NHS
South Yorkshire
Integrated Care Board

NHS
Barnsley Hospital
NHS Foundation Trust

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Virtual Wards:
The Barnsley Experience

GP BEST Update March 2025

Learning Objectives

Knowledge:

- To understand local pathways for investigating and managing a complex older person with frailty, especially Virtual Ward pathways, and the pilot Community Frailty clinic.

Skills:

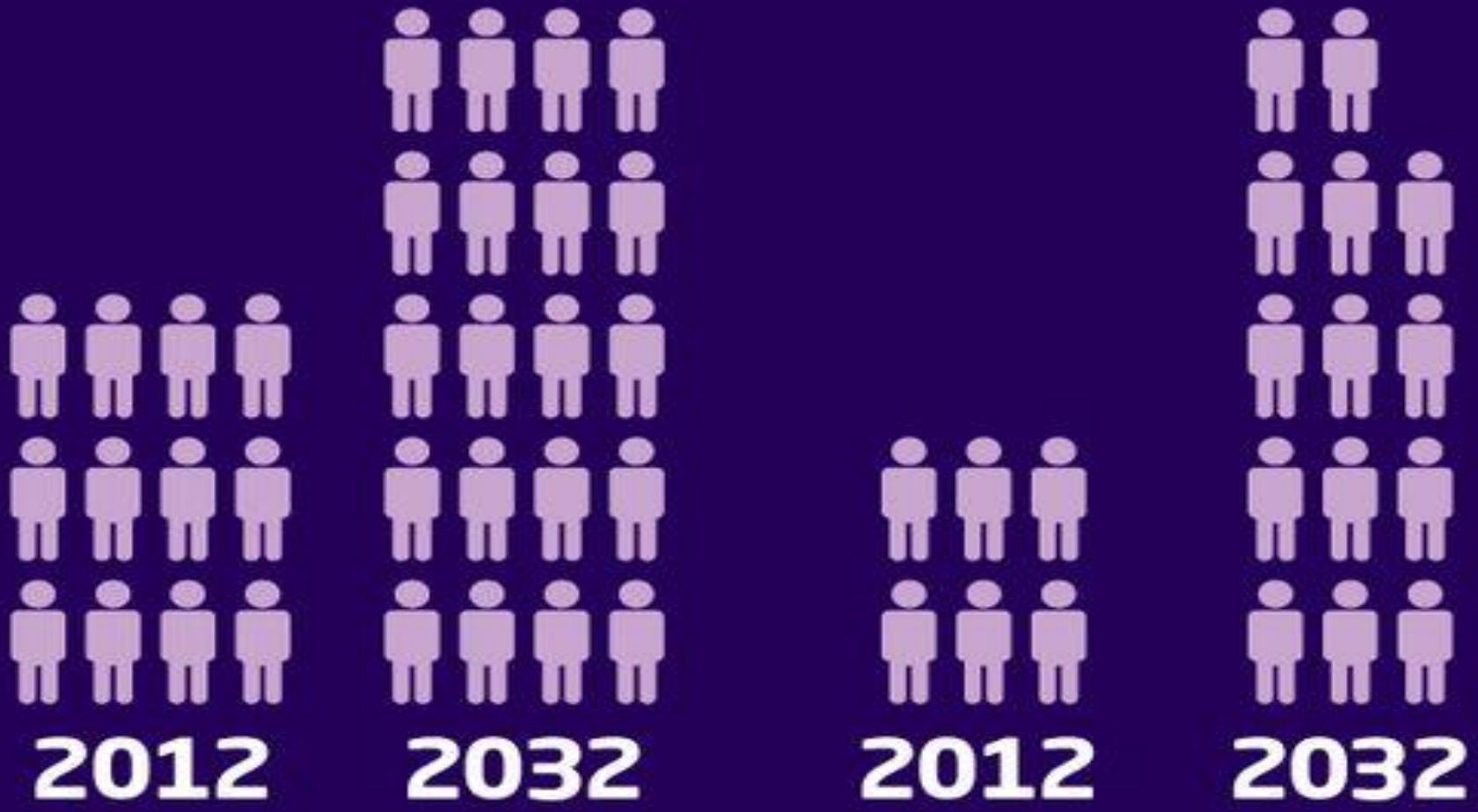
- To use the Rockwood Frailty score to assess level of frailty

Attitudes:

- To develop confidence in identifying and referring on complex older patients with frailty to appropriate services in Barnsley

Why is Frailty Important?

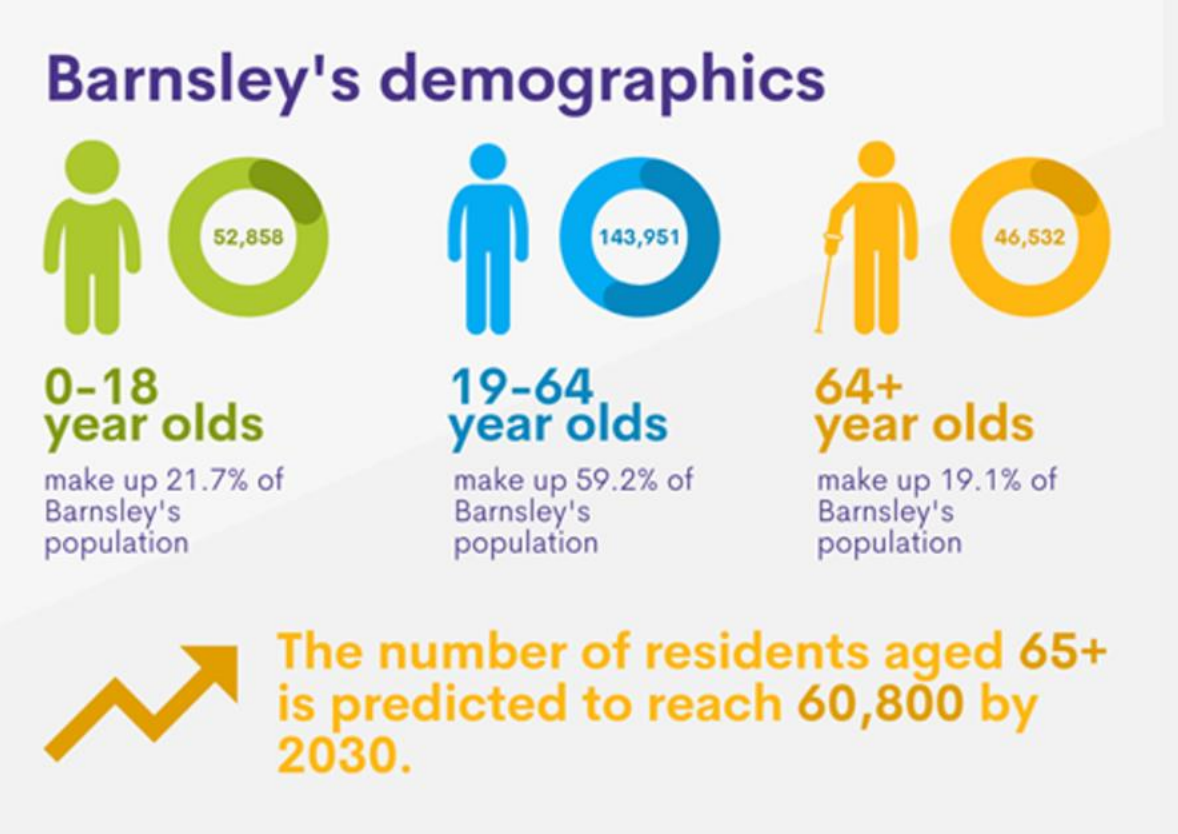
Over the next 20 years the number of people in England aged 65-84 will grow by over a third and those over 85 will more than double.



The King's Fund

In the future, **the increasing numbers** of frail older people and more patients with long-term conditions will mean we need to **rethink where and how care is delivered.**

The King's Fund



2023/24

- 15,025 social care users aged 65+
- 41 care homes, 5 of which offer nursing care
- 1751 CQC registered beds in total

Service type	Number of service users
Residential nursing care	995
Home care	1047

Adult social care market position statement

- Population of roughly 250,000
- 21.5% >65 years - equates to 52,813
- 60,800 by 2030 - increase of 33%
- Life expectancy in most deprived areas is 8.9 years lower for men and 8.2 for women than least deprived

