Frailty care in a community based clinic – maximising the potential of integrated care

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Aims

To develop a pragmatic model for frailty care in one locality, and assess both the benefits and blocks to wider application within one vanguard multispecialty community provider (MCP) in Hampshire.

Methods

A series of facilitated meetings were funded in 2016 to establish an integrated care approach to reducing inappropriate admissions for frail patients in crisis. A local champion and the appointment of two frailty nurses within Hampshire provided a focus on frailty. The clinic evolved as part of a series of Plan, Do, Study, Act (PDSA) cycles, and was then evaluated with interviews and feedback questionnaires for patients, carers and staff.

Results

Thirty local healthcare leads working across the NHS, local authority and voluntary sector were invited to meet. Applying group work principles, a shared vision of frailty care, linked IT records and an information resource were established. Local leads volunteered to set aside time to pilot a frailty clinic. Primary care premises and administrative support were made available at basic running costs.

Patients with either relatives or carers attended the local community based clinic for 2 hours and received a 1-hour comprehensive assessment followed by voluntary sector signposting to social support. The pilot was deemed successful from recorded outcomes and feedback from patients and staff. There was a reduction in subsequent appointment use.

Developments, following the pilot period, were to increase pre-clinic information, to stagger appointments, to add fire service falls assessment, to link the clinician action plan to the patient wellbeing sheet and greater utilisation of the primary care records. Monthly clinics were established.

Key principles emerged in relation to community-based integrated care frailty services. This clinic was part of a full spectrum of services ranging from community advice, through to rapid assessment hubs in secondary care. The level of frailty and speed of decline determined which part of the service should be referred to. The clinic was integrated and multiprofessional, but access to each members of the team could differ. For example community frailty clinics had face-to-face assessments with nurses, same day remote access to consultants and same week access to investigations, social care or therapy. The aim was to meet the right person, in the right timeframe and right place.

Conclusion

The intervention of a facilitated meeting, local leadership and a consultant frailty nurse can identify and mobilise existing opportunities for multiprofessional working, with innovations in frailty care provision. There are advantages to placing an integrated clinic within the primary care setting and these should be more widely promoted and researched. ■

Conflict of interest statement

The author was a participating clinician in the facilitated meetings and had funded protected time to attend. This abstract was submitted and accepted in 2017 for the RCP conference but the author was unable to present due to hip surgery.

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