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The New Forest Frailty Support Team- Success and Challenges

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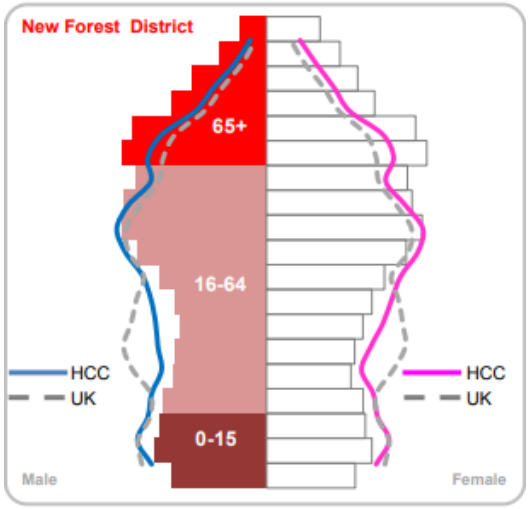
New Forest in Hampshire – Our Challenge

- Highest concentration of older people in the country
- Longer life expectancy but healthy life expectancy is decreasing
- Local demographics
- General Practitioner visits
- Number of care homes



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Developing the Frailty Service Model

Aims of the New Forest Frailty Support Team

- Support patient flows across the New Forest
- Integration across acute, community, primary, social and voluntary sector
- Build on current service provision

New Frailty Support Team Model

- Dedicated Teams
- Proactive identification of people
- Local Assessment Unit
- GPs aligned to care/nursing homes
- Reducing Excess Bed Days & Delayed Transfers of Care
- Multi professional practitioner workforce

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Reablement Team Model

- Response within 2 hours and delivery of support within 24hours
- And working from the hospital 'front door'
- Enabling people to remain at home
- Supporting people to regain their independence and working with people for up to 6 weeks if required
- Consists of occupational therapists, sensory specialists, therapy assistants and community response team staff
- Identification of any long term support needed

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The Frailty Team Model

- Urgent response with senior clinical assessment and interventions
- Care planning and care co-ordination
- Complimenting each Extended Primary Care Team
- Care Homes training
- Alignment with Medicine Optimisation Teams
- Care Navigators and alignment with 3rd Sector
- Practices aligned with specific Care Homes

Reactive Care

- 7 day service provision
- 8:30 to 18:00 core service
- Care packages as required - short term
- Service provision coordinated with Lymington New Forest Hospital

Proactive Care

- Monday to Friday 8:30 to 16:30
- Development and supporting care plans
- Advice & Guidance

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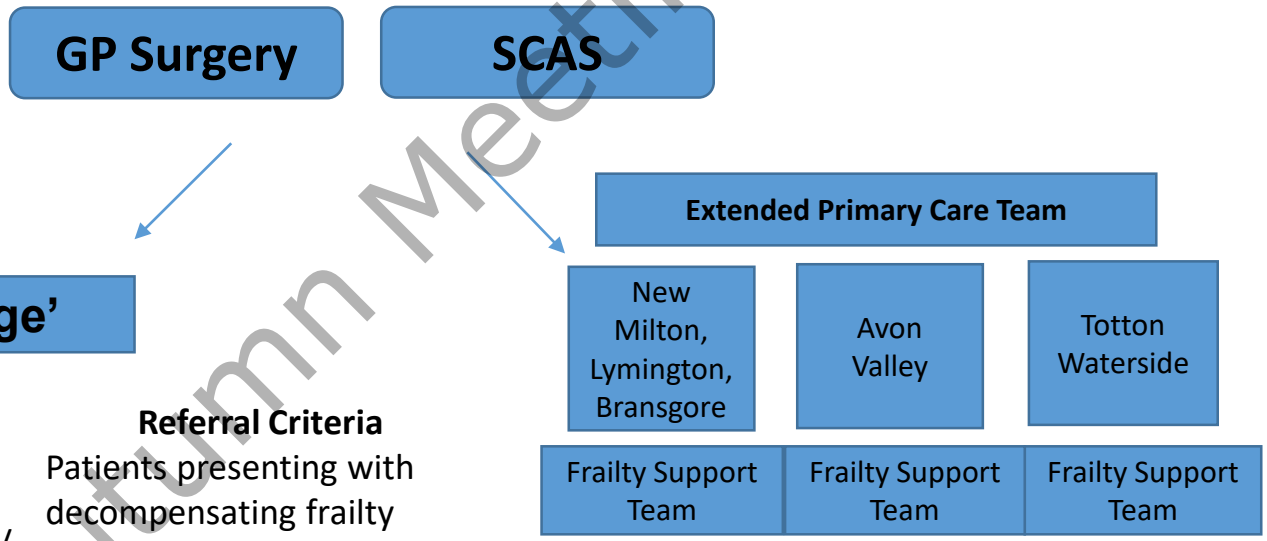
The Frailty Team Model



- Urgent Home Visiting Service
- Care Package < 2 weeks
- Consultant Advice Line 12 hour / 7/7
- Frailty Clinic (LNFH)
- Forest Assessment Centre
- Medical Assessment Unit
- Reablement up to 2 weeks

Referral Criteria

Patients presenting with decompensating frailty syndrome e.g.

- Fall or collapse
- Found on floor
- Sudden loss of mobility
- Acute confusion
- Sudden loss of function
- Etc.'

