EPUT- FrEDA (Assessment & Review - QOF)

Patient

Name: [I/S]
NHS Number: [I/S]
Address: The Lodge, Runwell Chase
Runwell, Wickford
SS11 7XX
Date of Birth: [I/S]
Telephone:
Mobile Tel.: [I/S] Work number for SMS testing

Done By

Name:
Date:

Introduction

Frailty/Dementia Assessment & Review

Introduction

Please click on the link below to access the template introduction which will explain how the template can be used in your role.

Consent (MCA1 Included)

EPUT Consent Template

Tick from list below whichever may apply

Frail elderly assessment	☐	Resuscitation discussed with patient	☐
Mild cognitive impairment	☐	Personalised Care and Support Plan agreed	☐
Subject of comprehensive geriatric assessment plan	☐		

For Dementia Care Plan ONLY:

Dementia care plan ☐

Dementia care plan codes

Dementia care plan review code

Dementia care plan exception codes

Introduction Information

What makes a difference

New Word letter with 'YoC Questionnaire' template

DIST & DIST SLT Referrals

Refer to EPUT SEE Dementia Intense Support

EPUT- FrEDA (Assessment & Review - QOF)

Patient

Name: [I/S] " NHS Number: [I/S]

Frailty Score / Contents

Frailty/Dementia Assessment & Review - Frailty Score and Contents Links

Rockwood Frailty Score - *please complete at every interaction.*

EPUT Rockwood Based Frailty Score

Frailty Diagnosis for under 65's without Dementia
Tick one

- ☐ Mild frailty (XabdY)
- ☐ Moderate frailty (Xabdb)
- ☐ Severe frailty (Xabdd)
- ☐ Fit and well (Xa96k)

Able Like Mable : https://www.activeessex.org/-able-like-mabel/

Alzheimers Society 'This is Me' booklet: https://www.alzheimers.org.uk/sites/default/files/2019-03/Alzheimers-Society_NEW_This-is--me-booklet_190318.pdf

Fall Proof: https://www.midandsouthessex.ics.nhs.uk/health/campaigns/fall-proof-preventing-falls-and-staying-well/

Mobilising exercises ☐

Quicknavigation

- Physical Health Check
- Medication & polypharmacy review
- Cognition & Mental Health
- Antipsychotics
- Behaviours
- Driving & Risks
- Functional Assessment & Falls Risk Assessment
- Nutrition & Hydration and Swallowing
- Patient Support Needs
- Social History
- Benefits and Management of Finances
- Carer Details
- End of Life
- Electronic Referrals

Set a Recall

New Recall

EPUT- FrEDA (Assessment & Review - QOF)

Patient

Name: [I/S] " NHS Number: [I/S]

Patient Health Check

Frailty/Dementia Assessment & Review - Patient Health Check

EPUT Observations	EPUT - Community Smoking Status
EPUT - Weekly Alcohol Intake	EPUT Abbey Pain Scale
Launch NEWS 2	EPUT Pain Assessment
EPUT Bristol Stool Chart & Guidance	Record Allergy or Sensitivity
Create Reminder	ASSKING Care Bundle
EPUT Waterlow	EPUT UCRT Assessment

Multiple long term conditions ☐

Please record relevant current active Long Term Conditions & symptoms

General symptoms

Please list current active crisis plan in record and state location using pencil icon next to the check box

Emergency health care plan ☐

Continence

Continent	☐	Suprapubic catheter	☐
Incontinence of faeces	☐	Urinary catheter	☐
Urinary incontinence	☐	Trial without catheter	☐
Double incontinence	☐		

Advice

Advice on smoking	☐	Patient advised to lose weight	☐
Patient advised about alcohol	☐		

