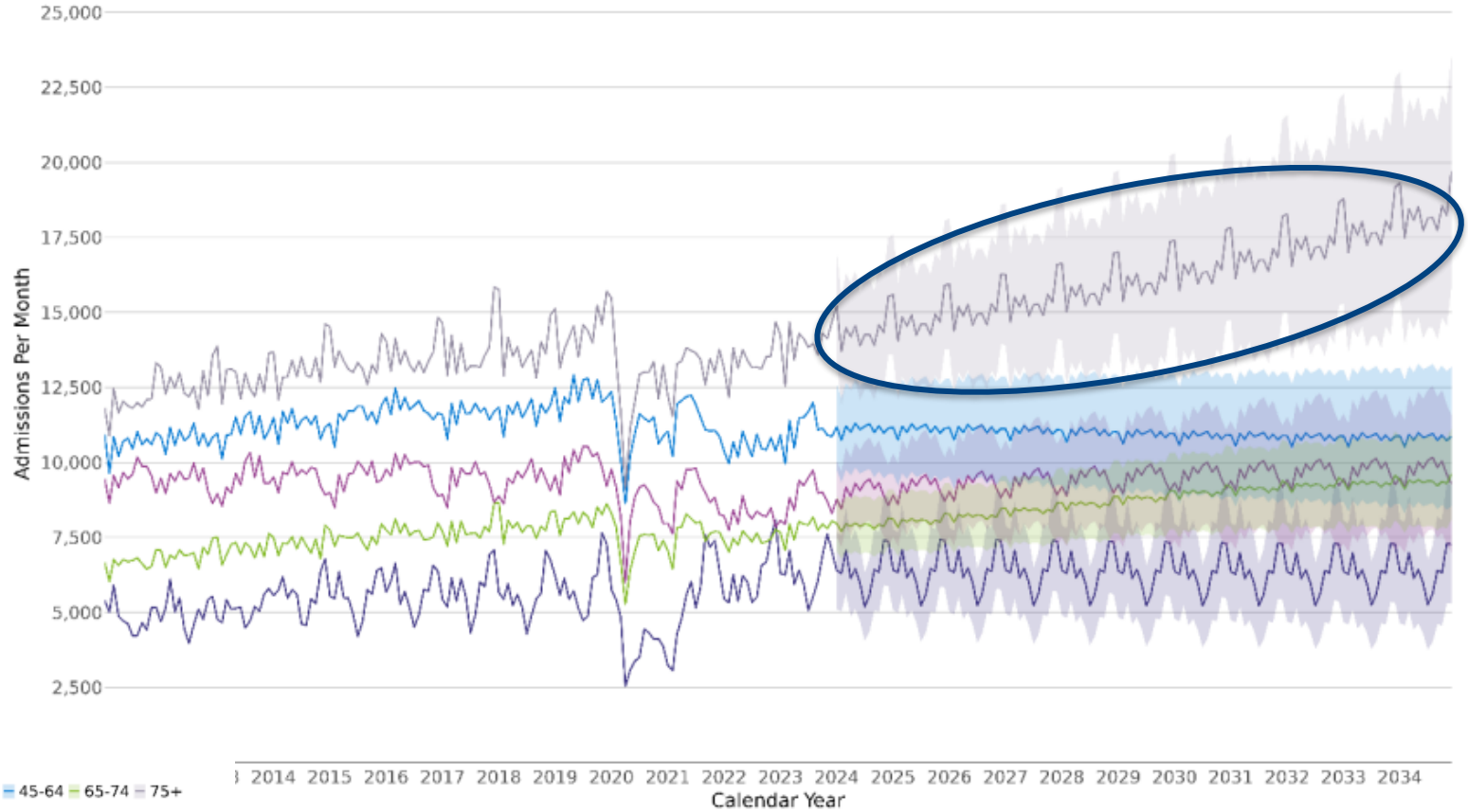
14 regional NHS boards
31 health and social care partnerships

6 special NHS boards
1 public health body (PHS)

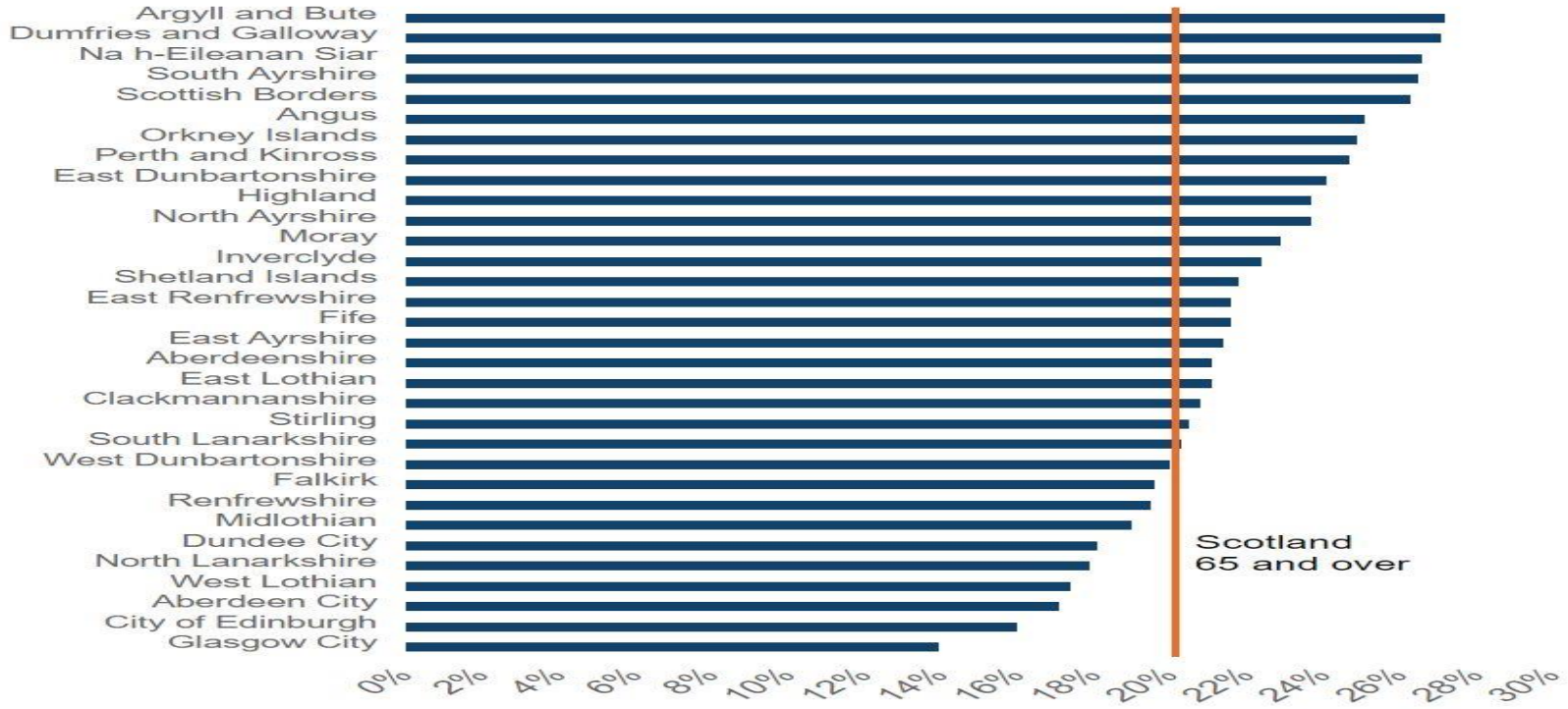
Population 5.55 million
Average life expectancy
Female 81 years
Males 77 years



Monthly acute admissions by age group: Scotland



65 and over age group as a proportion of population



[Scotland's Population 2023 - The Registrar General's Annual Review of Demographic Trends - National Records of Scotland (NRS)]

Once upon a time.....

