Primary Care Strategic Plan 21/22

Prevention & Early Intervention

- Identify people who are living with frailty in Midlothian
- Improve anticipatory support for people living with frailty
- Make it easier for people with frailty to access support from third sector organisations

Support and Treatment

- Improve continuity and coordination of care in the community for people living with frailty
- Support services to identify people living with frailty to improve treatment plans
- Improve the support offered to people with frailty by Primary Care

Crisis and Emergency

- Develop approaches to reduce avoidable unscheduled activity
- Adopt a “No place like Home” approach to care delivery

Midlothian
Health & Social Care
Partnership

Frailty
Action Plan

2021-2022

Prevention & Early Intervention

Strategic Aim 1: Identify people who are living with frailty in Midlothian

IJB	Action	Target	Partner	Budget
	Use the electronic frailty index to identify people estimated to have frailty living in Midlothian.			
	Identify analytical support to improve understanding of how people with frailty use services to develop and implement an improvement plan.			

Strategic Aim 2 Improve anticipatory support for people living with frailty

IJB	Action	Target	Partner	Budget
	Develop a joint HSCP/Quality Cluster quality improvement plan including collaborating on improving the coordination and continuity of primary care for people living with frailty			
	Work collaboratively with General Practice and use the learning from MidMed and other frailty pilots in Midlothian to improve use of anticipatory care planning, increase uptake of power of attorney.			
	Develop a process in the Pharmacotherapy service to support people identified as living with frailty (e.g. polypharmacy review)			

Strategic Aim 3 Make it easier for people with frailty to access support from third sector organisations

• IJB	Action	Target	Partner	Budget
	Establish the process which shares information with the Red Cross to allow all people estimated with frailty to be contacted to offer support and connect people to other third sector organisations .		HSCP	PCIF

Support & Treatment

Improve continuity and coordination of care in the community for people living with frailty

IJB	Action	Target	Partner	Budget
	Develop and scale-up the Penicuik Multidisciplinary Meeting model to improve coordination of care across community services			

IJB	Action	Target	Partner	Budget
	Collaborate between the HSCP and General Practices to develop and implement a plan that improves continuity of care for people with frailty			

- Strategic Aim 2: Support services to identify people living with frailty to improve treatment plans

IJB	Action	Target	Partner	Budget
	Work with all relevant health and care services to identify how using the electronic frailty index can improve treatment plans for people living with frailty			

Strategic Aim 3: Improve the support offered to people with frailty by Primary Care

IJB	Action	Target	Partner	Budget
	Use the joint HSCP/Quality Cluster frailty improvement plan to develop the primary care model for people living with frailty			

Crisis & Emergency

Strategic Aim 1: Develop approaches to reduce avoidable unscheduled activity

IJB	Action	Target	Partner	Budget
	Assess the impact of the new pathway where people with severe and moderate frailty who have attended ED are assessed by a multidisciplinary community team			