Wound (Legs & Vascular) Assessment

EPUT SEE Wound Assessment 1

Sepsis Tool: https://sepsistrust.org/professional-resources/clinical-tools/

HbA1c Frailty Levels

HbA1c Frailty Levels: https://nhs.sharepoint.com/:b:/r/sites/99F_PrimaryCareResourceHub/MSEMOC/09.%20Endocrine%20system/Type-%202%20Diabetes%20Mellitus%20Treatment%20Guidelines.pdf?csf=1&web=1&e=HzhTF6

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Patient

Name: [I/S] NHS Number: [I/S]

Medication

Frailty/Dementia Assessment & Review - Medication

Medication review

All acute medication			
Donepezil 1mg/ml oral solution sugar free	5mg	09 Sep 2024	
Rivastigmine 1.5mg capsules	3mg	09 Sep 2024	
Summary of all medication			
Donepezil 1mg/ml oral solution sugar free		1 issue	09 Sep 2024
Rivastigmine 1.5mg capsules		1 issue	09 Sep 2024
All Read coded entries below Medication changed (8B316)			
Alerts and warnings			
Additional Communication requirements			
This patient has specific communication requirements - please review entries within the Accessible Information template view for further details of needs			
Missing demographics for sharing verification			
Reminders			
Active Reminders			
PLEASE DO NOT ADD DATA TO THIS TEST PATIENT			High

Remember Medication can adversely affect cognitive function, Frailty and Risk of falls.

Patient reviewed	☐	Structured medication review	☐
Patient medication advice	☐	Shared decision making	☐
Polypharmacy medication review	☐	History of substance misuse	☐

Medications as reported by patient

Click on links below to see prescribing guidance on medication risks, rationalising meds and reducing polypharmacy:

STOP START: https://www.cgakit.com/_files/ugd/2a1cfa_bcf4d63c427e-4e18963c64e74663728e.pdf

Acetylcholine Burden Guidance: http://www.acbcalc.com/

Compliance - *on selection, please click the pencil icon and specify in the comment box:*

Drug compliance checked	☐	Drug compliance aid requested	☐
Patient understands why taking all medication	☐	Uses dispensed monitored dosage system	☐
Compliance issues discussed with patient	☐	Issue of chronic obstructive pulmonary disease rescue pack	☐

Past medical history

All Read coded entries matching Past medical history (14...)

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Patient

Name: [I/S] " NHS Number: [I/S]

Cognition and MH

Frailty/Dementia Assessment & Review - Cognition & Mental Health

Cognition
Tick one

- ☐ Normal cognition (XaYQx)
- ☐ GDS level 3 - mild cognitive decline (XaJBT)
- ☐ Impaired cognition (Ua189)
- ☐ Delirium (XE1Xv)

Delirium 4 AT Tool Guidance: https://static1.squarespace.com/static/543cac47e4b0388ca43554df/t/57ebb74ad482e9f4d47b414d/1475065676038/-4AT_1.2_English.pdf

Assessment using 4AT (4 As Test) ☐ 4AT (4 As Test) score

History of Dementia - *only tick if there is a formal diagnosis*

H/O: dementia ☐

EPUT - SEE MASS Diagnostic Assessment

EPUT - CN Dementia - Staging Tool

EPUT - CN Dementia - Global Deterioration Scale

New Diagnosis of Dementia ONLY

■ Dementia Register

Dementia medication review done ☐

Cognitive function observations

Mood / Anxiety / Mental health issues

Level of Mood

Mental Capacity

Mental capacity assessment ☐

Lacks capacity to give consent (Mental Capacity Act 2005) ☐

Best interest decision made on behalf of patient (MCA 2005) ☐

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Patient

Name: [I/S] NHS Number: [I/S]

Antipsychotics

Frailty/Dementia Assessment & Review - Antipsychotics

Antipsychotics should be used with extreme caution and consider referral to OP CMHT prior to use. When used antipsychotics should be time limited and regularly reviewed (at least every three months).

EPUT - CN Antipsychotics in Older People.

