Frailty

Delegates were asked to reflect on the question and write their thoughts on the post-it notes provided and place them on the flip-chart paper on the table. These comments have been set out below and themed as much as possible.

Question

"We know from research that an unnecessary hospital stay does not deliver the best outcomes for older people. Because of this in Northamptonshire, our frailty programme aims to enable people to have healthy, independent lives at home for as long as possible.

What services do you feel help maintain your independence and what areas of healthcare could be looked at to support independence?

When things deteriorate what do you think works well and what could be improved in terms of managing your health needs at home rather than needing hospital?"

Prompts:

- Services
    - What services support independence?
    - How can we support people to stay in their homes for longer?
    - Follow Up Care?
    - Other?

- Support people to stay in their homes for longer
    - Carers?
    - Adapting homes?
    - Other?
- Prevention
    - Exercise?
    - Identifying frail patients?
    - Home assessments?
    - Other?

Support

Lifelines – help if you fall, if you have Next of Kin (NOK)

Informal/family support helps you stay at home x 2

GPs need to know your support circle and have contact details

Sheltered housing – options for 24/7 warden to be reinstated

Psychological/emotional support very important

Clear contact list in obvious plan in house (+/-DNAR info)

Info pack on key birthdays – info on imms/services/clubs/care etch

On discharge: want someone to come and check on me x 2 Day friendly face

Advocates and voluntary sector to support

Home helps to help keep independent

People who know you should know all changes

Befriending service in hospital

Respiratory/panic ring 999

Home nursing service to support you for the first 3 days

Nursing homes/convelesent homes

Rehab

No warden in controlled houses

Communication

PPG: newsletters = useful resource from practices

Communication should be 2-way – let patients tell services what they think they will need

Listen to what patients/people want

Information to patients to help specific conditions, eg dementia help – Just beware app

Better communications between pathways if you have lots of conditions

Information about available services. This also needs to readable for all groups

Quality

Frail patients have information sheet and have contacts. GP, emergency information

Use of IT and apps ok if literate but if not inequalities

Need patient led advance care plans

Single point of access

Frailty is not just older people, it can also effect younger adults after an accident or as a result of illness. EG cancer. Children can be frail because of disability, illness, sensory impairment

ACPs not used enough

Trees and music

EOL monitoring

Prevention

Annual check to discuss changing needs and actions for year F2F or letter

What education is going into schools or your group. Role for school nurses?

Mental resilience key to remaining independent and mindset

Appointments to cover all chronic conditions not just isolated illnesses

Social clubs – keep min active (anti-loneliness clubs)

Taking responsibility for own health

Avoiding social isolation

Advanced care planning when I am well

If people do go into crisis – more earlier intervention

Don't ring the GP because you end up in hospital

Water and drinking

Low level interventions earlier