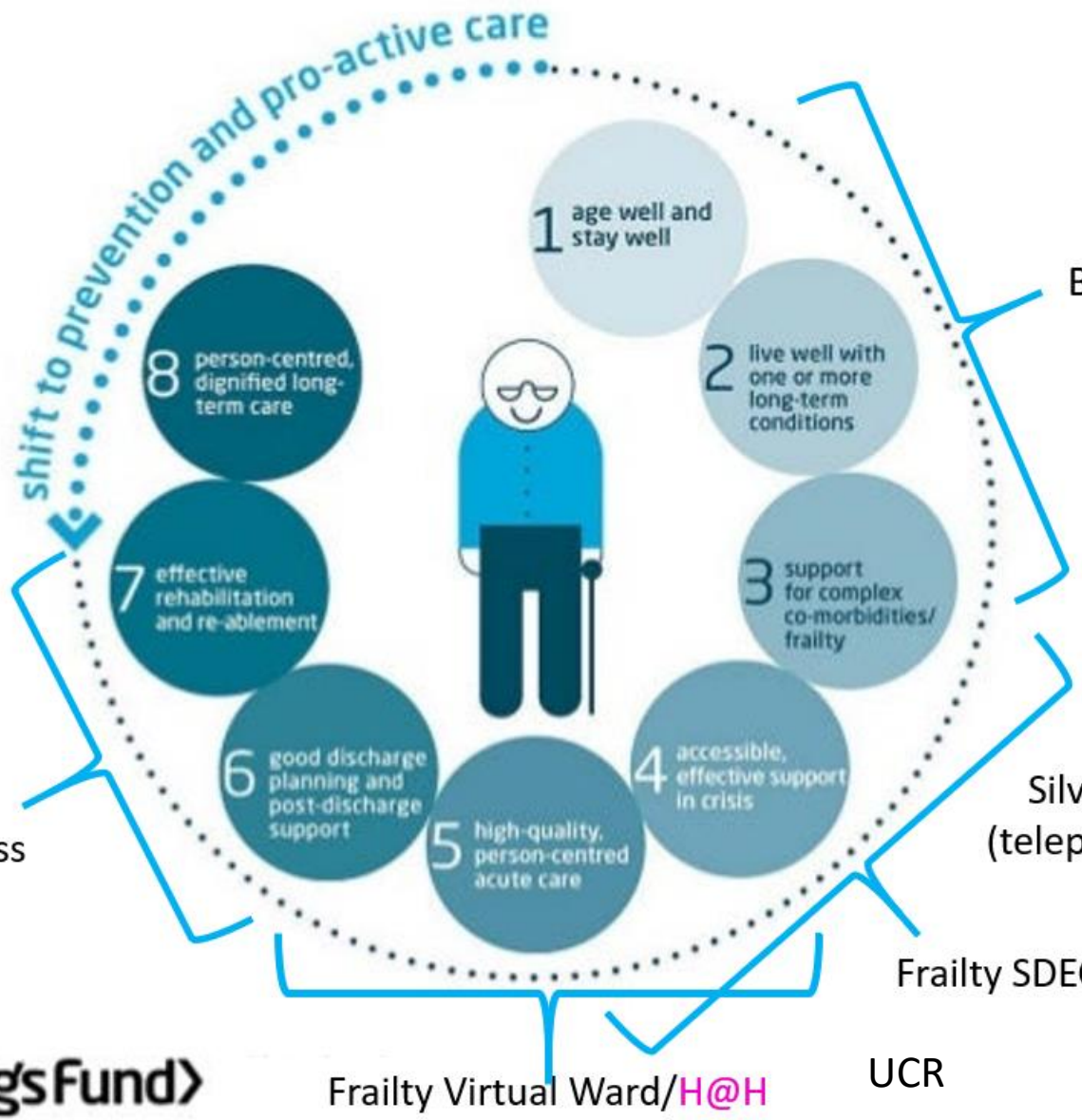
Improving Care for Older People in the UK

- NHSE are working with partners across health and social care to:
  - reframe frailty as a long term condition
  - reduce the amount of time someone spends in long term ill health in later life
  - supporting public services to work together to support people.
  - identify and support implementation of best practice interventions for key stages of frailty
  - promote proactive frailty case finding (identifying people at risk of frailty) to target prevention strategies among those most at risk
  - promote tailored care and personalised care planning for people with advanced frailty

Where does FVW fit in?

Care home liason service /community frailty clinics

NHS South Yorkshire Integrated Care Board



Barnsley Frailty Proactive Care Programme

Acorn Unit
Discharge to Assess

Silver Phone service (telephone support from geriatrician)

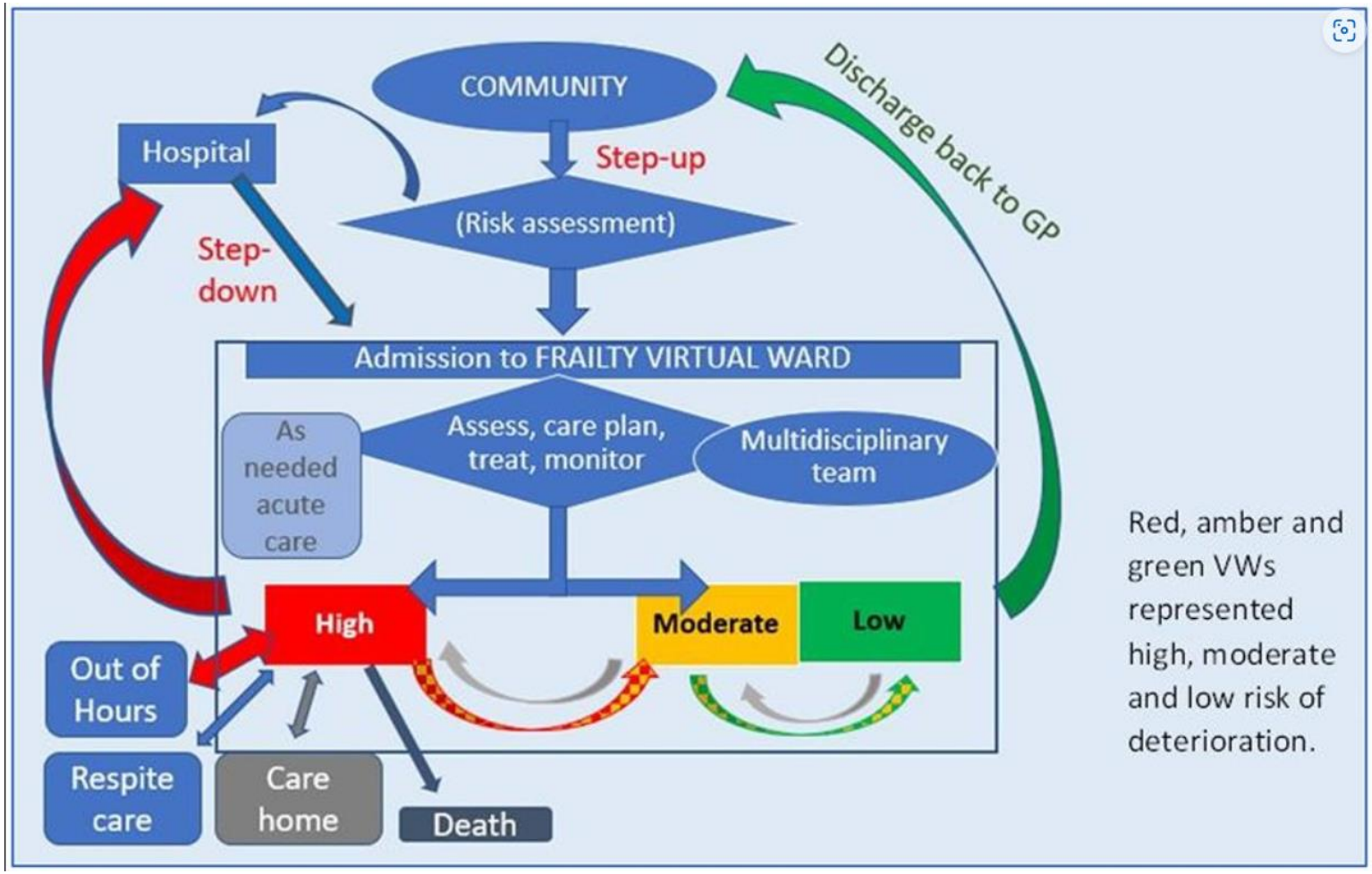
Frailty SDEC/ED frailty team

UCR

Frailty Virtual Ward/H@H

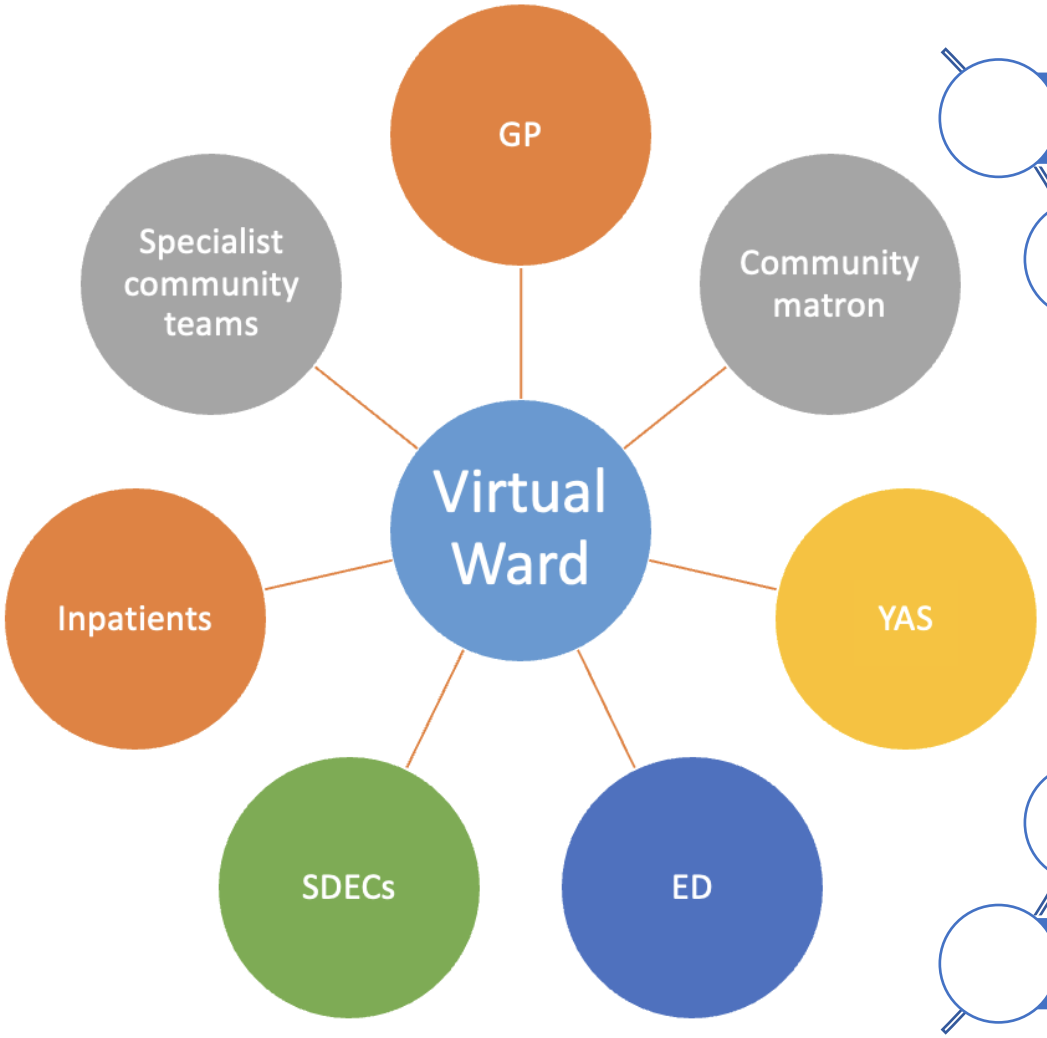
The Kings Fund

What is a Virtual Ward?