How it can be so different.....

Number needed to treat = 33 for one person to live independently at home

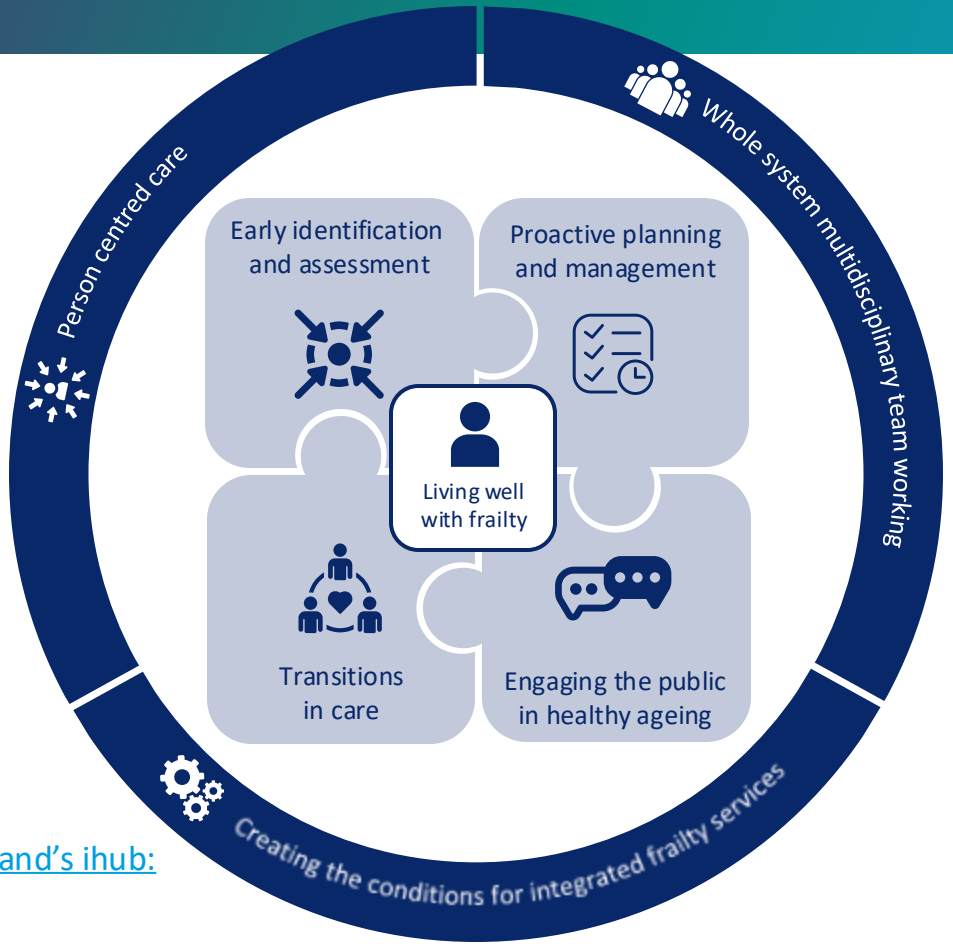
Multidisciplinary and multiagency working

Health and social care system

Cathy's frailty journey

	Mild frailty	Moderate frailty	Severe frailty	End of life
	Routine frailty screening at a vaccination clinic	**Unexplained collapse, taken to emergency department**	**Reduced mobility, change identified in clinical frailty scale**	**Deterioration in condition and function**
	Frailty identification in primary care	Frailty identification at the front door	Frailty identification in primary care	Frailty identification in primary care
	Holistic MDT assessment	Comprehensive geriatric assessment, in the frailty unit, by the MDT	Holistic MDT assessment	Holistic MDT assessment
	• Healthy ageing and preventative approaches • Recommended physical activity programmes • Community appointment days	• Polypharmacy review communicated to GP • Person centred care planning, including future care planning • Referred for community based reablement	• Primary care team review future care planning in the community • Polypharmacy review	Support to meet future care planning wishes
	• Improved quality of life • Fewer GP appointments • Lives at home for longer	• Timely hospital discharge • Reduced risk of readmission • Staff deliver care in a more integrated way	• Care managed in the community rather than in hospital • Reduced medications	Wishes of patient and carers met

90 day learning cycle



[Healthcare Improvement Scotland's ihub: 90 day learning cycle on frailty]

Healthcare Improvement Scotland

Healthcare Improvement Scotland: Focus on Frailty

Leading quality health and care for Scotland

NHS SCOTLAND

Focus on Frailty: aim

People living with, or at risk of frailty have improved experience of, and access to person centred, co-ordinated health and social care

Early identification and assessment of frailty

People living with frailty, carers and family members access person-centred health and social care services

Leadership and culture to support integrated working

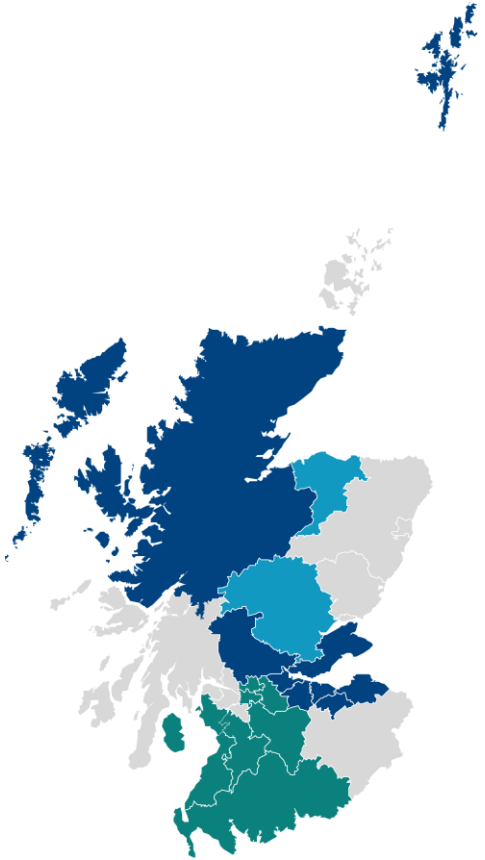
Frailty Change Package, Healthcare Improvement Scotland, 2022

Focus on Frailty

Participated in the Focus on Frailty programme
April 2025 – March 2026

Participated in the Focus on Frailty programme
April 2025 – March 2026 and May 2023 – December 2024

Participated in the Focus on Frailty programme
May 2023 – December 2024



Focus on Frailty programme: impact

93%

of acute teams (14/15) provide front door frailty services.

