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Integrated Frailty Services

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South Warwickshire University Foundation Trust

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Why?

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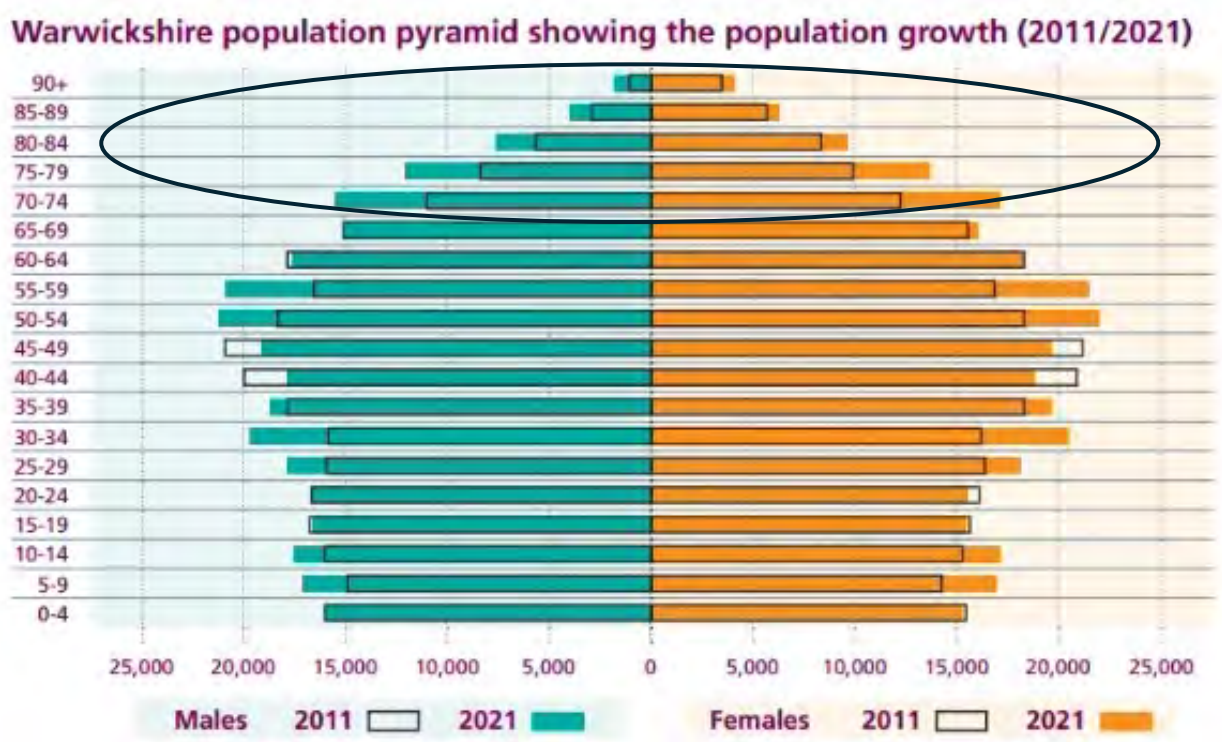
- 47% of SWFT's medical admissions are patients aged 75+, with 63.5% of all bed days in hospital deriving from this cohort
- Caring for a group of older people at home can improve patient outcomes, while reducing pressures on hospitals
- Therefore, SWFT embed **Right Patient, Right Bed, Right Time** in all we do