Antipsychotic drug therapy for dementia ☐

Antipsychotic medication review ☐

EPUT Observations

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Patient

Name: [I/S] NHS Number: [I/S]

Behaviours

Frailty/Dementia Assessment & Review - Behaviours

Adult protection issues

Vulnerable adult ☐ Referral to safeguarding adults team ☐

For patients/carers living in Southend or Thurrock please contact their local councils directly to report safeguarding concerns:

Refer to EPUT SEE Dementia Intense Support

Essex Safeguarding : https://www.essexsab.org.uk/reporting-concerns

Thurrock Council Safeguarding: https://www.thurrock.gov.uk/keeping-safe-from-abuse/reporting-concerns

Southend Council Safeguarding: https://www.southend.gov.uk/social-care/reporting-concern

DATIXReported - *please record incident number below:*

Incident details

If at risk of wandering consider completing the police 'Herbert protocol':

Herbert Protocol: https://www.essex.police.uk/notices/af/herbert-protocol/

Questions to ascertain carer stress or behaviours that challenge
For the person with dementia - **Does your imagination ever play tricks on you?**
For the carer - **Does the person you are caring for do or say anything to make you feel uncomfortable?**

Feeling agitated	☐	Self-neglect	☐
Verbal aggression	☐	Wandering	☐
Physical aggression	☐	Inappropriate sexual behaviour	☐

Consider early referral to OP CMHT & Care Home Liaison teams

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Patient

Name:[I/S] NHS Number:[I/S]

Driving and Risks

Frailty/Dementia Assessment & Review - Behaviours - Driving & Risks

Driving - *Dementia is a condition that you need to tell the Driver & the DVLA about*

Driving status
Tick one

- ☐ Does drive a car (Xa7fg)
- ☐ Does not drive a car (Xa7fh)
- ☐ Driving licence class 1 (Y3088)
- ☐ Driving licence class 2 (Y3089)

Alzheimers Org - Driving & Dementia: https://www.alzheimers.org.uk/info/20030/staying_independent/27/driving

DVLA Form: https://www.gov.uk/dementia-and-driving

Patient advised about driving	☐	Patient advised to inform DVLA	☐
Education : Implications to license	☐	Patient advised to inform insurance company	☐

Risks

Fire Safety Visit: https://www.essex-fire.gov.uk/book-home-safety-visit

Risk of self neglect	☐	Multiple long term conditions	☐
At risk of falls	☐	Social isolation	☐
Drug compliance poor	☐	Carer can no longer cope	☐
Patient themselves providing care	☐	Antipsychotic drug therapy for dementia	☐

Referral

Referral to voluntary service	☐	Referral to counselling service	☐
Referral to community mental health team	☐	Referral to pharmacy service	☐

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Patient

Name: [I/S] NHS Number: [I/S]

Functional ADL Assessment

Frailty/Dementia Assessment & Review - Functional ADL Assessment

General wellbeing

Mobility
Tick one

- ☐ Fully mobile (13C1.)
- ☐ Mobile outside with aid (13C2.)
- ☐ Mobile in home (13C3.)
- ☐ Housebound (13CA.)
- ☐ Needs walking aid in home (13C4.)
- ☐ Confined to chair (13C5.)
- ☐ Bed-ridden (13C6.)

Activities of Daily Living

Housebound ☐

Washing
Tick one
- ☐ Able to wash self (Xa2uI)
- ☐ Unable to wash self (Xa2uJ)

Dressing
Tick one
- ☐ Able to dress (Xa2xE)
- ☐ Needs help with dressing (3951.)