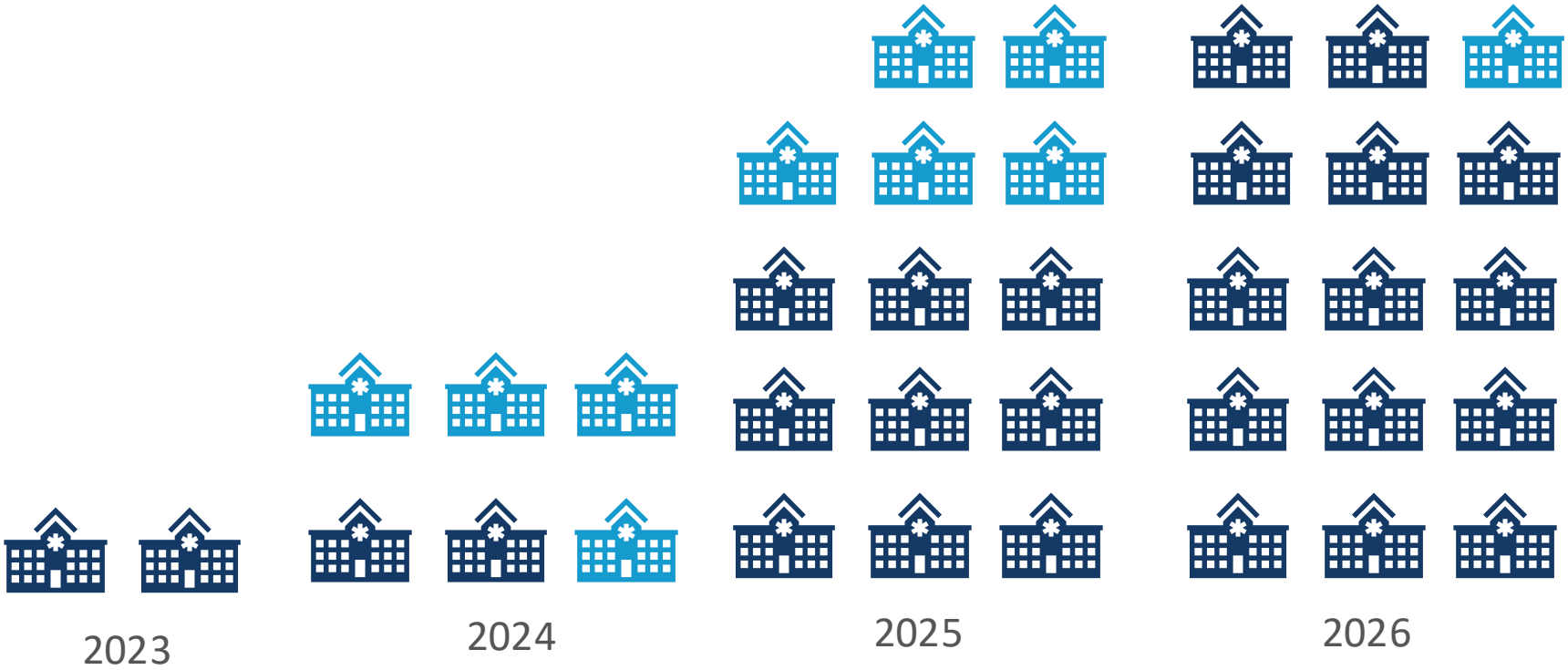
83%

of community teams (5/6) have reliable processes in place for frailty identification. 4 of these teams are delivering holistic assessments.

100%

of teams (15/15) have progressed to testing changes.

Growth in hospital front door frailty services



Frailty units established in 2025/26

Dumfries and Galloway Royal Infirmary, NHS Dumfries and Galloway

University Hospital Wishaw, NHS Lanarkshire

Victoria Hospital, NHS Fife

Forth Valley Royal Hospital, NHS Forth Valley

Frailty services established in 2025/26

Western Isles Hospital,
NHS Western Isles

Raigmore Hospital,
NHS Highland

Frailty units established since 2023

University Hospital Hairmyres, NHS Lanarkshire

Glasgow Royal Infirmary, NHS Greater Glasgow and Clyde

University Hospital Ayr, NHS Ayrshire and Arran

University Hospital Crosshouse, NHS Ayrshire and Arran

Improvements to community services in 2025/26

59% of people over 75 registered with a GP have a recorded Clinical Frailty Score in NHS Shetland since 2024

1 in 25 over 65s have been screened for frailty in the community in Dumfries and Galloway HSCP since January 2025

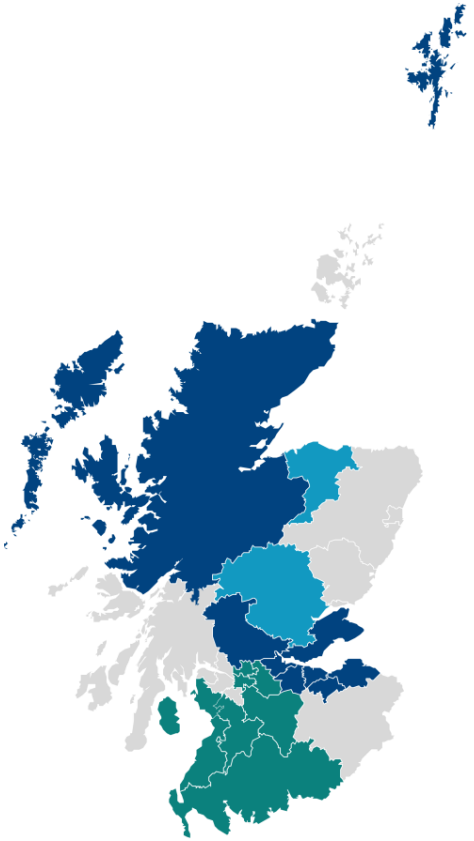
185 older people have had a comprehensive geriatric assessment in Maybole, Troon and Prestwick, South Ayrshire HSCP, since January 2025

16% of over 65s on the district nurse caseload screened for moderate to severe frailty have received a general assessment since November 2025 in Richmond and Kinneil Practice, Falkirk HSCP