N.B the above is census data therefore not captured from 2024

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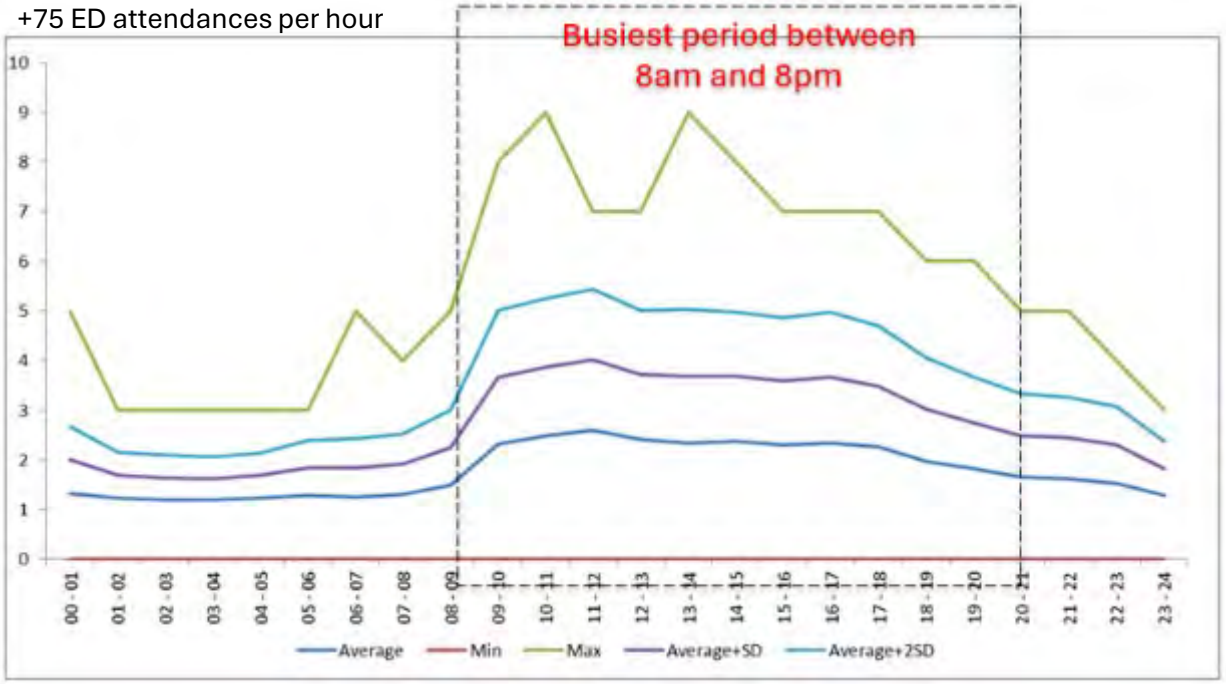
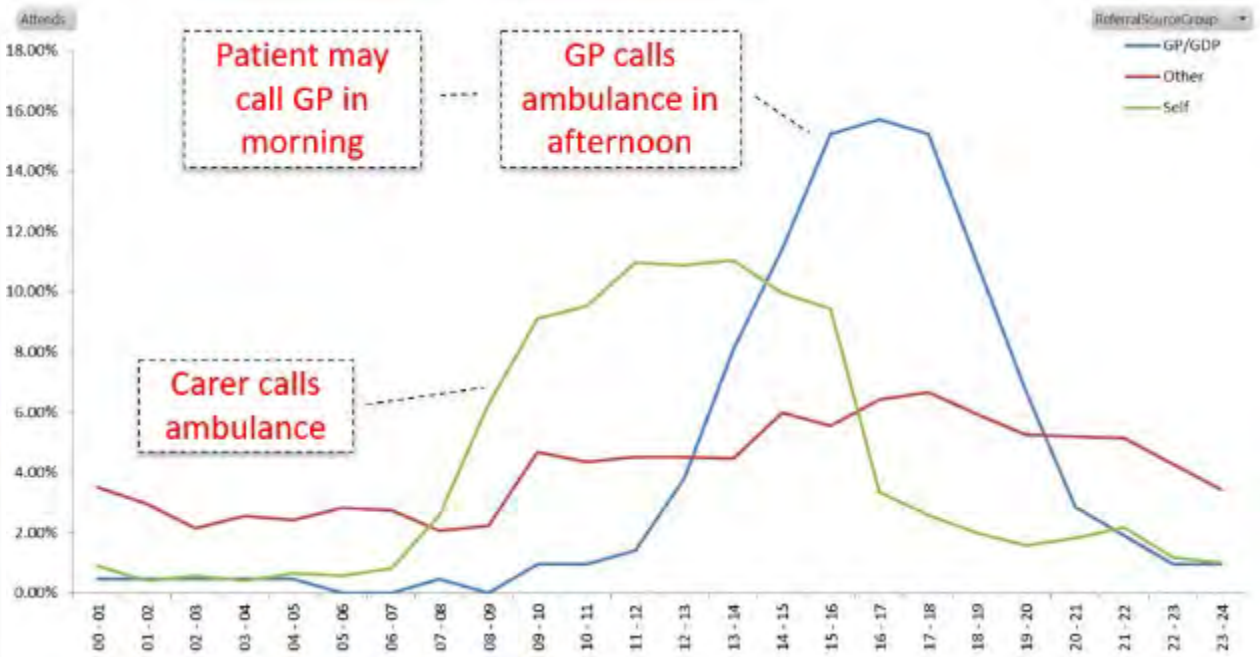
Why?