Referrals accepted from:

- GPs
- Ambulance Service
- 111 / OOH
- Hospital ' consultant silver line'

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West New Forest Area

- Care is provided over 3 communities with a registered population of 30,000+
- A greater range of community services serving a wider population of 100,000+ is provided by our Primary Care Access Hub at Lymington New Forest Hospital.

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Impact of the Frailty Service

No of Referrals

2,397 up to end Jun '19
407 direct from Ambulance Service

Impact on GPs

2,397 home visits avoided

Patient Experience

Positive – people can remain at home

Single Multi Professional Team

One point of access

Bespoke Frailty Training

Staff Retention

Satisfaction of staff

Savings

£965,296 during 18/19

NEL Growth

Maintained at 3.8% below national rate 5.8%

Resources

Increase in use of Lymington Hospital

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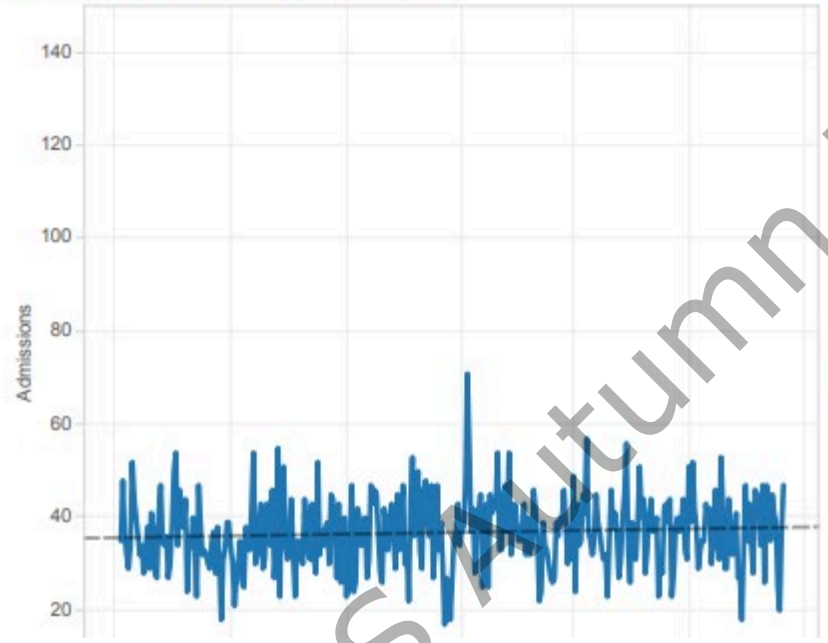
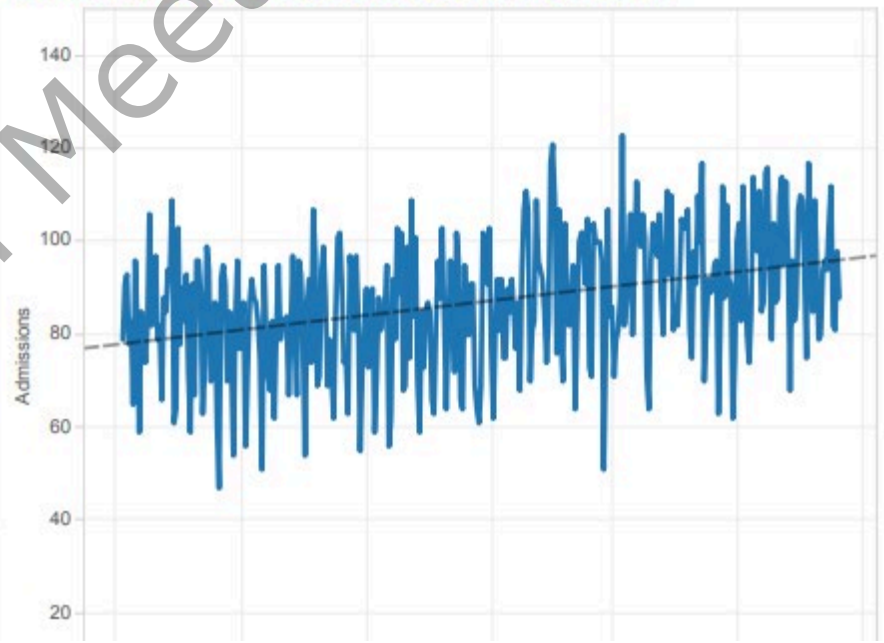
Impact of Reactive work





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Service Challenges

- Recruitment- workforce challenges
- Capacity of the service
- IT challenges and communication
- Level of clinical acuity and risk
- Interface with Emergency Departments
- Culture change around home support

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Successes- From GPs and commissioners

- savings- 950k in first year
- Responsiveness and accessibility of the service
- Clinical skill mix
- Clinical co-ordination and Frailty Support Team updating GP records
- Care planning for escalations of care

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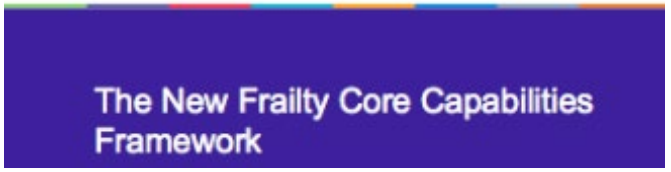
Workforce development

- Frailty Friends
- Core Capabilities
- ACP competencies with BGS
- Career Development

Skills for Health

NHS Health Education England



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