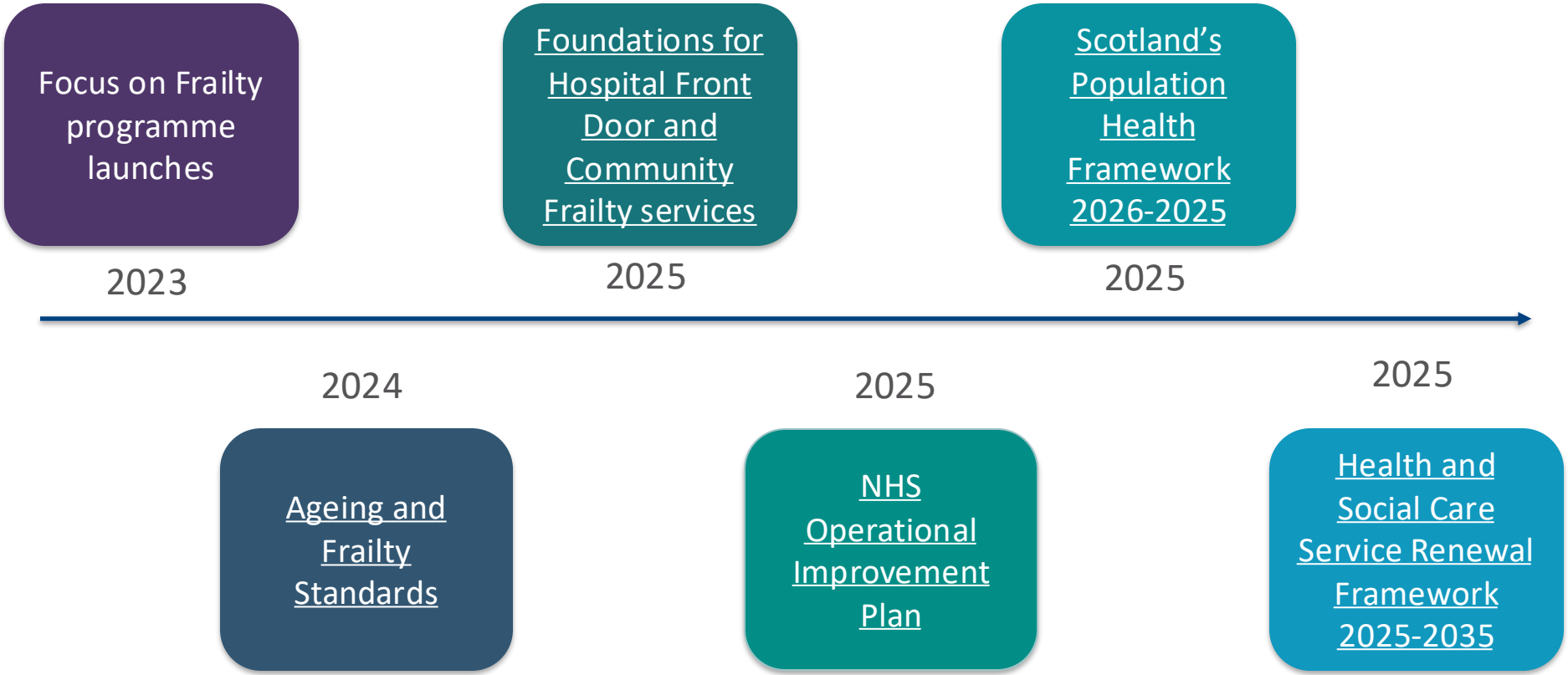
53 community teams can now access the Clinical Frailty Scale through the clinical system for community, an increase of 50 since April 2025, Fife HSCP

Focus on Frailty

- Quality improvement coaching
- Support with data and measurement
- Connection with other teams across Scotland
- Clinical leadership