- SWFT identified the busiest ED attendance time for those aged +75 was between 8am-8pm
- Data highlighted that ambulance conveyance time for this demographic was also predominantly within this timeframe (as detailed on following slide)

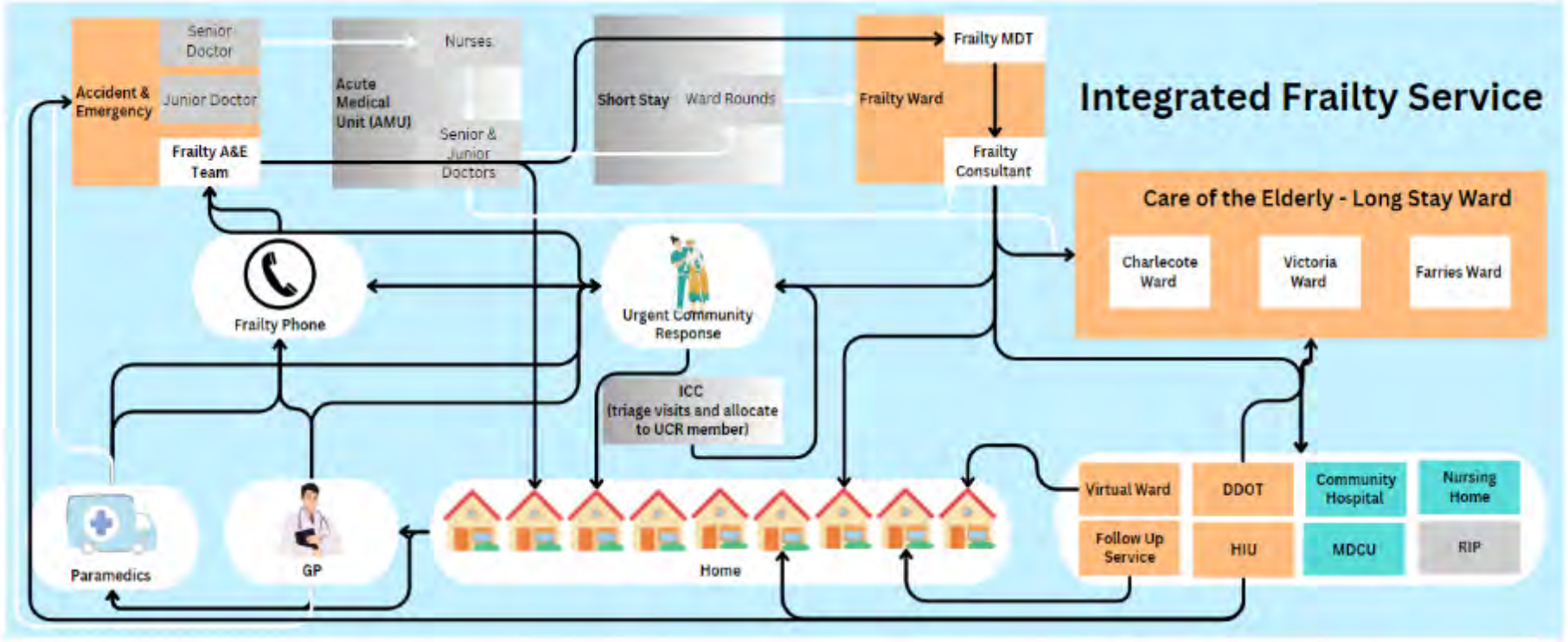
+75 ED attendances per hour



+75 ambulance convevance



How?



(Black arrows detail integrated process. White arrows detail process prior to integration)

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SWFT developed:

- WhatsApp Advice and Guidance (2018)
- Frailty assessment area (2018)
- Frailty phone & Call before convey initiative via Consultant Connect (2020)
- Virtual Wards (2021)
- + 75 discharge follow-up service (2022)
- Medical Day Case Unit (MDCU) (2022)
- Dementia and Delirium Outreach Team (DDOT) (2023)
- Care Home pathway (2024)

How has this service improved patient care?