Feeding
Tick one
- ☐ Able to feed self (Xa4KZ)
- ☐ Unable to feed self (Xa4Ka)

Medication
Tick one
- ☐ Able to manage medication (Xa2yC)
- ☐ Unable to manage medication (Xa2yD)

Housework
Tick one
- ☐ Independent in housework (XaXkx)
- ☐ Needs help with housework (Xalwu)

Shopping
Tick one
- ☐ Able to perform shopping activities (Xa7h0)
- ☐ Needs assistance with shopping (XaXZQ)
- ☐ Unable to perform shopping activities (Xa7h1)

Falls/Risk

Falls
Tick one
- ☐ Low risk of falls (XaObN)
- ☐ At moderate risk for fall (Y1f0a)
- ☐ At high risk of falls (XaZHg)

Falls risk assessment complete ☐

Recurrent falls ☐

Referral to falls service ☐

Orthostatic hypotension ☐

At risk of osteoporotic fracture ☐

Osteoporosis medication prophylaxis ☐

Transfers

Ability to transfer

Please record number of falls experienced by patient in the last month

EPUT Rockwood Based Frailty Score

Frailty Diagnosis for under 65's without Dementia
Tick one
- ☐ Mild frailty (XabdY)
- ☐ Moderate frailty (Xabdb)
- ☐ Severe frailty (Xabdd)
- ☐ Fit and well (Xa96k)

FRAX Score - *use pencil to record action taken*

FRAX Score ____ %

WHO FRAX with BMD ____ %

Mobilising exercises ☐

Fraxs and Osteoporosis:
https://frax.shef.ac.uk/FRAX/tool.aspx?country=1

FRATScreening

FRAT Screening Tool

Able Like Mable:
https://www.activeessex.org/able-like-mabel/

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Patient

Name: [I/S] " NHS Number: [I/S]

Nutrition and Hydration

Frailty/Dementia Assessment & Review - Nutrition & Hydration

IDDSI Fluid Stage
Tick one

- ☐ Able to swallow thin drinks - IDDSI (International Dysphagia Diet Standardisation Initiative) level 0 (Y1ca
- ☐ Able to swallow slightly thick drinks - IDDSI (International Dysphagia Diet Standardisation Initiative) level
- ☐ Able to swallow mildly thick drinks - IDDSI (International Dysphagia Diet Standardisation Initiative) level 2
- ☐ Able to swallow moderately thick drinks - IDDSI (International Dysphagia Diet Standardisation Initiative) l
- ☐ Able to swallow extremely thick drinks - IDDSI (International Dysphagia Diet Standardisation Initiative) le

IDDSI Food Stage
Tick one

- ☐ Able to swallow liquidised food - IDDSI (International Dysphagia Diet Standardisation Initiative) level 3 (Y
- ☐ Able to swallow pureed food - IDDSI (International Dysphagia Diet Standardisation Initiative) level 4 (Y1e
- ☐ Able to swallow minced and moist food - IDDSI (International Dysphagia Diet Standardisation Initiative) le
- ☐ Able to swallow soft and bite-sized food - IDDSI (International Dysphagia Diet Standardisation Initiative) l
- ☐ Able to swallow easy to chew food - IDDSI (International Dysphagia Diet Standardisation Initiative) level
- ☐ Able to swallow regular food - IDDSI (International Dysphagia Diet Standardisation Initiative) level 7 (Y1c

IDDSI

IDDSI Dysphagia Framework

MUST

Malnutrition Universal Screening Tool - MUST

Nutritional Status

Nutrition
Tick one

- ☐ Poor nutrition (XaLT8)
- ☐ Well nourished (X76Bi)

Swallowing - *please record observations using pencil icon*

Swallowing difficulty identified ☐

Hydration Adequate ☐

Risk feeding document completed ☐

To be completed by relevant trained staff ONLY

At risk for aspiration ☐

GULP

GULP Assessment

Neuro SLT Referrals ONLY

Refer to EPUT SEE Speech and Language Therapy

Referral to speech and language therapy service ☐

Dysphagia ☐

Web Links

Patient Resource: Eating & Drinking:
https://www.alzheimers.org.uk/get-support/daily-living/eating-drinking