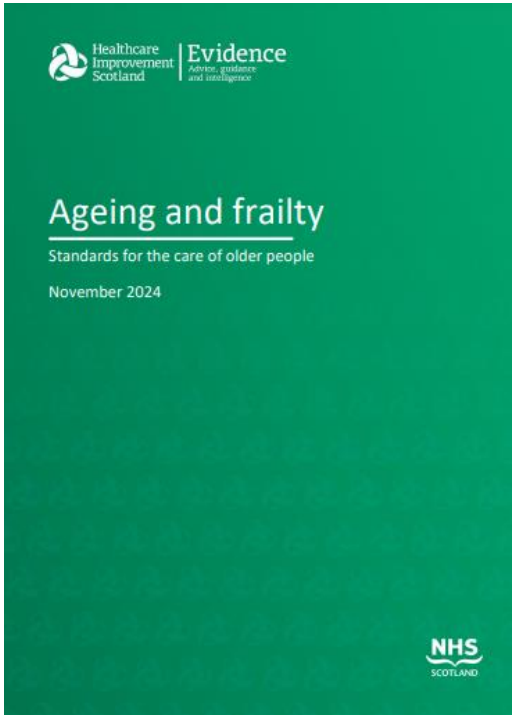


Hospital and community services for older people living with frailty in Scotland



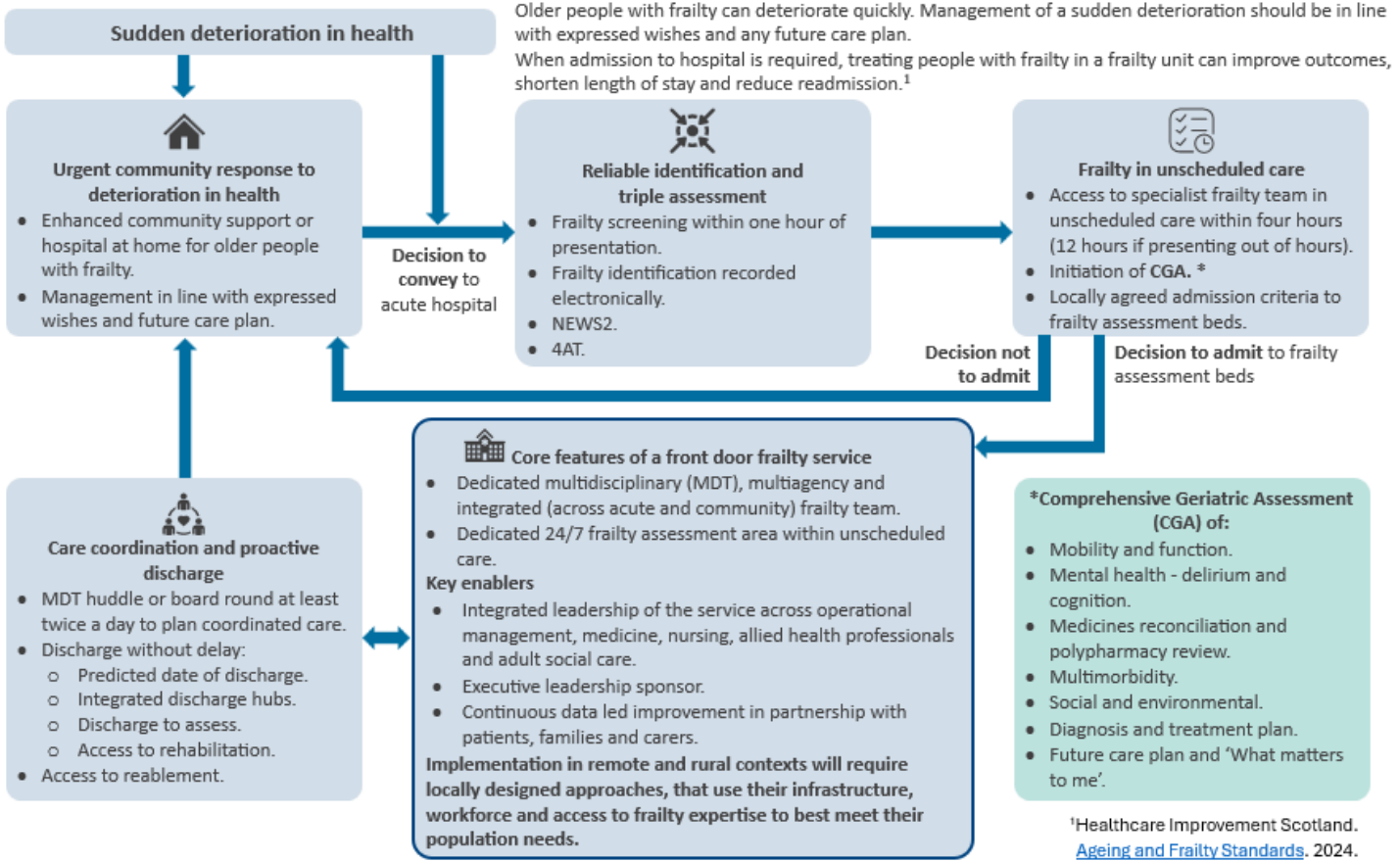
Ageing and frailty standards Nov 2024

- Following a deterioration in health older adults can access appropriate care
- Identify frailty within one hour of admission
- Access to a specialist frailty team/ comprehensive geriatric assessment within four hours of admission
- Hospital at Home/ front door frailty units/ dedicated areas
- Proactive discharge planning/ Future Care Planning
- Medicines reconciliation



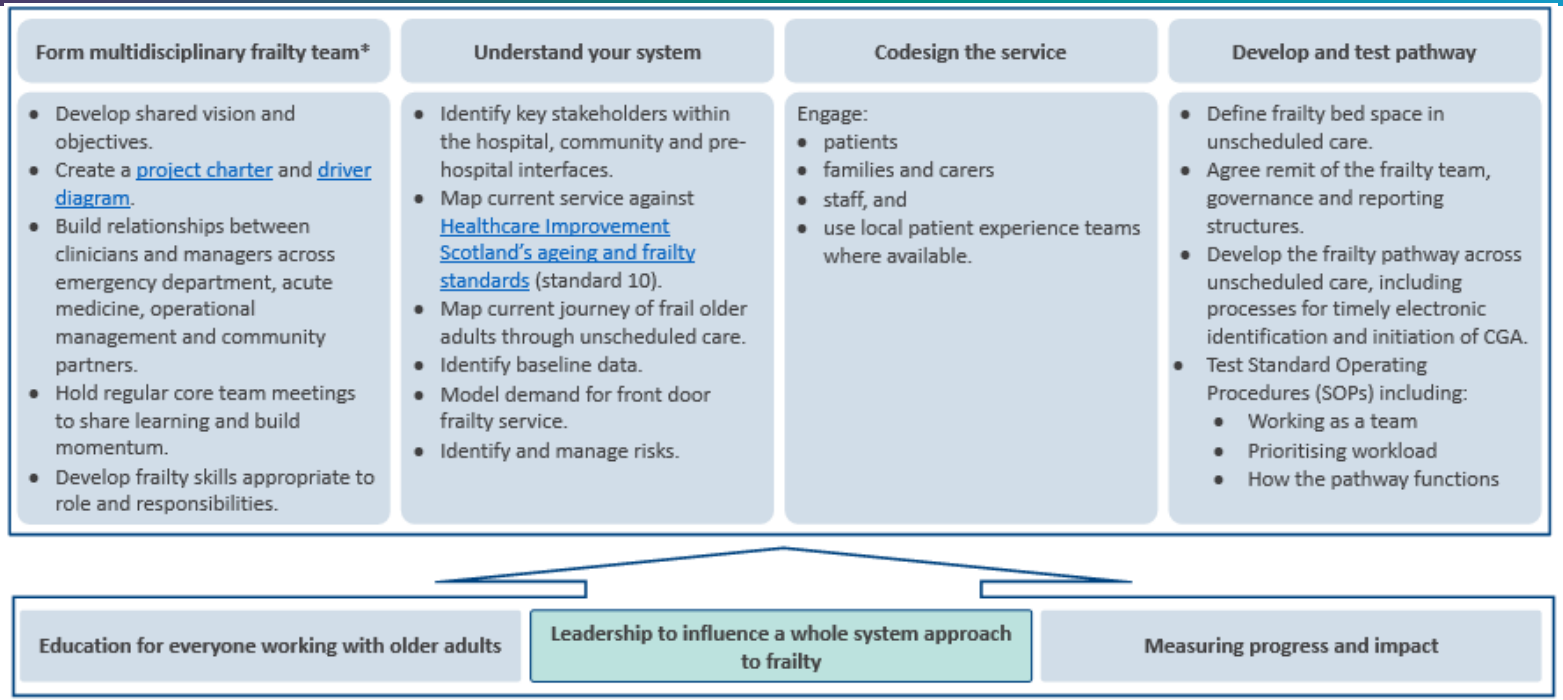
(Ageing and Frailty Standards, Healthcare Improvement Scotland, 2024)

Foundations for hospital front door frailty



[1]Healthcare Improvement Scotland. Ageing and Frailty Standards. 2024.

Key steps to setting up a front door frailty service



***Multidisciplinary team may include** nursing, medicine, specialist frailty roles (nurses), specialist frailty roles (AHP), operational management, HSCP, pharmacy, social work, dietician, speech and language therapy, discharge coordinator, psychiatry, occupational therapy, physiotherapy, community frailty practitioners, adult social care.

Healthcare Improvement Scotland's frailty change package is for teams in health and social care partnerships (HSCPs), GP practices, and acute care settings interested in frailty improvement work. It is designed to support teams to improve the experience of access to person centered, coordinated health and social care, for people living with or at the risk of frailty. The change package consists of a number of high-level outcomes supported by activities that when tested and implemented, bring about improvement.

Foundations for community frailty services

Core features of a community frailty service

- Multidisciplinary and multiagency integrated frailty team.
- Clearly defined care pathways for older people living with frailty.
- Processes in place for care coordination and shared decision-making.
- Focus on proactive and preventative care as well as urgent response.

"Frailty services should be designed to support people to maintain independence and remain in the community as much as possible. This requires a fundamental shift in culture towards proactive, preventative and integrated services."