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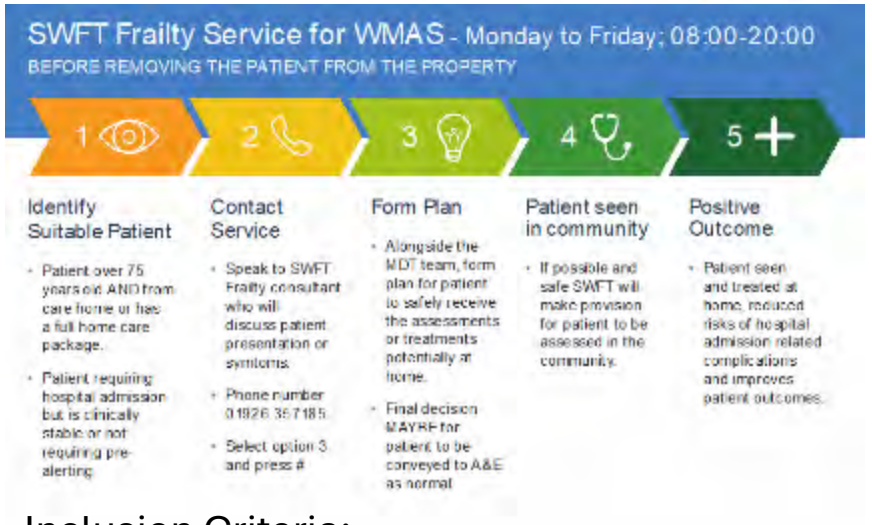
Claire (Paramedic)

Video



Inclusion Criteria:

- Over 75 years
- Under 74 from a care home or has full care package
- Range of stable conditions and presentations
- South Warwickshire GP

Exclusion Criteria:

- Clinically unstable or requires pre-alert into nearest ED

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Frailty Virtual Ward

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Presenting Complaint:

Fall, long lie

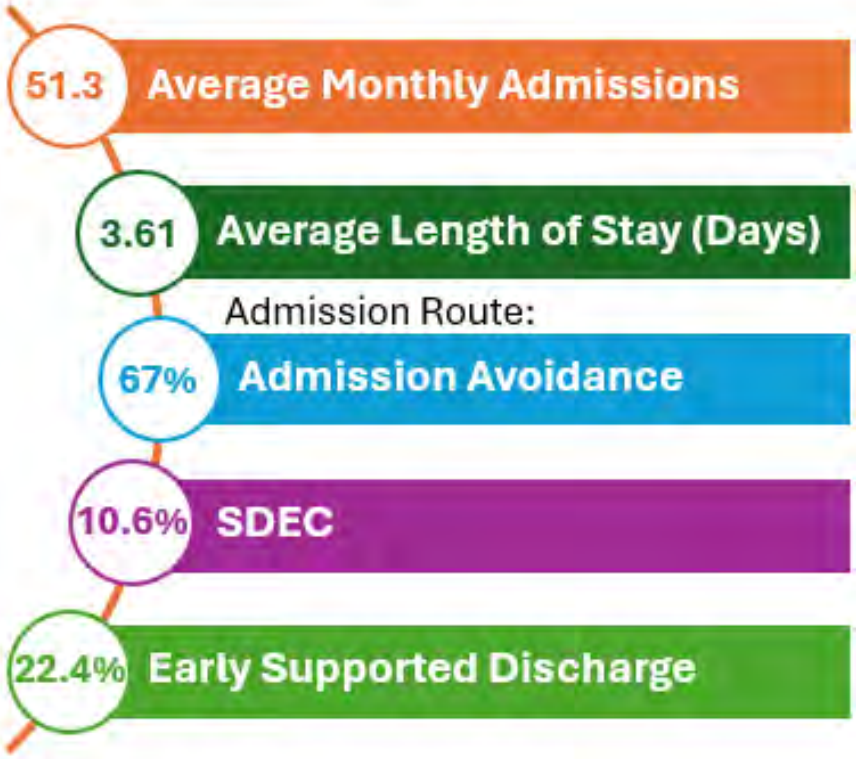
History of Presenting Complaint:

Patient 'woke from a nightmare, got out of bed tripped'. Wife discovered 2200hrs, unable to get up, would not allow wife to call ambulance service, laid on floor throughout the night

Outcome:

The patient was visited by UCR and admitted to the Virtual Ward. This resulted in admission avoidance, acute care within the patients home and a 4 day LOS on the VW.