Food First:
https://nhs.sharepoint.com/sites/99F_PrimaryCareResourceHub/MSEMOC/Forms/AllItems.aspx?id=%2Fsites%2F99F%5FPrimaryCareResourceHub%2FMSEMOC%2F12%2E%20Nutrition%20and%20blood%2FOral%20nutritional%20supplements%2FFood%2DFirst%2DAdvice%2DMaking%2Dyour%2Dfood%2Dwork%2Dfor%2Dyou%2Epdf&parent=%2Fsites%2F99F%5FPrimaryCareResourceHub%2FMSEMOC%2F12%2E%20Nutrition%20and%20blood%2FOral%20nutritional%20supplements

ONS Guidelines:
https://nhs.sharepoint.com/sites/99F_PrimaryCareResourceHub/MSEMOC/Forms/AllItems.aspx?id=%2Fsites%2F99F%5FPrimaryCareResourceHub%2FMSEMOC%2F12%2E%20Nutrition%20and%20blood%2FOral%20nutritional%20supplements%2FONS%2DFull%2Dguideline%2Epdf&parent=%2Fsites%2F99F%5FPrimaryCareResourceHub%2FMSEMOC%2F12%2E%20Nutrition%20and%20blood%2FOral%20nutritional%20supplements

End of Life Frailty Nutrition:
https://www.bgs.org.uk/resources/end-of-life-care-in-frailty-nutrition

continued on next page

Patient

Name:[I/S] NHS Number:[I/S]

Nutrition and Hydration (continued)

IDDSI:
https://iddsi.org/Framework

End of Life Frailty Dysphagia:
https://www.bgs.org.uk/resources/end-of-life-care-in-frailty-dysphagia

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Patient

Name: [I/S] " NHS Number: [I/S]

Patient Support Needs

Frailty/Dementia Assessment & Review - Patient Support Needs

***Please state if the patient is receiving any support from the following*:**

Under care of social services	☐	Under care of forensic psychiatrist	☐
Receives help from voluntary agency	☐	Under care of mental health team	☐
Attending day centre	☐	Under care of psychiatrist	☐
Under care of occupational therapist	☐	Under care of speech and language therapist	☐

Referrals

Referral required

Refer to IAPT

Refer to EPUT SEE Therapy For You / IAPT

Senses (vision & hearing) and Communication (reading & writing)

Hearing
Tick one

- ☐ Hearing normal (1C11.)
- ☐ Hearing difficulty (1C12.)
- ☐ Partial deafness (1C132)
- ☐ Profound deafness (Y017f)
- ☐ Hearing aid worn (Xa0LN)

Wears glasses ☐

Vision
Tick one

- ☐ Normal vision (668A.)
- ☐ Registered partially sighted (Xa7nF)
- ☐ Registered blind (6689.)

Wears contact lenses ☐

Communication, speech and language observations

Reading
Tick one

- ☐ Difficulty reading (XaBmg)
- ☐ Unable to read (XaBmf)
- ☐ Able to read (XaBme)

Writing
Tick one

- ☐ Able to write (XaAzO)
- ☐ Difficulty writing (XaAzQ)
- ☐ Unable to write (XaAzP)

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Patient

Name: [I/S] NHS Number: [I/S]

Social History

Frailty/Dementia Assessment & Review - Social History

EPUT Ethnicity, Religion, Spiritual & Cultural

Provision of social services care package ☐ Living temporarily in care home ☐

Discharge (D2A) Pathway
Tick one

- ☐ Pathway 0 (Discharge to assess model) - No additional support (Y33ad)
- ☐ Pathway 1 (Discharge to assess model) - Additonal support at home / usual residence
- ☐ Pathway 2 (Discharge to assess model) - Rehab +/- reablement in a temporary beddin
- ☐ Pathway 3 (Discharge to assess model) - Complex (Y33b0)

Permanent Residence Only

Place of Residence
Tick one

- ☐ Lives in own home (13KD.)
- ☐ Lives in a nursing home (13F61)
- ☐ Lives in a residential home (XaImT)
- ☐ Lives in sheltered housing (13F40)