Healthcare Improvement Scotland, Ageing and Frailty Standards (2024)

Frailty identification

- System in place to identify older people living with frailty using a recommended or validated tool.
- Staff are trained and knowledgeable about clinical frailty scores.

Frailty assessment

- Access to comprehensive geriatric assessment or comparable assessment.
- Clear information of the outcome of an assessment and what to expect in future.
- Proactive reassessment and follow up where required.

Integrated care coordination

- Multidisciplinary team responsible for delivery and coordination of frailty services.
- Clear referral pathways and key point of contact.
- Access to person led care, future care planning and polypharmacy review.

Urgent community response to deterioration in health

- Urgent assessment and access to appropriate community-based support, including Hospital at Home.
- Rapid response from emergency services where needed.

Key enablers

- Joint leadership across operational management, general practice, geriatricians, nursing, allied health professionals and adult social care.
- Strong relationships with the third sector and community supports.
- Executive leadership sponsor.
- Links to local governance frameworks.
- Continuous data led improvement in partnership with patients, families and carers.
- Clear system-wide strategic vision for integrated delivery of services for older people living with frailty.
- System to share learning and promote professional development.

Safe Delivery of Care for Older People

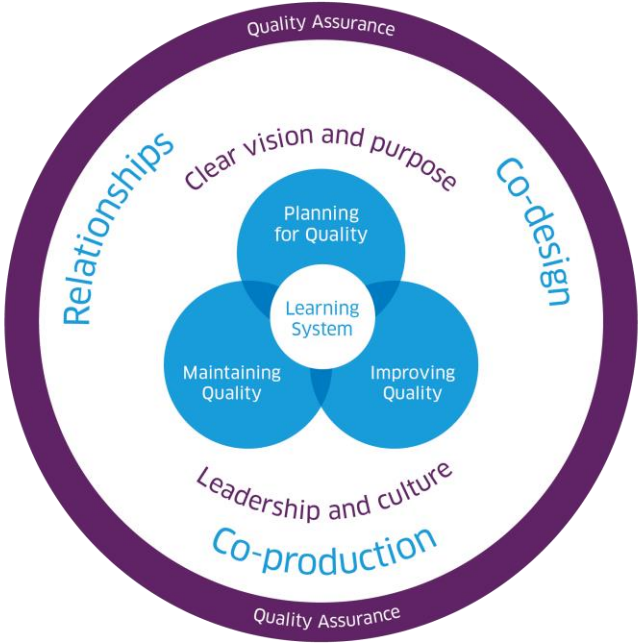
Planning for quality

- Ageing and Frailty Standards
- SIGN 168 Assessment, diagnosis, care and support for people with dementia and their carers

Maintaining quality

- Excellence in Care
- Healthcare Staffing Programme

High-level Quality Management System Framework (working draft 4)



Improving quality

- Focus on Frailty Improvement Programme
- Hospital at Home
- Scottish Patient Safety Programme in Acute Care
- Focus on Dementia Improvement Programme

Quality assurance

- Safe delivery of care inspections

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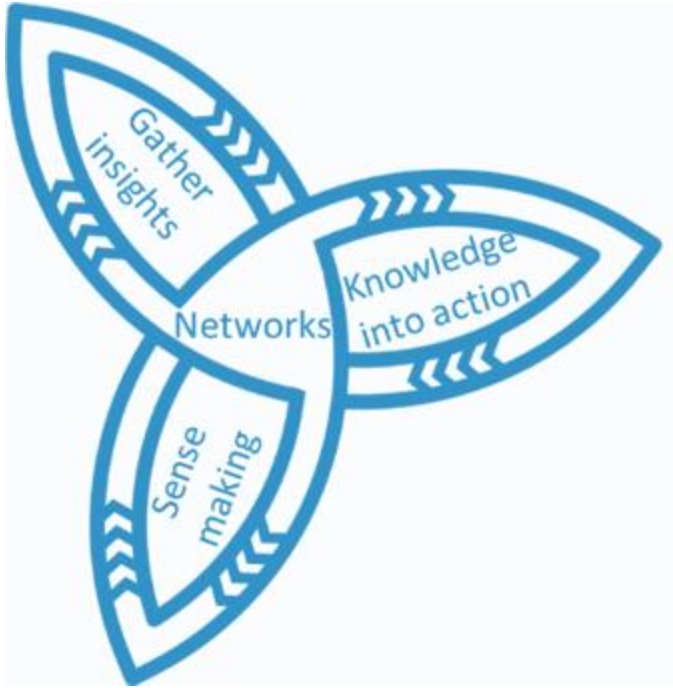
Please note: The QMS Framework is continuously evolving, for the most up to date version please visit: https://ihub.scot

Focus on Frailty: learning system

Frailty learning system MS Teams channel has increased membership to over 2,485 members



(Join the frailty learning system)

Further together

The Scottish Government
Riaghaltas na h-Alba

Healthcare Improvement Scotland

Public Health Scotland

Safe Delivery of Care for Older People

Discharge without delay

Unscheduled Care

Centre for Sustainable Delivery

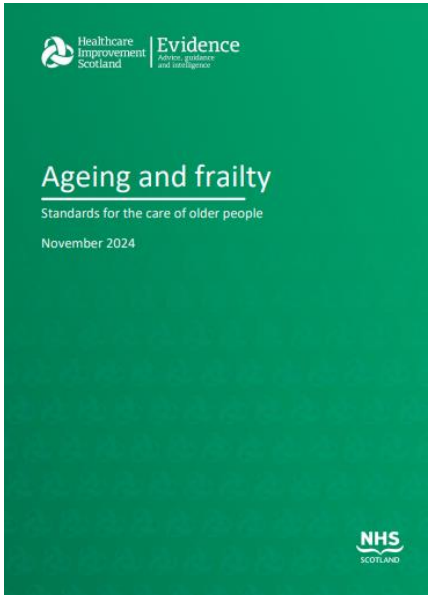
NHS SCOTLAND

Focus on Frailty: policy context

[Scottish Government, Scottish Budget: 2025-26]