ED avoidance saved £785 in ED fees alone.



+75 Follow Up Service

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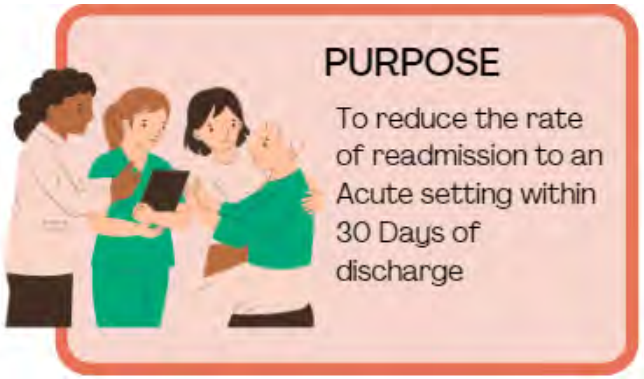

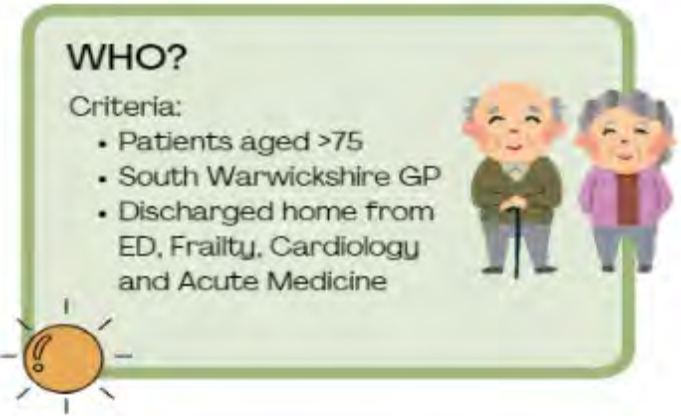

Faye

Faye attended ED having fallen at home → Faye was discharged, and Discharge Nurses (DNs) were suggested to make a home visit by an ACP → Faye was seen at home, DNs removed medications and returned to Faye's usual pharmacist → DNs contacted Faye's Son whilst still with Faye and discussed 'moving on' options

Outcome:

The patient was supported at home by +75 discharge nurses who ensured medication management was correct, therefore safer for the patient. The patient and family was not coping, providing the Discharge Nurses opportunity to discuss next steps.

