



Who Are We Supporting?



Patients with dementia, high intensity users, people recognised as housebound and those with a high electronic frailty index (eFI) score. This cohort forms the core patient group.

Next Steps

- Continue to expand team and widen our scope of practice, building on our partnership work across the public, voluntary and community sectors to achieve the best possible outcomes for our patients and their families.
- Continually seek out opportunities to share best practice including the Frailty Virtual Ward, Bimonthly Frailty Networking.
- Detailed analysis of the work is being planned, led by the Clinical Director, with the aim of informing future local developments and to share with other localities.
- QI funding of HCA to support basic reviews to free frailty matrons capacity for complex cases – awaiting confirmation

Support from the System?



- ASC decision makers to support work and unblock barriers for frontline staff
- BI support with data since not available on system since switch to look at service utilisation and impact of frailty service
- Sharing examples of work expanding elderly care including cancer support to support future aspirations

Outcomes & Impact



- Our proactive care approach has reduced unplanned admissions and requests for urgent visits by GPs.
- Offering over 2,000 home visits in the last 12 months. The team have freed up clinician time and provided continuity of care to patients who need it.
- 295 patients have a current ReSPECT form and in the past month 54 patients had Social Prescribing personal care plans
- Improved primary-secondary care interface with better communication and information sharing.
- The team provides additional points of contact for carers/relatives reduces pressure 'at the front door'.
- We have created a seamless overlap with in-house Mental Health and Learning Disability teams in our 'team of teams' approach.
- Improved take up of COVID-19 vaccinations in vulnerable patient groups.
- Remote access to the hospital's 'Sunrise Go' system allows us to identify patients who have been admitted to hospital and those who may need a post discharge review in a timely manner.
- Understanding what happens to patients during admission is vital.
- Effective communication between primary and acute services drives 'productivity'.
- Addresses health inequalities by improving access to vaccinations and health checks for housebound and elderly people.
- Drives continuity of care and in-depth knowledge of patients and their social situation, allowing much more appropriate and tailored care and advice to be delivered.



Why?

Aspen Medical Practice has a total population of over 31,000 with high deprivation and disease prevalence, 5,000 are aged over 65 giving a significant number of high intensity users and demand for GP home visits. Delivering over 250,000 consultations per year for a large, rapidly ageing, population with increasingly complex issues, therefore appointed a clinician to focus on health and wellbeing in older, frail, patients (not living in residential care).



In Action

- Our frailty team model delivers seamless anticipatory care and support to frail older patients and their families.
- Strengthens our partnerships with other healthcare providers and community/voluntary organisations to minimise gaps in care and improve integration.
- There are regular Multi-Disciplinary Team meetings, which are attended by Community Nurses from GHC. Taking a wide partnership approach, we also engage with a wide range of community services and voluntary organisations.
- Having addressed immediate health/wellbeing issues, we begin working with the patient and their carer(s) to plan for the future (Advanced Care Planning), using tools such as 'Me at my Best' frailty plan (as early adopters), and the ReSPECT form.
- Patients referred to service via hospital discharge, referrals from practices and external orgs and through patient review by EFi



Working With

Aspen Medical Practice Frailty Team

- 2 frailty nurse matrons
- 2 elderly/frailty social prescribers/ HCP
- 2 senior GPs
- Supported by the Clinical Director

Working closely with

- District nursing team
- Dementia nurses
- Mental health team
- Secondary care
- SWAST
- VCSE including clubs, friendship cafes, fit for life, Age UK

INT Meeting 9th August 2024

Describe your INT development thus far. What has been most successful? When have things been more challenging?

Working well – INT frailty team well integrated MDT with district nurses, contacts with partners including acute and VCSEs, access to sunrise system to support - not PPW as additional resource and this works . Team invited to hospital MDT– complex patient from hospital on discharge. Referrals - 1. discharge hospital, 2. Within PCN and external orgs including district nurses (mainly on referrals) 3. Patient review by EFI -so many patients to sift through can be challenging.

Challenges - how develop further, need to be more informalized? connections ok as is – BB outcomes from the work doing . ASC relationship with frontline staff but can be frustrating due to ASC processes/red tape which can hold up decision making. Understanding review process of patients – different to PCNs conflicting decisions on patient. Involving ASC MDT more frequently help - most pts under ASC so more likely already seen/on case load

What are your aspirations and key next steps?

Including more external partners including more regularly attendance from ASC at MDTs and explore who else be involved. Through QI funding HCA to do basic reviews including blood pressure to free capacity for frailty matrons to support complex frailty patients and housebound patients

What support needs does your INT have to reach these aspirations?

Better understanding data to support demo of impacts– support from BI? Switch over of clinical system didn't bring all hisotrial data (2 years) number of appts, home, ultisiation of services across the system – work with BI to support an approach to show impact and outcomes. formalized process for the INT

Are all partners fully engaged? Who is missing? Who leads? Would everyone feel part of the team?

ASC engaged include more frequently MDT, VCSE (include in stock take)

Linked CC@H through step down discharge through the acute MDT and frailty service refer CC@H . Staff employed through Aspen frailty service came from within CC@H etc therefore already had knowledge/ relationships which helped

Are you clear on the Gloucestershire ambition for INTs and what makes a successful INT?

Yes

What Learning and sharing opportunities across INTs would you like to see?

Learning from other areas on further elderly care including Cancer support to expand/enhance elderly care –short readable summaries of examples

Any further detail you wish to be included in the stocktake for your neighbourhood? Is anything missing?

Include working with VCSEs

Actions

- Ask ASC who would be named senior manager for front line staff with blockers/challenges for Aspen and regular attender for Aspen frailty MDT
- Link BI team member with Frasier to explore data no longer on the system to show impact of service
- Sharing examples from other areas of elderly care expansion to support future aspirations