A substitute for acute IP care delivered to people in their own homes

Delivering Virtual Wards in Barnsley



Referral Sources

- Since September 2022
- Consultant led acute level care through remote monitoring and face to face support from community clinicians.
- **Integrated model** between acute, community and social care teams.
- Frailty and Acute Respiratory Infection pathways
- Step up and step down model
- 8am – 8pm seven days a week
- 75 beds total – 50 frailty, 25 ARI

Who are we? Our staffing…

The VW team was built on an existing team rather than creating a completely new one

Multiple employing organisations (but seamless care) Comprises:

- Virtual Ward nursing team
- Community Matrons
- Breathe Team
- Urgent Care Response Team
- Specialist Community Teams
- Admin
- Pharmacy
- Operational Manager
- Service Development Manager

Frailty Pathway:

- Dr Kath Shakespeare, Consultant Geriatrician
- Community Matrons and Frailty Nurses
- Wider wrap around services e.g., Social Services, Community Nursing, Urgent Community Response and therapy teams.

Acute Respiratory Pathway:

- Dr Akhtar Akhtar, Respiratory Consultant
- Breathe Specialist Respiratory Nursing Team
- Wider wrap around services e.g., Social Services, Community Nursing, Urgent Community Response and therapy teams.

Frailty VW Criteria

Inclusion Criteria

- Patient and/or Next of Kin consents to admission onto virtual ward
  (or 2 professionals)
- Patient declining hospital admission
- Hospital admission not in patient's best interests
- Equivalent care can safely be provided in community without harm to patient
- Rockwood score ≥ 5
- Able and willing to participate in virtual monitoring (or patient has relative / carer / care home support)
- NEWS2 Score <4
  - (Excluding 3 in any one parameter, except COPD with target SATS 88-92%)
- Patient has a frailty syndrome
- Early Supported discharge from Inpatient ward area

Exclusion Criteria

- Not responding to initial treatment
- Pneumonia with CURB 65 score >3
  - *If patient has got appropriate advanced care plans in place to be managed at home / care home they will be accepted
- Severe cognitive impairment and no other support with monitoring calls
  (would affect ability to be supported by Virtual Ward team)

Respiratory VW Criteria

Inclusion Criteria

Patient and/or Next of Kin consents to admission onto virtual ward

(or 2 professionals)

Patient declining hospital admission

Hospital admission not in patient's best interests

Equivalent care can safely be provided in community without harm to patient

Oxygen sats 95% or higher *or individual target met (e.g. 88-94% in patients within known chronic hypoxia)

Able and willing to participate in virtual monitoring (or patient has relative / carer / care home support)

NEWS2 Score <4

- (Excluding 3 in any one parameter, except COPD with target SATS 88-92%)

Patient has a suspected or confirmed Acute Respiratory infection or COPD (inc exacerbation)

Early Supported discharge from Inpatient ward area

Exclusion Criteria

Not responding to initial treatment

Pneumonia with CURB 65 score >3

- *If patient has got appropriate advanced care plans in place to be managed at home / care home they will be accepted

Worsening peripheral oedema

Severe cognitive impairment and no other support with monitoring calls

(would affect ability to be supported by Virtual Ward team)

Identifying Patients

Identify

Step Up:

- GP
- UCR
- RightCare
- Paramedic
- Community Matron
- Specialist Community Teams
- ED

Step Down:

- Inpatient – proactive case finding

Refer

Telephone call to RightCare Barnsley SPA

Onboard

Information leaflet and safety netting advice given

Consent obtained

Digital monitoring equipment provided (if needed)

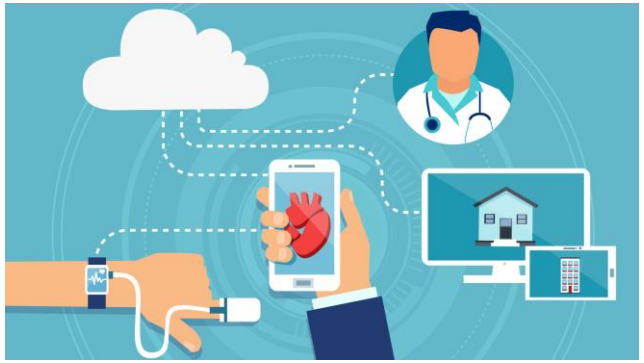
Discharge planning liason if inpatient

FVW entry onto SystmOne

Onboarding letter sent to GP

Clinical responsibility now lies with FVW team, not GP

Monitoring



- Face to face review by community matron, frailty nurse or specialist Breathe team, where required, within 24h of referral. Discussion with consultant as needed.
- Daily monitoring calls tailored to patient need and agreed with patient
- Remote monitoring (via Doccla) available
- Investigation and intervention in patient's own home wherever possible and appropriate. Supported by Neighbourhood Teams.
- Electronic prescribing and meds delivery using NHS Responder Scheme
- 3 times weekly MDT where care plans are discussed, and daily discussion for unstable patients
- Daily consultant/matron/Breathe input as needed in addition

Key Interventions:

Specialist BREATHE, Community matron or frailty nurse review

Oxygen, Nebulisers

IV antibiotics, SC fluids

Medication review

POC testing

Comprehensive Geriatric Assessment

Advance Care Planning

Therapy /specialist nursing/AHP referrals

Remote observations

Escalations of Care

Our Urgent Community Response team can respond within 2 hours if a patient needs urgent observations or review. This service is available 24/7 and patients have a direct phone line.

The virtual ward team have the support of the Consultant or specialist nurses (Matrons / Breathe) to discuss or escalate concerns from 8am-6pm.

Patients are provided with safety netting advice at every contact. Advising them of what to do if they need support and when to ring 999.

If a patient is escalated to the acute hospital, the frailty team are contacted to advise of the admission and prioritise the patient for review on arrival to:

- ED
- Frailty SDEC
- Acute Medical Unit

Discharge

Maximum of 14 days, through telephone and face to face support

The VW team will arrange for other support

e.g. social services, tissue viability, therapy and continence as required.

Discharge letter sent to GP detailing diagnosis and medication alterations.

Key Headlines

- 2,790 patients have been seen on the VW to date
- 1,347 patients admitted in the past 9 months.
- 52% of Frailty VW patients are from a step-up pathway
- Over 35,000 beds days on the VW service.