Lives with

Access *(including keysafe)*

Access

Patient & Carer Personal Concerns and Goals

Identifying personal goals

Social Circumstances *(see preset notes)*

Social circumstances

Social isolation ☐

Activities*(see preset notes)*

Activities of everyday life

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Patient

Name: [I/S] NHS Number: [I/S]

Benefits and Management of Finances

Frailty/Dementia Assessment & Review - Benefits and Management of Finances

Benefits, entitlements and rights

Benefits received ☐

No benefits received ☐

Completion of SR1 medical report ☐

Application for funding

Management of financial affairs

Lasting Power of Attorney

Personal Welfare
Tick one

- ☐ Lasting power of attorney personal welfare (XaOc5)
- ☐ Has appointed person with personal welfare LPA (MCA 2005) (XaYlg)
- ☐ Has apnt persn persnl welf LPA auth life sust decns MCA 2005 (XaYlh)

Property & Affairs
Tick one

- ☐ Lasting power of attorney property and affairs (XaOc4)
- ☐ Has appointed person with property and affairs LPA MCA 2005 (XaYlf)

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Patient

Name: [I/S] NHS Number: [I/S]

Carers Details

Frailty/Dementia Assessment & Review - Carers

If the carer is registered at your practice, they should be offered a Carer's Annual Health Check. If Carer is registered elsewhere, please advise them to contact their usual GP to discuss. ***The Carer's health check MUST be completed within the carer's own patient record. Only use the below health check template if the patient is a carer for someone else.***

Has a carer ☐ EPUT CN Dementia - Carers Health Check

Carer consents for their details to be held on patient record ☐ Patient consent given to contact carer about care ☐

Patient's next of kin

Record Relationship

Carer Contingency Health Plan

Primary carer	☐	Emergency contact details	☐
Patient themselves providing care	☐	Carer health check offered	☐
Is no longer a carer	☐	Carer health check declined	☐
Informal carer	☐	Carer health check completed	☐
Carer of a person with physical disability	☐	Carer health check	☐
Carer of a person with learning disability	☐	Carer annual health check declined	☐
Carer	☐	Carer annual health check	☐
Has Carer Contingency Plan	☐		

Patient

Name: [I/S] NHS Number: [I/S]

End of Life

Frailty/Dementia Assessment & Review - End of Life

EPUT PEPSI COLA / Palliative Care Template

GSF Status

GSF Status
Tick one

- ☐ GSF prognostic indicator stage A (blue) - yr plus prognosis (XaZb7)
- ☐ GSF prognostic indicator stage B (green) - months prognosis (XaZbA)
- ☐ GSF prognostic indicator stage C (yellow) - weeks prognosis (XaZbD)
- ☐ GSF prognostic indicator stage D (red) - days prognosis (XaZbE)

GSF Proactive Indentification Guidance (all conditions) - *click link below*

GSF Guidance:
https://www.goldstandardsframework.org.uk/cd-content/uploads/files/PIG/NEW%20PIG%20-%20%20%2020.1.17-%20KT%20vs17.pdf

Diabetes EoL Guidance - *click link below*

Diabetes EoL Guidance:
https://trenddiabetes.online/portfolio/end-of-life-guidance--for-diabetes-care/

Is the patient reaching the last years of life (consider severe frailty and Rockwood Score of 7, 8 or 9)?
Please consider whether this person may be nearing toward the end of their life using either one or both of the suggested symptom/ indicator guidance tools- GSF Prognostic Indicator Symptom guidance (GSF PIG- see link below) and/ or, for those aged over 65, who have a clinical frailty Rockwood score of 7,8 or 9 /or any adult with a level of frailty deemed severe/very severe.

