







Meeting the COVID Challenge

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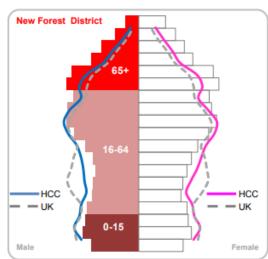






New Forest in Hampshire - background

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











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.











The Frailty Team Model

- Urgent response with senior clinical assessment and interventions
- Care planning and care co-ordination
- Complimenting each Extended Primary Care Team

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









The Frailty Team Model

GP Surgery

SCAS

'Triage'

- 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.'

Extended Primary Care Team

New Milton, Lymington, Bransgore

Avon Valley

Totton Waterside

Frailty Support Team Frailty Support Team Frailty Support Team

Referrals accepted from:

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









Impact of Reactive work











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

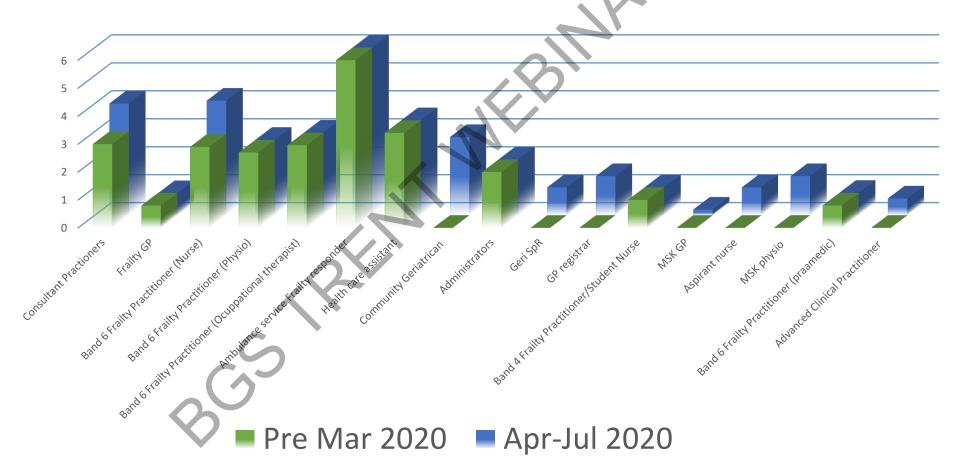








COVID changes











Referral Comparison

	Mar-19	Apr-19	May-19	Jun-19	
Accepted	144	118	129	137	528
Inappropriate	4	5	6		15
No Capacity	18	25	26	18	87
	166	148	161	155	630

	Mar-20	Apr-20	May-20	Jun-20	
Accepted	136	216	233	206	791
Inappropriate	4	4	5	6	19
No Capacity	12	26	5	27	70
	152	246	243	239	880

Strengths

- MDT working
- Good communication with Integrated care team & GP
- Good team dynamic "Can do"
- What we do for people & their families
- Easier to escalate concerns (senior available) and can get feedback in the same day to do a second review
- Constantly adapting to the changing service

Opportunities

- Working as one team with Integrated Care Teem
- Closer working with hospital Older persons' assessment & liaison team
- Lots of new skills
- Expand team to match skills
 set and numbers of covid19
 phase
- Work with care homes post discharge

Aspirations

- Lots more frailty learning
- Handovers become daily teaching events
- Write discharge letters to service users as well a GPs

Resources

- Older people's front door teams in 3 local hospitals
- More frailty practitioners for continuity especially ACPs
- Training trainees (GPs, ACPs, SpRs)









What we've learned

WHAT PRACTICE AREWE SEEING IN COMMUNITIES, INSTITUTIONS, POLICIES?

Understanding crisis-response measures

Collective Sense-making



DURING CRISIS

STARTED

STOPPED

END

WE'VE DONE THESE THINGS TO RESPOND TO IMMEDIATE DEMANDS BUT THEY ARE SPECIFIC TO THE CRISIS

AMPLIFY

WE'VE BEEN ABLE TO TRY
THESE NEW THINGS AND THEY
SHOW SOME SIGNS OF
PROMISE FOR THE FUTURE

NEW PRACTICE

LET GO

WE'VE BEEN ABLE TO STOP DOING THESE THINGS THAT WERE ALREADY / ARE NOW UNFIT FOR PURPOSE

RESTART

WE'VE HAD TO STOP THESE THINGS TO FOCUS ON THE CRISIS BUT THEY NEED TO BE PICKED UP IN SOME FORM

OLI

OLD PRACTICE

STOPPED

STARTED

POST-CRISIS









COVID 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









Feedback



"@EstherClift the frailty team are fantastic! Gary and his colleague just came out to see my Dad.

We've been up all night with him. I could cry with relief they were so supportive, knowledgeable and now going to come out daily to see him until he improves.

Thank you so much"

Gary – "Thank you so much for this tweet! We thoroughly enjoyed meeting you all! Hope you have a better night tonight, you're all doing great!









Acknowledgements

