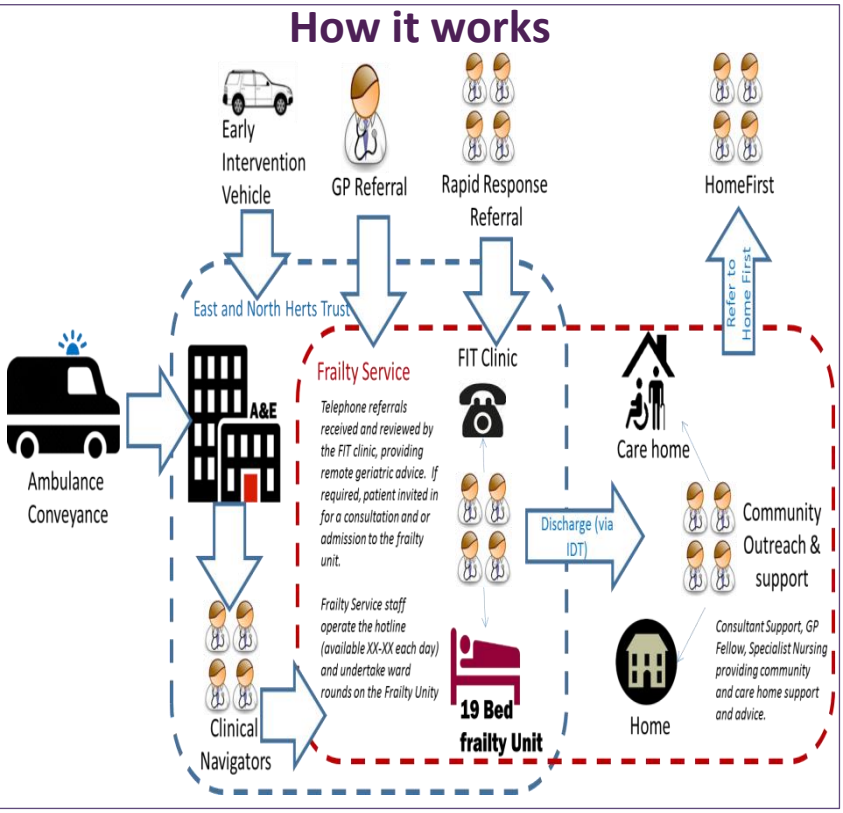
Frailty Service

What was the issue?

- Acute and Community healthcare services are not integrated making it difficult for frail elderly residents to receive the most appropriate care.
- There is little identification of frailty and the different levels of frailty (mild, moderate and severe)

How it works



How did we tackle the problem?

Co-ordinating enhanced management of frailty in primary and community care through multidisciplinary teams. Activation measures to empower patients/carers through self management. Expanding already existing MDTs aligned with Care Delivery Groups, including social care and mental health staff in the teams. The Implementation of end-to-end pathways including key components of prevention, self management, planned and unplanned care in all settings.

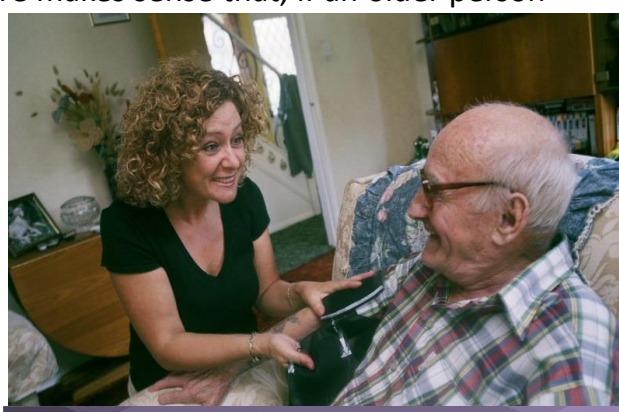
Benefits

- Better identification of frail patients to enable preventative, proactive supported care and personalised holistic care planning.
- Co-ordinated whole system support across primary, secondary, community and third sector services.
- Greater use of acute frailty and geriatric liaison services in the acute setting to increase the proportion of older people to be managed in a community setting.
- Patient centred care tailored to the individual and based on preferences and priorities at all stages of frailty.
- A service that meets the needs of those with dementia and their carers, providing coordinated care, with early diagnosis and support to remain in the community.

Case study

Dr Abdul Rahman Malik is a Consultant Physician and Interface Geriatrician at Lister Hospital he leads the Frailty Clinic which has been a vital part of the Vanguard initiative. The clinic is making a difference to older patients, who may have safety or minor health needs preventing them from leaving the hospital. The clinic provides an assessment to identify the barriers they're facing and creates a treatment plan which will offer them the support to be discharged from hospital.

"Older people living with frailty are at risk of dramatic deterioration in their physical & mental wellbeing after a small event or crisis. We know that the longer a frail patient remains in a hospital setting the greater their chance of developing an infection, having reduced mobility and strength as well as experiencing many other health related complications. It therefore makes sense that, if an older person is medically well, we help to get them discharged into a safer, more comfortable and familiar environment whether that's in their own home or into a nursing or residential care setting. This partnership approach of medical staff working alongside the integrated social care team means that we can improve patient outcomes and overall satisfaction. Getting frail patients the right support when it's needed can also significantly reduce the likelihood of readmission, so overall we are ensuring that hospital and emergency department resources are preserved for those who really need that acute level of care."



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