**Ashford Rapid Access Clinic**

HCA for BP & Bloods. Plus any other tests requested following triage of referral letter. Appt in RAC asap.

**Refer to Ashford Rapid Access Clinic**

**How? Via eRS –Referral Services**

**Requires soon medical review only**

**A Brief Guide for North West Surrey GPs on services available for patients with Frailty**

**THINK FRAILTY**

**Patient requires routine or soon comprehensive assessment in the community**

**Refer to SAMS outpatient clinic**

**How? eRS – Referral Services**

**SAMS outpatient clinic or Ashford Rapid Access Clinic** Following triage by Consultant pt given appropriate clinic appointment slot

**Requires routine medical review only**

**Requires routine or soon MDT assessment**

**Assessment at proactive frailty service:**

* Comprehensive Geriatric Assessment service, creating individual management plans
* Post discharge reviews for patients discharged from hospital
* Patients with frailty score between 4 and 8 can be referred

**Refer to proactive frailty service at Locality Hub**

**How?** Email CSH SPA form to csh.spareferrals@nhs.net

**ASPH SAMS consultant telephone advice**

* ASPH SAMS consultant available for telephone advice Monday to Friday 8am – 4pm
* Consultant Connect Monday to Friday 8am – 4pm

**Telephone ASPH SAMS consultant**

**How?** Phone ASPH SAMS consultant on 0750009941 or

Consultant Connect via practice number

**Patient requires urgent assessment within 24 hours, but does not need admission to hospital**

**Requires medical review only**

**Requires MDT support to stay at home**

**Refer to Urgent Community Response service**

**How?** Phone the clinical coordinator on 0300 303 4741

**Urgent Community Response service**

* MDT assessment and support at home within 2 hours
* Monday – Friday 8am – 6pm, Weekends 8am – 4pm

**Refer to Community beds in Woking or Walton hospital**

**How?** Phone the clinical coordinator on 0300 303 4741

**Requires 24 hour care**

**Community rehabilitation beds**

* Inpatient rehabilitation units
* MDTs with geriatrician, community services and social care

**Patient is acutely unwell and requires acute hospital for assessment and treatment and possibly acute hospital bed**

**ASPH/CSH Frailty Liaison service:**

* MDT providing CGA, and links with community services and rehab beds
* Fast track CGA on the Acute Frailty Unit if beds available

**Refer via consultant connect for review by Frailty Liaison Team in ED or AECU (Ambulatory emergency care unit)**

**How?** If medical emergency (e.g. stroke, chest pain), refer through usual route. Alternatively, refer to frailty team for advice or admission on **07500099414 Monday-Friday 8-4pm**

**For advice, please contact:**

**Community frailty services: Clinical coordinator on 0300 303 4741**

**ASPH frailty services: SAMS consultant on 07500099414 or via Consultant connect**