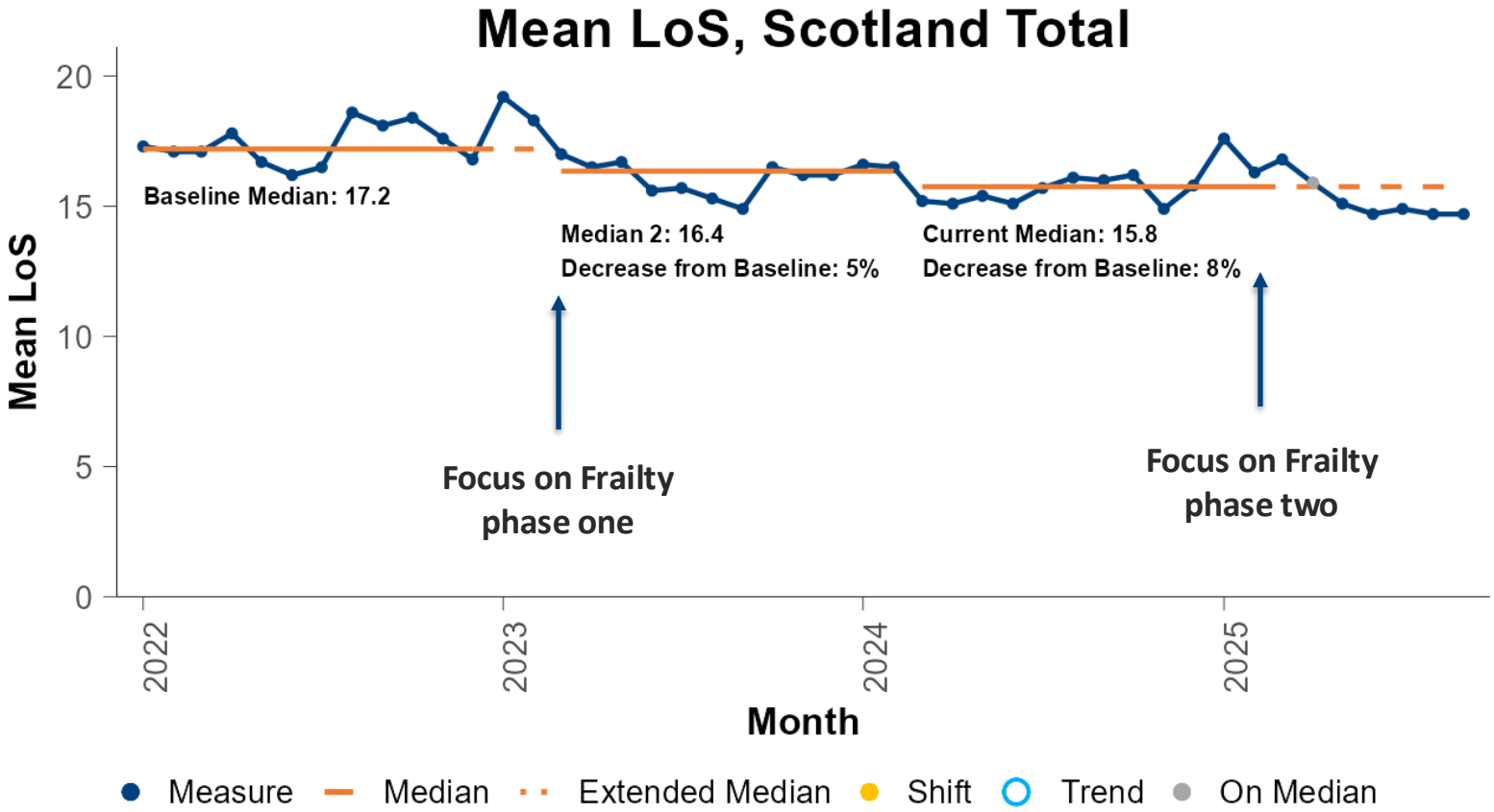
[Scottish Government, NHS Scotland operational improvement plan, March 2025]

[Scottish Government, Programme for Government 2025-26]



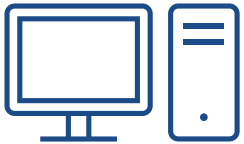
[Ageing and frailty standards – Healthcare Improvement Scotland]

Mean geriatric length of stay: Scotland



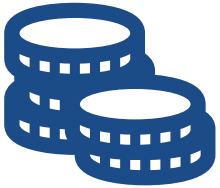
Challenges to overcome

Staff capacity



Clinical information systems

Training



Resources

Time

Healthcare Improvement Scotland

Stories from around Scotland

Leading quality health and care for Scotland

NHS SCOTLAND

Timely access to care

Increased identification of frailty across hospital front door areas

Glasgow Royal Infirmary, NHS Greater Glasgow and Clyde

5 new frailty assessment units

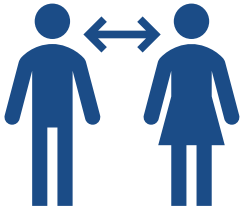
District nurse specialists carrying out comprehensive geriatric assessment in the community

South Ayrshire HSCP and NHS Ayrshire and Arran

Strengthened relationships

Frailty strategy published and network established.

NHS Lanarkshire and North Lanarkshire HSCP



Discharge coordinator and template letter

NHS Tayside and Perth and Kinross HSCP

Integrated comprehensive geriatric assessment huddles

Glasgow Royal Infirmary, NHS Greater Glasgow and Clyde

Increased knowledge of frailty

Patient journey mapping and experience stories have helped shape changes.

Perth and Kinross HSCP and NHS Tayside

A frailty simulation session improved staff knowledge of identifying and assessing frailty from 5/10 to 8/10

Perth and Kinross HSCP and NHS Tayside

Publication of an ageing well toolkit for the public and professionals

NHS Dumfries and Galloway and Dumfries and Galloway HSCP

Reduced demand on other services

79% of patients who received occupational therapy wellbeing reviews reduced GP visits

South Ayrshire HSCP and NHS Ayrshire and Arran

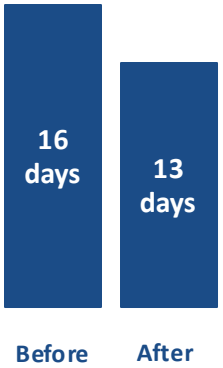
Community appointment day led to 30% of patients being discharged from the service they had been referred to without a need for further treatment

Moray HSCP and NHS Grampian

Potential 74 visits per day reduced due to medication reviews for people with care at home packages.

Moray HSCP and NHS Grampian

More time at home



Three-day reduction in average length of stay for people living with frailty

Glasgow Royal Infirmary, NHS Greater Glasgow and Clyde

152 patients avoided hospital admission over eight months through a frailty practitioner at the hospital front door

NHS Lanarkshire and North Lanarkshire HSCP

71% of patients discussed on a new geriatrician advice line remained at home

NHS Dumfries and Galloway and Dumfries and Galloway HSCP

Improved wellbeing

Polypharmacy reviews led to 11% of medications being deprescribed. 25% of these had a high anticholinergic burden