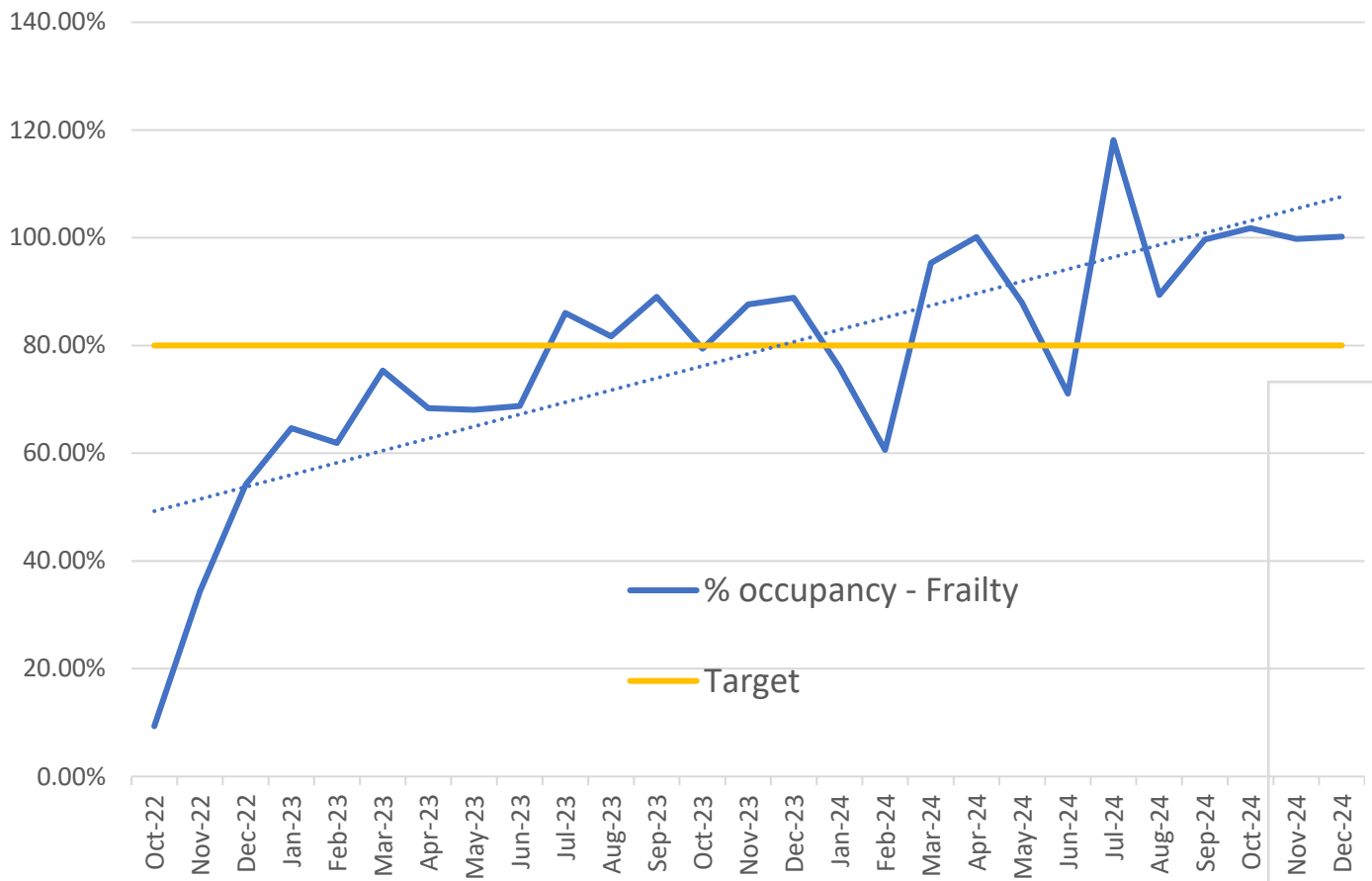
- 95.2% of VW patients rated the service good or very good.
- The VW service has enhanced partnership working creating far reaching benefits, particularly in Care Homes.

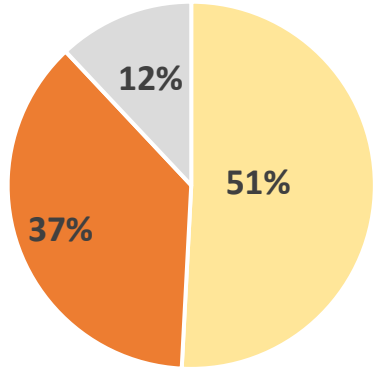
- Over 10,000 inpatient bed days saved with the majority being Frailty patients

- Delivered a positive return on investment, achieving £3.30 for every £1 invested in FY24-25 based on opportunity saving