By supporting the patient and family at home, readmission was avoided

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Benefits

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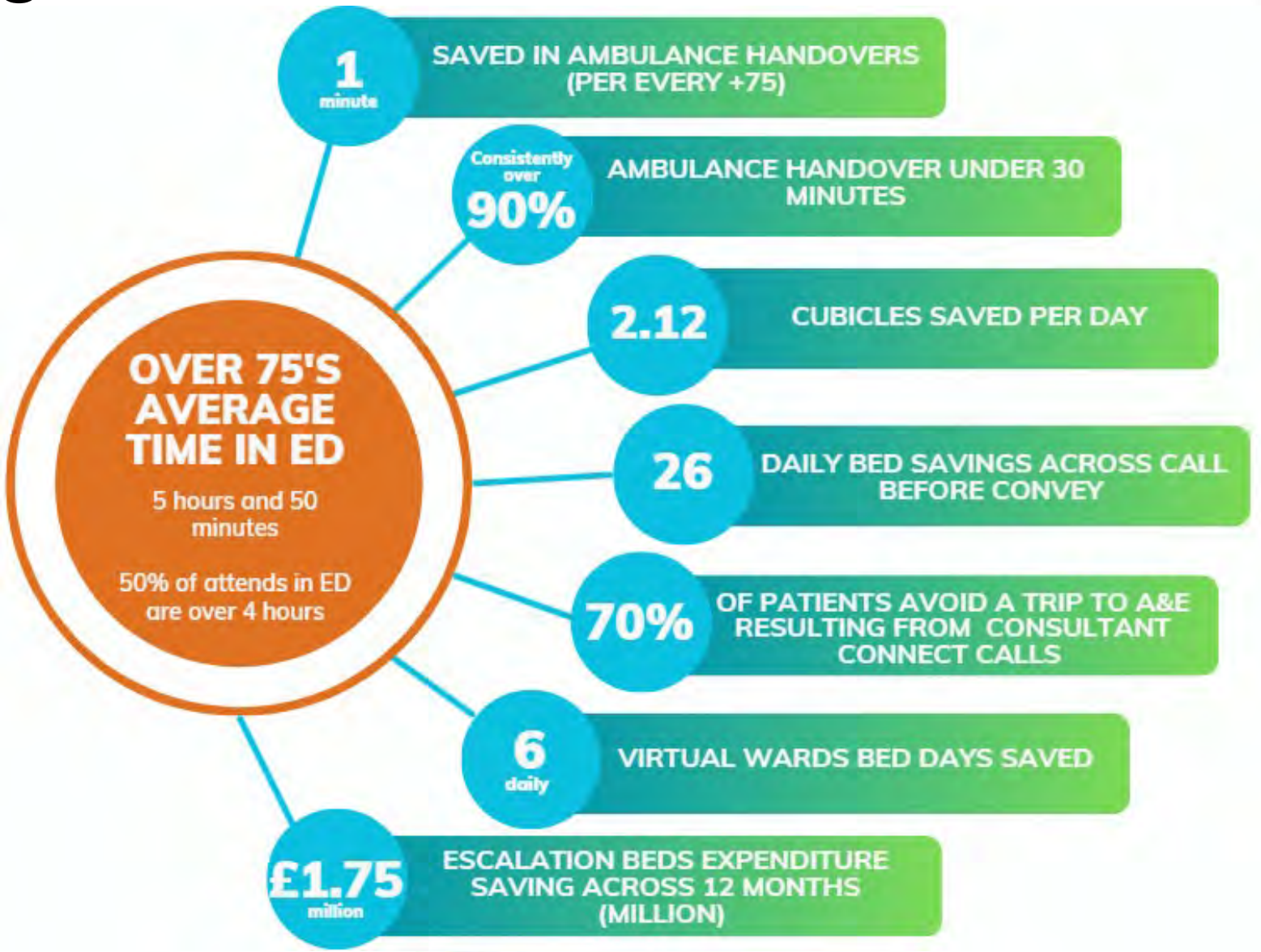

Outcomes - SWFT ED Attendance and Performance

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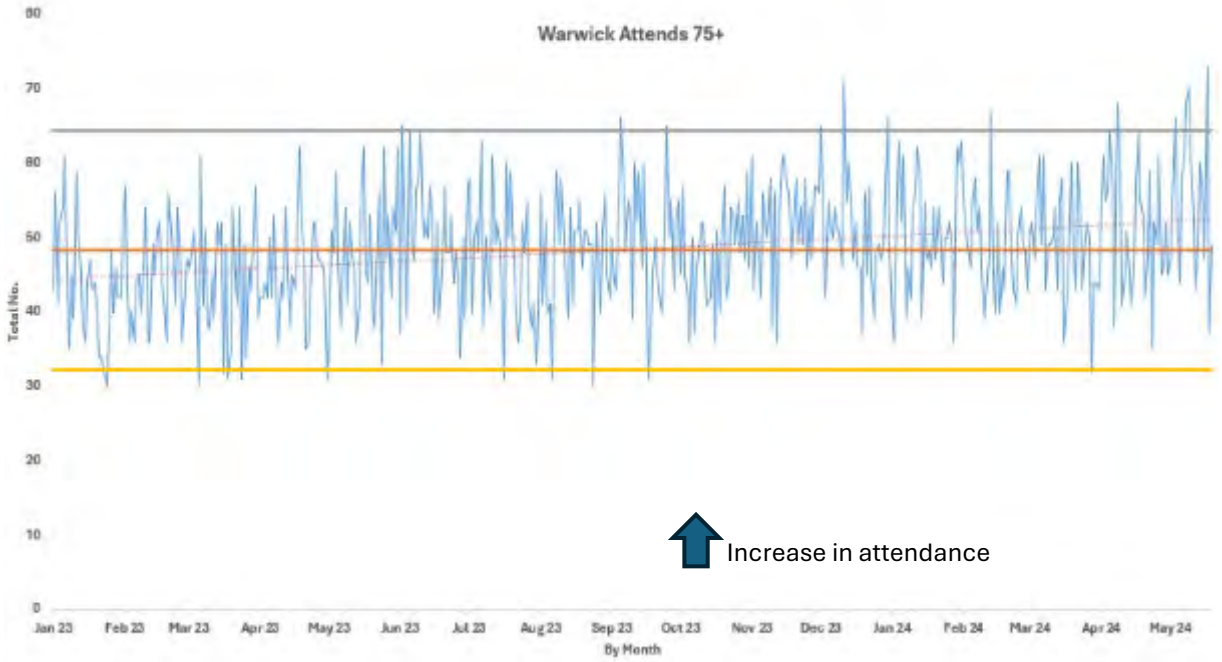