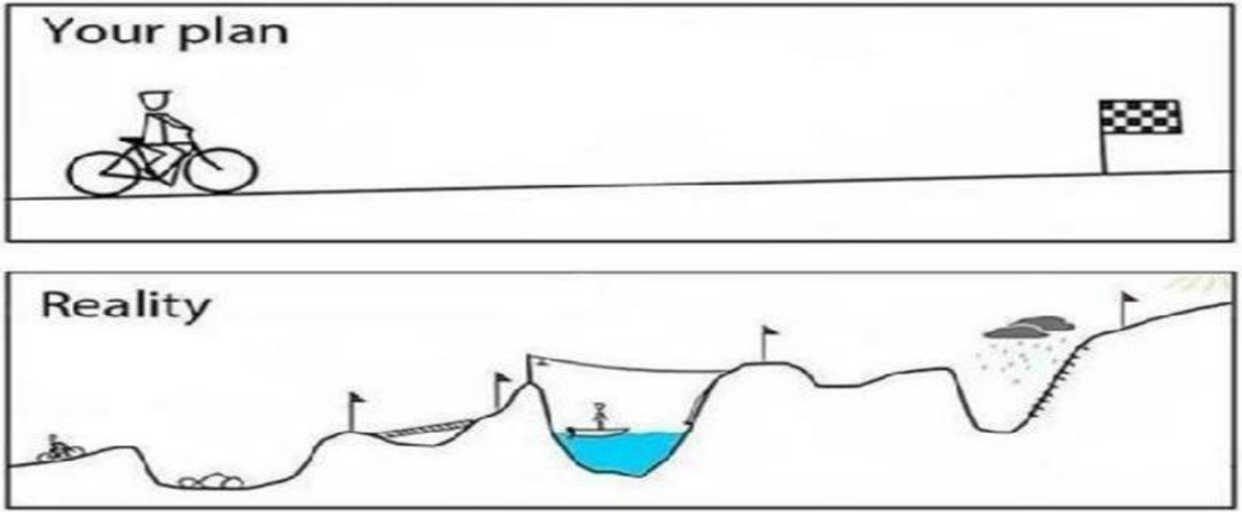
NHS Dumfries and Galloway and Dumfries and Galloway HSCP

Making every opportunity count (MEOC) ageing well tool

NHS Grampian and Moray HSCP

77% of people who had an occupational therapy wellbeing review reported an improvement in their wellbeing

South Ayrshire HSCP and NHS Ayrshire and Arran



'Difficulties are just small things to overcome after all'

J ust pause take a **breath**,
celebrate **success** and consider **next directions**

O **ptimism, hope, positivity** a force multiplier

U **nderstand** what **worked well** and what is needed
for your **future work**

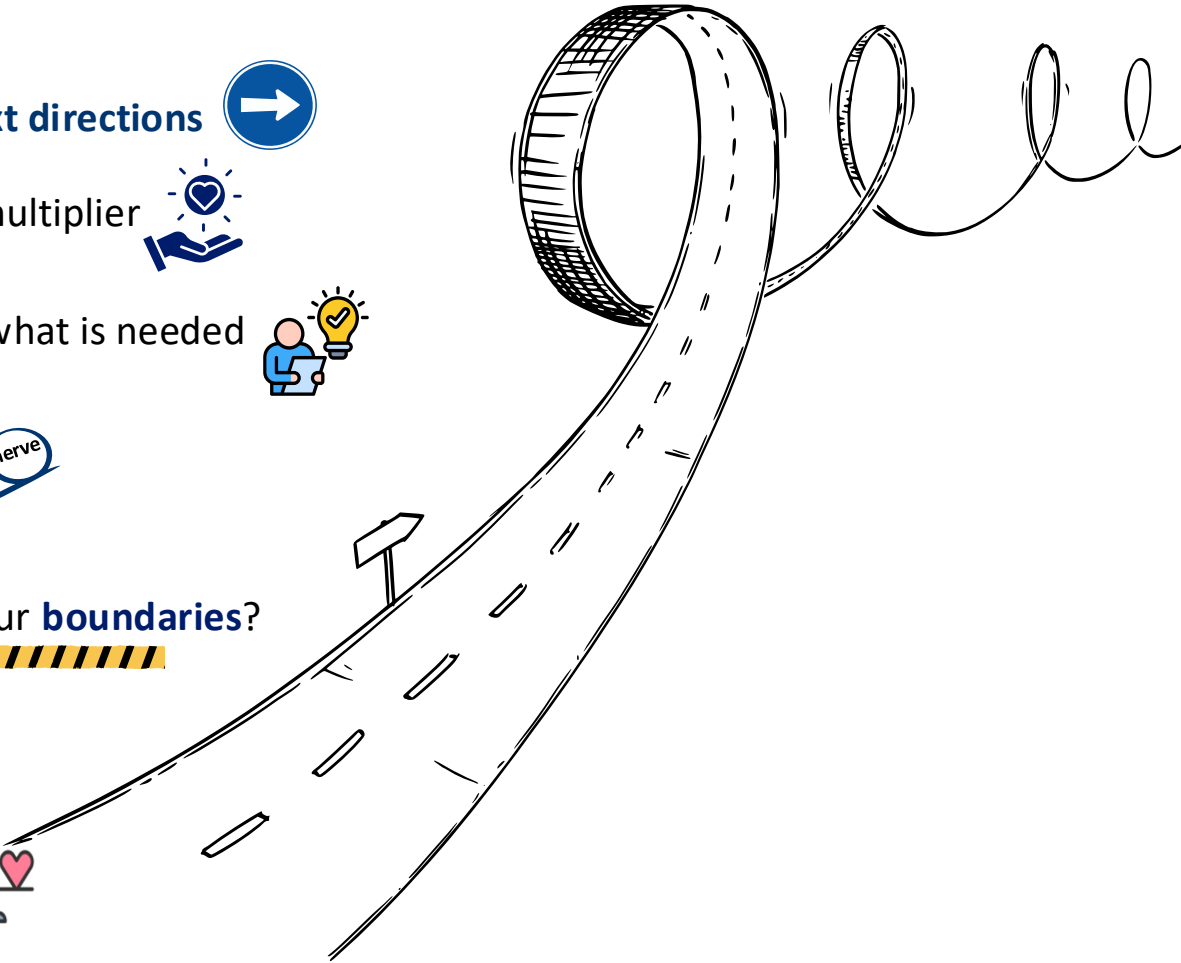
R **esolve, grit, hold your nerve**

N **on-negotiables/ nimble**
What do you need and what are your **boundaries**?
Can you change tack if required?

E veryone, **look after** your

Y ou - **consider work/ life balance**

S **hape/sway** your stakeholders



Older adults living with frailty: key resources

Essentials of Safe Care, Healthcare Improvement Scotland, 2021

90 day learning cycle on frailty, Healthcare Improvement Scotland, 2022

Focus on Frailty programme Healthcare Improvement Scotland

Ageing and Frailty standards, Healthcare Improvement Scotland, 2024

Joining the dots: A blueprint for preventing and managing frailty in older people, British Geriatrics Society, 2023

Front door frailty: Advice on setting up services, British Geriatrics Society, 2023

Rethinking unscheduled care, Healthcare Improvement Scotland, 2023

Developing hospital front door frailty services webinar, Healthcare Improvement Scotland, 2024

Foundations for hospital front door and community frailty services: April 2025 – Healthcare Improvement Scotland

Frailty in Older Adults, Dae Hyun Kim, and Kenneth Rockwood, M.D. K. Rockwood et al, New England Journal of Medicine, 2024

Scottish care of older people project (Scoop) report, 2023

Scottish care of older people project (Scoop) report, 2025