October 2022 - December 2024

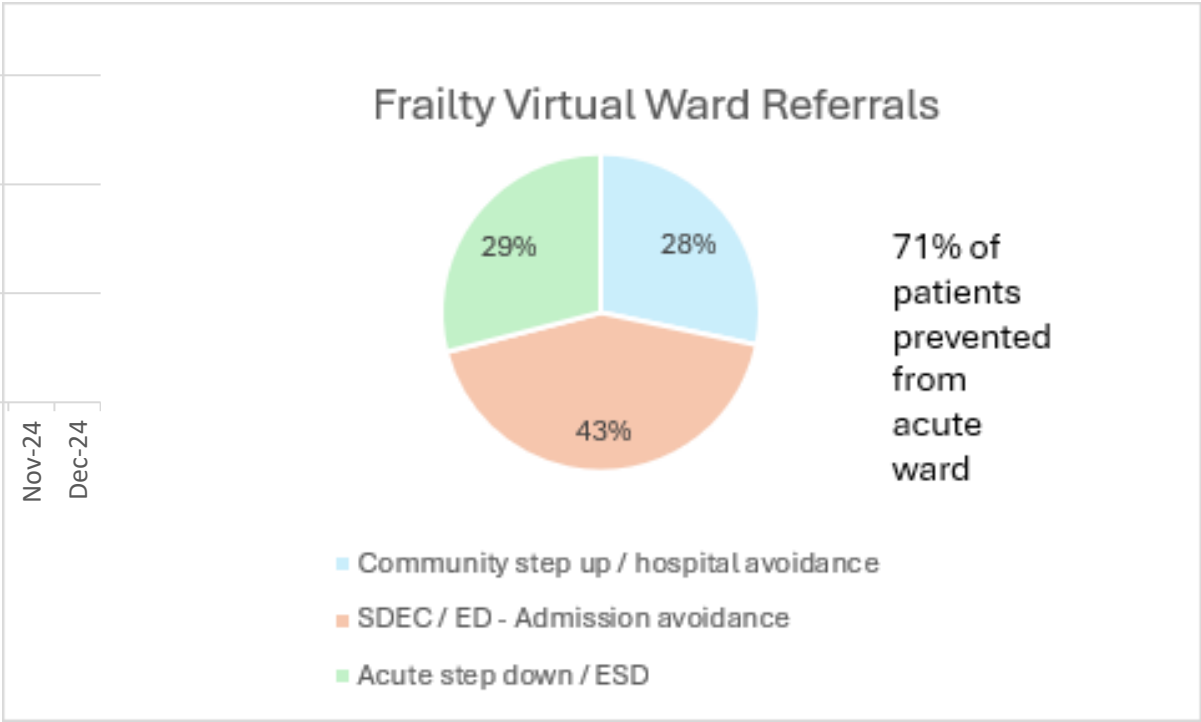
Frailty VW Outcomes



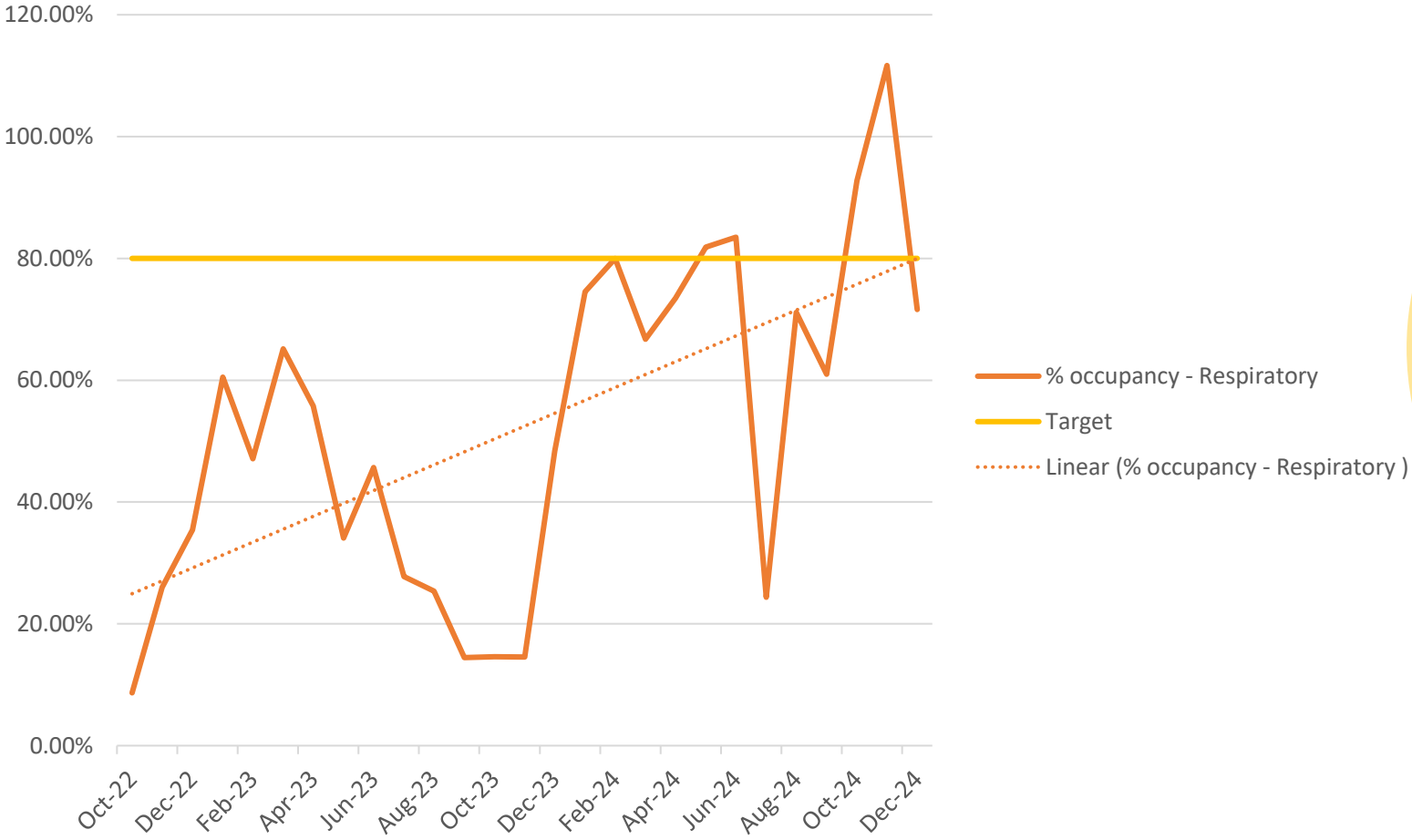


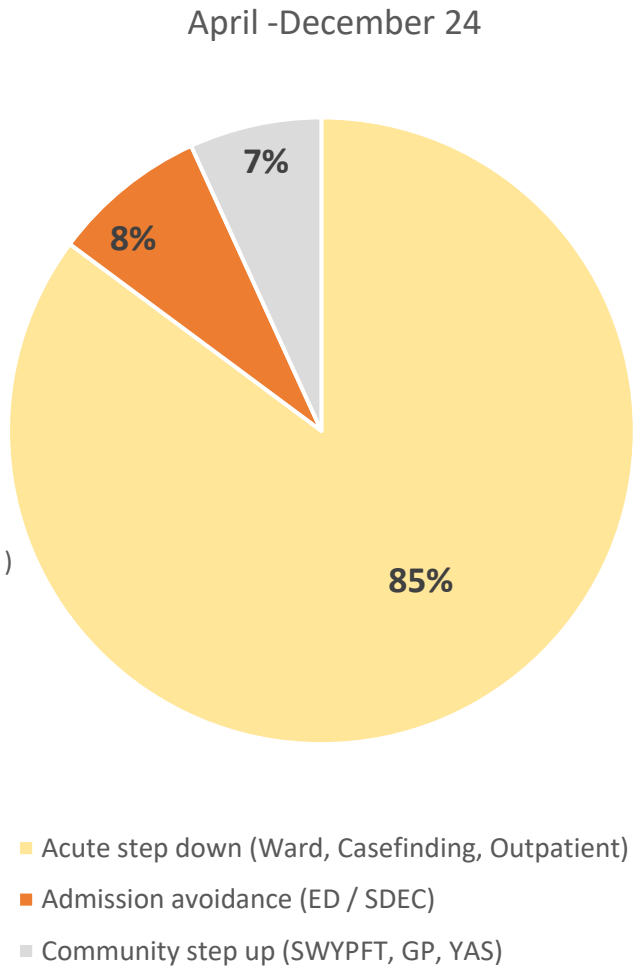
Acute step down (Ward, Casefinding, Outpatient)

Admission avoidance (ED / SDEC)



Respiratory VW Outcomes





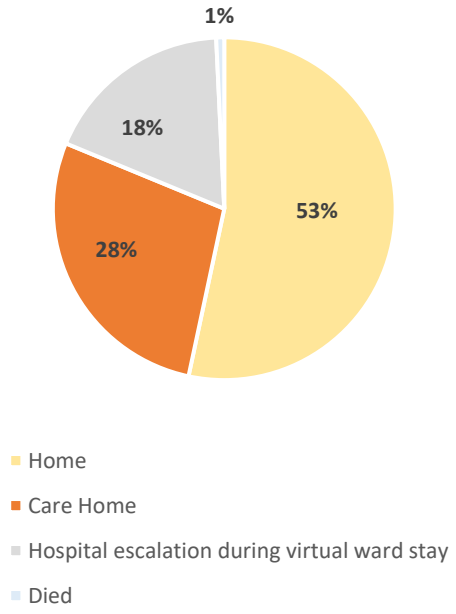
Outcomes

Frailty - 1987 discharges:

Average Length of Stay: 14.04 days.

Acute admission (inc ED attendance during VW stay) 18%

Destination on discharge from Frailty Virtual Ward. October 2022- December 2024



Mortality rate data:

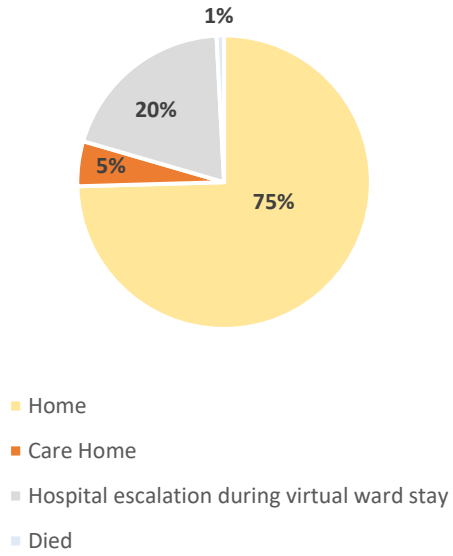
October 2022- December 2024		
Deaths within 30 days of discharge	138	7%
Deaths between 31-90 days of discharge	127	6%

Respiratory -727 discharges:

Average Length of Stay: 13.02 days.

Acute admission (inc ED attendance during VW stay) 20%

Destination on discharge from Respiratory Virtual Ward. October 2022- December 2024



Mortality rate data:

October 2022- December 2024		
Deaths within 30 days of discharge	34	5%
Deaths between 31-90 days of discharge	30	4%

Readmission data- Frailty

South Yorkshire Integrated Care Board

		VW Readmissions					
		Within 7 days		Within 8-28 days		Total 1 - 28 days	
Frailty	Discharges	Number	%	Number	%	Number	%
Oct 22 -March 23	151	3	1.99%	19	12.58%	22	14.57%
Apr 23 - March 24	828	23	2.78%	104	12.56%	127	15.34%
Apr 24 - Dec 24	1006	41	4.08%	123	12.23%	164	16.30%
Total	1985	**67**	**3.38%**	**246**	**12.39%**	**313**	**15.77%**

	BHNFT Average readmission rates				
		Within 7 days		Within 28 days	
Hospital based care		Average	7.7%	Average	21.1%

- The Frailty VW has 4.32% less readmissions in 7 days and 5.33% less readmissions within 28 days compared to the same cohort receiving care in an acute setting.

Readmission data- ARI

NHS South Yorkshire Integrated Care Board

		VW Readmissions					
		Within 7 days		Within 8-28 days		Total 1 - 28 days	
Respiratory	Discharges	Number	%	Number	%	Number	%
Oct 22 -March 23	111	8	7.21%	19	17.12%	27	24.32%
Apr 23 - March 24	277	11	3.97%	46	16.61%	57	20.58%
Apr 24 - Dec 24	338	22	6.51%	46	13.61%	68	20.12%
Total	**726**	**41**	**5.65%**	**111**	**15.29%**	**152**	**20.94%**

	BHNFT Average readmission rates			
		Within 7 days		Within 28 days	
Hospital based care		Average	7.7%	Average	21.1%

- The ARI VW has 2.05% less readmissions in 7 days and 0.16% less readmissions within 28 days compared to the same cohort receiving care in an acute setting.

Frailty VW patient feedback

NHS South Yorkshire Integrated Care Board

100%
Response Rate

Positive: 95.95%
Negative: 2.70%
Ratings

What did you like about virtual ward?

The care from the virtual team was outstanding. They went above and beyond in the care for my mum, and we will be forever grateful for their help in looking after my mum.

Virtual Ward kept me informed of what was happening. They also gave me my blood test results and answered any questions I had efficiently. I have only praise for this team!

Everything was fine by me. Your team were excellent in their work. I don't think anything could have been better, was very good teamwork from your staff. Thanks, and regards to all... 🙂↔🤗

They made me feel important and they looked after me when I needed it.

The ease of access and the follow up service provided by all members of staff. Having this service come to you is a good idea.

I had visits from a nurse practitioner Vicky who was very thorough and caring. I also had regular telephone calls and felt safe at home as if I was in hospital.

Nothing could have been better. The care I have had has been excellent. Knowing there was a lifeline was very reassuring.

Kept in touch and follow up was excellent. Really felt looked after. Nurses were excellent, nothing was too much trouble for them. Got me through a very bad patch.

Felt well supported and able to keep my mum at home. Was great to be able to have contact numbers you can ring if you are worried. As her main carer I felt well supported.

Excellent service lovely staff

I have no complaints. The team were great and a great support to me as a caregiver. My mum is much improved and doing well. The team managed to keep her in her home environment as much as possible. Cannot thank them enough. A great team. Thank you.

Virtual ward have rung me every day regarding my elderly aunt as I care for her, and due to family circumstances, I have been worn out. They have helped get things in place for her; continence nurse and social prescribing to help me with her needs. They have been excellent, and I want to thank all the team.

The care that my husband received was amazing.

This service was excellent for my uncle. The team were very professional, and it was clear they were trying to do everything they could to help him. When he has been admitted to hospital in the past it has made him very confused, so this was perfect for him and a great idea. Thanks to all the team for your help

Nothing could have been better. Everything was excellent, from the staff in the hospital to the staff ringing me every day for a fortnight

Service has been impeccable, friendly and reliable.

The attentiveness of the staff. Had to call out the nursing staff to my mum, quickly came, were very patient and very professional regarding her care. Could not ask for better care. Regular contact on my mum's progress through the care stage. Excellent!

ARI VW patient feedback

NHS South Yorkshire Integrated Care Board

100%
Response Rate

Positive: 90.38%
Negative: 5.77%
Ratings

What did you like about virtual ward?

Excellent service, had a call every other day, everyone was really polite and courteous. This is a really excellent service gives one peace of mind knowing someone is there should you need them. Thankyou for everything.

This service has been a very satisfactory experience, the aftercare is absolutely brilliant.

Nothing could have been done better. I was treated with kindness and respect. Everyone was helpful and reassuring.

They included the Breathe team . Everyone was very helpful.

There is nothing to improve with your service. I found them very helpful

Amazing service looked after me well

For me, nothing could have been better. The care I was given was exemplary and gave me reassurance as I recovered in my own home.

A great service for myself I felt I wasn't on my own if I had a problem, they sorted it out for me. Phone calls reassured me and helped with my recovery. A great service.

Peace of mind that i only had to ring if I had any questions.