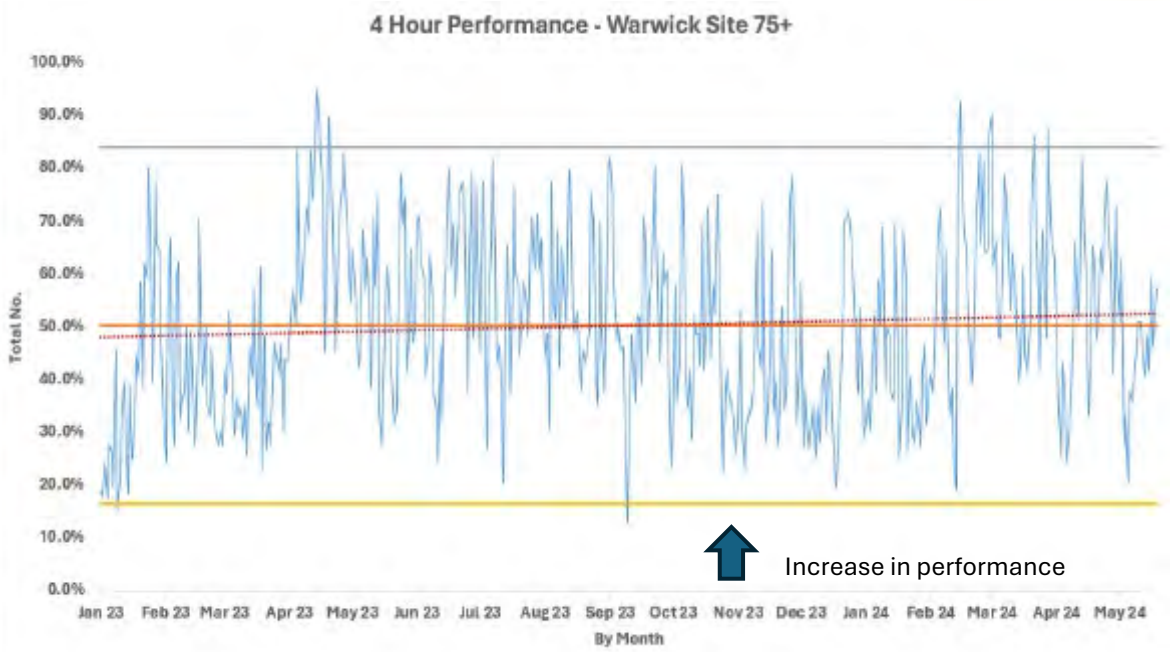

- +75 attendances at SWFT has consistently grown since 2023
- Despite the increase in attendance, +75 has seen an increase of 4-hour performance within ED

