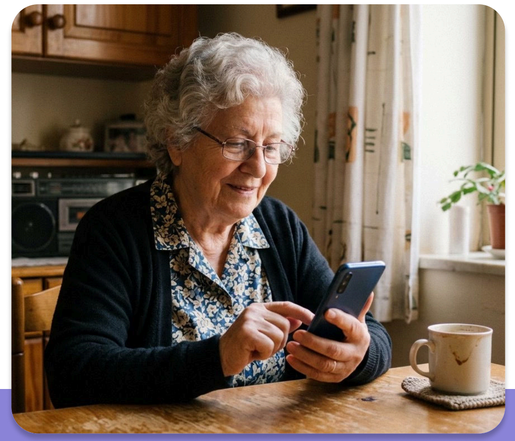


The Frailty Patient Pathway

Navigating the Frailty pathway within the Neighbourhood Health Hub

This pathway illustrates each stage of a patient's journey within NHS Frailty Services; from initial patient contact through to follow-up and care plan. EBO's Neighbourhood Health Hub encompasses the patient journey in one place enhancing access, efficiency, and outcomes at each step. This enables neighbourhood teams to work together and view patient records without requiring EPR access.

01

Patient Initiating Contact

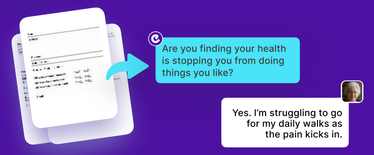
Sandra is experiencing hip pain. She accesses **EBO's Neighbourhood Health Hub,** where she is greeted by the Virtual Assistant (VA) which asks her about her symptoms.

02

Assessment Triage Form Sent

Based on Sandra's responses the VA sends over a digital assessment triage form, informed by relevant assessments such as the Comprehensive Geriatric Assessment.

- **Consistent data capture, risk alerts, integration to EPR**

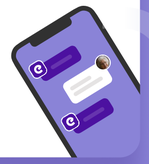


03

Form Completion & Support

Sandra fills out the form directly within the Hub, asking the VA for support whenever she gets stuck.

- Tedious paper forms transformed into a digital two-way conversation. Patient is automatically matched to the correct clinical pathway.



04

Triage Activity & Patient Record Updated

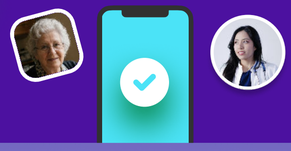
The completed assessment is sent to Sandra's appropriate GP administrative team, who receive an instant notification. The information is simultaneously linked to Sandra's patient record.

05

Clinical Review

The relevant clinician reviews Sandra's triage form to determine the most appropriate next steps.

- **Reduces manual triage time; flags risk for clinical review**



06

Appointment Notification

Sandra receives an SMS notification confirming her first appointment; a home visit by the frailty team.

- **Keep patient informed, removes the need for telephone contact.**

07

Treatment Sessions

During the home visit, the frailty team carry out a holistic assessment and work with Sandra to formulate a personalised care plan and identify any additional needs.

08

Clinical Record Updated & Staff informed

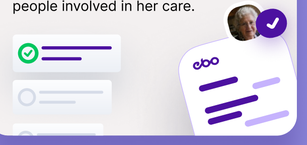
The team update Sandra's clinical record with the care plan and assessment findings. Relevant staff members are informed and can access all information in the Neighbourhood Health Hub.

- **A central source of information for staff, easily shared across different clinical and record-keeping systems.**

09

Patient-driven Recovery

Sandra receives her care plan directly through the Neighbourhood Health Hub. She can now follow it and show it to all people involved in her care.



10

Seamless Information Sharing

The Multi-Disciplinary Team (MDT) is notified of the care plan and onward pathways, including referrals to relevant Allied Health Professionals who are all working towards keeping Sandra safe and independent at home.