

Anna Makepeace – Integrated Frailty Manager

Frailty and Falls



What the NHS Long Term Plan will deliver for patients

Making sure everyone gets the best start in life

Delivering world-class care for major health problems

Supporting people to age well

- **Increasing funding** for primary and community care by at least £4.5bn
- Bringing together different professionals to **coordinate care better**
- Helping more people to **live independently at home** for longer
- Developing more **rapid community response teams** to prevent unnecessary hospital spells, and speed up discharges home.
- **Upgrading NHS staff support** to people living in care homes.
- Improving the **recognition of carers** and support they receive
- Making further progress on **care for people with dementia**
- Giving more people **more say about the care they receive** and where they receive it, particularly towards the end of their lives.



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! Frailty is not an inevitable part of ageing.



THE FUTURE



An 'Older person living with frailty' - a long-term condition



Timely identification, preventative proactive care & self-management



Community based person centered and co-ordinated



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What we are trying to achieve



Pathways

Best practice evidence-based pathways to be implemented locally



Hub

Scoping a 'Single Point of Access' co-ordination hub to navigate a frail person to the most appropriate service



Resource pack

Development of a resource pack for frail people containing self-management advice.



Care plans

Universal care plans which can be shared across the system



Training

Identification of training needs to upskill workforce in managing frail people.



Peer review

Learning from other areas and sharing examples of good practice.



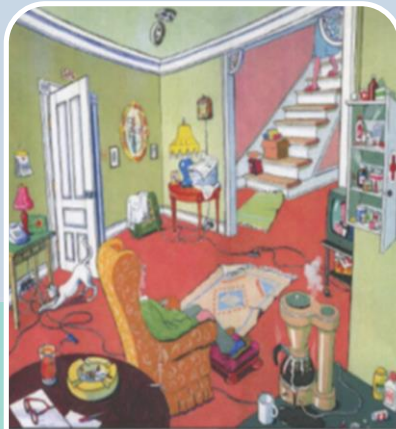
Templates

Templates to support consistent data collection which can be shared

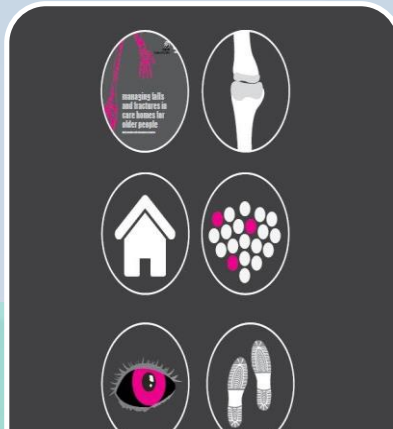
Focus on Falls



PREVENTION



IDENTIFICATION



TAKE ACTION



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Aims of the falls

To reduce falls and fracture risk through early identification of falls risk

To promote self management

Consistent approach to risk of falls identification

Multi agency co-ordination of provision including classes

Person centred approach to falls provision



How we are looking to achieve this?

Falls group established across health, social care and voluntary sector

Commissioning of falls vehicle to prevent unnecessary hospital admission

Frailty clinics

Clear communication resources

Falls prevention in care homes (delivered by the Care Providers Association)

Assessment tool to identify falls risk rolled out

Sharing records across the system



Resources



- Animations on GP screens
- Leaflets
- <https://www.healthierfuture.org.uk/>