I appreciated that the virtual ward kept an eye on me and were only a phone call away if needed

Everything was fine thankyou so much for looking after my darling husband. I was really scared he's my rock my life thankyou all very much

I can't think of any improvements. The service was very helpful with relevant information and advice when asked a few questions regarding my oxygen level and dry throat etc.

I don't think you could have done any better i was very happy with the service.

Everything was so good, even questions I had were answered in a manner that I could understand.

Very pleased with the care and after care.

Everything was perfect

Very satisfied gave peace of mind

Nothing better. Was treated with compassion and respect. Thankyou

The talking was very helpful

Patient feedback areas of improvement

NHS South Yorkshire Integrated Care Board

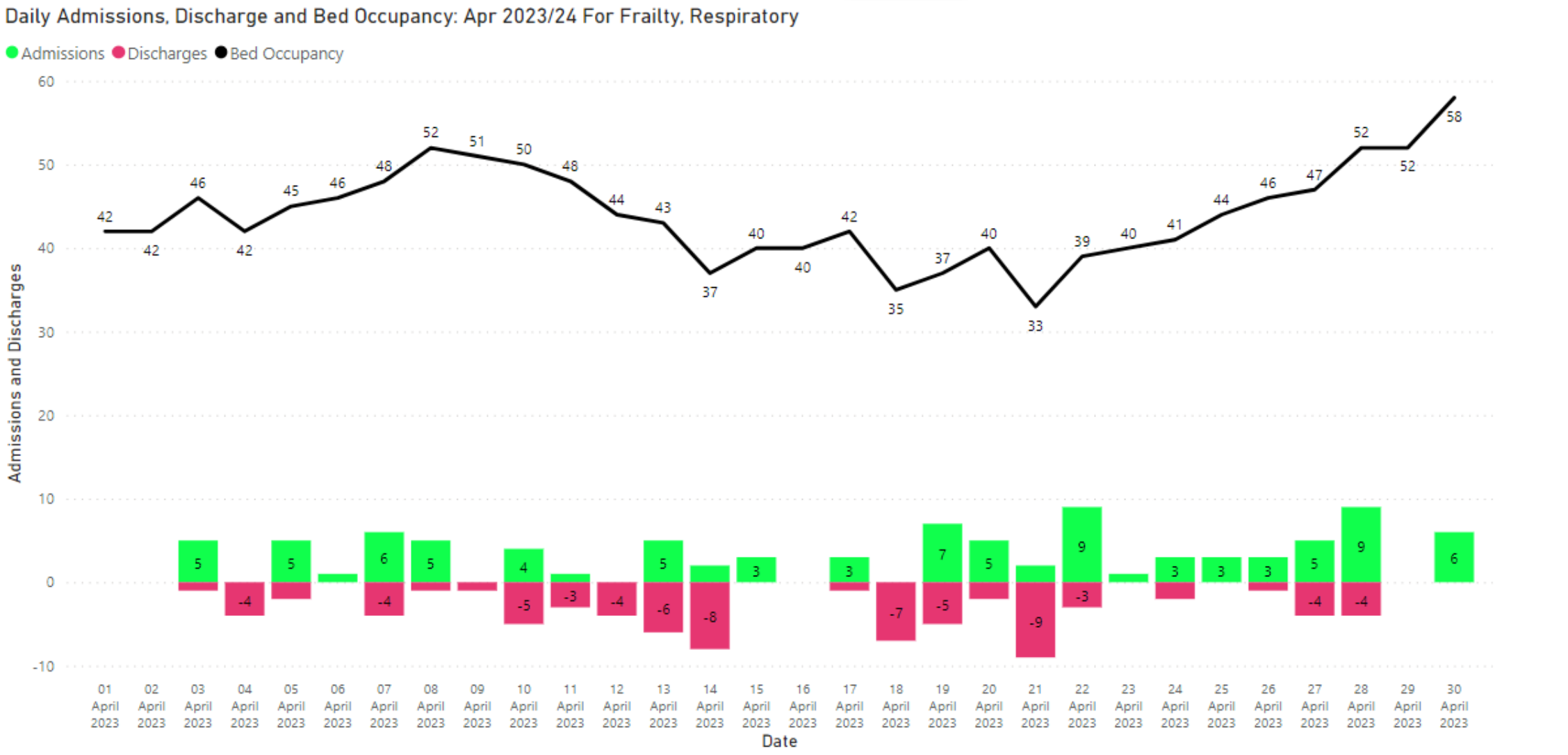
Respiratory:

- Terminology and questions used on digital monitoring could have been clearer around what was meant by “new symptoms” especially when feeling unwell. But noted that there was always a nurse checking up on the patient which they appreciated.
- Frequency of contact and response times for x-ray and blood test results. The patient was referred onto Breathe for ongoing care which they were happy about.
- Communication about virtual ward and what to expect could have been clearer; felt rushed.

Frailty:

- Trouble getting through to the telephone number.
- Asking that staff ring the phone for a little longer to allow time to answer.
- Communication between GPs, patients and Virtual Ward could have been smoother.
- Medication availability closer to home.

Data and Reporting



Good Practice
(GIRFT Feedback)

- There is good data and information collected and reviewed on health conditions and prevalence linked to deprivation levels. This allows the trust to understand which patients are accessing virtual wards and where there may be opportunities to improve.
- The service has been evaluated and identified improved patient outcomes and positive patient feedback.
- Understanding patient experience is a key priority and every patient / carer receives a link to the FFT questionnaire to provide feedback.
- No age cut off for the frailty service.
- Electronic prescribing implemented on the frailty ward.
- First VW in South Yorkshire to roll-out digital monitoring devices.
- Good integration with existing community team and access to a patient 24/7 advice line

Challenges

Pharmacy resource to support virtual ward.

- This is a key risk to developing a sustainable model. Providers need to recruit to Clinical Pharmacist and pharmacy technician's post to help define and improve the service offer.

Workforce redesign

- We're seeing an increased reliance on existing Neighbourhood teams services teams to support these patients and this needs to be considered when planning further pathways.

Ongoing evaluation

- To ensure model is affordable, sustainable and had a positive impact on patient outcomes

Digital monitoring

- Lengthy lead time for procurement delayed progress.
- Patient's report they prefer the regular telephone contact – personalised.
- As this was not embedded during the infancy of our VWs, we have struggled to introduce (especially on frailty VW) due to patient cohort, logistics (esp care home patients), and changing ways of working takes time.
- Looking at other areas and how they've successfully implemented within Frailty and Respiratory pathways.

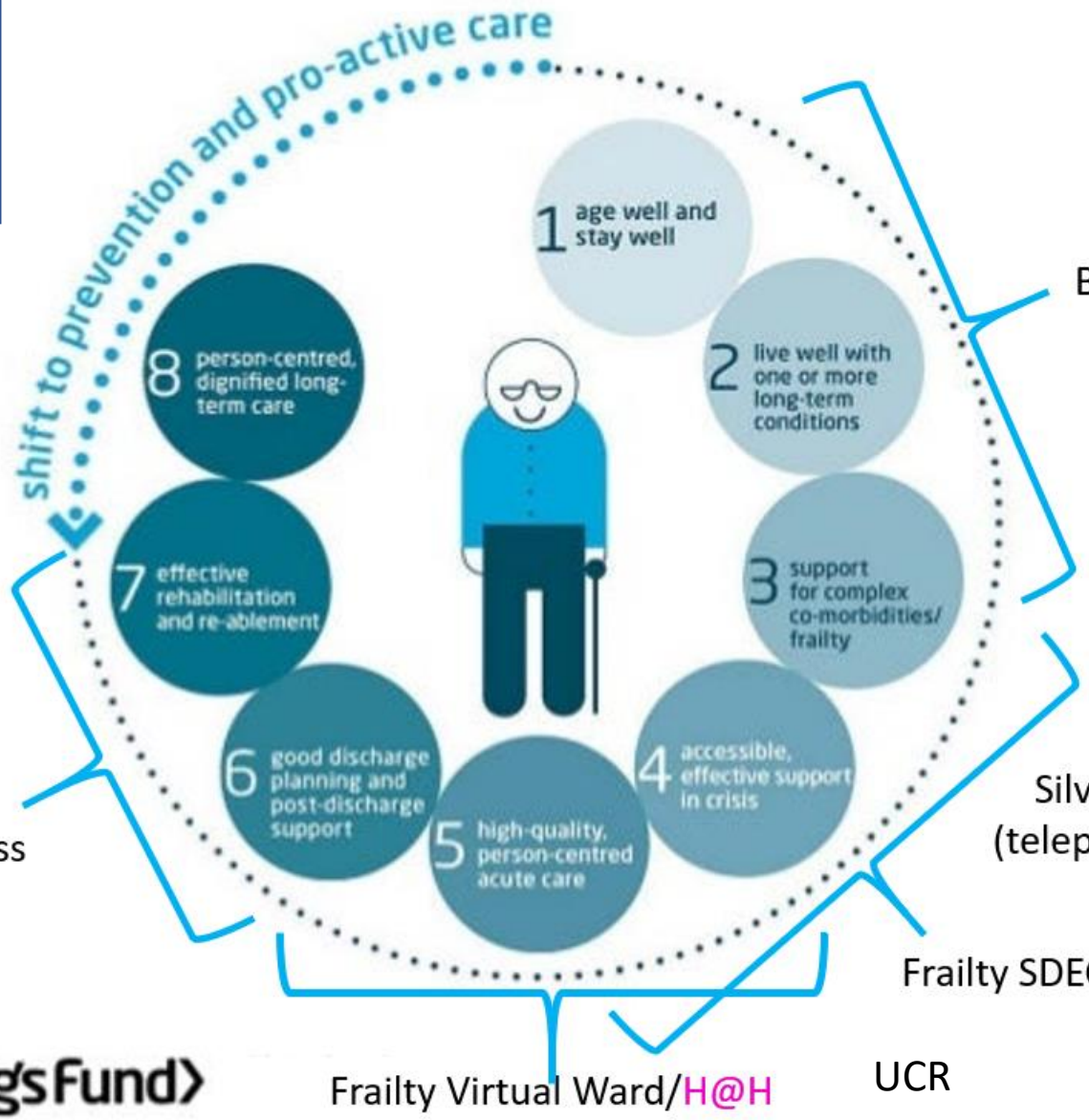
Next Steps/Aspirations

- Increase patient numbers on existing pathways and increase hospital avoidance referrals
- Increase number of patients on remote monitoring
- Greater acuity of patients/true Hospital @ Home model
- AKI pathway
- Heart failure pathway
- Surgical / General medicine pathways