Treatment Escalation Plan Completed ☐

Preferred Place of Care
Tick one

- ☐ Preferred place of care - home (XaQTk)
- ☐ Preferred place of care - community hospital (XaQU4)
- ☐ Preferred place of care - hospice (XaQU3)
- ☐ Preferred place of care - care home (XaaYt)
- ☐ Preferred place of care - hospital (XaQU5)
- ☐ Preferred place of care - nursing home (XaQU7)

Preferred Place of Death
Tick one

- ☐ Preferred place of death: home (XaJ3g)
- ☐ Preferred place of death: community hospital (XaJ3i)
- ☐ Preferred place of death: hospice (XaJ3h)
- ☐ Preferred place of death: residential home (XaQiX)
- ☐ Preferred place of death: hospital (XaJ3j)
- ☐ Preferred place of death: nursing home (XaJ3k)

DNACPR

Not for attempted CPR (cardiopulmonary resuscitation) ☐

For attempted cardiopulmonary resuscitation ☐

Resuscitation discussed with patient ☐

Resuscitation discussed with carer ☐

Not aware of DNACPR clinical decision ☐

EPUT End of Life Template

Information About Me (I.A.M) patient document

MSE PEACE Community Document 2025

Refer to EPUT SEE Palliative Care Services

DNACPR form MSE for Community 2025

HPAL MSE:
https://mse.medindex.co.uk/c

Has end of life advance care plan ☐

Preferred priorities for care discussed ☐

Patients with emergency drugs
Tick one

- ☐ Prescription of palliative care anticipatory medication (XaaD3)
- ☐ Prescription of anticipatory care medication declined (Xabv1)
- ☐ Prescription of anticipatory care medication not appropriate (Xabvh)

continued on next page

Patient

Name [I/S] NHS [I/S]

End of Life (continued)

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Electronic Referrals

Frailty/Dementia Assessment & Review - Electronic Referrals

UCRT (formally SWIFT) Referrals

EPUT Essex Community Crisis Team

Essex Community Crisis Team: This referral is for people who are presenting with a range of conditions including but not limited to: acute exacerbation of long term conditions, viral and bacterial infections, urinary tract infections, frailty syndromes.

EPUT SEE Palliative Care Services

Palliative Care Services: This referral is for people with advanced and progressive illness that cannot be cured.

DIST & DIST SLT Referrals

EPUT SEE Dementia Intense Support

Dementia Intensive Support: Please use for urgent referrals to DIST, Dementia SLT, Routine Dementia review and Dementia Diagnostic Pathways – please select the appropriate service offer and a note of the reason for referral.

EPUT SEE Care Coordination Service

Care Coordination: This referral is for people aged 18+ who are presenting with some form of frailty linked to a long term condition.

EPUT SEE Tissue Viability

SEE Tissue Viability: This referral is for prevention of pressure ulcers and tissue damage offering specialist advice, assessment and treatment regardless of age.

EPUT Bladder & Bowel Service

SEE Adult Bladder and Bowel Specialist Service: This referral is for people who require assessments for complex bowel and bladder problems. This may include pelvic floor assessment and exercises, bladder retraining, pelvic floor stimulation and feedback, intermittent catheterisation, food fluid and toileting advice. Information on aids gadgets and pad products.

Refer to EPUT SEE Occupational Therapy

SEE Occupational Therpy: This referral is for adult patients who have a health or medical condition that affects their ability to live independently at home and/or which significantly affects their quality of life. The OT team work with patients in their own homes and addresses long and short-term health needs.

EPUT SEE Integrated Adult Services

SEE Integrated Adult Services: This referral is for people who are housebound and require services provided by district nursing team.

Refer to EPUT SEE Adult Diabetes Service

SEE Adult Diabetes - The Community Diabetes Service is a nurse led service that facilitates self-management, enabling people with diabetes to make the necessary adjustments to remain well, reducing mortality, morbidity and the need for hospitalisation. Referrals are accepted from GP, other Health Care Professionals, Self-referral accepted for advice line but GP referral needed if on-going care required.

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Patient

Name: [I/S] NHS Number: [I/S]

Electronic Referrals cont.