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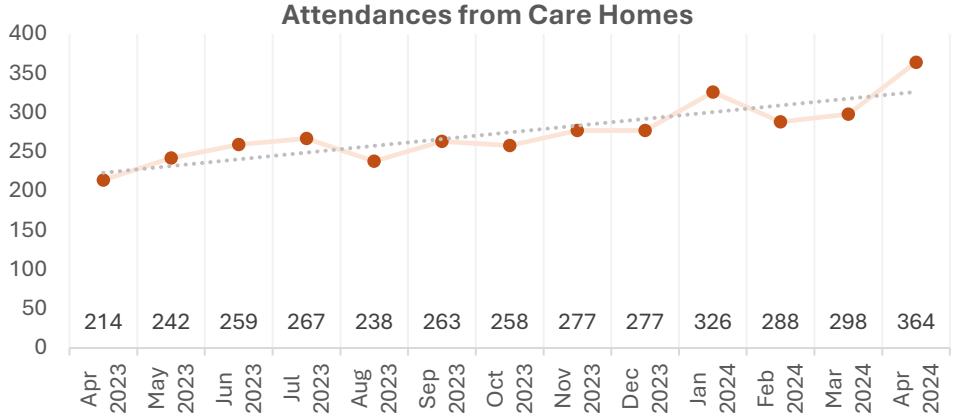
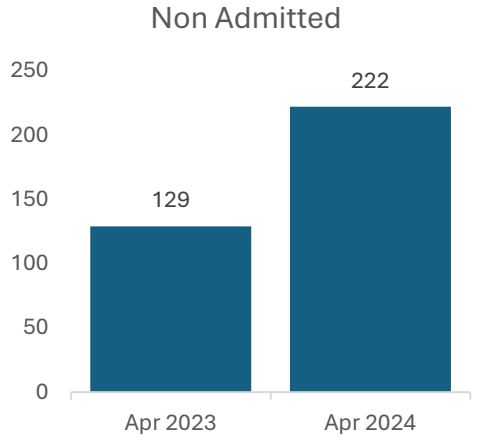
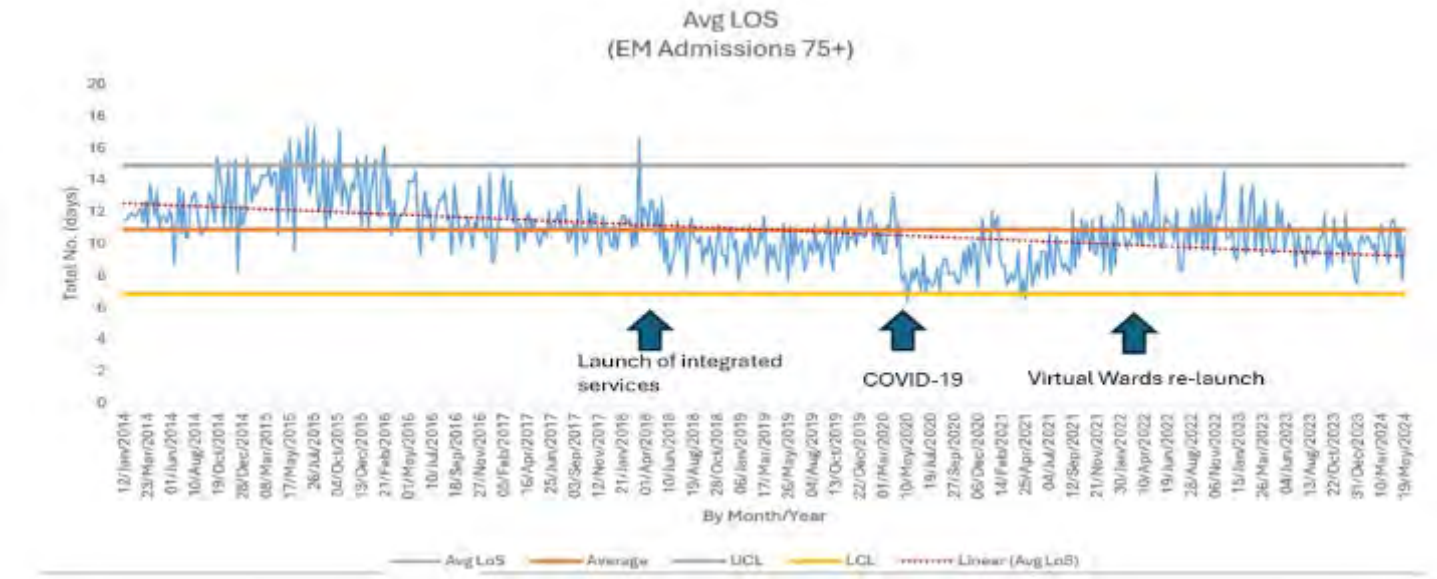
ED Care Homes Attendance & LOS







- There was an increase of 72% for care home attendances, however SWFT turned this around to ensure patients were not admitted as this is in the patients' best interest

- In 2014, the average LOS was consistently over 10 days
- Since 2023, the average LOS has reduced to roughly 7days

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Liv and Paula, two community musicians, paid a visit to Victoria Ward at Warwick Hospital to perform music for our patients.