Community Frailty Clinic Pilot - Dearne

Care home liason service /community frailty clinics

NHS South Yorkshire Integrated Care Board



Barnsley Frailty Proactive Care Programme

Acorn Unit

Discharge to Assess

Silver Phone service (telephone support from geriatrician)

Frailty SDEC/ED frailty team

UCR

Frailty Virtual Ward/H@H

The Kings Fund

Dearne Community Frailty Clinic |

British Geriatrics Society
Improving healthcare for older people

BGS

Frailty as an acute condition

Late presentation in crisis (falls, delirium etc)

Hospital, episodic, disjointed, and disruptive

Frailty as LTC

Preventative, proactive care by supported self-management & personalised care planning

Community-based:

person-centred & coordinated

(Health, Social, Voluntary & Mental Health)

Be proactive:
Evidence supporting proactive care for older people with frailty

Who and How

Identify

- eFI/ECLIPSE data + CFS
- Case finding across health and social care
- Own home and care homes
- Frailty needs based, not age

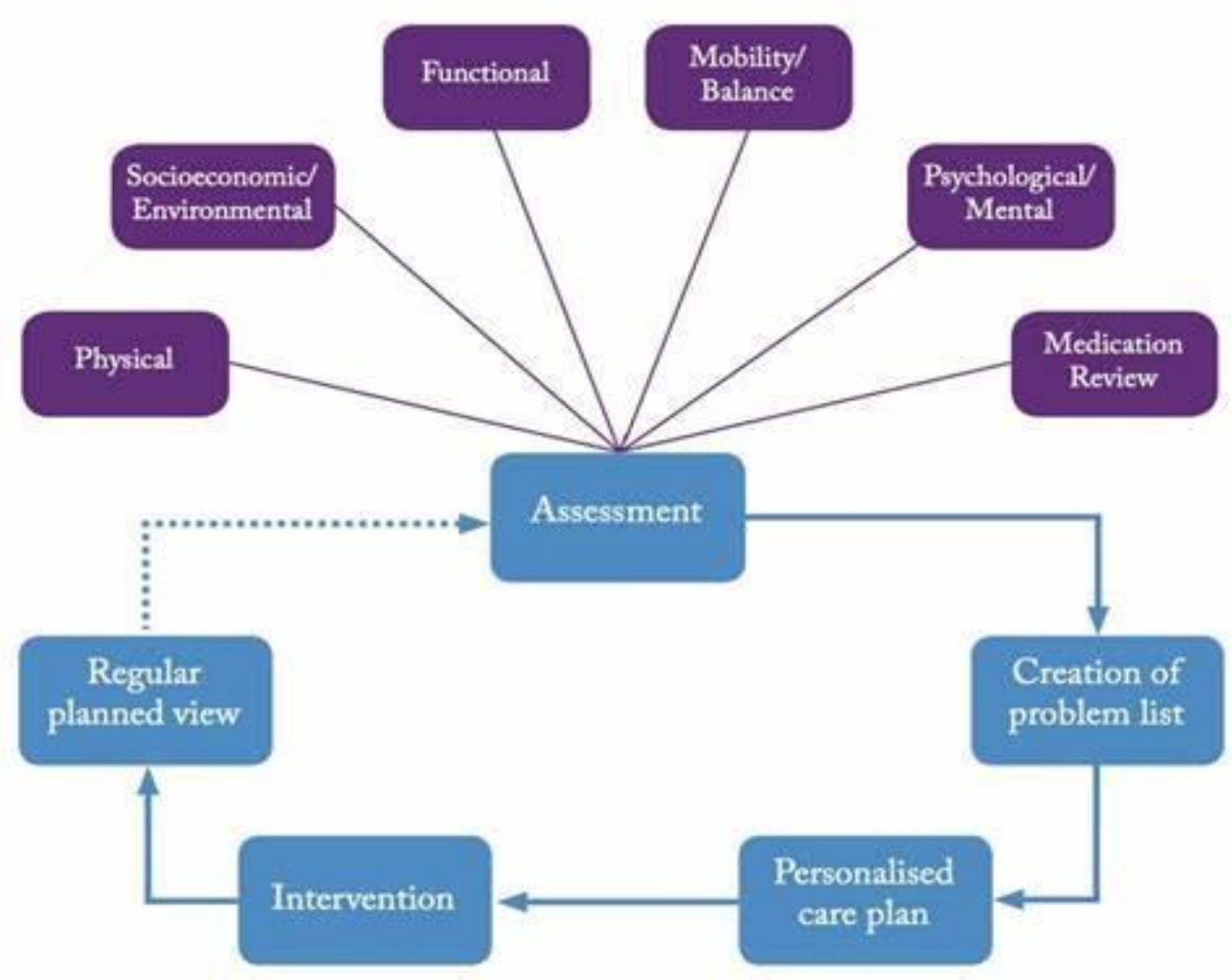
Stratify

- Clinical Frailty Score 5 or more
- Willing to attend clinic
- Able to get to Goldthorpe and get in and out of a vehicle – no service for housebound…yet

Intervene

- Specialist MDT
- Comprehensive Geriatric Assessment
- Includes structured medication review
- Development of personalised structured care plan:
- Patient concerns inventory
- Advance care planning Co-ordination
- Record sharing

Comprehensive Geriatric Assessment (CGA)



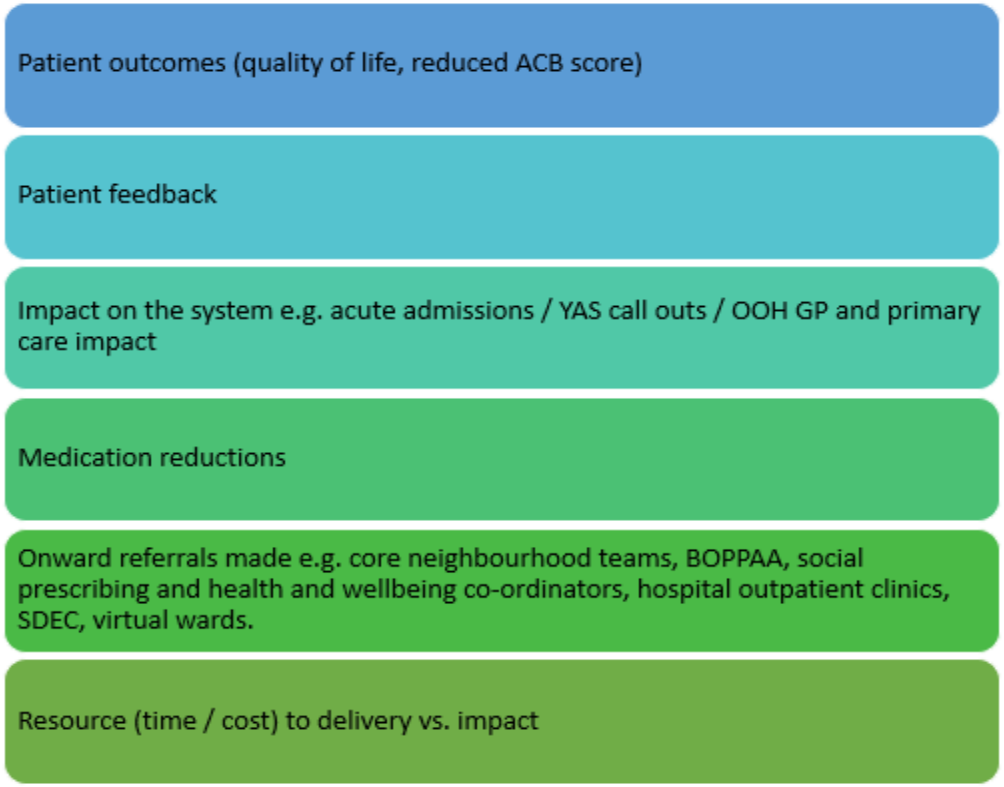
- Care coordinator
- ACP/Community Matron
- Dietician
- Pharmacy
- Physio
- OT
- Geriatrician (virtual review)

- Carousel assessment followed by MDT discussion and agreement of plan

- Majority of workload consumed by the team. May occasionally need GP help.

