BaNES Primary Care Frailty Quick Referral Guide

Urgent Professional Line HCRG:	Routine Community Referrals	Acute Frailty Team RUH	Consultant Geriatrician	Community Wellbeing Hub	RUH Hospital at Home	BSW Care Coordination
2 hour response when there is a risk of admission within 24hrs, including virtual wards	Routine Referral for Community Services	Royal United Hospitals Bath NHS Foundation Trust Admission being considered 65yrs+, Clinical Frailty Scale 5+ Conditions associated with increasing frailty + any care home resident	Royal United Hospitals Bath NHS Foundation Trust For advice and non-urgent queries	Community Wellbeing Hub Practical & emotional support to build confidence, independence & connect the local	Royal United Hospitals Bath NHS Foundation Trust Advice/ Support for pts recently discharged from Hospital at Home. Time limited service of secondary care healthcare professionals	Bath and North East Somerset, Swindon and Wiltshire Together Clinician support prior to ambulance call out - except for a time critical or life threatening
Options	Options	Options	Options	community Options	visiting pts at home Options	reason Options
-2hr Urgent Community Response (UCR) HCRG Virtual Ward (Step up) High level of care, assessment, monitoring and treatment in own home -Urgent Social Care Contact & Availability 01225 410240	Adult Speech/Language Therapy, Bladder and Bowel Service, Community Matrons, Falls and Parkinson's, Heart Failure, Leg Ulcer Clinic, Lymphoedema, Podiatry, Reablement, Tissue Viability, Community Nursing <u>service</u> Contact & Availability	-Acute admission under the acute frailty team - Frailty Flying Squad – MDT for assessment, diagnosis and treatment -Frailty Same Day Emergency Care (SDEC) (potential for next day/planned admission for urgent assessment and investigation) Contact & Availability	Contact & Availability	-Debt, money & benefit advice, Short term financial crisis help, Housing advice, Access to low cost food, Mental Health support, Employment, Keeping a family active and healthy, Managing type 2 Diabetes and Stopping smoking Contact & Availability	-Hospital at Home for patients recently discharged from Hospital (Step-down) -Admission avoidance -All patients have inpatient status & access to tests, consultants, therapists and full MDT Contact & Availability	Supportive clinical navigation discussion for clinicians who may not have seen the patient with the BSW Care Coordination service, regarding any alternative local options prior to ambulance call out or ED attendance Contact & Availability
Referral: 24/7 Triage: Mon-Fri 8-6 Sat-Sun 8-5 Virtual Ward Clinician:	0300 247 0200 Mon-Fri 9-5 Community Nursing	Cinapsis > Acute Frailty- RUH 07584771329	Cinapsis > Older Adult Medicine-non-urgent-RUH >phone or >e-opinion	03002470050 or https://communitywellb einghub.co.uk/for-	07824520 192 or Cinapsis > hospital at home	0300 111 5818 option 7 for Care Co 'Paramedic on scene' or option 3 for
07385 005604 Mon-Sun 8-8	service - 24hr	Mon-Fri 8-8 Sat- Sun/Bank Hol 8-5	Mon-Fri 8-8	professionals Mon-Fri 9-5	Hospital led Mon-Sun 8-6	Access to Care Mon-Sun 8-8

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