Complex Case Management, Locality MDT, and Frailty Clinics

This service is available to those patients identified as most vulnerable in the community with long term health conditions and at risk of recurrent or avoidable hospital admission. It is a Multidisciplinary approach aimed at coordinating community health services, social care, voluntary and GP services to support the patient in their own home. The service is available to all patients, including those in care homes and those with learning disabilities

Referrals are received via the *'Community Complex Case Management (CCM) including Locality Multidisciplinary Team (MDT) Intervention and MDT Frailty Clinic'* referral form.

Pathway:

1. Decision to Refer

Mental Capacity / Informed Consent / Referral in *Best Interests*

2. Referral Process

Complete *Referral form* in as much detail as possible, identifying main risks and issues requiring intervention.

Include Frailty score (EFI/Rockwood) and FRAT if clinically appropriate.

3a. Complex Case Management

Available to all adult patients with multiple complex health needs and chronic long term conditions at long term risk of hospital admission.

Holistic assessment & time limited support for long term conditions management.

3b. Locality MDT

Available to all adult patients with complex multi disciplinary needs, including Frailty.

To be attended by referrer, GP, Consultant Geriatrician, and appropriate representation from other professionals according to patient need.

3c. Frailty Clinic

Patients who are moderately frail (Rockwood 6 or FRAT >3).

Multidisciplinary Comprehensive Geriatric Assessment from a nurse, occupational therapist, physiotherapist, consultant geriatrician.

4. Care Plan implemented and shared

To include Self Care Management Plans, Advance Care Plans, Treatment Escalation plans

Discharge.

Covid 19 update: We are reducing clinic based activity and will predominantly complete virtual **and** home based assessments, with clinic based Consultant Geriatrician assessment when deemed essential to treatment planning. The provision of consultant geriatrician resource to these services is dependent on partnership working with local acute trusts. *We anticipate that during periods of heightened covid related pressures in acute trusts it will be necessary to temporarily suspend the consultant geriatrician element of these services.*

For more information, please contact Louise Ayres, CBU Manager: Louise.ayres1@nhs.net

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