Data and outcomes

- **Currently evaluating the pilot – ends June 25.**
- Looking at:



- Linking with other areas to look at their delivery models: Jean Bishop Integrated Care Centre for Frailty – very similar offer (but on a much larger scale)

Patient feedback

- Couldn't be happier that they were put forward for this clinic. The outcomes from attending have really changed their life and feel like they are not alone. They felt forgotten about before this clinic and the help that they received, and are still receiving, has been fantastic.
- Felt like there was many subjects discussed to help with him at home. Got him thinking about his personal care at home and how he can make a difference. Physiotherapist has been out already and seen him which he was very happy about.
- Very glad she attended the clinic. The clinic helped her with everything from her medications to what she should be doing at home to make her health better and she was very grateful.
- Fast, friendly and first class.
- The service was great. They have already had involvement from services referred into and are so thankful that they attended. They have found it very supportive and, that before the clinic, they felt forgotten about and are now getting help and support that is right for them.
- Felt believed and of interest. Pleasant and knowledgeable staff

Plans for the future – Frailty Clinics

Upscale clinic numbers – improve efficiency and through put of the clinic

Direct GP referral – initially from the Dearne practices (hoping to launch April 25)

Evaluate and make recommendations for next steps

Further role out of Point of Care testing

e.g. improving access to diagnostics such as X-ray / Ultrasound – neighbouring areas are trialling.

We offer ECG, bladder scanning, Doppla, CRP and other POCT blood analysis in community.

Role of AI for proactive case finding and support with digital record keeping to maximise clinical time.

Barnsley Frailty Offer: A Summary

Palliative

Proactive:
Frailty Clinic
+ all other proactive frailty work e.g. falls, bone health, nutrition, health on the high street etc.

Referral via RCB

Restorative:
Intermediate Care/rehab

Reactive:
UCR
Virtual Ward/H@H
Silver Phone
Frailty SDEC

Rockwood Integrated Services Guide

Reviewing and hoping to develop an **interactive** version (web link) to share with partners in primary care, acute and community.

Integrated service guide

South West Yorkshire Partnership NHS Foundation Trust

Classification and Definition	Reference	Rockwood Score	Patient Description	So What? e.g. Per Service what documents / Referrals / Pathways utilised per service.
LOW Patient is stable / low complexity. Symptoms controlled or needs met by current care plan. Discrete short-term interventions and support may be needed.		1	People are robust, active, energetic, and motivated. They exercise regularly. Among fittest for age.	Undertake personalised care planning conversations and encourage the development of personalised goal setting to achieve positive behaviour change. • Promote the uptake of healthy lifestyle services such as smoking cessation and weight management where deemed appropriate. • Consider nutritional screening to identify any risk of malnutrition • If appropriate, consider offering discussions about advance care planning (utilise advance care planning information booklet to aid conversation if needed). Record any advance care planning on Barnsley future planning incorporating Electronic Palliative Care Coordination Systems (EPaCCS), ticking that palliative care not indicated at this time. Conversation may include: » Statement of preferences and wishes for future care (include likes, dislikes, things that really matter e.g. family, place of care, pets, financial, funeral preferences and planning etc.) e.g. Preferred Priorities for Care (PPC) or alternative document. » Advance decision to refuse treatment to possibly include CPR decision. » Lasting power of attorney – property, finances, health, and welfare.
		2	**Well** People who have no active disease symptoms but are less fit than level. 1. They exercise or are active occasionally.	Undertake activities as per previous score whilst considering the additional points: • Encourage regular activity / exercise and referral to exercise referral schemes. • Consider referral to community exercise groups (e.g. Age UK, BOPPAA)
		3	**Managing well** People whose medical problems are well controlled but are not regularly active beyond routine walking.	Undertake activities as per previous scores whilst considering the additional points: • Provide falls prevention advice / undertake bone health assessment. • Possible referral to equipment, adaptations and sensory impairment service for assessment / provision of equipment and adaptations to manage activities of daily living (i.e. second stair rail / grab rails). • Consider referral to the community equipment service if equipment is needed.
MEDIUM Patient has fluctuating stability / some complexity / expected deterioration Some complexity of symptoms or needs which are mostly met by current care plan at a maintenance level. Occasional exacerbations may require additional management and support.		4	While not dependent on others for help, often symptoms limit activities. Complain of being 'slowed up,' or being tired during the day.	Undertake activities as per previous scores whilst considering the additional points: • Offer advice regarding accessing pharmacy delivery service for medication. • If undernourished, liaise with community nutrition and dietetic service for food first advice and consideration of appropriate nutritional support including nutritional supplements. • Dependent on patient's mobility consider service's ability to deliver care within the home environment. • Undertake medication review and if necessary, liaison with clinical pharmacist. • Discuss the patient and their care requirements at relevant Multidisciplinary Team (MDT) meetings. • Liaise with South West Yorkshire Partnership NHS Foundation Trust in-reach nurse or virtual ward nurses, if patient has been admitted to hospital. • Consider need for continence aids. • Consider social needs and requirements for adult social care assessment. • Consider advance care planning conversations e.g., lasting power of attorney for health and welfare, and for property and affairs (use advance care planning information booklet, advance decisions to refuse treatment decisions. Document and advance care planning on Barnsley future planning incorporating EPaCCs template, ticking palliative care is not indicated currently on the template.
		5	**Mildly frail** People have more evident slowing and need help in higher order independent activities of daily living (e.g. finances, transport, medications).	Undertake activities as per previous scores whilst considering the additional points • Re-review mobility aids. Consider mobility drop-in clinic at New Street. • Consider does patient require bone health supplements. • Consider referral to therapy teams if patient not known to these services. • Ensure key worker has been established and that this has been reviewed since patient became frailer. • Consider referral to community sisters (NNS) for core holistic assessment. • Consider referral to virtual ward if patient escalates / deteriorates, as an alternative to hospital admission. • Begin advance care planning conversations to introduce the concept of advance care planning if not already done so. Document on Barnsley future planning incorporating EPaCCs template ticking palliative care is not indicated currently on the template. Complete baseline modified Karnofsky score in this template.
		6	People need help with all outside activities and house-keeping. Inside they need bathing and may need minimal assistance (cuing) with dressing.	Undertake activities as per previous scores whilst considering the additional points: • Consider referral for driving assessment, where appropriate, or flag with primary care. • Refer to equipment, adaptations and sensory impairment service to aid with re-housing if required. • Consider and review patient's mental capacity to make decisions about their care. • Consider discussing patient at respective MDT's with relevant teams including specialist nursing and therapy. • Consider increasingly complex symptom management e.g. pain, breathlessness, fatigue management. » Consider welfare rights and benefits. » Psychological support for adjustment to change. » Support at all levels for person and carers to manage emotional distress. » Consider spiritual support. • If enteral nutrition support is indicated/required, refer to/liaise with community nutrition and dietetics.
HIGH Patient is unstable / high complexity / complex deterioration Symptoms or needs are unstable or of high complexity. Some unexpected episodes of a deterioration in health with the need to change the care plan. Regular reviews with worsening family distress and or social burden. Condition management and support needed.		7	Completely dependent for personal care, from whatever cause (physical or cognitive.) However not considered high risk of dying within six months.	Undertake activities as per previous scores whilst considering the additional points: • Consider discussions regarding care home respite / long term admission to care homes. Determine if there is Lasting Power of Attorney (LPA) for health and welfare if patient does not have capacity to make these and use the Best Interest process to direct decision-making. Always check LPA documents. Record on Barnsley future planning incorporating EPaCCs template. • Undertake mobility / transfer assessment to maintain independence and/or to assist family/carers maintain patient at home. • Review of equipment and adaptation needs. • Discuss specialist equipment needs e.g. beds, seating etc. • Complete future care planning and emergency treatment plans in case of deterioration (best interest where incapacity determined) • Complete Barnsley future planning incorporating EPaCCs template alongside ReSPECT plan. » Undertake full assessment to consider holistic need. » Consider symptom management » Consider night service offer (via UCR) for any out of hours support to keep people comfortable at home. » Complete modified Karnofsky score. • Ensure key worker documentation is accurate and shared with all relevant care providers.
		8	**Very severely frail** Completely dependent, approaching end of life. Typically, would not recover from minor illness.	Undertake activities as per previous scores whilst considering the additional points: • Re-review capacity for decisions regarding care. • Develop emergency treatment plans for potential deterioration according to previous planning and person's expressed wishes and preferences (may need best interest decision making). • Discussion at GP palliative care MDT. • Update/ start Barnsley future planning incorporating EPaCCS template. Complete modified Karnofsky score. • Medical review including medications review and pre-emptive medication if appropriate and loss of swallow anticipated in next week's / days. • Key worker to trigger deteriorating patient or last days of life care plans when appropriate. If in last days, then 'my care plan' should be used to support care. • Reassess to consider holistic need including physical, social, psychological, spiritual: » Consider symptom management. » Consider social care package and NHS Continuing Healthcare (CHC) funding. » Consider referral to community NHS supportive care at home team for night support and assessment if patient fits CHC fast track criteria » Ensure equipment is in place for current and consider future care need. » Carer assessment and sign posting for support. » Psychological and emotional support. » Consider spiritual support. • Consider ongoing pressure care referral onto tissue viability if required.
		9	**Terminally ill** Approaching end of life. Life expectancy less than 6 months who are not otherwise evidently frail.	Undertake activities as per previous scores whilst considering the additional points: • Undertake relevant moving and handling assessments. • Consider referral to community NHS supportive care at home team for night support and assessment (patient to be fast tracked for CHC fast track funding or meet fast track criteria) • More communication and liaison with GP/matron/district nurses/other Allied Health Professionals (AHPs) and social services. MDT working. • Consider referral to the community specialist palliative care team if needs are complex. • Difference in goals of nutritional intervention (comfort rather than weight difference/prolonging life). Liaise with dietitian for specialist palliative care where needs are complex. • Consider need for continence aids, these are provided with no restrictions on amount per day and type.

Questions