Frailty/Dementia Assessment & Review - Electronic Referrals

Neuro SLT Referrals only

- EPUT SEE Speech and Language Therapy
- New Word letter with 'Community SLT Ref...
- Refer to EPUT SEE Community Podiatry S...
- Refer to EPUT SEE Heart Failure Service
- Refer to EPUT SEE Community Integrated ...
- Community Physio - New Referral Form

SEE Speech and Language: This referral is for people in the South East Essex area with communication and/or swallowing problems arising from neurological conditions (including stroke, head injury, brain tumour, Parkinson's disease, multiple sclerosis, motor neurone disease) and people with voice and fluency (stammering) disorders.
SEE Community Podiatry: This referral is for patients who meet the following criteria: • Diabetes and have a podiatric need. • People with an active foot problem e.g. ulcers, corns and callous in patients that have a health problem that puts them at risk such as diabetes, circulatory disorders, daily steroid tablets, current chemotherapy, neurological problems, inflammatory arthritis for example rheumatoid arthritis, ulcers. • A systemic medical condition, which may render their limbs at risk and have a podiatric need.
Community Heart Failure: The Community Heart Failure Service provides specialist evidenced based treatment, management, advice and support for adults aged 18 years and over with a confirmed diagnosis of heart failure.
Criteria for referral: A confirmed diagnosis of heart failure on recent echocardiogram; which shows either a reduced left ventricular ejection fraction lower than 45% (HFrEF) or heart failure with preserved left ventricular function (HFpEF) and are symptomatic due to fluid overload.
Community Integrated Respiratory Service : Specialist Community Nursing: The Community Integrated Respiratory Service covers the service provisions of Community Respiratory Nurse Specialist and Home Oxygen Assessment and Review (HOSAR). Criteria for referral to: Community Respiratory Nurse Specialist

- COPD which has been confirmed by spirometry assessment
- Interstitial Lung Disease (ILD) including pulmonary fibrosis
- Bronchiectasis
- Nonspecific interstitial pneumonia (interstitial pneumonitis)

Community Physio: This is a service that is able to support patients in their own home if they require physio therapy; they are also able to review patient mobility equipment etc.

EPaCCS (End of Life Referrals)

- Refer to EPUT SEE Palliative Care Services
- Refer to Provide Mid Essex EPaCCS
- Refer to St Luke's Hospice, Carers Suppo...

MSE Frailty Register

- Refer to MSE eFraCCS Frailty register

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Patient

Name: [I/S] " NHS Number: [I/S]

Introduction Statement

Frailty/Dementia Assessment & Review

Introduction Statement

The fields in this template can be used by professionals across both health and social care (in either primary care/community, intermediate care or hospital settings) when assessing adults who may have any element of Frailty, Dementia and /or who may have End of life (EOL) care assessment needs. Using this template can improve quality and coordination of care between all professionals and it can improve the health and care outcomes for the individual who is being assessed.

It can be used to assess/review those with Frailty, Dementia and/or those near End of life (or any combination of these needs which may be present together).

This is a consultation aid and does not intend to provide a rigid structure. Parts or all can be completed by any one of a qualified multi-disciplinary team (MDT) of professionals -Including GPs, hospital doctors, nurses, complex care/ specialist health teams, clinical pharmacists, mental health teams, social care professionals and therapists (physiotherapy, occupational therapy, SALT etc) -either separately or together as part of an MDT assessment.

Not all of the content may be relevant to the person who is being assessed. It is also not required to complete the relevant parts all at once. The sections relevant to your professional role and /or which are relevant to the needs of the person being assessed (as appropriate) can be completed at the professional's discretion.

It is good practice to proactively reassess people regularly as required -especially where there is a noted change in health or care needs, new emergent problems or the condition of the person is changing- (including following any recent hospital admission/crisis care need.)
It can also be completed as part of a proactive annual/ or 6 monthly review.

For emergency referrals contact
Community Coordination Centre [I/S]

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